Project Report

An Evaluation and Manual Composition of the Cognitive Behavioural Therapy
Home and Community-Based Services

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Date: March 2017

CAUTION
This report was completed as part of a supervised student placement. It should not be placed on any official file, nor would it be appropriate to discuss its findings in official agency reports.

Honours Bachelor of Behavioural Psychology

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Abstract

Cognitive Behaviour Therapy is a well-established treatment for a wide range of clinical and psychological disorders (Farmer and Chapman, 2016). This applied thesis project has two separate components. The first component is designed to evaluate the current home and community-based CBT services at the Ottawa Institute of Cognitive Behaviour Therapy (OICBT). The project addresses current inputs, outputs, activities, and outcomes the program offers. The second goal of this project was to develop a manual for the Home and Community Program to include current practices and findings. The manual was designed to assist therapists and staff in conducting CBT procedures outside of the traditional office setting. Overall the evaluation component indicated that the program would benefit from using an evaluation method used to track client progression such as the Personal Planning Tool (PPT) created by Webster and Hadwin (2015). The results also indicated that without formal assessment of the manual it is unclear whether the manual will be effective in the what it is intended for. This being said, it is still suggested that providing clear expectations in a formalized manual will benefit therapists working within the Home and Community Program at OICBT.
Acknowledgements

I would like to acknowledge all of my professors for helping me complete the last 4 years of this program. Without you motivating me along the way, I probably would have not made it this far. I would also like to acknowledge all my fellow classmates for their hard work and dedication, and for putting in the effort in every presentation, group assignment, and classroom activity. Lastly I would like to acknowledge both my college and agency supervisors. You all have helped me grow in my chosen profession and provided with the feedback I needed in order to improve and build on all my skills.
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Chapter I: Introduction

Cognitive Behavioural Therapy (CBT) has become well known for its success in the treatment of a wide variety of psychological conditions including but not limited to: anxiety disorders, major depressive and other mood disorders, personality disorders, as well as eating and sleeping disorders (Farmer & Chapman, 2016). CBT combines the use of behavioural interventions, which address the environmental and physical factors related to psychological conditions, with cognitive therapeutic strategies to help improve emotions and underlying cognitions influencing an individual’s behaviour (Farmer & Chapman, 2016). Two long but clear sentences. Is it possible to shorten them?

There are multitudes of contributing variables which can influence the effectiveness of CBT. Some controlling factors include session length, number of sessions, intensity of therapy and environmental conditions (Federici, Rowa, and Antony, 2010). Some studies have suggested that there is no statistically significant advantage to completing office-based therapy versus therapy provided in-home or community-based; and some individuals have displayed little be consistent; in-home, community-based, in-office success during traditional in-office therapy. It is opined that often a naturalistic environment is beneficial and clients are more likely to successfully progress (Federici, Rowa, & Antony, 2010). According to Pizzi et al. (2014), home and community-based care is also a very cost effective form of treatment. This intervention modality tends to be more intensive and can be offered at home, in a fewer number of visits with efficacious results. It is also a lower cost treatment (Pizzi et al., 2014). Therefore, community-based programs can benefit low-income individuals or those who are unemployed, who may not otherwise seek health care services due to financial concerns (Leviton and Raczynski, 2004). This is true to some degree in Canada, but likely applies more to countries where there is no universal health care. You may wish to clarify this. Overall, home and community-based care can provide effective results for the treatment of specific psychological disorders in a timely, cost-efficient manner.

The Ottawa Institute of Cognitive Behaviour Therapy (OICBT) uses a variety of therapeutic techniques in the treatment of a wide range of disorders (The Ottawa Institute of Cognitive Behaviour Therapy, 2016). The Home and Community-based Program provided at OICBT works toward treating a range of disorders. These include obsessive-compulsive disorder, anxiety disorders such as generalized anxiety disorder (GAD) and social anxiety, and major depressive disorder (The Ottawa Institute of Cognitive Behaviour Therapy, 2016). This sentence is a bit awkward so I have suggested some changes. Techniques commonly used by OICBT, specifically in the Home and Community-based Program are behavioural activation, exposure, cognitive restructuring, as well as a range of others (Ottawa Institute of Cognitive Behaviour Therapy, 2016). All the above strategies are used to help reduce symptoms associated with specific psychological disorders (Ottawa Institute of Cognitive Behaviour Therapy, 2016).

The purpose of this research project was to evaluate the effectiveness of the Ottawa Institute of Cognitive Behavioural Therapy Home and Community-Based Program in. Program evaluation involved reviewing existing protocols and organization procedures, reviewing the literature on practices used, and making recommendations. This included determining the most effective ways to evaluate the success of the program as a whole. After completing and evaluating all the elements of the Home and Community-Based Program, the results are formally displayed in a program matrix or logic model.

The final component of this project was the formalization of all necessary information
gathered in the form of a clinical manual for the Ottawa Institute of Cognitive Behavioural Therapy’s Home and Community-Based Program. The manual consists of specific sections determined by the chosen exemplar clinical model of best practice. Sections include: General Program Information, Fees and Services, CBT with Specific Disorders, Policies and Procedures, Financial Form Templates, Intake Assessments, Treatment Planning, Psycho-education Materials, Psychological Testing Measures by Disorder, etc. The manual consists of material provided by the agency and agency documents, as well as recommended changes or additions, supported by the literature. This manual is a valuable resource for mental health practitioners working within the community, and for new employees to this field. It can also be used to further educate the client about the program and to inform the treatment provided.

It is hypothesized that the combination of a program evaluation for the Home and Community-Based Services provided at OICBT and the introduction of a formalized manual will prove to be a beneficial source of information for both the agency and those seeking services at OICBT.

Chapter II: Literature Review

Psychological Disorders Commonly Treated Using CBT

Obsessive-compulsive disorder (OCD) affects an estimated 2% to 3% of adults over the course of their lifespan (Ruscio, Stein, Chiu, and Kessler, 2010). According to the DSM-5, OCD can be expressed in either obsessive or compulsive behaviour, with the majority of those diagnosed with OCD exhibiting symptoms within both domains (DSM-5; American Psychiatric Association, 2013). Common features of OCD include obsessions which are often referred to as intrusive thoughts, or urges that cause increased levels of anxiety (American Psychiatric Association, 2013). Common obsessions include fears of contamination (fear or germs or illness), harming fears (intrusive thoughts of harming self or others), symmetry obsessions (need to have things perfectly orderly or arranged), somatic obsessions (obsessing about bodily functioning and appearance), and unwanted imagery (usually unwanted thoughts of a sexual nature) (Worden and Tolin, 2014). Another common feature of OCD is having maladaptive beliefs such as being able to control thoughts, perfectionism, overestimating threat and inflated responsibility for the harm of others (Worden and Tolin, 2014). Another defining feature of OCD is the presence of compulsions, or the need to engage in particular compensatory behaviours to avoid distress and anxiety associated with an obsession (American Psychiatric Association, 2013). Compulsive Behaviours include checking, excessive cleaning or washing, repeating, having specific mental rituals, ordering or arranging, passive avoidance or avoiding triggers for compulsions (American Psychiatric Association, 2013). These are the most common behaviours expressed by those with a diagnosis of OCD (American Psychiatric Association, 2013).

Generalized Anxiety Disorder (GAD) is a chronic disorder described as having excessive worry and having difficulty trying to control worry, which causes significant distress and impairment in the individual’s daily functioning (Ritter, Blackmore, and Heimberg, 2010). The worrying must be persistent for a minimum of a 6-month period, and worry is usually associated with a global and diverse range of activities or events (Ritter, Blackmore, and Heimberg, 2010). Worry is typically accompanied by a variety of physiological symptoms, such as increased heart rate, sweating, slow breathing etc., (Ritter, Blackmore, and Heimberg, 2010). Generalized Anxiety Disorder is one of many disorders commonly treated using the principles of CBT (Ritter, Blackmore, and Heimberg, 2016).
Cognitive Behaviour Therapy is also an effective treatment for those with social anxiety or social phobia (Wensel, 2011). Social Phobia is described as having excessive distress in social situations as a result of fear of being negatively evaluated (Wenzel, 2011). Features include intense anxiety when exposed to fear, excessive fear in social situations, avoidance of situations to avoid an anxiety response and remarkable distress as a result of symptoms (Wenzel, 2011). Social Anxiety can severely impact one’s daily functioning and is often associated with lower life satisfaction (Wenzel, 2011).

CBT is also an empirically validated treatment in intervention with those with depressive disorders. Major depressive disorder (MDD) is characterized as persistent depressed mood, difficulty concentrating, decreased pleasure and interest in activities, change in weight or appetite, sleep issues, fatigue, and suicidal thoughts or ideation (Simon, 2016; American Psychiatric Association, 2013). According to the DSM-5 (2013), a minimum five of the above symptoms must be present for at least a 2-week period. Persistent depressive disorder is another mood disorder, which is described as having at least 2 of the above symptoms associated with MDD, in combination with irritability and depressed mood for more days than not (Simon, 2016; American Psychiatric Association, 2013). CBT treatments have displayed success in the treatment of both of the described mood disorders (Simon, 2016). Overall, CBT practices are frequently used for disorders such as obsessive-compulsive disorders, generalized anxiety disorders, social phobias, and depression, as well as a variety of other disorders.

**CBT and Procedures**

Over the past four decades Cognitive-Behavioural Therapy (CBT) has been used to improve mental and physical health for a wide variety of client populations, and has become more popular (Lovell & Richards, 2000). CBT has been proven to be an effective treatment for many psychological disorders (including all of the aforementioned) (Farmer & Chapman, 2016). CBT has been recognized as a form of best practice and evidence-based treatment (Wenzel, Dobson, and Hayes, 2016). CBT is comprised of three main components addressing maladaptive behaviour, challenging automatic thoughts and underlying beliefs and incorporating relapse prevention strategies (Wenzel, Dobson, and Hayes, 2016). Some popular and effective techniques incorporated into CBT include: problem-solving, exposure, behavioural activation, cognitive restructuring, relapse prevention etc., (Wenzel, Dobson, and Hayes, 2016). The following literature describes some of the main procedures of CBT and distinct techniques and interventions for each component.

**Exposure Therapy**

Exposure Therapy is a component of CBT that is widely used for the treatment of obsessive-compulsive (OCD) and anxiety disorders (Stewart et al., 2016). The purpose of exposure therapy is to introduce clients to anxiety provoking situations eliciting fear, reducing safety behaviours and avoidance of these situations. The aim is a decrease in anxiety symptoms across trials (Stewart et al., 2016). When considering the use of exposure plus response prevention (ERP) in the treatment of OCD, the goal is to expose the patient to an intrusive thought, fear, or overestimated event repeatedly until the person habituates to the situation (Whittal and McLean, 2000). Stewart et al., (2016), completed a study which surveyed 65 clinicians on their use of exposure based treatments of OCD and anxiety disorders. The results indicated that a significant proportion of clinicians indicated using exposure therapy with both
patients with anxiety and OCD (Stewart et al., 2016). Another form of exposure therapy is titled Interoceptive Exposure (IE). IE is a commonly utilized intervention for panic-based disorders and has assisted in the treatment of PTSD, phobia disorders, and Generalized Anxiety Disorders (GAD is a distinct diagnosis) (Boettcher, Brake, and Barlow, 2016). IE is a specific type of exposure which reduces anxiety sensitivity by exposing the person to anxiety-provoking physiological sensations (Boettcher, Brake, and Barlow, 2016). Researchers Dixon, Kemp, Farrell, Blakey and Deacon (2015) investigated the effectiveness of IE on individual with social anxiety, specifically a fear of others witnessing them blushing, sweating or experiencing another physical reaction to their anxiety. Participants engaged in activities such as slow breathing, push-ups, drinking hot drinks or eating hot sauce, to purposefully induce somatic sensations (Dixon et al., 2015). The results of this study indicated the high levels of anxiety and sensations were experienced within the interoceptive exposure tasks. However, further research is required to determine how effective this method is in the treatment of social anxiety disorders (Dixon et al., 2015). Other researchers have examined the use of IE in the treatment of heightened anxiety sensitivity (AS) within a group of 120 participants (Deacon, Kemp, Dixon, Sy, Farell, and Zhang, 2013). The results displayed significant reductions in AS among all individuals who participated in the study, and therefore suggest that IE is an effective component in the treatment of anxiety disorders (Deacon et al., 2013). Moreover, there is another form of exposure commonly used in the treatment of PTSD referred to as Prolonged Imaginal Exposure and Virtual Reality Exposure (VRE) (Reger et al., 2016). I believe this is the first citation, which means the authors should all be listed Imaginal exposure is a technique that exposes the individual to the traumatic event by recalling the memory in the form of imagery (Reger et al., 2016). VRE is an advanced form of exposure that uses computer programmed virtual reality to place the person in a computerized representation of the fearful situation (Reger et al., 2016). Regel et al. (2016) conducted a study which examined the use of the prolonged imaginal exposure versus VRE in the treatment of PTSD symptoms. One hundred and sixty-two active duty soldiers with PTSD were involved in the study. The findings suggest that both prolonged imaginal exposure and VRE were effective and reliable methods in reducing PTSD symptoms for the majority of participants. All of these aforementioned research studies suggest that different forms of exposure are proven to be evidence-based treatments for a range of psychological disorders and are important components of Cognitive-Behavioural Therapy.

**Behavioural Activation**

Behavioural activation is another element in CBT. The purpose of this approach is to increase rewarding experiences in order to activate and motivate clients to engage in treatment (Ross et al., 2016). Researchers have examined the use of Behavioural Activation Treatment for Depression (BATD) in comparison with Supportive Counselling (SC) with 46 participants experiencing depressive symptoms (Collado, Calderón, MacPherson, & Lejuez, 2016). BATD proved to be superior to SC in reducing depressive symptoms and demonstrated higher remission rates compared to SC, indicating that BATD is an effective component of CBT in the treatment of depression Was the difference significant? (Collado, Calderón, MacPherson, & Lejuez, 2016). Multiple studies have displayed positive outcomes when using Behavioural Activation (BA) in the treatment of adult depression. A meta-analysis, which compared the results of 34 studies using BA to treat major depressive disorder in adults, supports the use of BA to address depressive symptoms (Mazzucchelli, Kane, & Rees, 2009). There is evidence to suggest that BA yields similar results to that of Cognitive-based Therapies (Mazzucchelli, Kane, & Rees, 2009).
In another research experiment conducted by McIndoo, File, Preddy, Clark, and Hopko (2015) researchers compared the use of mindfulness-based therapy (MBT) and BA in the treatment of depression for a group of 50 college students. The major findings of this study indicate that both MBT and BA are effective in reducing depressive symptoms, with roughly 56-76% of all students displaying significant improvements (McIndoo et al., 2015). Overall, the research suggests that BA and MBT are effective treatments for depression. Randomized trials assess the effectiveness of BA strategies in improving depressive symptoms in a group of breast cancer patients (Ryba, Lejuez, and Hopko, 2014). This was a nice clear description of participants. Twenty-three women with clinical diagnoses of major depression participated in this study. The BATD involved increased levels of activity, activity monitoring and a hierarchy of difficult activities, in which each patient was required to progressively master each item on the hierarchy of activities (Ryba, Lejuez, and Hopko, 2014). The results of this study indicated higher levels of activity completion were associated with a reduction in depressive symptoms (Ryba, Lejuez, and Hopko, 2014). Therefore, the findings indicate a positive link to symptom reductions after engaging in BA procedures. Behavioural Activation plays an invaluable role in the intervention and treatment for those with mood disorders.

Cognitive Restructuring

One of the key features of CBT is having clients address their maladaptive thought processes and reviewing the effects on emotions and behaviours. Cognitive restructuring is a key element to help clients address irrational or negative thinking (Beck & Beck, 2011). There are several strategies to address maladaptive thinking patterns (Arch & Craske, 2008). These techniques include: deconstructing thoughts by considering evidence for and against, determining cognitive distortions or thinking errors and developing more positive alternative thoughts; all of which to evaluate consequent changes in moods (Arch & Craske, 2008). Whittal and McLean (2000) note there are many components of CBT used to addressing thought processes. When considering the thought process of individuals with OCD, it may be necessary to challenge cognitive appraisals such as overestimations of danger. Also, normalizing intrusive thoughts is an important component to treatment (Whittal and MacLean, 2000). In a study conducted by Larsson, Hooper, Osborne, Bennett, and McHugh (2015) researchers evaluated Cognitive Restructuring on 47 clients. The results indicated that they experienced positive improvements on abating negative thoughts and thought discomfort. Understanding ones maladaptive thought processes and the impact on affective states is a crucial component of CBT intervention.

CBT Thought Records

Thoughts records are a CBT tool used to assist clients in identifying and addressing negative thought patterns or beliefs (Persons, Davidson, and Tompkins, 2001). According to the authors this specific strategy is used to change automatic thoughts that contribute to maladaptive behaviours and coping mechanisms. The thought record is divided into sections (Persons, Davidson, and Tompkins, 2001). The sections include the situation (the external event eliciting automatic thoughts), mood (moods experienced during situation), automatic thoughts (thoughts occurring during situation), evidence that supports the thought, evidence that does not support the thought, alternative thoughts, and emotion and feeling (feelings about the situation now in the present moment) (Persons, Davidson, and Tompkins, 2001). In a study conducted by McManus, Van Doorn, and Yield in 2012, which examined the effects of using thought records and
behavioural experiments to improve thought patterns showed promising results. Findings indicated that using both thought records in combination with behavioural experiments proved to have positive results on belief change, and a reduction in anxious belief ratings (McManus, Van Doorn, and Yield, 2012). Overall thought records are a frequently used and well-established CBT treatment strategy and prove to have positive change on maladaptive thought patterns (McManus, Van Doorn, and Yield, 2012).

Relapse Prevention

Relapse Prevention is a component of CBT that involves teaching the client strategies and coping skills to prevent relapse of symptomatology (Wenzel, Dobson, and Hayes, 2016). Relapse may be defined as the return or onset of symptoms after temporary improvement and before the remission of a mental illness (Wenzel, Dobson, and Hayes, 2016). Recurrence is defined as the reappearance after being in remission for a period of time (Wenzel, Dobson, & Hayes, 2016). There are multiple components incorporated into relapse prevention to be considered effective (Wenzel, Dobson and Hayes, 2016). The main strategy used in relapse prevention is creating a relapse prevention plan. This acts to detail the warning signs, coping tools, social support, indication/methods of contacting a mental health care professional (and contact information). Each category is individually tailored to each client’s specific triggers and needs (Wenzel, Dobson & Hayes, 2016). Wenzel et al. (2016), suggest relapse prevention is an important component of CBT and is important to aid in long-term results.

In summary, Cognitive Behavioural Therapy is a well developed, empirically validated treatment for a number of psychological disorders. The theoretical orientation is posited on the hypothesis that one’s maladaptive thoughts assist in the creation of consequent aversive mood states and influence behaviours. The utilization of cognitive interventions and restructuring; paired with behavioural activation and social experiments assist in challenging clients to understand their experience and alter their perception. The research suggests that this facilitates in a reduction of a variety of symptoms and psychological distress, particularly for those with anxiety and depressive-based symptomatology.

Psychological Assessment

Psychological testing and diagnostics are considered an invaluable source of information, and are also considered to be an evaluative device for treatment efficacy and outcomes (Hogan & Tsushima, 2016). Researchers Hogan and Tsushima (2016) noted that psychological assessment can be conceptualized as encompassing records, interviews, psychometrics, medical tests, and more. However, certain types of assessment measures (e.g. collateral data obtained from interviews with family members) may not be considered to be as valid and as reliable as other testing measures due to lack of standardization in administration. When considering the use of psychological testing measures it is important that the tests consist of the main psychometric principles. They should have been proven to be reliable, validated (both internal and external validity), culturally appropriate and standardized (Hogan & Tsushima, 2016). Validity refers to the extent the test measures what it is supposed to measure (Hogan & Tsushima, 2016). Reliability refers to the ability to test consistently across time and participants to ensure that research studies can be replicated (Hogan & Tsushima, 2016). ‘Fairness’ is a newly established principle, which describes the validity of the test in comparison to all individuals, meaning that the test is equally fair and unbiased for all individuals taking the test (Hogan & Tsushima, 2016).
This is particularly important when discussing cultural appropriateness of psychometrics. Lastly, normative data is plural (norms) considers whether the test and results are reflective of a standard and normal distribution (Hogan & Tsushima, 2016). Researchers Hogan and Tsushima (2016) noted that there are a few key sources used to help determine whether a test is reflective of these psychometric principles. Testing manuals consistently refer to Standards, the Buros Mental Measurements Yearbooks (Carlson, Geisinger, & Jonson, 2014), the Ethical Principles of Psychologists and Code of Conduct created by the American Psychological Association in 2010, the Education Testing Service (2015), and lastly, PsycTESTS, an online database used to determine the effectiveness of specific psychological tests (Hogan & Tsushima, 2016).

Psychometrics are an integral part of the assessment, case conceptualization and evaluation of client progress.

The Patient Health Questionnaire for Depression

The Patient Health Questionnaire for Depression (PHQ-9, Spitzer, Williams, & Kroene) is a frequently used assessment to screen for depression and determine the severity of symptoms (Hinz et al., 2016). The instrument consists of a 9-item questionnaire, with four possible responses (Hinz et al., 2016). Responses can very from 0 - not at all, 1 - several days, 2 - more than half of the days, and 3 - nearly every day (Hinz et al., 2016). Scores can range anywhere from 0 to 27 to indicate the severity of the depression (Hinz et al., 2016). The results suggest (?) that those who score between 5-10 can be categorized as having mild depression; 10-15 suggest moderate levels of depression, and scores greater than 15 indicate severe depression levels (Hinz et al., 2016). Many studies using the PHQ-9 have shown this measure to be a valid assessment source (Hinz et al., 2016). Hinz and colleagues completed a study to test the performance of the PHQ-9 in determining depression severity of a group of 2,059 cancer patients in comparison to the general population of 2,693 people. The research study suggests the test was proven to demonstrate solid reliability according to standards and performs efficiently in testing depression. The one dimensional-scale should not be used to formulate a formal clinical diagnosis without further consultation with a specialist (Hinz et al., 2016). In a test review completed by Kroenke, Spitzer, and Wiliams (2009), they noted that the PHQ-9 displayed sufficient internal and test-retest reliability. There was also evidence to support both criterion and construct reliability of test results. Overall, the Patient Health Questionnaire demonstrates success in screening for depression severity and monitoring of symptoms.

Overall Anxiety Severity and Impairment Scale (OASIS)

Another common assessment psychometric utilized within clinical settings is the Overall Anxiety Severity and Impairment Scale (OASIS) (Norman, Hami-Cissell, Means-Christensen, & Stein, 2006). The OASIS is a self-report questionnaire that consists of five items used to assess severity of multiple different anxiety disorders (Campbell-Sills et al., 2009). Campbell and colleagues (2009) completed a study to determine the validity of the OASIS and assess psychometric properties on a sample of 1036 primary care patients. The results indicated that OASIS scores were positively correlated with anxiety, and scores did not vary depending on each specific anxiety disorder (Campbell-Sills et al., 2009). The results also indicate that the OASIS demonstrates strong validity and reliability (Campbell-Sills et al., 2009). Overall, the study conducted by Campbell-Sills et al., suggests that the OASIS is a useful tool in assessing symptom severity and impairment in relation to anxiety disorder. Another research study
completed by Bragdon, Diefenback, Hannan, and Tolin (2016) examined the psychometric properties of the OASIS among a group of psychiatric outpatients. The sample for this current study consisted of 202 outpatients seeking treatment for a variety of anxiety disorders (Bragdon, Diefenback, Hannan, and Tolin, 2016). The scores for patients with anxiety disorders were much higher than those with no diagnosis of anxiety (Bragdon, Diefenback, Hannan, and Tolin, 2016). The results of this study support previous research findings, by displaying high internal consistency and validity for the use of the OASIS scale (Bragdon, Diefenback, Hannan, and Tolin, 2016).

*Work & Social Adjustment Scale (WSAS)*

Work and Social Adjustment Scale (WSAS) created in 1986, is common assessment measure used to determine how severely impacted a person’s daily life is as a result of his or her current symptoms. The Work and Social Adjustment Scale is a five-item questionnaire (Zahra, Qureshi, Henley et al., 2014). This psychological testing method is a self-report scale with eight response likert scale ranging from ‘not at all’ to ‘very severely’ (Zahra et al., 2014). Zahra et al. (2014) investigated the reliability, sensitivity and value of the WSAS, by using this measure to assess work and social impairment on a group of 4,835 patients. The completion of the item-analysis demonstrated high item-total and item-item correlation, meaning the WSAS has high consistency and internal reliability among all five items (Zahra et al., 2014). The findings of this study also suggest that the WSAS displays high levels of sensitivity for treatment effects (Zahra et al., 2014). In conclusion this study shows the WSAS to be an appropriate method for testing social and work impairment severity (Zahra et al., 2014).

*The Mood Disorders Questionnaire (MDQ)*

The Mood Disorders Questionnaire (MDQ) was created by Hirschfeld and colleagues in 2000. It is a psychological testing measure designed to screen for manic or hypomanic disorders (Massidda, Giovanna Carta, and Altoè, 2016). The questionnaire consists of 13 yes or no questionnaires relevant to DSM-IV criteria for bipolar disorder (Massidda, Giovanna Carta, & Altoè, 2016). In order for a person to screen positive for Bipolar Spectrum disorder, a person must answer yes to a minimum of seven items in question number one, yes to question number two, as well answer moderate or serious to question number three (Hirschfeld et al., 2000). The MDQ should not be used as formal diagnostic tool, and therefore if a person screens positive on the MDQ, a comprehensive psychological and medical evaluation should be completed (Massidda, Giovanna Carta, and Altoè, 2016; Hirschfeld et al., 2000). Boschloo et al. (2013) investigated the long-term reliability in a sample of 2087 participants after two years of follow-up. Researchers wanted to compare the validity of the MDQ against DSM-IV criteria for (hypo) manic episodes (Boschloo et al., 2013). The MDQ proved to have adequate internal consistency, however, the results for long-term test-retest reliability were limited (Boschloo et al., 2013). The results also indicated that the MDQ displays solid validity in determining recent (hypo) manic episodes, but displayed poor performance in relation to the detection of lifetime (hypo) manic episodes (Boschloo et al., 2013). In conclusion the results of this study suggest that the MDQ is an acceptable measure for screening for recent and current (hypo) manic episodes, but lacks ability to predict/or/measure lifetime prevalence rates (Boschloo et al., 2013). Researchers recommended that the MDQ be paired with more reliable psychological testing measures when assessing for pervious long-term manic symptoms, and to refrain from using this method as a formal diagnostic tool (Boschloo, et al., 2013).
**Social Phobia Inventory (SPIN)**

Another psychological testing measure used frequently to assess symptoms of anxiety, specifically social phobia or social anxiety disorder, is the social phobia inventory (SPIN) (Connor et al., 2006). SPIN is a 17-item self-report questionnaire that evaluates symptoms including by not limited to fear and avoidance in relation to specific social situations (Connor et al., 2006). Score can range from 0 to 68, with scores above 19 are considered to be positive screens for social phobia disorder (Connor et al., 2006). Higher scores indicate increased severity of social phobia related symptoms (Connor et al., 2006). Antony, Coons, McCabe, Ashbaugh, and Swinson (2006), wanted to evaluate the psychometric properties of the SPIN. To do so they completed a study examining the result of the SPIN self-report of 251 participants from outpatient units with formal diagnoses of either social phobia, panic disorder, agoraphobia, or obsessive-compulsive disorder (OCD) (Antony et al., 2006). This study displayed similar findings to previous studies, suggesting that the SPIN is both a reliable and valid measure to assess social phobia symptoms (Antony et al., 2006). The SPIN demonstrated good discriminative validity, as individuals’ results differentiated between social phobia and other disorders including OCD (Antony et al., 2006). The results of this study also demonstrated variance in internal consistency among subscales (avoidance, fear, and physiological symptoms). Antony and colleagues (2006) concluded that the SPIN is therefore a suitable method to assess the severity of social phobia disorder.

**Manualized Treatment for Psychological Intervention**

Manualized treatments such as Cognitive Behavioral Therapy are becoming more commonly used as they provide standardized evidenced based practice and intervention (Cox et al., 2013). This approach differs from supportive counselling practices and other less segmented forms of clinical intervention. Researchers have explored clinicians’ views on the use of manualized treatment. The literature suggests that those exposed to treatment manuals often deem them as reliable and helpful to building rapport with clients, as well as for keeping therapy on schedule (Forbat, Black, & Dulgar, 2014). All these variables are key components used in the CBT Home and Community-Based Program, and therefore it is essential to understand how the agency uses these practices and how they are reflected in the literature.

**Ethical Concerns**

Within psychological intervention, ethical decision making and ethical dilemmas are embedded within clinical practice. Mental health care professionals operate under licensed regulated health professions (RHPA). When discussing service delivery within community, and specifically home-based interventions, there are ethical concerns that need to be acknowledged. Home-based psychological intervention does not any subsets within the formalized ethical code. However, Bryant, Lyons, and Wasik (2016) discuss ethical issues in relation to home and community-based services. They suggest that the client’s safety and well-being is the most important variable to consider when delivering home-based services. Within the mandatory reporting requirements, psychologists are obligated to report any suspected child maltreatment or abuse. Within home-based intervention, clinicians are obligated to report child abuse or neglect,
even if witnessed unintentionally during a home consultation (Bryant, Lyons, & Wasik, 2016). Informed consent has to be obtained prior to the implementation of services, to ensure that clients are aware of these requirements prior to home-based intervention.

Another ethical consideration includes maintaining a client-centered approach (Bryant, Lyons, & Wasik, 2016). This may sometimes be difficult during home-based intervention, as others including family members are peripherally involved in treatment. It is important that all clinical decisions are made in the best interest of the client and discerning who your client is prior to the onset of treatment (Bryant, Lyons, Wasik, 2016). Researchers Bryant, Lyons and Wasik (2016) also assert that there may be a need to address the potential for client dependency on the therapist. Due to the intensity of the program and naturalistic environment of the consultations, therapeutic boundaries must be clearly defined and adhered to from the onset. If client dependency is noticed, the therapist may be required to address this with the agency supervisor and client before moving forward with treatment (Bryant, Lyons, Wasik, 2016). For mental health practitioners working in the community and at home with clients, issues with client confidentiality may also arise as a result of the environment. For example, public consultations may be implemented for purposes of exposure tasks. It is important that client confidentiality and therapist expectations are discussed prior to beginning therapy and that clients are making an informed choice and consenting to treatment in this format (Bryant, Lyons, Wasik, 2016). These all need to be considered before delivering services.

Chapter III: Methodology

Consent to Use Company Name and Logo (Appendix A)

This writer obtained consent to use both the organizations name, information and logo (appendix A) for the use of the described thesis project was signed by Dr. Connie Dalton on December 5th, 2016.

Program Evaluation and Logic Model (Appendix B)

A program evaluation of the Ottawa Institute of Cognitive Behaviour Therapy Home and Community Program was completed as a component of the described project. The evaluation was written in the form of a Program Logic Model (adapted from Program Logic Model, University of Arkansas System). The Program Logic Model is separated into different components. It describes the purpose of the program, the program inputs or in other words what the program invests (time, money, facilities etc.), outputs or what the program does, as well as the participants involved. Another section incorporated into the Program Logic Model is a breakdown of short-term and long-term outcomes produced as a result of the program. External factors contributing to program outcomes are considered and reported in the logic model. The final component of the logic model is the evaluation piece, which evaluates the program inputs, outputs and other variables in relation to program outcomes. It also provides feedback and suggestions for program adjustments and changes. This portion suggests an evaluation method for the program.

The main purpose of the Ottawa Institute of Cognitive Behavioural Therapy (OICBT) Home and Community-Based Program is to provide access to empirically-supported mental health services by offering these programs at home and within the community (Ottawa Institute
of Cognitive Behavioural Therapy, 2016). The OICBT provides treatment within the clients’ homes and at their base clinic setting. This permits increased access to services for those who experience treatment barriers that affect the clients’ ability to obtain services in an office-based setting.

There is a large emphasis on client participation and motivation when using CBT, in that clients are asked to practice CBT skills outside of the traditional office setting and instead in their natural environment (Ottawa Institute of Cognitive Behavioural Therapy, 2016). Prevalent issues being addressed may include: reducing compulsions, reduce avoidance of anxiety provoking situations, exposure to feared objects or situations etc. Clients who repeated fail to practice such exercises may require additional therapy outside of the office (Ottawa Institute of Cognitive Behavioural Therapy, 2016). The goal of the OICBT Home and Community-Based CBT Program is help individuals address and engage in specific difficult tasks and situations, by having a behavioural aide working directly with clients in the home and community.

**Inputs**

The OICBT invests time, training and skills to employees and clients. Staff is comprised of behavioural aides (Behaviour Science Technicians), a supervising psychologist and a social worker. Transportation is also required to reach clients within the home and community setting. Funding is required in order to cover cost of staffing, mileage and materials needed for therapy outside of the traditional setting. Required materials such as monitoring forms, assessment measures, homework, among other necessary resources are utilized to help meet each client’s need. Location and space for therapy may be required if additional sessions are necessary within the office setting.

**Activities**

OICBT works toward providing services to individuals with the home and community. To ensure the program is running successfully the program provides intensive training to their employee’s prior to allowing them to work within the community. This includes weekly supervision meetings to discuss on-going cases, and collaborate with other team members to determine the best treatment for each client. Consent, Confidentiality, and Disclosure Procedures are discussed and consent is obtained prior to beginning the delivery of services. Treatment plans are developed and verified under the supervision of Dr. Connie Dalton (C. Psych.).

Psychological intervention is provided to clients within the home and community setting to optimize client progress. The behavioural aide works with the client by implementing CBT strategies proven to be effective with target populations and specific problem behaviours. Such strategies include the use of Exposure Therapy in the treatment of a wide range of problems including: obsessive-compulsive behaviours, anxiety disorders, and specific phobias. Another therapeutic strategy frequently used within the home and community-based setting is behavioural activation in the treatment of depression. Cognitive restructuring is used to help address maladaptive thinking patterns and automatic thought processes within the context of the home and community setting. Relapse Prevention is an essential component of the therapy process, in that it helps to ensure long-term change. Overall the activities used within the home and community are all aimed at helping individual obtain access to Cognitive Behaviour Services within the context of the home and community.
**Clients**

The target population for this service is typically adults, 18 years or older (Ottawa Institute of Cognitive Behavioural Therapy, 2016). Candidates that would be considered appropriate to partake in the OICBT Home and Community-Based Program include those who have a diagnosis of: obsessive-compulsive disorder, mood disorders, depression, eating and sleeping disorders, as well as other anxiety disorders. Clients that would benefit most from this program are those who has displayed little success in the completion of homework exercises and practicing of CBT outside of the office setting or those who have symptoms (e.g. agoraphobia or significant panic that prevents leaving the home or getting into a vehicle) that effect the person’s ability to partake in traditional in-office therapy (Ottawa Institute of Cognitive Behavioural Therapy, 2016). Those with agoraphobia, who have a fear of crowds or small spaces may feel uncomfortable leaving the comfort of their home and being in a closed office space, therefore it may benefit them to obtain services within the community or their place of residence (Ottawa Institute of Cognitive Behavioural Therapy, 2016). Also those with social phobia may find it significantly challenging to be around other people, and CBT such as exposure therapy to stimuli outside of the office may prove to have a more positive impact on the client (Ottawa Institute of Cognitive Behavioural Therapy, 2016).

**Short-Term Outcomes**

Short-Term Outcomes of the providing CBT within the home and community include client improvement by decreasing the severity of psychological distress and symptoms. It also aides in increased improvement in daily functioning such as building more adaptive coping strategies and decrease in impairment in daily living activities. CBT within the home and community will also help to reduce maintenance behaviours and avoidance of anxiety provoking situations. Lastly the home and community program will improve quality of life of individuals partaking in the services provided at OICBT.

**Long-Term Outcomes**

To date, there has been limited research to indicate the long-term benefits of CBT. However, it is important to note possible positive long-term outcomes of the Home and Community Program provided at OICBT. Psychological intervention can lead to overall long-term improvement of relationships with friends, family and loved ones (Horn, 2012). It is also suggested that staff members and as well as clientele will gain knowledge and experience in using CBT procedures, disorder specific information and other relevant principles and practices. It is possible that long-term goals specific to each client’s treatment plan, will be attained over time. Moreover, the maintenance of short-term outcomes such as: symptom reduction (Schmidt, McCrae, Trakowski, Santiago, Woolaway, Bickel, & Ianlongo, 2003); Improved daily functioning; a reduction in maintenance behaviours and behavioural avoidance (Morgan and Raffle, 1999); and possible improvements of relapse rates (White, et al., 2013).

**Evaluation Plan**

Currently the program evaluation relies on self-report symptom questionnaires and monitoring forms to track client progression. OICBT uses a variety of questionnaires including the PHQ-9, OASIS, WSAS, among a wide range of others to record changes in client’s symptoms. It is recommended that it may be useful to incorporate an evaluation component that
addresses the procedures used within the Home and Community Program such as the Personal Planning Tool (PPT) created by Webster and Hadwin in 2015 (Appendix C). This method is unlike the other assessments currently being used to track client progression and is designed to track client progression towards goals and their affective reactions to these goals. It also is designed to determine the reason for responsivity factors, such as not completing weekly objectives or homework towards each goal. Responses for the 13 items are on a 10-point scale (1 being not very successful, not at all, not very challenging, or not very confident to 10 being very successful, extremely, very challenging, or very confident) (Appendix C).

OICBT Manual

A home and community treatment manual with a focus CBT with the home and community setting was developed. The manual is intended for future use of agency personnel for further clarification on the policies and procedures used within the context of the home and community. The manual is intended to assist therapists and psychologists at the Ottawa Institute of Cognitive Behaviour Therapy in ensuring success of procedures and treatment success.

Participants

Staff Personnel

The resource manual is designed to assist mental health practitioners in the implementation of CBT procedures within the home and community. The manual was developed for future use by Psychologists, Social Workers, and Behavioural Aides. It can also be provided as a resource for client’s looking for further clarification on the services offered by OICBT through the Home and Community-Based Program.

Target Population.

The manual is intended to help provide CBT services to adults at their homes or within the community. Those most suitable for services outside of the traditional office include adults with symptoms of anxiety disorders, OCD, specific phobia or depression. Services may be offered to not-specified disorders if it is suggested that they may experience higher levels of progression within the context of the home or community.

Manual Sections

Introduction: What is CBT?

This is the introductory section of the manual. It addresses what the purpose and goal of CBT therapy. It describes CBT procedures using empirically supported information. The portion addresses the main features of the manual and what it’s intended use is.

Psychological Disorders Commonly Treated Using CBT

This section describes the disorders commonly treated by CBT. It describes in detail various mental health disorders including: OCD, GAD, social phobia and major depressive disorder.

Participants and Target Population

The resource manual is designed to assist therapists in the implementation of CBT
procedures within the home and community. This section of the manual describes the intended target population and participants within the manual. A rationale is provided for use of these services with specified populations within the community setting.

**Cognitive Behavioural Interventions and Protocol**
Details on the use of CBT with different populations and problems will be reviewed, and recommended procedures will be incorporated. This will include reference to psycho-educational materials available for specific disorders and problem behaviours. Homework exercises designed to address specific problems such as will be described and examples of each will also be provided in the manual. All guidelines and sections will be reviewed by agency supervisor and approved before submission.

**Safety Procedures and CBT Protocols**
The safety and protocols portion discusses safety measures and insurance regarding vehicle use as well as protocols around the use of vehicles to drive clients. It also addresses precautions when working independently with an individual outside of the office. This section of the manual includes instructions on dealing with aggressive or severely depressed clients. Therapist requirements and topics such as using personal cell phones and email are discussed during this portion of the manual. All topics have been addressed with supervisor before finalizing. Peer-reviewed literature has been used within the context of section to support the use of such procedures.

**Safety and Therapist Requirements**
This portion discusses safety requirements such as monitoring of staff personnel when completing visits, immunizations, as well as safety equipment required. It also discusses the importance of recording all appointments so supervising staff members can locate therapists at all times. This section of the manual also describes therapist code of ethics, mandatory reporting obligations to report, professional standards and guidelines when delivering services within the community.

**Location Suitability**
This paragraph discusses required location assessment procedures needed to be completed prior to completing home visitations. It states rules and points the reader to the appendices, with the required risk matrix assessment to be completed prior to beginning therapy within the home or community setting.

**Personal Cellphones and Email.** This short paragraph of the manual describes cell phone and email related policies required by the agency. It also states instructions for the use of cell phones while completing sessions outside of the traditional office setting.

**Conditions for the Use of Private Vehicles.** This portion includes instructions on using personal vehicles during home visitations. It also discusses rules for driving clients or being a passenger in a client’s vehicle. A contract provided in the appendices formalizes these procedures, and both the supervisor and staff member must sign and confirm vehicle is suitable
for use.

Informed Consent, Capacity and the Limits to Confidentiality Procedures

Informed consent and the limits to confidentiality procedures are discussed in the evaluation and manual. This section includes ethical guidelines when working with clients outside of the office and directs readers to the appendices which will provide an example of the consent forms used by the agency. Consent procedures discuss the limits to confidentiality in relation to the Canadian Code of Ethics for Psychologists, and the policies around disclosure of information. Ethical concerns when working with clients within the home and community are considered and reviewed to ensure full understanding of the importance of maintaining confidentiality. The importance of consent and confidentiality is again, supported by peer-reviewed literature.

Psychological Testing Measures

Details on psychological testing measures and appropriate populations will be incorporated into the manual. Each of the testing measures will be briefly described and information on their intended uses provided. Testing measures incorporated within this section are those currently being used by agency personnel and those found by the researcher, which have been empirically proved to be reliable testing materials. The Mental Measures Yearbook will be used to provide this information. Below are the assessment measures provided in the manual. Copies of each assessment measure are provided in the appendices of the manual. Assessment measures below are those compiled within the manual.

Measures for Anxiety

The Overall Anxiety Severity and Impairment Scale (OASIS; Norman, Hami-Cissell Means-Christensen, & Stein, 2006). The OASIS is a 5-item self report questionnaire designed to assess for anxiety symptoms and severity (Norman, Hami-Cissell, Means-Christensen, & Stein, 2006).

The Pen State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990). The PSWQ is a 16 item self-report questionnaire designed to assess for excessive worrying and Generalized Anxiety Disorder (Meyer, Miller, Metzger, & Borkovec, 1990). It includes 5 response options ranging from 1 being not at all typical of me to 5 being very typical of me (Meyer, Miller, Metzger, & Borkovec, 1990). Scores can vary between 16 to 80 indicating different levels of severity of symptoms (Meyer, Miller, Metzger, & Borkovec, 1990). According to Meyer at al., 1990, typical mean scores for individuals with GAD range between 60-68.

Health Anxiety Questionnaire (HAQ; Lucock and Morely, 1996). The HAQ is a self-report assessment measure designed to screen for symptoms related to health anxiety (Lucock & Morely, 1996). It consists of 21 questions with 4 possible responses (Lucock & Morely, 1996). Responses can vary from not all or rarely to most of the time (Lucock, & Morely, 1996). According to Lucock and Morely, it is suggested that mean score of 35.3 is representative of health anxiety in comparison to mean scores of the general population. A mean score of roughly 17.7 suggests another form of anxiety being present (Lucock, & Morely, 1996).
Social Phobia Inventory (SPIN; Connor, Davidson, Churchill, Sherwood, Foa, and Weisler, 2006). The Social Phobia Inventory is a 17-item, self-report psychological testing measure designed to assess for social phobia or social anxiety disorders (Connor et al., 2016). Scores can vary anywhere between 0 to 68, higher scores indicate increased degree of severity of symptoms (Connor et al., 2006). Scores above 19 reportedly indicate a positive screen for social anxiety (Connor et al., 2006).

Measures for Obsessive-Compulsive Disorder (OCD)

Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010). Abramowitz and colleagues created DOCS to assess the four most common dimensions of OCD symptoms. These dimensions include Concerns about Germs and Contamination, Concerns about being Responsible for Harm, Injury, or Bad Luck, Unacceptable Thoughts, and lastly Concerns about Symmetry, Completeness, and the Need for Things to be ‘Just Right’ (Abramowitz et al., 2010). It includes 20 questions, 5 for each domain, and 5 possible response options for each item. Scores above 18 differentiate a person with OCD in comparison to someone without a psychiatric illness, and higher score represent increased severity of symptoms (Abramowitz et al., 2010).

Obsessive Activities Checklist (Grayson, 2014). The Obsessive Activities Checklist is 220-item self-report assessment designed to assess for impairment in completing daily activities in 12 different domains of functioning as a result of OCD symptoms (Grayson, 2014). Individuals are asked to rate each item on a 5-point scale, 1- no problem with activity to 5 being almost constant problems with activity (Grayson, 2014). Higher scores indicate higher level of impairment in daily activities (Grayson, 2014).

Obsessive Concerns Checklist (Grayson, 2014). The Obsessive Concerns Checklist, also created by Grayson (2014) is a 141-self report questionnaire which is designed to assess for the level of distress and troubling of OCD thoughts. 9 different thought dimensions are included in the checklist, and individuals are asked to rate the thoughts accordingly, 1 being this thought does not trouble me at all, to 5 being this thought troubles me continually (Grayson, 2014). Higher scores in each domain suggest increased level of distress associated with each thought (Grayson, 2014).

Obsessional Beliefs Questionnaire (OBQ-44; Obsessive Compulsive Cognitions Working Group; OCCWG, 2005). The OBQ-44 is a self-report questionnaire beliefs and appraisal of automatic thought. The questionnaire consists of 44 items and 7 different possible responses for each question (OCCWG, 2005). Response options range from disagree very much to agree very much. Each question is relevant to one of three different domains. These domains include responsibility and threat estimation, perfectionisms and intolerance of uncertainty, and importance and control of thoughts (OCCWG, 2005). When scoring the OBQ-44 individual scores are compared to both the means for an OCD group and the means of the community control group. Positive screens for OCD are those that fit within the normative mean scores of OCD and are within 1 standard deviation above and below mean scores for each domain (OCCWG, 2005). The version located in the manual is an adaptation of the original assessment.
Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989). The Y-BOCS is an psychological assessment measure used to assess the severity of obsessive-compulsive symptoms (Goodman et al., 1989). It is a 10-item self-report scale, 5 items relating to obsessional thoughts, and 5 items relevant to compulsive behaviours (Goodman et al., 1989). Scores range from 0 to 4, representing different levels impairment and severity (Goodman et al., 1989). Higher scores represent increased levels of severity of OCD symptoms and impact on daily living (Goodman et al., 1989).

Measures for Aggression

Bus-Perry Aggression Questionnaire (AQ; Buss & Perry, 1992). The Buss-Perry Aggression Questionnaire developed by Buss and Perry in 1992, is an assessment used to assess 4 different components of aggression. The four subcategories of aggression assessed in the AQ are physical, verbal, anger, and hostility expressed through aggression (Buss and Perry, 1992). The AQ is composed of 29 questions each reflecting one of the four specified domains (Bus and Perry, 1992). Results suggest that higher scores reflect higher levels of aggression. Scoring is further explained in the context of the manual.

Measures for Bi-Polar Disorders

The Mood Disorders Questionnaire (MDQ, Hirschfeld et al., 2000). The MDQ is an assessment measure used to screen for Bi-polar disorders (Massidda, Giovanna Carta, and Altoè, 2016). This questionnaire has a total of 13 items, with two response options, yes or no (Massidda, Giovanna Carta, and Altoè, 2016). A person must answer yes to at least 7 items in the first section, yes to question number 2, and responds either moderate or serious to the final question, to receive a positive screen for Bi-Polar Disorder (Hirschfel et al., 2000).

Measures for Depression

The Patient Health Questionnaire for Depression (PHQ-9, Spitzer, Williams, and Kroene, 2016). The PHQ-9 is an assessment used to screen for depressive symptoms and severity (Spitzer, Williams, Kroene, 2016). It is a nine item questionnaire, with four response options which vary from 0 being not at all, 1 being several days, 2 being more than half of the days, and 3 being nearly everyday (Hinz et al., 2016). Scores determine symptom severity and can range anywhere from 0 to 27, 0-5 suggesting mild depression, scores ranging between 10-15 suggesting moderate severity, and scores greater than 15 indicating severe levels of depression (Hinz et al., 2016).

Measures for Insomnia

Pittsburgh Sleep Symptom Questionnaire-Insomnia (PSSQ_I; Okun, Kavitz, Sowers, Buysee, & Hall, 2009). The PSSQ_I was developed by Okun and Colleagues in 2009, and is designed to screen for insomnia. It is a 13-item self-report questionnaire with 6 response options ranging from never to always (5-7 times per week) (Okun et al., 2009). If the participant has answered “frequently” or “always” to at least questions, 1, 2 or 5, has answered “greater or equal
to 4 weeks” to at least one of questions 1, 2, or 5, and has answered “quite a bit” or “extremely” to a minimum of one questions from items 6 to 13, it is considered to be a positive screen for insomnia disorder (Okun et al., 2009).

Measures for Posttraumatic Stress Disorder (PTSD)

**PTSD Checklist** (PCL-S: Monthly; Weathers, Litz, Herman, Huska, and Keane, 1993). The PCL-S is an assessment measure designed to assess for PTSD symptoms, but is not considered to be a formal diagnostic tool (Weathers et al., 1993). The PCL-S is composed of 17 questions, and 5 responses ranging from not at all to extremely. According to Weathers and colleagues, scores 45 or higher display positive signs of PTSD and therefore the person should be referred for a formal assessment of PTSD.

Measures for Panic Disorder

**Body Sensations Questionnaire** (BSQ; Chambless, Caputo, Bright, and Gallagher, 1984). The purpose of the body sensations questionnaire is to assess for symptoms of panic attacks in agoraphobics (Chambless, Caputo, Bright, and Gallagher, 1984). It is designed to assess physiological symptoms associated with anxiety (Chambless, Caputo, Bright, and Gallagher, 1984). Chambless and colleagues developed this 17-item self-report scale, with responses on a 5-point rating scale (1- not frightened or worried by this sensation to 5- extremely frightened by this sensation). The BSQ total score is the average of all answered questions, and if 3 or questions are skipped test results should be considered invalid (Chambless, Caputo, Bright, and Gallagher, 1984). Higher scores are an indication of greater levels of fear to physiological symptoms (Chambless, Caputo, Bright, and Gallagher, 1984).

**Panic Frequency Questionnaire** (Antony and Swinson, 1999). Antony and Swinson developed the Panic Frequency Questionnaire in 1999, to screen and assess the intensity of panic disorder symptoms. This questionnaire is a 6-item self report questionnaire, the first two items requesting requesting frequency of panic attack, and the final four questions symptom severity and range of symptoms expressed by those with panic disorder (Antony and Swinson, 1999). Higher scores suggest increased frequency and intensity of symptoms (Antony and Swinson, 1999).

Measures to Assess Substance Use

**The CAGE Questions Adapted to Include Drugs** (CAGE-AID; Brown and Rounds, 1995). This CAGE-AID is a 4-item self-report questionnaire designed to screen for alcohol and drug abuse (Brown and Rounds, 1995). This measure only has two response options, yes or no (Brown and Rounds, 1995). Higher scores indicate a possible substance use problem, and there is 2 or more yes responses, score should be considered as clinically significant (Brown and Rounds, 1995).

**Simple Screening Instrument for Alcohol and Other Drugs** (SSI-AOD; Treatment Improvement Protocol, Series 11, 1994) The SSI-AOD was developed by the consensus panel of Treatment Improvement Protocol, Series 11, in 1994. This is a 16-item scales designed to screen for alcohol or substance abuse (Treatment Improvement Protocol, Series 11, 1994). Only 14 of
the 16 questions are scored (questions 1 and 15 are not scored) (Treatment Improvement Protocol, Series 11, 1994). If an individual scores answers yes to four or more the 14 scored questions, this is considered a positive screen for a alcohol or substance use problem (Treatment Improvement Protocol, Series 11, 1994).

Other Measures

**Personality Belief Questionnaire** (PBQ; Beck and Beck, 1991). The PBQ was created by Beck and Beck in 1991 as a clinical assessment instrument developed to assess for maladaptive, dysfunctional, or unrealistic beliefs, specifically associated with personality disorders. The PBQ is a 126 item self-report designed to assess nice subscales of personality disorders (Beck and Beck, 1991). Scores for each domain are transformed into Z-scores and compared the Z-scores for patients with corresponding Personality Disorders and patient with no personality disorder (Beck and Beck, 1991).

**Work and Social Adjustment Scale** (WSAS; Marks, 1986). The WSAS is a five-item self-report questionnaire designed to assess the areas in daily living that are most impacted as a result of his or current condition (Marks, 1986). Response options range from not at all to very severely (Zahra, Qureshi, Henley et al., 2014).

**Community and Home Based CBT Program Evaluation Form** (Ottawa Institute of Cognitive Behavioural Therapy, 2015). The Community and Home Based CBT Program Evaluation Form was created by the staff at OICBT to evaluate the services provided through the Home and Community-based Program. It includes 14-items, the first 8 questions addressing learning objectives (OICBT, 2015). Responses for the first 8 questions range from 1 being strongly disagree to 5 being strongly agree. The next 2 questions are request feedback on client’s experiences and desired outcomes met through the services received at OICBT (OICBT, 2015). The final 3 questions ask the participants to rate the overall program on three levels (Therapist, Team, and Organization) on a 4-point scale, 1 being poor to 4 being excellent (OICBT, 2015). Finally, participants are asked to make additional comments on services and thoughts of the OICBT Home and Community-Based Program.

Treatment Schedule

The manual will also include a section which reviews the recommended session length, number of sessions and session structure. This section describes the initial screening call process, which is completed prior to the intake assessment. The screening call is designed to determine an individual’s suitability for the home and community-based services. Peer-reviewed literature will be used to support information obtained in this section. Appendices with the examples of screening forms, intake measures, progress notes and termination notes are provided.

Fees and Financial Information

This section of the manual describes all of the financial procedures involved in the Home and Community-Based Program. It describes duties of both the mental health practitioner and client, as well as directs the reader the appendices which has examples of the standard fees,
invoice templates, an example of the financial monitoring excel sheet, and payment forms.

**Effectively Using CBT Procedures**

This portion of the manual describes each of the relevant CBT procedures used within the Home and Community-Based Program. Exposure interventions and the different types of exposure are clarified using peer-reviewed literature and books. In vivo exposure, interoceptive exposure and imaginal exposure are described and disorders commonly treated using each method are listed. It also provides a step by step description of how to properly implement exposure therapy, and other relevant resources can be located in the appendices. The use of CBT thought records is outlined in the section as well. Steps for conducting behavioural activation, how to effectively use cognitive restructuring, and finally relapse prevention are all described in this piece of the manual. All-related homework materials and resources can be located in the appendices.

**Conclusion**

Finally, the manual is finalized with a conclusion which reviews the purpose of the manual. It has been designed to help provide clarity for employees working for the Ottawa Institute of Cognitive Behaviour Therapy on the procedures used within the Home and Community Program.

**Chapter IV: Results**

Overall the final project is displayed in the form of a program logic model and a training manual for the Ottawa Institute of Cognitive Behaviour Therapy Home and Community Based Program. The Program Logic Model was completed to display a formalized breakdown of inputs, outputs, activities, and benefits of the Home and Community-Based Program at OICBT. The inputs section reviews the organizations contributions to the Home and Community-Based Program. In the activities section of the Program Logic Model procedures and intervention strategies such as training of staff and the development of treatment plans etc., are discussed. The Home and Community Program at OICBT has a wide range of benefits, both short-term and long-term. These outcomes are described in detail in both the short-term and long-term sections of the Program Logic Model. Examples of some of benefits include improvement in daily functioning and relationships, as well as a decrease in safety behaviours etc. The research literature indicates that benefits of these specific types of services and supports Cognitive-Behavioural Therapy within the home and community for a wide range of psychological disorders. Through research and observation, it has been recommended that OICBT add a measure which will allow them to follow client goal progression and homework completion.

The second component of the project, the manual was designed to assist behavioural aides and therapists working at OICBT in the implementation of services outside of the traditional office setting. The manual incorporates procedures currently being used by the agency, recent peer-reviewed literature, and additional resources found to be beneficial when treating mental illness using CBT procedures. Sections are broken down starting with an introduction, components of CBT, Psychological Disorders commonly treated with using CBT, CBT Procedures, safety procedures, consent, psychological testing measures, steps in using
specific CBT procedures, and finally a conclusion to sum up the contents of the manual. In the introduction and CBT procedures, both CBT and home and community-based services are defined. Target population and participants are all briefly described as well. Some individuals recommended for this specific type of CBT treatment include those with depression, anxiety, and OCD etc. Exposure Therapy specifically for OCD, social anxiety, and PTSD are introduced with the Specific CBT Procedures section of the manual. Behavioural Activation (for depression), cognitive restructuring, and relapse prevention are described with peer-reviewed literature within this component of the manual as well. Safety procedures and agency protocols, both previously described by the agency guidelines to treatment, and those found to be empirically supported, are found within the contents of the manual as well. The importance of consent and confidentiality, as well as how to effectively communicate and gain consent is an essential piece of the manual. Another section of the manual is a description of all psychological testing measures available for use to evaluation symptom severity, and how to effectively obtain appropriate results from each test are also provided within the manual. A typical treatment schedule with suggested changes is provided to those reviewing the contents of the Home and Community-Based Manual. A breakdown of Fees and Payment are also provided to readers. The second past component of the manual includes a breakdown of how to effectively use the CBT procedures described within the Specific CBT Procedures section, including how to provide psycho-education, exposure and the different forms, behavioural activation, cognitive restructuring and lastly relapse prevention. Finally, the contents of the manual and its purpose are summed up in a conclusion. Appendices are included of each specific strategy, such as psychological procedures, and other resources necessary within the home and community-based program.

Overall the program manual has been designed as a resource for both agency personnel and clientele to improve the implementation and organization of services provided by the agency within the home and community program. It is an additional resource for training of new staff members working at OICBT in particular area of CBT implementation. Overall the manual and program logic model provide the agency with an organized layout of all program information and can be proven to be a beneficial resource to the agency.

**Chapter V: Discussion**

This project incorporates both an evaluation of the Home and Community-Based Program at OICBT, and a manual incorporating evaluation components and instructions on using CBT within the home and community. Overall the project has been designed to help therapists and staff, as well as provide knowledge to clients about using CBT outside of the traditional office setting.

There are a few limitations that need to be noted in regards to this project. The first limitation of this type of project is the absence of data collection in the form of monitoring or survey scores. To determine the benefits of the manual, a survey requesting feedback on the manual development could have been useful in providing further information in order to make changes and improve the final product of the Home and Community-Based Manual.

Another limitation found while completing this project is the lack of literature supporting the use of therapist conducted CBT with clients within the home and community setting. There was much literature to support the use of CBT for a wide range of psychological disorders, but little information discussing its effectiveness outside of the traditional clinical office setting.
Overall the project was successful in collecting and organizing all necessary data requested by OICBT to be incorporated into the manual. It is suggested that as the program advances, OICBT make necessary adjustments to the manual as needed. The project is an important resource to help therapists when using CBT within the home and community setting.
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Appendix A: Consent to Use Company Name and Logo

Consent for Use of Agency Logo Template

St. Lawrence College
www.sl.on.ca

I, Dr. Connie Dalton, consent to the use of the logo of The Ottawa Institute of Cognitive Behavioural Therapy in Christy McCance's applied thesis poster for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.

Agency Staff Signature

Student Signature

Printed Name

Printed Name

Connie Dalton

Christy McCance

LOGO [REPLACE ST. LAWRENCE LOGO WITH YOUR AGENCY'S LOGO]

Date: Dec 5th, 2016

Consent for Use of Agency Logo

Ottawa Institute Of Cognitive Behavioural Therapy

L'institut de thérapie cognitivo-comportementale d'Ottawa
Consent for Use of Agency Name Template

Date: Dec 5th 2016

St. Lawrence College
www.sl.on.ca

Consent for Use of Agency Name

I consent to the use of the name of The Ottawa Institute of Cognitive Behavioural Therapy (OICBT) in Christy McCance's applied thesis for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.
NAME OF PROGRAM/PROJECT: The Ottawa Cognitive Behaviour Therapy Home and Community-Based Program

SITUATION/PURPOSE: The main purpose of the Ottawa Institute of Cognitive Behavioural Therapy (OICBT) Home and Community-Based Program to provide access to empirically-supported mental health services by offering these programs at home and within the community.

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<th>INPUTS</th>
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<td>1. Time</td>
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<td>1. Decrease in severity of Mental Health symptoms (improvement in OCD, anxiety, and depressive symptoms).</td>
</tr>
<tr>
<td>2. Location/Space</td>
<td></td>
<td>2. Improvement in daily functioning (increase in adaptive coping strategies, and decreased impairment in daily living activities).</td>
</tr>
<tr>
<td>3. Staff</td>
<td></td>
<td>4. Decrease in Maintenance Behaviours such as Safety Behaviours and Avoidance (decrease in avoidance of anxiety provoking behaviours, or safety behaviours such as checking and repeating, or taking medication).</td>
</tr>
<tr>
<td>4. Transportation</td>
<td></td>
<td>5. Improved Quality of Life</td>
</tr>
<tr>
<td>5. Funding</td>
<td></td>
<td>6. In-Office Therapy Sessions</td>
</tr>
<tr>
<td>6. Service Delivery</td>
<td></td>
<td>7. Termination of Therapy and Evaluation of Treatment</td>
</tr>
<tr>
<td>7. Training</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EXTERNAL FACTORS

1. Stigma surrounding Mental Illness
2. Client’s attitudes toward treatment
3. Condition of Client’s place of residence
4. Individual’s within the community

EVALUATION PLAN:

Currently the program focuses on using self-report symptom questionnaires, and monitoring forms to track client progression. OICBT uses a variety of questionnaires including the PHQ-9, OASIS, WSAS, among a wide range of others to record changes in client’s symptoms. It is recommended that it may be useful to incorporate an evaluation component that addresses the procedures used within the Home and Community Program such as the Personal Planning Tool (PPT) created by Webster and Hadwin in 2015. This method is unlike the other assessments currently being used to track client progression. This method, is designed to track client progression towards goals, and feelings toward each goal. It also is designed to determine the reason for not completing weekly objectives or homework towards each goal. Responses for the 13 items are on a 10-point scale (1 being not very successful, not at all, not very challenging, or not very confident to 10 being very successful, extremely, very challenging, or very confident) (Appendix C).
THINK ABOUT LAST WEEK

1. What goal did you set in your reflection last week?

2. How successful were you in achieving your goal from last week? On a scale from 1 to 10, I was... (1 = Not very successful to 10 = Very successful)

3. How did you feel while trying to accomplish your goal last week? Please indicate your rating for ALL of the emotions listed below.

On a scale from 1 to 10, I felt... (1 = Not at all to 10 = Extremely)

(a) Enjoyment:
(b) Hope:
(c) Pride:
(d) Relief:
(e) Anger:
(f) Anxiety:
(g) Shame:
(h) Hopelessness:
(i) Boredom:
(j) Other (specify):

4. Select one feeling from above that negatively affected progress toward your goal.

5. How much did that feeling negatively affect your progress? On a scale from 1 to 10, this feeling had... (1 = Very little effect to 10 = Extremely negative effect)

6. How did that feeling affect your motivation to accomplish your goal? On a scale from 1 to 10, this feeling had... (1 = Very little effect to 10 = Extremely negative effect)

7. What did you try to do to change that feeling?

8. What could you try to do next time you experience that feeling?
THINK ABOUT THIS WEEK

9. Name one specific task (e.g. a reading, an assignment, studying, etc.) to focus on this week. 
10. Set one good goal for the task you have chosen.

Personal Planning Tool PPT

Items 
11. What is your goal about? Choose one from the list below (put an X beside it).

(a) Learning  
(b) Behaviour  
(c) Motivation  
(d) Feelings  
(e) Time management/organization

12. How challenging or difficult do you think your goal is this week? On a scale from 1 to 10, 
my goal is... (1 = Not very challenging to 10 = Very challenging)

13. How confident are you that you will accomplish your goal this week? On a scale from 1 to 10, I am... (1 = Not very confident to 10 = Very confident)

Note: *Items analyzed in this study.

PsycTESTSTM is a database of the American Psychological Association
Appendix D: Home and Community-Based Manual

Ottawa Institute
Of Cognitive
Behavioural Therapy

L’institut de thérapie
cognitivo-comportementale
d’Ottawa

Ottawa Cognitive Behaviour Therapy
Home and Community-Based Program Manual

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Introduction: What is CBT?

Over the past four decades, Cognitive-Behavioural Therapy (CBT) has been used to improve mental and physical health for a wide variety of populations and professions, and is becoming increasingly more impactful as the years’ progress (Lovell & Richards, 2000). CBT has been proven to be an effective treatment for many psychological disorders including anxiety and depressive disorders, compulsion disorders such as Obsessive Compulsive disorders, sleeping and eating disorders, as well as phobias (Farmer and Chapman, 2016). CBT has been recognized as form of best practice and evidence-based treatment (Wenzel, Dobson, and Hayes, 2016). CBT is comprised of three main components addressing maladaptive behaviour, challenging automatic thoughts and underlying beliefs, and lastly incorporating relapse prevention strategies (Wenzel, Dobson, and Hayes, 2016). Some popular and effective techniques incorporated into CBT include problem-solving, exposure, behavioural activation, cognitive restructuring, relapse prevention etc., (Wenzel, Dobson, and Hayes, 2016). The following literature describes some of the main procedures of CBT, and support for each component.

Home and Community Service Delivery

According to Federici, Rowa, and Antony (2010), many factors can influence the effectiveness of CBT. Some controlling factors include session length, number of sessions, intensity of therapy and environmental conditions (Federici, Rowa, and Antony, 2010). Although studies have suggested that there is no significant advantage to completing office-based therapy versus therapy provided in home or community-based, some individuals have displayed little success during traditional in-office therapy. It is opined that often a naturalistic environment is beneficial and individuals are more likely to successfully progress (Federici, Rowa, & Antony, 2010). According to Pizzi et al., (2014), home and community-based care is also a very cost effective form of treatment. As treatment tends to be more intensive and can be offered at home, it is suggested that treatment can be delivered in a fewer number of visits and still provide the most effective treatment results, and therefore, the cost of treatment is less (Pizzi et al., 2014). Community-based programs can greatly benefit low-income individuals or those who are unemployed, who may not seek health care services due to financial concerns (Leviton and Raczynski, 2004). These services are more accessible to these types of individuals because it is more cost-effective, and provided within the home (Leviton and Raczynski, 2004; Pizzi et al., 2014). Overall, home and community-based care can provide effective results for the treatment of specific psychological disorders in timely, and cost-efficient manner.

The Ottawa Institute of Cognitive Behaviour Therapy (OICBT) uses a variety of...
therapeutic techniques in the treatment of a wide range of disorders (The Ottawa Institute of Cognitive Behaviour Therapy, 2016). The Home and Community-based Program provided at OICBT works toward helping treat disorders including obsessive-compulsive disorder, anxiety disorders such as generalized anxiety disorder (GAD) social anxiety, and depression (The Ottawa Institute of Cognitive Behaviour Therapy, 2016). Techniques commonly used by OICBT, specifically in the Home and Community-based Program are behavioural activation, exposure, cognitive restructuring, and a range of others (Ottawa Institute of Cognitive Behaviour Therapy, 2016). All the above strategies are used to help reduce symptoms associated with specific mental disorders (Ottawa Institute of Cognitive Behaviour Therapy, 2016). The purpose of this manual is to provide clarification to therapist’s on OICBT procedures and assist in the implementation of successful service delivery of CBT procedures within the community.

Psychological Disorders Commonly Treated Using CBT

**Obsessive-Compulsive Disorder**

Obsessive-compulsive disorder (OCD) affects an estimated 2% to 3% of adults over the course of their lifespan (Ruscio, Stein, Chiu, and Kessler, 2010). According to the DSM-5, OCD can be expressed in either obsessive or compulsive behaviour, but the majority of those diagnosed with OCD exhibit both (DSM-5; American Psychiatric Association, 2013). Common features of OCD include obsession often referred to as intrusive thoughts, or urges that cause increased levels of anxiety (American Psychiatric Association, 2013). Common obsessions include fears of contamination (fear or germs or illness), harming fears (intrusive thoughts of harming self or others), symmetry obsessions (need to have things perfectly orderly or arranged), somatic obsessions (obsessing about bodily functioning and appearance), and unwanted imagery (usually unwanted thoughts of a sexual nature) (Worden and Tolin, 2014). Another common feature of OCD is having maladaptive beliefs such as being able to control thoughts, perfectionism, overestimating threat, and inflated responsibility for the harm of others (Worden and Tolin, 2014). A defining feature of OCD is compulsions, or the need to engage in a particular behaviour to avoid distress and anxiety associated with an obsession (American Psychiatric Association, 2013). Compulsive Behaviours include checking, excessive cleaning or washing, repeating, having specific mental rituals, ordering or arranging, passive avoidance or avoiding triggers for compulsions (American Psychiatric Association, 2013). These are the most common behaviours expressed by those with a diagnosis of OCD (American Psychiatric Association, 2013).

**Generalized-Anxiety Disorder**

Generalized Anxiety Disorder (GAD) is a chronic disorder described as having excessive worry and having difficulty trying to control worrying, that causes significant distress and impairment in the individual’s daily functioning (Ritter, Blackmore, and Heimberg, 2010). The worrying must be persistent for a minimum of a 6-month period, and worrying is usually associated with a number of activities or events (Ritter, Blackmore, and Heimberg, 2010). Worrying is typically accompanied by a variety of physiological symptoms, such as increased heart rate, sweating, slow breathing etc., (Ritter, Blackmroe, and Heimberg, 2010). In a meta-analysis conducted by Hofmann, Wu, and Boettcher (2014), which examined the use of CBT for anxiety disorders found that CBT is a very effective treatment for anxiety disorders, and CBT has also been linked to increased quality of life. Generalized Anxiety Disorder is one of many
disorders commonly treated using the principles of CBT (Ritter, Blackmore, and Heimberg, 2016).

**Social Phobia**

Another mental disorder treated using Cognitive Behaviour Therapy is social anxiety or social phobia (Wensel, 2011). Social Phobia is described as having excessive distress in social situations as a result of fear of being negatively evaluated (Wenzel, 2011). Features include intense anxiety when exposed to fear, excessive fear to social situations, avoidance of situations to avoid anxiety response, and remarkable distress as a result of symptoms (Wenzel, 2011). Social Anxiety can severely impact one’s daily functioning and is often associated to lower life satisfaction (Wenzel, 2011).

**Depression**

There are two main subtypes of depression disorders (Simon, 2016). Major depressive disorder (MDD) is characterized as persistent depressed mood, difficulty concentrating, decreased pleasure and interest in activities, change in weight or appetite, sleep issues, fatigue, and suicidal thoughts or ideation (Simon, 2016; American Psychiatric Association, 2013). According to the DSM-5 (2013), a minimum five of the above symptoms must be present for at least a 2-week period. Dysthymia is another mood disorder, which is described as having at least 2 of the above symptoms associated with MDD, in combination with irritability and depressed mood for more days than not (Simon, 2016; American Psychiatric Association, 2013). CBT treatments have displayed success in the treatment of both of the described mood disorders (Simon, 2016). In a meta-analysis conducted by Honyashiki et al., which examined the effectiveness of CBT with depression, found that CBT was significantly more effective in comparison to no treatment for improving depressive symptoms.

Overall, CBT practices are frequently used for disorders such as obsessive-compulsive disorders, generalized anxiety disorders, social phobias, and depression, as well as a variety of other disorders.

**Participants and Target Population**

Participants include both those providing the services as well as those receiving treatment through the home and community based program. Typically, services are provided by behavioural aides with an educational background in behavioural therapy, as well as training using the principles of CBT.

The target population for this service is typically adults, 18 years or older (Ottawa Institute of Cognitive Behavioural Therapy, 2016). Candidates that would be considered appropriate to partake in the OICBT Home and Community-Based Program include those who have a diagnosis of Obsessive-Compulsive Disorder, mood disorders, depression, eating and sleeping disorders, as well as other anxiety disorders. Clients that would benefit most from this program are those who has displayed little success in the completion of homework exercises and practicing of CBT outside of the office setting or those who have symptoms (ex: extreme panic when leaving the home or getting into a vehicle) that effect the person’s ability to partake in traditional in-office therapy (Ottawa Institute of Cognitive Behavioural Therapy, 2016).
Specific CBT Procedures

Exposure Therapy
Exposure Therapy is a component of CBT that is widely used for the treatment of obsessive-compulsive disorders (OCD) and anxiety disorders (Stewart et al., 2016). The purpose of exposure therapy is to introduce participants to anxiety-provoking situations eliciting fear, reducing safety behaviours, and avoidance of these situations, and promoting a decrease in anxiety symptoms across trials (Stewart et al., 2016). When considering the use of exposure plus response prevention (ERP) in the treatment of OCD, the goal is to expose the patient to an intrusive thought, fear, or overestimated event repeatedly until the person habituates to the situation (Whittal and McLean, 2000).

Exposure for OCD
Stewart et al., (2016), completed a study which surveyed 65 clinicians on their use of exposure based treatments of OCD and anxiety disorders. The results indicated that a large number of clinicians indicated using exposure therapy with both patients with anxiety and OCD (Stewart et al., 2016). This suggests that exposure is a commonly used component of CBT and is widely accepted by clinicians for the treatment of specific mental disorders (Stewart et al., 2016).

Interoceptive Exposure for Social Anxiety
Another form of exposure is titled interoceptive exposure (IE), a common method of treatment for panic disorders and has assisted in the treatment of PTSD, phobia disorders and other generalized anxiety disorders (Boettcher, Brake, and Barlow, 2016). IE is a specific type of exposure which reduces anxiety sensitivity by exposing the person to anxiety-provoking physiological sensations (Boettcher, Brake, and Barlow, 2016). Dixon, Kemp, Farrell, Blakey, and Deacon (2015), investigated the effectiveness of IE on individual with social anxiety, specifically a fear of others witnessing them blushing, sweating or experiencing another physical reaction to their anxiety. Participants engaged in activities such as slow breathing, push-ups, drinking hot drinks or eating hot sauce, to purposefully induce somatic sensations (Dixon et al., 2015). The results of this study indicated the high levels of anxiety and sensations were experienced within the interoceptive exposure tasks, but further research is needed to determine how effective this method is in the treatment of social anxiety disorders (Dixon et al., 2015). Another study examining the use of IE in the treatment of heightened anxiety sensitivity (AS) of a group of 120 participants (Deacon, Kemp, Dixon, Sy, Farell, and Zhang, 2013). The results displayed significant reductions in AS among all individuals who participated in the study, and therefore suggest that IE is an effective component in the treatment of anxiety disorders (Deacon et al., 2013).

Imaginal Exposure for PTSD
Another type of exposure commonly used in the treatment of posttraumatic stress disorder is prolonged imaginal exposure and virtual reality exposure (VRE) (Reger et al., 2016). Imaginal exposure is a technique that exposes the individual to the traumatic event by recalling the memory in the form of imagery (Reger et al., 2016). VRE is an advanced form of exposure that uses computer programmed virtual reality to place the person in a computerized representation of the fearful situation (Reger et al., 2016). Regel et al. (2016), conducted a study which examined the use of the prolonged imaginal exposure versus VRE in the treatment of PTSD symptoms.
One hundred and sixty-two active duty soldiers with PTSD were involved in the study. The findings of this study suggest that both prolonged imaginal exposure and VRE were effective and reliable methods in reducing PSTD symptoms for the majority of participants. All of the studies mentioned above indicate that different types of exposure are proven to be evidence-based treatments for a wide range of psychological disorders and are an important component of Cognitive-Behavioural Therapy.

**Behavioural Activation**

Behavioural activation is another element in CBT, which is used most commonly for the treatment of depression (Ross et al., 2016). The purpose of behavioural activation is to increase rewarding experiences in order to activate and motivate clients to engage in therapy (Ross et al., 2016).

**Behavioural Activation for Depression**

A study was conducted that examined the use of Behavioural Activation Treatment for Depression (BATD) in comparison with Supportive Counselling (SC) on 46 participants with depressive symptoms (Collado, Calderón, MacPherson, & Lejuez, 2016). BATD proved to be superior to SC in reducing depressive symptoms and demonstrated higher remission rates compared to SC, indicating that BATD is an effective component of CBT in the treatment of depression (Collado, Calderón, MacPherson, & Lejuez, 2016). Multiple studies have displayed positive outcomes when using Behavioural Activation (BA) in the treatment of adult depression. A meta-analysis, which compared the results of 34 studies using BA to treat major depressive disorder in adults, supports the use of BA to address depressive symptoms (Mazzucchelli, Kane, & Rees, 2009). There is evidence that suggests that Behavioural Activation yields similar results to that of Cognitive Therapy (Mazzucchelli, Kane, & Rees, 2009). In another research experiment conducted by McIndoo, File, Preddy, Clark, and Hopko in April of 2015, compared the use of mindfulness-based therapy (MBT) and Behavioural Activation (BA) in the treatment of depression for a group of 50 college students. The major findings of this study indicate that both MBT and BA are effective in reducing depressive symptoms, and roughly 56-76% of all students displayed significant improvements (McIndoo et al., 2015). Overall, this study adds to previous studies findings, which suggest that BA and MBT are effective treatments for depression. Randomized trials assess the effectiveness of BA strategies to improve depressive symptoms in a group of breast cancer patients (Ryba, Lejuez, and Hopko, 2014). Twenty-three women with clinical diagnoses of major depression participated in this study. The BATD involved increased levels of activity, activity monitoring and a hierarchy of difficult activities, in which each patient was required to progressively master each item on the hierarchy of activities (Ryba, Lejuez, and Hopko, 2014). The results of this study indicated higher levels of activity completion were associated with a reduction in depressive symptoms (Ryba, Lejuez, and Hopko, 2014). Therefore, the findings indicate a positive link to symptom reductions after engaging in BA procedures. Overall, the above studies indicate there is a vast amount of evidence that support the use of behavioural activation as a suitable treatment for depression.

**Cognitive Restructuring**

A component within CBT designed to address irrational or negative thinking is known as cognitive restructuring (Beck & Beck, 2011). There are several strategies to address thinking patterns during this component of CBT (Arch & Craske, 2008). These techniques include breaking down thoughts by considering evidence for and against, determining cognitive
distortions or thinking errors and developing more positive alternative thoughts (Arch & Craske, 2008). Whittal and McLean (2000) note there are many components of CBT used to addressing thought processes. When considering the thought process of individuals with OCD, it may be necessary to challenge cognitive appraisals such as overestimations of danger. Also, normalizing intrusive thoughts is an important component to treatment (Whittal and MacLean, 2000). In a study conducted by Larsson, Hooper, Osborne, Bennett, and McHugh (2015) which looked at the use of Cognitive Restructuring on 47 individuals and thinking patterns, displayed significant improvements in negative thoughts and thought discomfort. Overall this indicates a positive movement towards the use cognitive restructuring as a CBT element.

**Relapse Prevention**

Relapse Prevention is a component of CBT, which involves teaching the client strategies and giving them knowledge to prevent relapse (Wenzel, Dobson, and Hayes, 2016). To clarify, relapse can be defined as the return of symptoms after temporary improvement and before the remission of a mental illness (Wenzel, Dobson, and Hayes, 2016). Recurrence is defined as a mental disorder reappearing after being in remission (Wenzel, Dobson, and Hayes, 2016). There are multiple components incorporated into relapse prevention to be considered effective (Wenzel, Dobson, and Hayes, 2016). The main strategy used in relapse prevention is creating a relapse prevention plan, detailing the warning signs, coping tools, social support, indication that a professional should be contacted, as well as contact numbers, each category tailored each individual’s needs (Wenzel, Dobson, and Hayes, 2016). Wenzel et al. (2016), suggest relapse prevention is an important component of CBT used to help produce long-term results. In conclusion, a wide range of strategies are incorporated into Cognitive-Behavioural Therapy and if these strategies are implemented correctly they can result in positive treatment outcomes for a variety of psychological and physical disorders.

**Safety Procedures and OICBT Protocols**

**Safety and Therapist Requirements:**

Staff at OICBT that are working out in the community are required to record on a designated OICBT google calendar the appointment time, the client’s initials and the location the services are being offered. OICBT personnel are required to check out at the end of the day or before leaving for a home visitation. This it to ensure the institute is aware of the whereabouts at all times. Staff members are required to carry their cellphones with them during home and community visitations in case of an emergency. Behavioural aides are required to carry first aid kits, hand sanitizer, as well as other safety equipment including masks and gloves if applicable. When working out of the agency setting, the Ottawa Institute of Cognitive Behavioural Therapy requests that all participating staff members confirm that all vaccines are up-to-date, including completing tuberculosis testing, and Hepatitis B shots. Behavioural Aides are also expected to have completed and obtain certification in non-violent crisis intervention.

**Location Suitability:**

The screening is done prior to the first visitation. However, the assessment may be conducted in the individual’s home if necessary. To ensure safety two OICBT team members will conduct an assessment on the home before committing to visitations in the home. Head
Office should be notified of all visitation locations prior to beginning home and community-based services. A service contract should be completed which reviews the roles and responsibilities of the client and behavioural aide, agency policies regarding no tolerance for violence or the use of alcohol or illegal substances during visitations.

Things that need to be considered prior to beginning home sessions include the cleanliness of the home, animal control, does the client has access to weapons within the home, are children or other adults present during sessions, as well as privacy of the client. Staff must maintain confidentiality at all times, and boundaries on what is expected when a client or staff members runs into someone they know during a session are discussed.

**Personal Cellphones and Email:**

Behavioural Aides are not permitted to give clients their personal phone number or email, and should only contact clients using agency phones. If they do need to use a personal phone to contact a client, they should take the necessary steps to ensure the call number is not visible to the client. To block this information from the client prior to calling, use the code *67 feature.

**Risk Assessment Prior to Visitation (Appendix B):**

A risk assessment is designed to determine if the therapist or client is in potential danger if home-based services are provided. Factors assessed include whether the person has history of violence or aggression, substance abuse, a psychiatric illness, threatening or argumentative behaviour, aggressive animals, accommodation or household issues, and history of illegal activity. The factors are then scored between very likely, likely, unlikely, highly unlikely, and unknown. If any of the factors are indicated as very likely or likely, the level of risk is much higher, and therefore more than one therapist must attend the home visitations. If unsure about the level of risk consulting with another health professional is recommended.

**Conditions for the Use of Private Vehicles (Appendix C):**

Vehicles must be kept maintained and safe for the road. Drivers must display a valid driver’s license and proof of insurance to the program manager. Verification that the vehicle is permitted to use for work related purposes must be confirmed by insurer. When transporting clients, the agency requests that all vehicles be kept clean. OICBT asks that if vehicles or drivers become unsafe to drive, that drivers advise their primary supervisor of this change. Reasons may include loss of license or insurance, under the influence of drugs or alcohol, and taking medication or having a medical condition that may impair driving. A contract discussing all these terms must be signed by both the OICBT staff member and manager, and dated to keep for records.

**Consent and Confidentiality**

Clients receiving treatment by personnel working in the Home and Community services sector are required to formally consent by signing a consent and confidentiality form (Appendix D). This form provides a description the services offered by the behavioural aide, as well as the goal of the program. It also reviews the insurance policies, appointment times, payment forms, policies on cancelled and missed appointments, and most importantly the policies around confidentiality. The Ottawa Institute of Cognitive Behavioural Therapy works toward keeping all client information confidential. All identifying information is kept in a locked file and any device
being used, such as computer or USB has encryption software to prevent any possible breaches of confidentiality.

OICBT also has an obligation to breach confidentiality for certain ethically approved reasons. These are clearly outlined on the consent form in order to make clients aware of the limits to confidentiality. OICBT follows ethical guidelines regarding the agency’s obligation to release information for specified reasons. According to the Canadian Code of Ethics for Psychologists (2000), the agency is required to inform Children’s Aid Society if they have been informed of child under the age of 16 of has previously, currently, or a risk of being abused or neglected. OICBT has an obligation to break confidentiality if a client is a risk of harming self or others, or has informed agency personnel that the they have previously been abused by a regulated healthcare professional, the agency has a duty to report the name of the professional to the professional’s regulatory college (Canadian Code of Ethics for Psychologists, 2000). The fourth reason the agency is required to break confidentiality is if client information has been subpoenaed by the court, the information being requested must be released, and lastly when the quality assurance reviews are being conducted by the College of Psychologists, and in this case they may obtain access to client files (Canadian Code of Ethics for Psychologists, 2000).

Recently, learning that a vulnerable person in an extended care situation is harmed or at risk of being harmed, psychologists now have an obligation to report such harm. All of these limits are formally stated in the consent form provided to all clientele prior to beginning therapy at OICBT. The consent form is reviewed by therapist with the client and both parties are required to sign the document to document consent. This form should then be placed in the client’s file, which is secured under lock and key in a designated filing cabinet.

**Disclosure of Information (Appendix E)**

To ensure the confidentiality remains kept, a disclosure form should be provided prior to beginning therapy. This form allows participants to give permission to OICBT personnel to communicate and provide treatment information to individuals with whom participants have named (OICBT, 2016). This form is completely voluntary and if the client would not like any information disclosed to outside sources, they have the ability to decline permission (OICBT, 2016).

**Psychological Testing Measures**

A psychological test is considered a source of information, and is also considered to be an evaluative device (Hogan & Tsushima, 2016). Hogan and Tsushima (2016) also note that psychological assessment and testing can be applied in the form of records, interviews, medical tests, and more. However, certain types of assessment measures (e.g. interviews with family members) may not be considered to be as valid and as reliable as other testing measures due to lack of standardization in administration. When considering the use of psychological testing measures it is important that they follow the main psychometric principles, meaning they have been proven to be reliable, valid, fair, follow norms and are standardized (Hogan & Tsushima, 2016). A psychological test is considered a source of information, and is also considered to be an evaluative device. When describing these psychometrics, validity refers to the extent the test measures what it is supposed to measure (Hogan & Tsushima, 2016). Testing reliability is described as “the stability and consistency from a test or any measurement procedure” (p. 37, Hogan & Tsushima, 2016). Fairness is a newly established principle, which describes the validity of the test in comparison to all individuals, meaning that the test is equally fair and unbiased for
all individuals taking the test (Hogan & Tsushima, 2016). Lastly, norms consider whether the
test and testing results are reflective of a standard and normal distribution (Hogan & Tsushima,
2016). Hogan and Tsushima (2016) note that there are a few key sources used to help determine
whether a test is reflective of these psychometric principles. Testing manuals consistently refer to
Standards, the Buros Mental Measurements Yearbooks (Carlson, Geisinger, & Jonson, 2014), the
Ethical Principles of Psychologists and Code of Conduct created by the American Psychological
Association in 2010, the Education Testing Service (2015), and lastly, PsycTESTS, an online
database used to determine the effectiveness of specific psychological tests (Hogan & Tsushima,
2016).

Measures for Anxiety (Appendix F)

The Overall Anxiety Severity and Impairment Scale (OASIS; Norman, Hami-Cissell
Means-Christensen, & Stein, 2006). The OASIS is a 5-item self report questionnaire designed to
assess for anxiety symptoms and severity (Norman, Hami-Cissell, Means-Christensen, & Stein,
2006).

The Pen State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec,
1990). The PSWQ is a 16 item self-report questionnaire designed to assess for excessive
worrying and Generalized Anxiety Disorder (Meyer, Miller, Metzger, & Borkovec, 1990). It
includes 5 response options ranging from 1 being not at all typical of me to 5 being very typical
of me (Meyer, Miller, Metzger, & Borkovec, 1990). Scores can vary between 16 to 80
indicating different levels of severity of symptoms (Meyer, Miller, Metzger, & Borkovec, 1990).
According to Meyer at al., 1990, typical mean scores for individuals with GAD range between 60-
68.

Health Anxiety Questionnaire (HAQ; Lucock and Morely, 1996). The HAQ is a self-
report assessment measure designed to screen for symptoms related to health anxiety (Lucock &
Responses can vary from not all or rarely to most of the time (Lucock, & Morely, 1996).
According to Lucock and Morely, it is suggested that mean score of 35.3 is representative of
health anxiety in comparison to mean scores of the general population. A mean score of roughly
17.7 suggests another form of anxiety being present (Lucock, & Morely, 1996).

Social Phobia Inventory (SPIN; Connor, Davidson, Churchill, Sherwood, Foa, and
Weisler, 2006). The Social Phobia Inventory is a 17-item, self-report psychological testing
measure designed to assess for social phobia or social anxiety disorders (Connor et al., 2016).
Scores can vary anywhere between 0 to 68, higher scores indicate increased degree of severity of
symptoms (Connor et al., 2006). Scores above 19 reportedly indicate a positive screen for social
anxiety (Connor et al., 2006).

Measures for Obsessive-Compulsive Disorder (OCD) (Appendix G)

Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010).
Abramowitz and colleagues created DOCS to assess the four most common dimensions of OCD
symptoms. These dimensions include Concerns about Germs and Contamination, Concerns
about being Responsible for Harm, Injury, or Bad Luck, Unacceptable Thoughts, and lastly Concerns about Symmetry, Completeness, and the Need for Things to be ‘Just Right’ (Abramowitz et al., 2010). It includes 20 questions, 5 for each domain, and 5 possible response options for each item. Scores above 18 differentiate a person with OCD in comparison to someone without a psychiatric illness, and higher score represent increased severity of symptoms (Abramowitz et al., 2010).

**Obsessive Activities Checklist** (Grayson, 2014). The Obsessive Activities Checklist is 220-item self-report assessment designed to assess for impairment in completing daily activities in 12 different domains of functioning as a result of OCD symptoms (Grayson, 2014). Individuals are asked to rate each item on a 5-point scale, 1- no problem with activity to 5 being almost constant problems with activity (Grayson, 2014). Higher scores indicate higher level of impairment in daily activities (Grayson, 2014).

**Obsessive Concerns Checklist** (Grayson, 2014). The Obsessive Concerns Checklist, also created by Grayson (2014) is a 141-self report questionnaire which is designed to assess for the level of distress and troubling of OCD thoughts. 9 different thought dimensions are included in the checklist, and individuals are asked to rate the thoughts accordingly, 1 being this thought does not trouble me at all, to 5 being this thought troubles me continually (Grayson, 2014). Higher scores in each domain suggest increased level of distress associated with each thought (Grayson, 2014).

**Obsessional Beliefs Questionnaire** (OBQ-44; Obsessive Compulsive Cognitions Working Group; OCCWG, 2005). The OBQ-44 is a self-report questionnaire beliefs and appraisal of automatic thought. The questionnaire consists of 44 items and 7 different possible responses for each question (OCCWG, 2005). Response options range from disagree very much to agree very much. Each question is relevant to one of three different domains. These domains include responsibility and threat estimation, perfectionisms and intolerance of uncertainty, and importance and control of thoughts (OCCWG, 2005). When scoring the OBQ-44 individual scores are compared to both the means for an OCD group and the means of the community control group. Positive screens for OCD are those that fit within the normative mean scores of OCD and are within 1 standard deviation above and below mean scores for each domain (OCCWG, 2005). The version located in the appendices is an adaptation of the original assessment.

**Yale-Brown Obsessive Compulsive Scale** (Y-BOCS; Goodman et al., 1989). The Y-BOCS is an psychological assessment measure used to assess the severity of obsessive-compulsive symptoms (Goodman et al., 1989). It is a 10-item self-report scale, 5 items relating to obsessional thoughts, and 5 items relevant to compulsive behaviours (Goodman et al., 1989). Scores range from 0 to 4, representing different levels impairment and severity (Goodman et al., 1989). Higher scores represent increased levels of severity of OCD symptoms and impact on daily living (Goodman et al., 1989).
Measures for Aggression (Appendix H)

**Bus-Perry Aggression Questionnaire** (AQ; Buss & Perry, 1992). The Buss-Perry Aggression Questionnaire developed by Buss and Perry in 1992, is an assessment used to assess 4 different components of aggression. The four subcategories of aggression assessed in the AQ are physical, verbal, anger, and hostility expressed through aggression (Buss and Perry, 1992). The AQ is composed of 29 questions each reflecting one of the four specified domains (Bus and Perry, 1992). Results suggest that higher scores reflect higher levels of aggression. Scoring is further explained in the context of the manual.

Scores for physical aggression can range between 9 to 45 (Buss & Perry, 1992). Scores between 9-24 suggest low levels of physical aggression, scores ranging between 25-35 suggest average levels of physical aggression, and scores 36 and above suggest high levels of physical aggression (Buss & Perry, 1992).

Scores for verbal aggression can range from 5 to 25 (Buss & Perry, 1992). Ratings between 5 to 10 suggest low levels of verbal aggression and scores between 11 to 18 indicate average verbally aggressive behaviour. Lastly, scores ranging from 19 to 25 indicate possible high levels of verbal aggression.

Scores for anger can vary from anywhere between 7 to 35 (Buss & Perry, 1992). Ratings between 7 to 18 indicate low amounts of anger, 19-28 propose average anger, and scores above 29 suggest high levels of anger (Buss & Perry, 1992).

Buss and Perry state scores for the hostility subscale can vary between 8 to 40. An indication of low levels of hostility is any score between 8 to 20 (Buss & Perry, 1992). Scores ranging from 21 to 32 suggest average levels of hostility whereas scores above 33 indicate possible high amount of hostile behaviour (Buss & Perry, 1992).

Total final rating can vary anywhere between 29 to 145 (Buss & Perry, 1992). Rating between 29 to 64 suggest overall low amounts of aggression, 65 to 94 indicate average aggressive behaviour, 95 to 119 reportedly suggest fairly high levels of aggressive behaviour and finally scores ranging from 120 to 145 indicate very high levels of aggression. For an example of the excel scoring sheet see Appendix H.

Measures for Bi-Polar Disorders (Appendix I)

**The Mood Disorders Questionnaire** (MDQ, Hirschfeld et al., 2000). The MDQ is an assessment measure used to screen for Bi-polar disorders (Massidda, Giovanna Carta, and Altoè, 2016). This questionnaire has a total of 13 items, with two response options, yes or no (Massidda, Giovanna Carta, and Altoè, 2016). A person must answer yes to at least 7 items in the first section, yes to question number 2, and responds either moderate or serious to the final question, to receive a positive screen for Bi-Polar Disorder (Hirschfeld et al., 2000).

Measures for Depression (Appendix J)

**The Patient Health Questionnaire for Depression** (PHQ-9, Spitzer, Williams, and Kroene, 2016). The PHQ-9 is an assessment used to screen for depressive symptoms and severity (Spitzer, Williams, Kroene, 2016). It is a nine item questionnaire, with four response options which very from 0 being not at all, 1 being several days, 2 being more than half of the days, and 3 being nearly everyday (Hinz et al., 2016). Scores determine symptom severity and can range
anywhere from 0 to 27, 0-5 suggesting mild depression, scores ranging between 10-15 suggesting moderate severity, and scores greater than 15 indicating severe levels of depression (Hinz et al., 2016).

**Measures for Insomnia (Appendix K)**

- **Pittsburgh Sleep Symptom Questionnaire-Insomnia (PSSQ_I; Okun, Kavitz, Sowers, Buysee, & Hall, 2009).** The PSSQ_I was developed by Okun and Colleagues in 2009, and is designed to screen for insomnia. It is a 13-item self-report questionnaire with 6 response options ranging from never to always (5-7 times per week) (Okun et al., 2009). If the participant has answered “frequently” or “always” to at least questions 1, 2 or 5, has answered “greater or equal to 4 weeks” to at least one of questions 1, 2, or 5, and has answered “quite a bit” or “extremely” to a minimum of one questions from items 6 to 13, it is considered to be a positive screen for insomnia disorder (Okun et al., 2009).

**Measures for Posttraumatic Stress Disorder (PTSD) (Appendix L)**

- **PTSD Checklist (PCL-S; Monthly; Weathers, Litz, Herman, Huska, and Keane, 1993).** The PCL-S is an assessment measure designed to assess for PTSD symptoms, but is not considered to be a formal diagnostic tool (Weathers et al., 1993). The PCL-S is composed of 17 questions, and 5 responses ranging from not at all to extremely. According to Weathers and colleagues, scores 45 or higher display positive signs of PTSD and therefore the person should be referred for a formal assessment of PTSD.

**Measures for Panic Disorder (Appendix M)**

- **Body Sensations Questionnaire (BSQ; Chambless, Caputo, Bright, and Gallagher, 1984).** The purpose of the body sensations questionnaire is to assess for symptoms of panic attacks in agoraphobics (Chambless, Caputo, Bright, and Gallagher, 1984). It is designed to assess physiological symptoms associated with anxiety (Chamless, Caputo, Bright, and Gallagher, 1984). Chambless and colleagues developed this 17-item self-report scale, with responses on a 5-point rating scale (1- not frightened or worried by this sensation to 5- extremely frightened by this sensation). The BSQ total score is the average of all answered questions, and if 3 or questions are skipped test results should be considered invalid (Chambless, Caputo, Bright, and Gallagher, 1984). Higher scores are an indication of greater levels of fear to physiological symptoms (Chambless, Caputo, Bright, and Gallagher, 1984).

- **Panic Frequency Questionnaire (PFQ; Antony and Swinson, 1999).** Antony and Swinson developed the Panic Frequency Questionnaire in 1999, to screen and assess the intensity of panic disorder symptoms. This questionnaire is a 6-item self report questionnaire, the first two items requesting requesting frequency of panic attack, and the final four questions symptom severity and range of symptoms expressed by those with panic disorder (Antony and Swinson, 1999). Higher scores suggest increased frequency and intensity of symptoms (Antony and Swinson, 1999).
Measures to Assess Substance Use (Appendix N)

The CAGE Questions Adapted to Include Drugs (CAGE-AID; Brown and Rounds, 1995). This CAGE-AID is a 4-item self-report questionnaire designed to screen for alcohol and drug abuse (Brown and Rounds, 1995). This measure only has two response options, yes or no (Brown and Rounds, 1995). Higher scores indicate a possible substance use problem, and there is 2 or more yes responses, score should be considered as clinically significant (Brown and Rounds, 1995).

Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD; Treatment Improvement Protocol, Series 11, 1994) The SSI-AOD was developed by the consensus panel of Treatment Improvement Protocol, Series 11, in 1994. This is a 16-item scale designed to screen for alcohol or substance abuse (Treatment Improvement Protocol, Series 11, 1994). Only 14 of the 16 questions are scored (questions 1 and 15 are not scored) (Treatment Improvement Protocol, Series 11, 1994). If an individual scores answers yes to four or more the the 14 scored questions, this is considered a positive screen for a alcohol or substance use problem (Treatment Improvement Protocol, Series 11, 1994).

Other Measures (Appendix O)

Personality Belief Questionnaire (PBQ; Beck and Beck, 1991). The PBQ was created by Beck and Beck in 1991 as a clinical assessment instrument developed to assess for maladaptive, dysfunctional, or unrealistic beliefs, specifically associated with personality disorders. The PBQ is a 126 item self-report designed to assess nice subscales of personality disorders (Beck and Beck, 1991). Scores for each domain are transformed into Z-scores and compared the Z-scores for patients with corresponding Personality Disorders and patient with no personality disorder (Beck and Beck, 1991). Examples of scoring sheets can be located in Appendix O.

Work and Social Adjustment Scale (WSAS; Marks, 1986). The WSAS is a five-item self-report questionnaire designed to assess the areas in daily living that are most impacted as a result of his or current condition (Marks, 1986). Response options range from not at all to very severely (Zahra, Qureshi, Henley et al., 2014).

Community and Home Based CBT Program Evaluation Form (Ottawa Institute of Cognitive Behavioural Therapy, 2015). The Community and Home Based CBT Program Evaluation Form was created by the staff at OICBT to evaluate the services provided through the Home and Community-based Program. It includes 14-items, the first 8 questions addressing learning objectives (OICBT, 2015). Responses for the first 8 questions range from 1 being strongly disagree to 5 being strongly agree. The next 2 questions are request feedback on client’s experiences and desired outcomes met through the services received at OICBT (OICBT, 2015). The final 3 questions ask the participants to rate the overall program on three levels (Therapist, Team, and Organization) on a 4-point scale, 1 being poor to 4 being excellent (OICBT, 2015). Finally, participants are asked to make additional comments on services and thoughts of the OICBT Home and Community-Based Program.
Treatment Schedule

The OICBT Home and Community-Based CBT Program treatment length can range from anywhere between 6-15 weekly sessions. However, it may be necessary to adjust the number of sessions and lengths of session per week to accommodate the needs of the client (Ottawa Institute of Cognitive Behavioural Therapy, 2016). According to a meta-analyses conducted by Honashika and colleagues, who investigated the use CBT for depression, found that the results of CBT were found to be more successful if given in 10 or more sessions, which should be taken into account when providing CBT services.

Screening Call (Appendix P)
Treatment typically begins with a screening call between the client and a staff member working at the OICBT to determine whether the person is a suitable candidate for treatment at OICBT.

Intake Assessment (Appendix Q)
After the screening call is completed the client will be asked to come in for an intake assessment. The intake assessment is designed to determine the most suitable treatment method for the client. The assessment process are approximately 2 hours in length. During this meeting, consent is obtained, payment is discussed and form is completed, and a review of the limits to confidentiality. During the intake the client is asked a series of questions to obtain information on the client’s developmental background, previous and current symptoms, physical and psychiatric history, maintaining factors etc. (see Appendix Q for intake assessment outline and demographic form template). Finally, individual client goals and discussed and determined, based on client’s needs.

Feedback Session
If the client is referred for the Home and Community-Based program, they will then have a meeting with the psychologist and the assigned behavioural aide to review and work towards finalizing a treatment plan. The treatment plan is developed based on information obtained during the initial intake assessment, and methods described for intervention, are those empirically proven as evidence-based best practice for the treatment of each client’s specific needs. The client can be provided with psychoeducational handouts for the individual to read. The scheduling of the next session will conclude the initial meeting.

Treatment Sessions
The client and the behavioural aide collaboratively discuss an appropriate number of treatment sessions. Sessions can be added if needed.

During the following pre-determined number of sessions, the behavioural aide works directly with the client to help the individual reach his or her specified goals. Clients are assessed during each session for anxiety or mood changes using a wide range of possible psychological testing measures. Homework is given to the individuals to be completed between sessions. According to Wenzel, Dobson, and Hays (2016), each session should follow a standard outline. This outline includes completing a brief check-in on mood, connection to previous
session, agenda setting, review of homework from previous session, and finishing with a summary of session points, receiving of feedback, and assigning homework (Wenzel, Dobson, and Hays, 2016) (See Appendix R for examples of Homework Assignments and Monitoring Sheets). Sessions are documented and payment is processed after each visitation. Sessions are documented and progress notes are signed by the supervising psychologist (Appendix S: Progress Note Template).

During the final session, goals and client progression is discussed. The behavioural aide helps to work with the client to understand relapse prevention strategies, and future steps. A follow-up date is determined during this session. Termination of treatment should be documented.

**Internal Referral Process (Appendix U)**

Individuals who have already receiving services from OICBT, can also be referred by the person they are working with, if that individual feels they would benefit from working with a behavioural aide within the home or community. Before officially referring the client to the Home and Community Program, the therapist must discuss this with the client, and provide a rationale for incorporating home and community services into the client’s treatment plan. If the client agrees to receiving further therapy, they must sign a disclosure form, (Appendix E), allowing the therapist to disclose relevant information to the behavioural aide. The referring psychologist must fill out internal referral form (Appendix U) and provide it to the Home and Community Services Coordinator.

**Fees and Payment Forms (Appendix V)**

OICBT has a standard payment process that should be followed. Behavioural Aides and OICBT staff are required to produce their own client invoices (Appendix V: Invoice Template). Payments are monitored and recorded on an excel file which is kept on an encrypted USB storage device. An example of excel sheet is provided in Appendix V.

The initial screening call is free of charge.

The intake assessment is typically $120.00.

Feedback session with only behavioural aide is $70.00.

The Feedback and Treatment Planning Session with a psychologist present can range from $175.00 to $200.00 depending on the psychologist or social worker’s fee. The supervising psychologist/social worker and behavioural aide are both present during this session.

Home and community individual sessions are $80.00. There may be an extra charge depending on travel time.

Any session including the presence of a psychologist or social worker range from $175.00 to $200.00.
Client’s who are receiving treatment through the Ottawa Institute of Cognitive Behaviour Therapy Home and Community-Based Program are required to fill out a payment form (Appendix V), in order for payments to be processed after visitations. This information is kept in a locked filing cabinet to ensure confidentiality is kept, and payment info is kept safe from fraudulent conduct.

**Effectively Using CBT Procedures (Appendix W)**

**Psychoeducation**

Psychoeducation is a term used to describe the procedure of teaching client’s or other individuals about relevant and important psychological principles, and providing them with knowledge to help them to better understand specific information related to mental condition or intervention procedures (Wenzel, 2013). Client’s can be provided this information verbally or in the form of handouts (brochures, self-help resources, book etc.) (Wenzel, 2013). According to Wenzel, 2013, Psychoeducation can fall under five different domains. These domains are the process of CBT and structure, client’s presenting problem, theory of CBT, evidence to support CBT, and pharmacotherapy (Wenzel, 2013). See Table 1 for an example of Psychoeducation and Motivational Enhancement Techniques taken from Wenzel, 2013 Strategic Decision Making in Cognitive Behavioral Therapy. Other examples of Psychoeducation resources can be found in Appendix W.

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description</th>
<th>Expected outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoeducation about presenting problem</td>
<td>Therapist educates patient about the presentation of the presenting problem.</td>
<td>Patient has a sound understanding of the presenting problem. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Psychoeducation about the structure and process of cognitive behavioral therapy (CBT)</td>
<td>Therapist educates patient about CBT’s (e.g., active, time limited) and rationale for session structure components.</td>
<td>Patient has a sound understanding of CBT’s components and structure. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Psychoeducation about the CBT model</td>
<td>Therapist educates patient about cognitive and behavioral therapy as it relates to his or her clinical presentation.</td>
<td>Patient has a sound understanding of the cognitive and behavioral principles that underlie CBT. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Psychoeducation about CBT’s evidence base</td>
<td>Therapist educates patient about results from CBT outcomes research.</td>
<td>Patient has realistic expectations for the degree to which CBT will be helpful. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Psychoeducation about pharmacotherapy</td>
<td>Therapist educates patient about the degree to which combined CBT and pharmacotherapy could be helpful and answers questions about side effects.</td>
<td>Patient has knowledge of how the medication will help him or her. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Identification of short-term goals</td>
<td>Therapist helps patient identify short-term goals that he or she would like to achieve in therapy.</td>
<td>Patient develops a better understanding of the manner in which CBT could be helpful. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Discussion of psychiatric symptoms</td>
<td>Therapist helps patient identify ways in which psychiatric symptoms have caused life interference and distress.</td>
<td>Patient becomes more motivated for treatment. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Identification and modification of negative attitudes toward treatment</td>
<td>Therapist identifies and modifies attitudes and assumptions that could disrupt treatment engagement.</td>
<td>Patient develops a sense of CBT’s collaborative empiricism. Therapeutic relationship is enhanced.</td>
</tr>
<tr>
<td>Overcoming of obstacles to participating in treatment</td>
<td>Therapist helps patient identify obstacles to participating in treatment and solutions to overcome those obstacles.</td>
<td>Obstacles are removed. Therapeutic relationship is enhanced.</td>
</tr>
</tbody>
</table>

Table 1: Psychoeducation and Motivation Enhancement Techniques (Taken from Wenzel, 2013; Strategic Decision Making in Cognitive Behavioral Therapy, Pg. 64).
Using Exposure Therapy

There are several different forms of exposure therapy used within Cognitive Behavioural Therapy. These types of exposure include in vivo exposure, interoceptive exposure, and imaginal exposure (Farmer and Chapman, 2016, pg. 285). See Appendix W for Guidelines for Conducting Exposure and Exposure Monitoring Sheets.

In Vivo Exposure
In vivo exposure involves directly exposing the client to feared/avoided situations, people, places, or any stimuli that causes increased anxiety and distress (Farmer and Chapman, 2016, pg. 285). This form of exposure is typically used individuals with PTSD, OCD, social anxiety and specific phobia (Farmer and Chapman, 2016, pg. 285).

Interoceptive Exposure
Interoceptive exposure is a specific exposure strategy designed to target those with fears of bodily sensations (Farmer and Chapman, 2016, pg. 285). Typically, this procedure involves exposing clients to bodily sensations by engaging in exercises that will produced physiological reactions associated with anxiety (Farmer and Chapman, 2016, pg. 285). Exercises include having the person spin to produce the sensation of dizziness, engage in exercise to increase heart rate and sweating, breathing through a straw to produce the sensation of hyperventilating (Farmer and Chapman, 2016, pg. 285). This form of exposure is used most frequently with those with panic disorder or fear/avoidance of physiological sensations (Farmer and Chapman, 2016, pg. 285).

Imaginal Exposure
Imaginal exposure involves exposing individuals to imaginal situations or recollections that cause the individual increased anxiety and distress (Farmer and Chapman, 2016, pg. 285). This type of exposure is commonly used to help treat client’s with PTSD or intrusive thoughts (Farmer and Chapman, 2016, pg. 285).

Steps to Implementing Exposure Therapy

1. Conduct A Functional Assessment. It is important to first conduct a functional assessment in order to determine antecedents, and consequences of the client’s behaviour (Wenzel, 2013, pg. 177). This will also help to determine emotional reactions, safety behaviours, and maintenance behaviours including avoidance of anxiety provoking stimuli (Farmer and Chapman, 2016, pg. 293).

2. Provide a clear rationale for using Exposure Therapy. This is essential in order to help clients better understand the purpose and reasoning for using exposure (Farmer and Chapman, 2016, pg. 293).

3. Select an Appropriate Type of Exposure. Choose the most suitable type of exposure for the client’s specific needs (example in vivo exposure, interoceptive exposure, or imaginal exposure (Farmer and Chapman, 2016, pg. 293).

4. Help Client Develop a Fear Hierarchy. This involves helping the client develop a hierarchy of
situations that cause them increased distress and anxiety and ordering them from least anxiety provoking to most anxiety provoking (Wenzel, 2013, pg. 178). This help both the therapist and client visually see a representation of all the events and stimuli that cause the client fear (Wenzel, 2013, pg. 178). The goal is to use specified situations during the exposure exercises (Wenzel, 2013, pg. 178). Examples of Exposure Hierarchy can be located in Appendix R.

5. Collaboratively Select Pace, Length of Exposure, and Schedule of Exposure Sessions with Client. Scheduling, length, and pace should be formatted in way that is going to produce the most beneficial outcome for the client and improve both long-term and short-term outcomes (Farmer and Chapman, 2016, pg. 292-295).

6. Plan prevention of Safety Behaviours, Avoidance, or Other Ritual Behaviours. This involves helping to make sure the client does not engage in safety behaviours such as using cellphone or taking medication to neutralize the exposure exercise (Farmer and Chapman, 2016, pg. 295-296).

7. Implement Exposure Exercise. The next step is actually implementing the exposure exercise. Ideally, it is recommended that you begin exposing the client to an item which produces low amounts of anxiety, eventually climbing the hierarchy until the items that produce the most amounts of anxiety are reached (Wenzel, 2013, pg. 179). According to Wenzel, the exposure session should follow a typical schedule, first preparing clients for the exposure, second, having clients remain in the exposure until their anxiety decreases to a mildly severe, debrief client after the complete of the exposure and lastly assign homework to the client to be completed between sessions. Clients anxiety levels should be rated throughout the exposure exercise and recorded on a monitoring sheet in order to track client progression (Wenzel, 2013, pg. 179). An example of an exposure monitoring sheet can be located in Appendix W.

8. Assign Homework. Homework should be assigned to the client after each session, to promote increased progression and help the client to practice exercises taught in therapy outside of therapy sessions (Wenzel, 2013, pg. 179-180).

**Thought Records**

Thoughts records are a CBT tool used to assist clients in identifying and addressing negative thought patterns or beliefs (Persons, Davidson, and Tompkins, 2001). According to Persons and colleagues, 2001, this specific strategy is used to change automatic thoughts that contribute to maladaptive behaviours and coping mechanisms. The thought record is divided into sections (Persons, Davidson, and Tompkins, 2001). The sections include the situation (the external event eliciting automatic thoughts), Mood (moods experienced during situation), Behaviour (associated with situation) automatic thoughts (thoughts occurring during situation), evidence that supports the thought, evidence that does not support the thought, alternative thoughts, and emotion and feeling (feelings about the situation now in the present moment) (Persons, Davidson, and Tompkins, 2001).

Guidelines for Using Thought Records According to Persons and Colleagues 2001:

1. Use Socratic Questioning.
2. Focus on a Specific Situation
3. Identify Negative Mood Associated with the Situation (example: Sad)
4. Identify Maladaptive Behaviour Associated with the Situation (example: avoidance,
overeating etc.)
5. Identify the Negative Automatic Thoughts Occurring during the Situation (example: I am incompetent)
6. Determine Evidence that Suggests Thought to be True
7. Determine Evidence that Suggests Thoughts to be False
8. Evaluate Feelings and Emotions after Completion of Thought Record

**Behavioural Activation**

Behavioural Activation (BA) is often used for the treatment of clients with depression and can be used in a group therapy session. Working within this framework the therapist helps clients to see depression not as something that is inside of them but as a natural consequence of the way they cope with the shifting contexts of daily life (Martell, Addis, & Jacobson, 2001). There is no search for mental illness, skill deficits, or distortions in thinking. Rather, the therapist coaches the client to engage in activities that will lead to a more rewarding life. The goal is to replace negative behaviours with behaviours that increase feelings of pleasure and mastery which in turn increase positive reinforcement and reduce negative reinforcement. During sessions, the therapist will first review the role of negative interpretations and biases in depression and introduce the theory and rationale underlying BA. He or she will then ask group members to come up with observations and problems with activation and will review common experiences with difficulties and how it may look like “laziness” when they are in fact struggling to make changes. They will also review intervention strategies to help identify and implement replacement behaviours, highlight the importance of assessment and of choosing the “right” activities, the importance of consistency, and of taking manageable steps in order to not experience failure. The clients are asked to identify behaviours they used in the past and to review the list of possible activities to use in the future. Next, they will rate how easy or difficult they believe it will be to implement their new behaviours, and fill-in their next week schedule with their designated tasks (appendix R). As a wrap-up the therapist can ask for feedback from the group members with an evaluation form (appendix O ) and discuss possible practice for the following week.

**Cognitive Restructuring**

Cognitive restructuring therapy consists of a variety of approaches used to modify the client’s mode of thinking and the premises, attitudes, and assumptions underlying his or her cognitions (Meichenbaum, 1977). The focus of the therapy is on identifying the ideational content involved in the irrational inferences and premises that the client has. Their distorted thought processes adversely affect his view of the world and lead to unpleasant emotions and behavioural difficulties. Thus, the cognitive therapist attempts to familiarize himself with the client’s thought content, style of thinking, feelings, and behaviours, in order to understand their inter-relationships. In this way, the therapist helps the client to identify the specific distortions in their thinking process in order to test their validity and reasonableness. Often, clients are given a journal or a table such as the one in appendix (R) to allow them to record their thoughts during specific incidents. In this table they begin by recording a specific situation, and the mood and automatic thoughts that accompany it. They then have to describe the evidence that supports the “hot” thought and evidence that does not, as well as alternative/balanced thoughts, and their overall mood after this activity. See appendix R for an example of this activity.
**Relapse Prevention**

Relapse Prevention (RP) strategies have been proven to be empirically supported in multiple research studies (McGrady, 2000). RP is a component of CBT, with a range of steps within it (Carrol, 1996; Carrol, 1997). Steps include reduction of exposure, with an emphasis on reducing safety behaviours (ex: substance use), motivational interviewing to determine the pros and cons to using safety behaviours, teach coping mechanisms to deal with the impulse to engage in compulsive behaviours, avoidance, or safety behaviours, self-monitoring, and developing a crisis plan (Carrol, 1996; Carrol, 1997). The stages of change should be considered in relapse prevention (Carrol, 1996; Carrol, 1997). The therapist is required to develop the therapy structure, to accommodate each stage of motivation or readiness for change (Carrol 1996; Carrol, 1997). According to Carrol (1997), these stages include the pre-contemplative stage, contemplative stage, preparation and action, and finally the maintenance stage. Individuals with little motivation for therapy or in the pre-contemplative stage, would be provided with therapy to motivate the client, and in contrast a person who appears to be ready for therapy (action stage) would be provided with therapy focused on skill building and tools to help them during recovery and prevent relapse (Carrol, 1997). During the maintenance stage the therapist would assist the client to help maintain therapy progress and develop a plan for potential relapse (Carrol, 1997). Essentially, each stage is meant to cater to the client’s readiness for treatment and can thus be dynamic as emotions and attitudes often are.

![Figure 2: Stages of Change, taken from Carroll, K. M. (1996). Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental and Clinical psychopharmacology*, 4(1), 46.](image-url)
Conclusion

This manual has been designed to help assist current and new employees at the Ottawa Institute of Cognitive Behavioural Therapy in conducting services with the Home and Community-Based Program. It has been created to provide insight on current procedures being used at the agency in combination with current literature. It also has been developed to help provide clarification on the use of psychological procedures and implementation of specific activities typically used with the Home and Community-Based Program.
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Appendix A: Community and Home-Based Services Fact Sheet and Brochure

FACT SHEET

COMMUNITY AND HOME-BASED COGNITIVE BEHAVIOURAL THERAPY

The Ottawa Institute of Cognitive Behavioural Therapy / Institut de thérapie cognitivo-comportementale d’Ottawa

THE OICBT IS COMMITTED TO INCREASING ACCESS TO EVIDENCE-BASED MENTAL HEALTH SERVICES IN THE COMMUNITY IN A COST-EFFECTIVE AND MEANINGFUL WAY

Based on recent data gathered from the Champlain Local Health Integration Network (LHIN; 2010 to 2013), there are numerous gaps in the treatment of mental health difficulties in Ottawa and the surrounding regions. According to the Integrated Health Service Plan (IHSP, 2005) for the Champlain LHIN, approximately 1 in 10 individuals 12 years or older has been diagnosed with a mood, anxiety or psychotic disorder.

One of the greatest challenges for the treatment of mental health difficulties is the accessibility of services. In some cases, the mental health difficulties themselves make it difficult for individuals to access services. Individuals with anxiety and mood disorders, for example, may have great difficulty even leaving their home to attend appointments. In addition, treatment outside the therapists’ office is often indicated as the therapists can then directly help the patient implement and practice strategies introduced in treatment. Few therapists, however, are able to provide off-site services.

To address these problems, the Training Program at the Ottawa Institute of Cognitive Behavioural Therapy, has initiated a program focused on increasing access to mental health services in the community. The overall goal of the community and home-based CBT service is to provide evidence-based treatment to individuals who will benefit from accessing services within their homes and/or receiving treatment within relevant community settings.

What is Cognitive Behavioural Therapy?

Cognitive behavioural therapy (CBT) is an evidence-based treatment that is structured, time-limited and skill-based. It has been used to treat a variety of problems including Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder and all anxiety disorders. The focus in CBT is often on the following:

- Providing education about attention, anxiety and mood problems using the CBT model
- Using cognitive strategies to identify unhelpful thoughts and learning how to question the validity of these thoughts
- Implementing behavioural strategies aimed at increasing activity level and goal attainment
- Helping individuals reduce their experience of anxiety by helping them to face fears in a stepwise and graded fashion and in collaboration with a therapist (e.g., fear of social evaluation, fear of taking the bus)
How Does Cognitive Behavioural Therapy Work?

CBT is the most well-researched psychotherapy in existence today. The efficacy of CBT for the treatment of depression and anxiety disorders has been well established in a number of randomized controlled trials (DeRubeis et al., 2005; DeRubeis et al., 2008; Hoffman & Smits, 2008).

The cognitive behavioural model of CBT proposes that mood, anxiety and interpersonal problems are related to the way we think about our problems, the beliefs we hold about the world, others and ourselves, as well as the way we behave or react within our environment. In this model, our thoughts, beliefs and behaviours maintain our problems, even though they may not be the cause. By examining our thoughts and behaviours, we are able to identify changes we need to make in order to improve our levels of attention, anxiety and depression. A necessary focus of CBT involves making real life behavioural changes through behavioural activation, exposure to feared situations, objects and events and increasing movement towards reaching our goals.

For example, people with social anxiety usually have thoughts centred on being negatively evaluated, negative beliefs about self-worth and a tendency to avoid feared social situations. Understanding the role that each of these components plays in their anxiety helps to direct and guide treatment. In this case, an important component to treatment would be exposure to feared social situations and events.

Why CBT in the Home and Community?

CBT is a skill-based approach that involves practicing a set of cognitive and behavioural skills. Given the focus of CBT on practicing skills outside of the therapists’ office, the need for coaching and modelling of these skills in the real world and with real problems is essential. These problems may include problems with home management, exercise, increasing social activity, difficulties with organisation and planning, reducing engagement in compulsive behaviours and exposing self to feared situations, events and objects. The importance of practice in therapy is emphasized by the benefits associated with completion of homework in CBT. Because individuals experiencing anxiety, depression and attentional problems often report difficulty initiating, maintaining or completing assigned homework tasks on their own, coaching plays an important role in the therapy process.

Community and Home-Based CBT Service will Help Put Goals in Place

The Community and Home-Based CBT service aims to specifically help individuals meet their therapy goals by having trained behavioural aides help individuals get started on tasks they have been avoiding or face fearful situations. These exercises are completed as part of a treatment plan developed in collaboration with a treating psychologist. While the length of CBT treatment within the community and home-based service is flexible, treatment is usually between 6 to 15 weekly or bi-weekly sessions. Therapists regularly evaluate a client’s progress by reviewing patterns in self-reported anxiety and depressive symptoms. This service is offered at the client’s home and/or in relevant community-based settings.
Which Strategies are Taught and Practiced?

In the Community and Home-Based CBT Service, the behavioural aide will encourage and help clients practice identified skills related to treatment goals. The goal is to help individuals master therapy skills so they can then put these skills to work independently. This model is consistent with a relapse prevention and recovery model, which reinforces the attainment of skills and a sense of mastery and self-efficacy within the relevant setting.

This service will primarily be helpful for individuals who are experiencing anxiety, mood and attentional problems, and more specifically, difficulty with:

- Putting identified therapy goals in place independently and outside the therapist’s office;
- Effectively organizing and structuring the home environment (completing overwhelming tasks);
- Getting started on home management tasks (e.g., setting up an organisation system for filing);
- Increasing engagement in physical and social goals (i.e., exercising, socializing);
- Facing events and situations that are being avoided and are important to face in treatment; and
- Putting exposure and response prevention goals in place for OCD (decreasing repetitive behaviours when completing a feared task).

The following strategies are used to help with these problems:

<table>
<thead>
<tr>
<th>Cognitive Strategies</th>
<th>Behavioural Strategies</th>
<th>Exposure Based Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify thoughts that interfere with life goals</td>
<td>• Identify activities that reinforce mastery and pleasure</td>
<td>• Identify avoided situations and events</td>
</tr>
<tr>
<td>• Develop alternative responses to thoughts about self and others</td>
<td>• Breakdown overwhelming tasks</td>
<td>• Develop a plan to expose self to these fears</td>
</tr>
<tr>
<td>• Adopt more helpful ways of seeing and responding to the world</td>
<td>• Help with putting enriching life goals and activities in place</td>
<td>• Decrease anxiety through repeated exposure</td>
</tr>
</tbody>
</table>

What is involved in the Community and Home-Based CBT Service?

The Community and Home-Based CBT Service is under the direction of Dr. Connie Dalton, a partner at the Ottawa Institute of Cognitive Behavioural Therapy. Treatment in this service involves:

- Meeting with a psychologist and a behavioural aide to set up a community and home-based treatment plan;
- Setting up an identified number of treatment sessions to take place in the selected setting. Additional sessions may be scheduled if necessary;
- Meeting with the supervising psychologist to review progress, revise treatment goals or terminate treatment; and
- Upon completion of treatment, a clear plan for follow up and next steps will be provided.
What if I am Already Seeing a Psychologist at the OICBT?

If already in treatment at the OICBT, this service can be coordinated through your treating psychologist and may be considered an adjunct to existing treatment.

How Much Does this Service Cost?

This service is associated with the OICBT Training Clinic and the cost for each session depends on who is delivering the service. For the initial meetings with a supervising psychologist or social worker the standard private practice rate applies (from $175 to $200 per hour). The cost for each hour with the behavioural aide, PhD student or Psychology Resident is approximately $80 per one-hour session, which includes the cost of transportation.

Are Costs Covered by Extended Health Care Coverage?

Although individual and group psychological services are not covered by provincial health plans (OHIP, RAMQ), they are typically covered by extended health care coverage. Social workers, behavioural aides and Ph.D. students providing services under the direct supervision of a registered psychologist are typically also covered under benefits associated with extended health care coverage. As extended health care coverage plans do differ, we do suggest verifying this with your insurance company prior to starting treatment to be sure.

For More Information

For additional information about the Community and Home-Based CBT Service at the OICBT, contact Lisa, the administrative coordinator at the OICBT. Email Lisa at info@ottawacb.ca or call the clinic at 613.820.9931 (extension 0). She will be able to provide you with details regarding this service.

References


CBT in the Home and Community

CBT is a skills-based approach that involves learning and practicing a set of cognitive and behavioral skills to address everyday problems. These problems may include problems with home management, exercise, social isolation, difficulties with organization and planning, and/or compulsive behaviors. While the skills for addressing these problems are introduced in the therapist’s office, the practice of these skills in the real world and with real problems is essential. While we know that benefits associated with therapy is directly proportional to completion and practice of homework, individuals experiencing anxiety, depression and/or attentional problems often report difficulty following through with practicing these skills on their own. That’s where home and community-based coaching can be helpful.

Community and Home-Based CBT Service will Help Put Goals in Place

The Community and Home-Based CBT service aims to specifically help individuals meet their therapy goals by having trained behavioral aides help individuals get started on tasks they have been avoiding or face fearful situations. These exercises are completed as part of a treatment plan developed in collaboration with a treating psychologist. While the length of CBT treatment within the community and home-based service is flexible, treatment is usually between 6 to 15 weekly or bi-weekly sessions. Therapists regularly evaluate a client’s progress by reviewing patterns in self-reported anxiety and depressive symptoms. This service is offered at the client’s home and/or in relevant community-based settings.

What Is Involved in the Community and Home-Based CBT Service?

The Community and Home-Based CBT Service is under the direction of Dr. Connie Dalton, a partner at the Ottawa Institute of Cognitive Behavioural Therapy and the Director of the OICBT Training Program.

Treatment in this service involves:

- Meeting with a psychologist and a behavioural aide to set up a community and home-based treatment plan;
- Setting up an identified number of treatment sessions to take place in the selected setting. Additional sessions may be scheduled if necessary;
- Meeting with the supervising psychologist to review progress, revise treatment goals or terminate treatment; and
- Upon completion of the treatment plan a clear planning for follow up and next steps will be provided.

Which Strategies are Taught and Practiced?

In the Community and Home-Based CBT Service, the behavioural aide will encourage and help clients practice identified skills related to treatment goals. The goal is to help individuals master therapy skills so they can then put these skills to work independently. This model is consistent with a relapse prevention and recovery model, which reinforces the attainment of skills and a sense of mastery and self-efficacy within the relevant setting.

This service will primarily be helpful for individuals who are experiencing anxiety, mood and attentional problems, and more specifically, difficulty with:

- Putting identified therapy goals in place independently and outside the therapist’s office;
- Effectively organizing and structuring the home environment;
- Getting started on home management tasks;
- Increasing engagement in physical and social goals (i.e., exercising, socializing);
- Facing events and situations that are being avoided and are important to face in treatment; and
- Putting exposure and response prevention goals in place (related to OCD).
Ottawa Institute of Cognitive Behavioural Therapy

Director Bio

Dr. Connie Dalton, Psychologist
Dr. Dalton is a founding member of the Ottawa Institute of Cognitive Behavioral Therapy and Excellence in Practice. She participated in the specialized Extramural Training Program at the Beck Institute for Cognitive Therapy and Research. She was also a clinical staff member at the Royal Ottawa Mental Health Centre, where she was responsible for the development of programming for major depressive disorder and bipolar disorder. She offers supervision and training for psychology and family medicine residents, as well as other mental health professionals. Dr. Dalton provides individual therapy for anxiety and mood disorders using CBT, and is the director of the OICBT Training Program. An area of focus and proficiency is the assessment, diagnosis and treatment of anxiety, major depressive disorder and bipolar disorder.

How Much Does this Service Cost?

This service is associated with the OICBT Training Clinic and the cost for each session depends on who is delivering the service. For the initial meetings with a supervision psychologist or social worker the standard private practice rate applies (from $175 to $200 per hour). The cost for each hour with the behavioural aide, PhD student or Psychology Resident is approximately $80 per one-hour session, which includes the cost of transportation.
Appendix B: Risk Assessment Prior to Home Visit

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Comment</th>
<th>Level of Risk</th>
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<tbody>
<tr>
<td></td>
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<td>Very Likely</td>
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<tr>
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<td></td>
<td>Likely</td>
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<tr>
<td></td>
<td></td>
<td>Unlikely</td>
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<td></td>
<td></td>
<td>Highly Likely</td>
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<td></td>
<td></td>
<td>Unknown</td>
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<tr>
<td>1. History of Violence/aggression</td>
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<tr>
<td>2. Substance Abuse</td>
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<td>3. Psychiatric Illness</td>
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<tr>
<td>4. Threatening/Argumentative Behaviour</td>
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<tr>
<td>5. Aggressive Animals</td>
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<tr>
<td>6. Accommodation/Household Issues</td>
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<td>7. History of Illegal Activity</td>
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</tr>
</tbody>
</table>

Where there are ticks indicating risk is “very likely” or “likely”, more than one therapist is recommended to attend home visit.
Appendix C: Conditions for Use of Private Vehicles

CONDITIONS FOR USE OF PRIVATE VEHICLES

I ____________________________ agree to the following conditions in regard to the use of my private vehicle for Community Care business.

1. I will maintain the vehicle in a roadworthy condition.

2. I will provide/have provided for the Manager’s perusal:
   a. My driver’s license
   b. Registration and compulsory third party insurance
   c. Third party property insurance or comprehensive insurance

3. I have checked with my insurer that I can use the vehicle for work purposes, and have complied with any requirements in this regard.

4. I agree to advise my supervisor immediately if I become unable to safely drive my vehicle due to any reason including:
   a. Loss of license
   b. Loss of insurance
   c. Being under the influence of alcohol or drugs
   d. Taking medication which may impact my ability to drive
   e. Having a medical condition which impacts on my driving ability

5. I am aware that the organization may at any time audit for compliance with the above.

__________________________  ______________________________
Staff Signature                  Manager Signature

______________  _____________
Date                  Date
Appendix D: Consent Form

Ottawa Institute
Of Cognitive
Behavioural Therapy

L'institut de thérapie
cognitivo-comportementale
d'Ottawa

*Therapist Name, B.A.A, Behavioural Therapist*
*(Under Supervision of Supervisor's Name, C.Psych)*

411 Roosevelt Ave., Suite 200, Ottawa, Ontario, K2A 3X9, Tel. 613-820-9931 ext. 228

**LIMITS OF CONFIDENTIALITY**

There are strict professional and ethical standards pertaining to confidentiality of client information. Information regarding psychological services provided to you by *Therapist’s Name* will be carried out under the supervision of *Supervisor’s Name, C. Psych.*, and matters related to these services will be discussed with *Supervisor’s Name*.

Information about yourself will not be shared with anyone without your written consent. The following are examples of situations where health professionals are required by law to disclose confidential information:

1. Where the health care provider has reasonable grounds to suspect that a person younger than 16 years of age is or may be suffering or may have suffered abuse in the form of either physical harm, emotional harm, sexual molestation, sexual exploitation, or neglect;

2. Where the health care provider is informed of sexual abuse of the client by a health care provider;

3. In response to court order, warrant, subpoena, or summons to witness;

4. Where the health care provider has reasonable grounds to believe that the client is at risk for harming self or others. The health care provider will consider if there is (a) a clear risk to a person or group of persons and (b) a risk of serious bodily harm or death and (c) a sense of urgency due to the nature of the threat.

This document has been reviewed with me by *Therapist’s Name* and I have had the opportunity to ask questions related to the above content.

___________________________________  __________________________________________________________  ____________
Client Name (Print)  Client Name (Sign)  Date

___________________________________  __________________________________________________________  ____________
Witness Name (Print)  Witness Name (Sign)  Date

*Note this is a Consent and Confidentiality Template. All words *underlined* and in *italics* must be changed prior to administering. Remove this note after changes are made.*
Description of the Service/Therapist Competencies

*Therapist’s Name* is hired by the OICBT as a behavioral aide to provide behavioral therapy services; this includes helping individuals who are experiencing anxiety, depression and attentional problems. Often individuals experiencing these difficulties report difficulty initiating, maintaining or completing treatment goals as well as daily tasks. This service aims at directly helping you meet your identified goals by helping you get started at tasks you have been avoiding or facing fearful situations. These exercises are completed as part of a treatment plan developed in collaboration with a registered psychologist or social worker. This service is offered at your home and in relevant community and exposure-based settings.

All services are provided under the supervision of Dr. Connie Dalton, a registered clinical psychologist at the Ottawa Institute of Cognitive Behavioural Therapy. This means that your case will be regularly reviewed with Dr. Connie Dalton. Should you have any concerns, you are welcome to contact Dr. Dalton at 613-820-9931, ext. 223.

Appointment Times

Appointments are available during the day and late afternoon. Appointment times can vary depending on the service provided. These times can vary between 1.5 and 3 hours depending on your financial situation, treatment recommendations, and the focus of the particular session.

Insurance Coverage

Although individual and group psychological services are not covered by provincial health plans (OHIP, RAMQ), they are typically covered by extended health care coverage. Often insurance companies require that you submit a referral form from a family physician or psychiatrist prior to commencement of services in order for the client to be eligible for insurance benefits and reimbursement. We do not require this, as we take self-referrals. Social workers, behavioral therapists and PhD students providing services under the supervision of a registered psychologist are typically also covered under benefits associated with extended health care coverage. However, it is recommended that you confirm this with your specific insurance care provider.

Payment for Services

It is expected that payment for service be made at the end of each session unless other arrangements have been made. Payment will be processed following the scheduled session. You will receive a receipt that can be forwarded to your insurance carrier. Receipts will be provided at the following session or can be made available for you for pickup at an alternate time at the office if wished. The fee is $80.00 per hour with travel cost included. Please find all details regarding payment on the payment form provided.
Cancelled and Missed Appointments
An appointment means that this time has been set aside for you. If you wish to cancel an appointment, notification as soon as possible, and not less than 48 hours before the scheduled time would be appreciated. Please leave a message at 613-820-9931 ext. 228. You will be billed for the full visit should you forget to come to an appointment or cancel less than 48 hours before the set time.

Frank and open discussion of any of the above is encouraged.
By signing this form, you are acknowledging your understanding and agreement of the conditions outlined above. You also acknowledge that confidentiality has been fully discussed with you and that all of your questions were answered to your satisfaction.

Note this is a Home Based Intervention General Information Template. All words underlined and in italics must be changed prior to administering. Remove this note after changes are made.
CONSENT TO DISCLOSE AND/OR RECEIVE INFORMATION

I, Mr./ Ms. __________________________________________________________
(Date Of Birth: ______________________) hereby authorize Therapist’s Name

who is under the supervision of Supervisor’s Name to:

Initials:______   _____ A. Send copies or provide information verbally concerning my assessment, treatment plan, progress notes, discharge summary and follow-up reports to the individual(s) listed below:

Initials:______   _____ B. Communicate with the following individuals to receive information concerning my psychological status, my treatment, my medical status, or other information relevant to my psychological assessment and/or treatment:

____________________________________________
Institution (please indicate address and phone number)

____________________________________________
Institution (please indicate address and phone number)

I have read and understand this information and provide my consent by signing and initializing this form. I also understand that this consent is valid for 12 months but may be revoked at any time, except in the case where the fee for the service is provided by a third party (for example: WSIB, Insurance company, etc). In such a case, my consent to disclose information to all other people listed above can be revoked, but not for the party paying for the service.

_______________________________________  _________________________
Client’s signature          Date

_______________________________________  _________________________
Witness          Date

Note this is a Consent and Disclosure Form Template. All words underlined and in italics must be changed prior to administering. Remove this note after changes are made.
Appendix F: Measures for Anxiety Disorders

Overall Anxiety Severity and Impairment Scale (OASIS)

Name: ___________________________  Todays Date: ___________________________

The following items ask about anxiety and fear. For each item, circle the number for the answer that best describes your experience over the past week.

1. In the past week, how often have you felt anxious?

   0 = No anxiety in the past week
   1 = Infrequent anxiety. Felt anxious a few times.
   2 = Occasional anxiety. Felt anxious as much of the time as not. It was hard to relax.
   3 = Frequent anxiety. Felt anxious most of the time. It was very difficult to relax.
   4 = Constant anxiety. Felt anxious all of the time and never really relaxed.

2. In the past week, when you have felt anxious, how intense or severe was your anxiety?

   0 = Little or None. Anxiety was absent or barely noticeable.
   1 = Mild: Anxiety was at a low level. It was possible to relax when I tried. Physical symptoms were only slightly uncomfortable.
   2 = Moderate: Anxiety was distressing at times. It was hard to relax or concentrate, but I could do it if I tried. Physical symptoms were uncomfortable.
   3 = Severe: Anxiety was intense much of the time. It was very difficult to relax or focus on anything else. Physical symptoms were extremely uncomfortable.
   4 = Extreme: Anxiety was overwhelming. It was impossible to relax at all. Physical symptoms were unbearable.

3. In the past week, how often did you avoid situations, places, objects, or activities because of anxiety or fear?

   0 = None: I do not avoid places, situations, activities, or things because of fear.
   1 = Infrequent: I avoid something once in a while, but will usually face the situation or confront the object. My lifestyle is not affected.
   2 = Occasional: I have some fear of certain situations, places, or objects, but it is still manageable. My lifestyle has only changed in minor ways. I always or almost always avoid the things I fear when I am alone, but can handle them if someone comes with me.
   3 = Frequent: I have considerable fear and really try to avoid the things that frighten me. I have made significant changes in my lifestyle to avoid the object, situation, activity, or place.
   4 = All the Time: Avoiding objects, situations, activities, or places has taken over my life. My lifestyle has been extensively affected and I no longer do things that I used to enjoy.
4. In the past week, how much did your anxiety interfere with your ability to do the things you needed to do at work, at school, or at home?

0 = None: No interference at work/home/school from anxiety.
1 = Mild: My anxiety has caused some interference at work/home/school. Things are more difficult, but everything that needs to be done is still getting done.
2 = Moderate: My anxiety definitely interferes with tasks. Most things are still getting done, but few things are being done as well as in the past.
3 = Severe: My anxiety has really changed my ability to get things done. Some tasks are still being done, but many things are not. My performance has definitely suffered.
4 = Extreme: My anxiety has become incapacitating. I am unable to complete tasks and have had to leave school, have quit or been fired from my job, or have been unable to complete tasks at home and have faced consequences like bill collectors, eviction, etc.

5. In the past week, how much has anxiety interfered with your social life and relationships?

0 = None: My anxiety does not affect my relationships.
1 = Mild: My anxiety slightly interferes with my relationships. Some of my friendships and other relationships have suffered, but, overall, my social life is still fulfilling.
2 = Moderate: I have experienced some interference with my social life, but I still have a few close relationships. I don’t spend as much time with others as in the past, but I still socialize sometimes.
3 = Severe: My friendships and other relationships have suffered a lot because of anxiety. I do not enjoy social activities. I socialize very little.
4 = Extreme: My anxiety has completely disrupted my social activities. All of my relationships have suffered or ended. My family life is extremely strained.

Penn State Worry Questionnaire (PSWQ)

Instructions: Rate each of the following statements on a scale of 1 (“not at all typical of me”) to 5 (“very typical of me”). Please do not leave any items blank. Enter the number that best describes how typical or characteristic each item is of you, putting the number next to each item. Please Note the direction of wording for questions 1, 3, 8, 10, and 11.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all typical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat Typical</td>
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<tr>
<td>Very Typical</td>
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</tbody>
</table>

1. ____ If I don’t have enough time to do everything, I don’t worry about it.
2. ____ My worries overwhelm me.
3. ____ I don’t tend to worry about things.
4. ____ Many situations make me worry.
5. ____ I know I shouldn’t worry about things, but I just can’t help it.
6. ____ When I’m under pressure, I worry a lot.
7. ____ I am always worrying about something.
8. ____ I find it easy to dismiss worrisome thoughts.
9. ____ As soon as I finish one task, I start to work about everything else I have to do.
10. ____ I never worry about anything.
11. ____ When there is nothing more I can do about a concern, I don’t worry about it anymore.
12. ____ I’ve been a worrier all my life.
13. ____ I notice that I have been worrying a lot.
14. ____ Once I start worrying, I can’t stop.
15. ____ I worry all the time.
16. ____ I worry about projects until they are all done.

Health Anxiety Questionnaire

This questionnaire is concerned with people’s attitudes about their health. Some of the questions concern your bodily symptoms and feelings which can mean pains, aches, sickness, dizziness, breathing difficulties, tiredness, etc. Read each question and circle the answer that best applies to you.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all or rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you ever worry about your health?</td>
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<tr>
<td>Are you ever worried that you may get a serious illness in the future?</td>
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<tr>
<td>Does the thought of a serious illness ever scare you?</td>
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<tr>
<td>When you notice an unpleasant feeling in your body, do you tend to find it difficult to think of anything else?</td>
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<tr>
<td>Do you ever examine your body to find whether there is something wrong?</td>
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<tr>
<td>If you have an ache or pain do you worry that it may be caused by a serious illness?</td>
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<tr>
<td>Do you ever find it difficult to keep worries about your health out of your mind?</td>
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<tr>
<td>When you notice an unpleasant feeling in your body, do you ever worry about it?</td>
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<tr>
<td>When you wake up in the morning do you find you very soon begin to worry about your health?</td>
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<tr>
<td>When you hear of a serious illness or the death of someone you know, does it ever make you more concerned about your own health?</td>
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<tr>
<td>When you read or hear about an illness on TV or radio, does it ever make you think you may be suffering</td>
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</tbody>
</table>
from that illness?

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all or rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. When you experience unpleasant feelings in your body do you tend to ask friends or family about them?</td>
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<tr>
<td>13. Do you tend to read up about illness and diseases to see if you may be suffering from one?</td>
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<tr>
<td>14. Do you ever feel afraid of news that reminds you of death (such as funerals, obituary notices)?</td>
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<tr>
<td>15. Do you ever feel afraid that you may die soon?</td>
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<td>16. Do you ever feel afraid that you may have cancer?</td>
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<td>17. Do you ever feel afraid you might have heart disease?</td>
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<td>18. Do you ever feel afraid that you may have any other serious illness? Which illness?</td>
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<td>19. Have your bodily symptoms stopped you from working during the past 6 months or so?</td>
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<td>20. Do your bodily symptoms stop you from concentrating on what you are doing?</td>
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<td>21. Do your bodily symptoms stop you from enjoying yourself?</td>
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Social Phobia Inventory (SPIN)

Please check how much the following problems have bothered you in the past week. Mark only one box for each problem, and be sure to answer all items.

| 1. I am afraid of people of authority. | Not at all (0) | A little bit (1) | Somewhat (2) | Very Much (3) | Extremely (4) |
| 2. I am bothered by blushing in front of people. |
| 3. Parties and social events scare me. |
| 4. I avoid talking to people I don’t know. |
| 5. Being criticized scares me a lot. |
| 6. Fear of embarrassment causes me to avoid doing things or speaking to people. |
| 7. Sweating in front of people causes me distress. |
| 8. I avoid going to parties. |
| 9. I avoid activities in which I am the centre of attention. |
| 10. Talking to strangers scares me. |
| 11. I avoid having to give speeches. |
| 12. I would do anything to avoid being criticized. |
| 13. Heart palpitations bother me when I am around people. |
| 14. I am afraid to do doing things when people might be watching. |
| 15. Being embarrassed or looking stupid are among my worst fears. |
| 16. I avoid speaking to anyone in authority. |
| 17. Trembling or shaking in front of others is distressing to me |

Appendix G: Measures for Obsessive-Compulsive Disorder (OCD)

Dimensional Obsessive-Compulsive Scale

This questionnaire asks you about 4 different types of concerns that you might or might not experience. For each type there is a description of the kinds of thoughts (sometimes called obsessions) and behaviors (sometimes called rituals or compulsions) that are typical of that particular concern, followed by 5 questions about your experiences with these thoughts and behaviors. Please read each description carefully and answer the questions for each category based on your experiences in the last month.

### Category 1: Concerns about Germs and Contamination

**Examples...**
- Thoughts or feelings that you are contaminated because you came into contact with (or were nearby) a certain object or person.
- The feeling of being contaminated because you were in a certain place (such as a bathroom).
- Thoughts about germs, sickness, or the possibility of spreading contamination.
- Washing your hands, using hand sanitizer gels, showering, changing your clothes, or cleaning objects because of concerns about contamination.
- Following a certain routine (e.g., in the bathroom, getting dressed) because of contamination
- Avoiding certain people, objects, or places because of contamination.

The next questions ask about your experiences with thoughts and behaviors related to contamination over the last month. Keep in mind that your experiences might be different than the examples listed above. Please circle the number next to your answer:

1. **About how much time have you spent each day thinking about contamination and engaging in washing or cleaning behaviors because of contamination?**
   - 0 None at all
   - 1 Less than 1 hour each day
   - 2 Between 1 and 3 hours each day
   - 3 Between 3 and 8 hours each day
   - 4 8 hours or more each day

2. **To what extent have you avoided situations in order to prevent concerns with contamination or having to spend time washing, cleaning, or showering?**
   - 0 None at all
   - 1 A little avoidance
   - 2 A moderate amount of avoidance
   - 3 A great deal of avoidance
   - 4 Extreme avoidance of nearly all things

3. **If you had thoughts about contamination but could not wash, clean, or shower (or otherwise remove the contamination), how distressed or anxious did you become?**
   - 0 Not at all distressed/anxious
   - 1 Mildly distressed/anxious
   - 2 Moderately distressed/anxious
   - 3 Severely distressed/anxious
   - 4 Extremely distressed/anxious

4. **To what extent has your daily routine (work, school, self-care, social life) been disrupted by contamination concerns and excessive washing, showering, cleaning, or avoidance behaviors?**
   - 0 No disruption at all.
   - 1 A little disruption, but I mostly function well.
   - 2 Many things are disrupted, but I can still manage.
   - 3 My life is disrupted in many ways and I have trouble managing.
   - 4 My life is completely disrupted and I cannot function at all.

5. **How difficult is it for you to disregard thoughts about contamination and refrain from behaviors such as washing, showering, cleaning, and other decontamination routines when you try to do so?**
   - 0 Not at all difficult
   - 1 A little difficult
   - 2 Moderately difficult
   - 3 Very difficult
   - 4 Extremely difficult

continued →
Category 2: Concerns about being Responsible for Harm, Injury, or Bad Luck

Examples...
-A doubt that you might have made a mistake that could cause something awful or harmful to happen.
-The thought that a terrible accident, disaster, injury, or other bad luck might have occurred and you weren’t careful enough to prevent it.
-The thought that you could prevent harm or bad luck by doing things in a certain way, counting to certain numbers, or by avoiding certain “bad” numbers or words.
-Thought of losing something important that you are unlikely to lose (e.g., wallet, identify theft, papers).
-Checking things such as locks, switches, your wallet, etc. more often than necessary.
-Repeatedly asking or checking for reassurance that something bad did not (or will not) happen.
-Mentally reviewing past events to make sure you didn’t do anything wrong.
-The need to follow a special routine because it will prevent harm or disasters from occurring.
-The need to count to certain numbers, or avoid certain bad numbers, due to the fear of harm.

The next questions ask about your experiences with thoughts and behaviors related to harm and disasters over the last month. Keep in mind that your experiences might be slightly different than the examples listed above. Please circle the number next to your answer:

1. About how much time have you spent each day thinking about the possibility of harm or disasters and engaging in checking or efforts to get reassurance that such things do not (or did not) occur?
   - None at all
   - Less than 1 hour each day
   - Between 1 and 3 hours each day
   - Between 3 and 8 hours each day
   - 8 hours or more each day

2. To what extent have you avoided situations so that you did not have to check for danger or worry about possible harm or disasters?
   - None at all
   - A little avoidance
   - A moderate amount of avoidance
   - A great deal of avoidance
   - Extreme avoidance of nearly all things

3. When you think about the possibility of harm or disasters, or if you cannot check or get reassurance about these things, how distressed or anxious did you become?
   - Not at all distressed/anxious
   - Mildly distressed/anxious
   - Moderately distressed/anxious
   - Severely distressed/anxious
   - Extremely distressed/anxious

4. To what extent has your daily routine (work, school, self-care, social life) been disrupted by thoughts about harm or disasters and excessive checking or asking for reassurance?
   - No disruption at all
   - A little disruption, but I mostly function well
   - Many things are disrupted, but I can still manage.
   - My life is disrupted in many ways and I have trouble managing.
   - My life is completely disrupted and I cannot function at all.

5. How difficult is it for you to disregard thoughts about possible harm or disasters and refrain from checking or reassurance-seeking behaviors when you try to do so?
   - Not at all difficult
   - A little difficult
   - Moderately difficult
   - Very difficult
   - Extremely difficult

Continued →
Category 3: Unacceptable Thoughts

Examples...

- Unpleasant thoughts about sex, immorality, or violence that come to mind against your will.
- Thoughts about doing awful, improper, or embarrassing things that you don't really want to do.
- Repeating an action or following a special routine because of a bad thought.
- Mentally performing an action or saying prayers to get rid of an unwanted or unpleasant thought.
- Avoidance of certain people, places, situations or other triggers of unwanted or unpleasant thoughts.

The next questions ask about your experiences with unwanted thoughts that come to mind against your will and behaviors designed to deal with these kinds of thoughts over the last month. Keep in mind that your experiences might be slightly different than the examples listed above. Please circle the number next to your answer.

1. About how much time have you spent each day with unwanted unpleasant thoughts and with behavioral or mental actions to deal with them?
   0 None at all
   1 Less than 1 hour each day
   2 Between 1 and 3 hours each day
   3 Between 3 and 8 hours each day
   4 8 hours or more each day

2. To what extent have you been avoiding situations, places, objects and other reminders (e.g., numbers, people) that trigger unwanted or unpleasant thoughts?
   0 None at all
   1 A little avoidance
   2 A moderate amount of avoidance
   3 A great deal of avoidance
   4 Extreme avoidance of nearly all things

3. When unwanted or unpleasant thoughts come to mind against your will how distressed or anxious did you become?
   0 Not at all distressed/anxious
   1 Mildly distressed/anxious
   2 Moderately distressed/anxious
   3 Severely distressed/anxious
   4 Extremely distressed/anxious

4. To what extent has your daily routine (work, school, self-care, social life) been disrupted by unwanted and unpleasant thoughts and efforts to avoid or deal with such thoughts?
   0 No disruption at all.
   1 A little disruption, but I mostly function well.
   2 Many things are disrupted, but I can still manage.
   3 My life is disrupted in many ways and I have trouble managing.
   4 My life is completely disrupted and I cannot function at all.

5. How difficult is it for you to disregard unwanted or unpleasant thoughts and refrain from using behavioral or mental acts to deal with them when you try to do so?
   0 Not at all difficult
   1 A little difficult
   2 Moderately difficult
   3 Very difficult
   4 Extremely difficult

Continued →
Category 4: Concerns about Symmetry, Completeness, and the Need for Things to be "Just Right"

Examples...

- The need for symmetry, evenness, balance, or exactness.
- Feelings that something isn't "just right."
- Repeating a routine action until it feels "just right" or "balanced."
- Counting senseless things (e.g., ceiling tiles, words in a sentence).
- Unnecessarily arranging things in "order."
- Having to say something over and over in the same way until it feels "just right."

The next questions ask about your experiences with feelings that something is not "just right" and behaviors designed to achieve order, symmetry, or balance over the last month. Keep in mind that your experiences might be slightly different than the examples listed above. Please circle the number next to your answer:

1. About how much time have you spent each day with unwanted thoughts about symmetry, order, or balance and with behaviors intended to achieve symmetry, order or balance?
   0 None at all
   1 Less than 1 hour each day
   2 Between 1 and 3 hours each day
   3 Between 3 and 8 hours each day
   4 8 hours or more each day

2. To what extent have you been avoiding situations, places or objects associated with feelings that something is not symmetrical or "just right."
   0 None at all
   1 A little avoidance
   2 A moderate amount of avoidance
   3 A great deal of avoidance
   4 Extreme avoidance of nearly all things

3. When you have the feeling of something being "not just right," how distressed or anxious did you become?
   0 Not at all distressed/anxious
   1 Mildly distressed/anxious
   2 Moderately distressed/anxious
   3 Severely distressed/anxious
   4 Extremely distressed/anxious

4. To what extent has your daily routine (work, school, self-care, social life) been disrupted by the feeling of things being "not just right," and efforts to put things in order or make them feel right?
   0 No disruption at all.
   1 A little disruption, but I mostly function well.
   2 Many things are disrupted, but I can still manage.
   3 My life is disrupted in many ways and I have trouble managing.
   4 My life is completely disrupted and I cannot function at all.

5. How difficult is it for you to disregard thoughts about the lack of symmetry and order, and refrain from urges to arrange things in order or repeat certain behaviors when you try to do so?
   0 Not at all difficult
   1 A little difficult
   2 Moderately difficult
   3 Very difficult
   4 Extremely difficult

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COMPULSIVE ACTIVITIES CHECKLIST

Name: ____________________________  Date: ____________

Age: ________  Sex: ________

Instructions: Rate each activity on the scale below according to how much impairment is present due to obsessive-compulsive symptoms. Impairment can be the result of how long it takes to complete an activity, how often you repeat the activity or how much you avoid the activity.

1. No problem with activity: takes about same time as most people; no need to repeat it, and/or avoids it.
2. Minor problems with activity: takes a little longer than most people, may repeat it a few times, and/or sometimes avoids it.
3. Moderate problems with activity: takes moderately longer than most people, often repeats it numerous times, and/or often avoids it.
4. Very often has problems with activity: takes much longer than most people; frequently repeats it many times, and/or frequently avoids it.
5. Almost constant problems with activity: takes very long compared to most people or unable to complete it; almost always repeats it an extreme number of times or almost always avoids it.

I. DECONTAMINATION COMPULSIONS

1. Washing your hands ritually and/or excessively
2. Bathing, or showering ritually and/or excessively
3. Disinfecting yourself
4. Brushing your teeth to remove contamination
5. Disinfecting others or having them disinfect themselves
6. Disinfecting and/or cleaning your environment or your possessions
7. Washing or cleaning items before they can be used or allowed in the house
8. Changing or having others change clothing frequently to avoid contamination
9. Discarding or destroying potentially contaminated items
10. Wiping, blowing on, or shaking out items before using them
11. Avoidance of certain foods which may be contaminated
12. Avoidance of specific persons, places, or objects which might be contaminated
13. Using gloves, paper, etc. to touch things
14. Having family or friends perform any of the above on your behalf
15. Performing, reciting, or thinking ritually to avoid or remove contamination
16. Excessive questioning of others about contamination

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COMPULSIVE ACTIVITIES CHECKLIST

17. Using public telephones
18. Touching door handles in public places
19. Handling or cooking food
20. Washing dishes
21. Washing clothing
22. Handling money
23. Handling garbage or waste baskets
24. Traveling on public transportation (buses, trains, taxis, etc.)
25. Using toilet to urinate
26. Using toilet to defecate
27. Using public restrooms
28. Visiting a hospital
29. Eating in restaurants
30. Going to movies
31. Other: ________________

II. CHECKING COMPULSIONS

1. Doors and windows
2. Water taps
3. Electrical appliances
4. Stoves
5. Light switches
6. Car doors, windows, headlights, etc.
7. Items to be mailed or mailboxes
8. Whereabouts of sharp objects
9. Extinguished cigarettes or matches
10. The arrangement of objects for symmetry or perfection
11. Surfaces or objects for marks or damage
12. Objects, surfaces, or your own body parts for contamination
13. Repetitive praying or crossing yourself
14. What you have read
15. Your paperwork or writing for errors
16. Your writing for obscenities or errors
17. Filling out forms
18. Doing arithmetic
COMPULSIVE ACTIVITIES CHECKLIST

1. Counting money and/or making change
2. Driving situations (to verify that you did not hit someone or something with a vehicle)
3. Your own or another's vital signs or body (for signs of illness)
4. For possible hazards to children
5. The possibility that unspecified harm will occur to yourself or others
6. Frequent phone calls to family and loved one's to insure they are safe
7. The possibility that you may have harmed yourself or others accidentally or through negligence
8. Whether or not someone has acted sexually toward you
9. Whether or not you have acted sexually toward someone else
10. For prowlers (in closets, under bed, etc.)
11. For objects dropped accidentally
12. That valuable items were not accidentally thrown away
13. That you haven't left anything behind when you leave any place
14. Container tops or lids for closure
15. That one did not injure another through negligence
16. Your own words or actions (to verify that you did not act inappropriately)
17. Your own memory (by asking yourself or others)
18. That you have made the perfect decision
19. Repetitively apologizing or asking for forgiveness
20. That you have not touched something hazardous or contaminated
21. Yourself or your environment for signs of contamination
22. For sources of dangerous gases or fumes
23. That you have not ingested foods which are unhealthy or forbidden
24. Your food or drink for drugs or chemicals put there by others or by accident
25. Your phone for eavesdroppers
26. Following your spouse or lover to make sure they are being faithful
27. The mail or phone usage of your spouse or lover to make sure they are being faithful
28. Questioning the whereabouts of your spouse or lover to make sure they are being faithful
29. Watching who your spouse or lover looks at (in public or in movies, TV, and magazines) to make sure they are not being unfaithful
30. Other:

III. MAGICAL/UNDOING COMPULSIONS

1. Reciting or thinking of certain words, names, sounds, phrases, numbers, or images
2. Moving your body or gesturing in a special way
COMPULSIVE ACTIVITIES CHECKLIST

1. Having to mentally arrange certain images, numbers, words, names, etc.
2. Having to physically arrange objects in your environment in special ways.
3. Stepping in special ways or on special spots when walking.
4. Repeating an activity with a good thought or image in mind.
5. Performing actions or movements in reverse.
6. Washing off ideas or thoughts.
7. Rethinking thoughts.
8. Thinking thoughts in reverse.
9. Having to eat or not eat certain foods.
10. Gazing at or thinking of certain numbers or words to cancel others out.
11. Gazing at objects in a special way.
12. Touching certain things in a special way.
13. Other: ____________________________

IV. PERFECTIONISTIC COMPULSIONS

1. Arrange objects or possessions in special or symmetrical ways.
2. Keep new possessions unused and in perfect condition.
3. Buy only items which are perfect.
4. Keep your home or living space perfectly clean and orderly.
5. Putting laundry away.
6. Avoid using rooms, closets, drawers, etc., once they have been arranged perfectly.
7. Keep your possessions perfectly neat and clean.
8. Having items in drawers, closets or cabinets perfectly and neatly arranged.
10. Remember or memorize things perfectly or in a special order.
11. Read or reread every word in a document to avoid missing anything.
12. Know or learn everything about a particular subject.
13. Keep remaking decisions to ensure picking the perfect one.
14. Rewrite or write over numbers or letters to make them perfect.
15. Perform ordinary activities extra slowly to get them done perfectly.
16. Think of certain things perfectly or exactly.
17. Be perfectly religious.
18. Punish or penalize yourself when you do not behave perfectly.
20. Look at certain things in the environment in a special or perfect way (visually tracing or lining them up, etc.)
COMPULSIVE ACTIVITIES CHECKLIST

1. Be perfectly aware of everything going on around you in your environment
2. Tell the truth or be perfectly honest
3. Perfectly confess about all your thoughts or behaviors to others
4. Confess to having done wrongful things whether you have done them or not
5. Make one's appearance perfect (e.g. hair, nails, clothes, makeup, etc.)
6. Cut your hair (to make it perfect or symmetrical)
7. Perform activities until they feel just right
8. Keep extensive lists or records of certain things
9. Only perform certain activities at perfect times
10. Other:

V. COUNTING COMPULSIONS

1. While performing certain activities
2. Repeating behaviors a special number of times
3. Performing behaviors an odd or even number of times
4. To ensure an activity has been done a certain number of times or for a long enough duration
5. To ensure that an activity has been done an odd or even number of times
6. The numbers of objects or occurrences of certain things in the environment
7. Up to or beyond certain numbers
8. Simply to count (unconnected with any special idea or activity)
9. The occurrences of certain body functions (e.g., breathing, steps, etc.)
10. Other:

VI. TOUCHING OR MOVEMENT COMPULSIONS

1. Gesture or pose in a special way
2. Look or glance at something in a special way
3. Move in symmetrical or special ways
4. Having to step in special ways or on special spots when walking
5. Tic, twitch, or grimace in a special way
6. Move in special ways while carrying out certain activities
7. Reverse movements you have just made
8. Repeat certain activities (e.g., sitting down, getting up, passing through doorways) or by certain locations a special number of times, or until they feel right
9. Touch furniture before sitting down or standing up
COMPULSIVE ACTIVITIES CHECKLIST

1. Touch doors or drawers before opening or closing them
2. Touch the edges or certain parts of things
3. Touch doorways before walking through them
4. Touch things a certain number of times
5. Touch things in special patterns
6. Touch, move, or handle possessions a certain way before using them
7. Other: __________________________

VII. MENTAL COMPULSIONS

1. Make mental maps of places
2. Memorize facts or information
3. Make mental lists or arrangements
4. Know or learn everything about a particular subject
5. Keep reviewing past situations to try to remember or understand them
6. Think specific thoughts in special ways
7. Think about specific topics
8. Create specific mental images or pictures
9. Repeat your own or someone else's words in your mind
10. Think of sequences of special numbers or words
11. Rethink specific thoughts
12. Think certain thoughts in reverse
13. Analyzing your thoughts to determine if they are (or were) appropriate
14. Analyzing your thoughts to determine if they are really obsessions or not
15. Checking your own memory to determine if you came to harm in the past
16. Whether your own thoughts or reactions indicate that you are sexually attracted to others in ways which are inappropriate to you
17. Other: __________________________

VIII. PROTECTIVE COMPULSIONS

1. Questioning others, or your own memory, to determine if you have harmed or insulted someone (recently or in the past)
2. Recording and collecting information about past events to help in determining if harm occurred to yourself or others in the past
3. Collecting and removing objects from the environment that could harm others (i.e., tacks, razor blades, nails, matches, lit cigarettes, glass, etc.)
4. Difficulty using sharp instruments (knives, scissors, etc.)
COMPULSIVE ACTIVITIES CHECKLIST

5. Checking on the whereabouts of others to be certain that harm has not occurred to them
6. Trying to limit the activities of others to prevent harm from happening to them
7. Warning others repeatedly of potential harm or danger
8. Asking others if you will be safe or if things will turn out well for you
9. Asking others if they will be safe or if things will turn out well for them
10. Confessing to having done things you believe may have harmed others
11. List making
12. Other: ________________________________

IX. BODY-FOCUSED COMPULSIONS

1. Checking your appearance in the mirror for problems or imperfections
2. Checking your appearance or physical reaction to assure yourself about your sexual identity
3. Choosing what clothes to wear
4. Questioning others directly or indirectly about your appearance
5. Seeking frequent medical consultations to check on your appearance
6. Having to have your appearance improved surgically
7. Your body for symmetry or perfection
8. Your appearance or grooming for symmetry or perfection
9. Cutting your hair to excess or for long periods of time to make it perfect
10. Washing your hair to make it perfect
11. Checking your body for a bad odor (e.g. breath, genital, armpits, etc.)
12. Picking or squeezing pimples or blemishes to make your skin perfect
13. Checking the way your body works
14. Seeking medical consultations for possible illnesses
15. Reading about illnesses in books or on the internet
16. Self examination of your body for lumps or marks that could mean you have an illness
17. Frequent examination of current symptoms of possible illness
18. Having family examine you for signs of possible illness
19. Discussing symptoms of possible illness with family and friends
20. Taking your temperature
21. Other: ________________________________

X. HOARDING/COLLECTING COMPULSIONS/IMPULSIONS

1. Saving broken, irreparable, or useless items
**COMPULSIVE ACTIVITIES CHECKLIST**

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<td>2</td>
<td>Buying excessive quantities of items beyond an amount needed for reasonable usage</td>
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<td>3</td>
<td>Retrieving from or searching through your own or other people's trash</td>
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<td>4</td>
<td>Inability to throw things out due to fear of accidentally throwing important items away</td>
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<td>5</td>
<td>Going to excessive lengths (including extreme self-denial) to save money</td>
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<td>Saving excessive quantities of informational matter (newspapers, old lists, magazines, junk mail, etc.)</td>
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<td>7</td>
<td>Saving items simply because they belong to yourself or loved ones</td>
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<td>8</td>
<td>Having to own complete collections of certain things, even if not important</td>
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<td>9</td>
<td>Keeping extensive lists or records of certain things</td>
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<td>10</td>
<td>Other: ____________________________</td>
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**XI. GROOMING IMPULSIONS**

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<tbody>
<tr>
<td>1</td>
<td>Hair pulling (from head, eyebrows, eyelashes, pubic area, body, etc.)</td>
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<td>2</td>
<td>Skin picking or biting</td>
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<td>3</td>
<td>Nail or cuticle biting, picking, or cutting</td>
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<td>4</td>
<td>Picking or squeezing pimples or blemishes for the sensation of it</td>
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<td>Other: ____________________________</td>
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**XII. SELF-MUTILATIVE IMPULSIONS**

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<td>1</td>
<td>Cutting or scratching yourself</td>
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<td>2</td>
<td>Burning yourself</td>
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<td>3</td>
<td>Poking yourself in the eyes</td>
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<td>4</td>
<td>Biting yourself (e.g., insides of cheeks)</td>
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<td>5</td>
<td>Other: ____________________________</td>
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OBSESSIVE CONCERNS CHECKLIST

Name: ___________________________ Date: ___________________________
Age: _______ Sex: _______

For some people certain thoughts may seem to occur against their will and they cannot get rid of them. Only endorse items which apply to you due to: (1) their having been performed excessively, (2) their undesirability, (3) your attempts to resist, and (4) their having interfered with your functioning in some way.
Rate the thoughts listed below from 1 to 5, according to the degree of disturbance during the past week:

1 – This thought does not trouble me at all
2 – This thought rarely troubles me (once a week or less)
3 – This thought often troubles me (several times weekly)
4 – This thought troubles me very often (daily)
5 – This thought troubles me continually (all waking hours)

I. AGGRESSIVE OBSESSIONS

1. Actively harming others intentionally
2. Harming yourself intentionally
3. Going crazy and harming others
4. Violent or repulsive images, thoughts or words
5. Blurring out obscenities or insults
6. Making embarrassing or obscene gestures
7. Writing obscenities
8. Acting out in antisocial ways in public
9. Having insulted or offended others
10. Acting on impulses to rob, steal from, take advantage of, or cheat others
11. Rejecting, divorcing, or being unfaithful to a loved one
12. Deliberately hoping that others will have accidents, become ill or die
13. Other: ___________________________

II. SEXUAL OBSESSIONS

1. Forbidden or perverse thoughts, images or impulses
2. Sex with children
3. Sex with animals
4. Incest

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OBSESSIVE CONCERNS CHECKLIST

5. Being homosexual or acting homosexually
6. Doubt about your sexual identity
7. Sex with religious figures or celebrities
8. Acting sexually toward others
9. Doubt about possibly having acted sexually toward others
10. Doubt about possibly having been acted upon sexually by others
11. Other: ____________________________________________

III. CONTAMINATION OBSESSIONS

1. Bodily waste or secretions, e.g. feces, urine, saliva, perspiration, blood, semen
2. Dirt or grime
3. Germs, or viruses
4. Environmental contaminants (asbestos, lead, radiation, toxic wastes, etc.)
5. Household chemicals (cleansers, solvents, drain openers, insecticides)
6. Auto exhaust or other poisonous gases
7. Garbage, refuse, or their containers
8. Grease or greasy items
9. Sticky substances
10. Medication, or the effects of having ingested medication in the past
11. Your food or drink having been adulterated or tampered with by others
12. Broken glass
13. Poisonous plants
14. Contact with live animals
15. Contact with dead animals Contact with insects
16. Contact with other people
17. Contact with unclean or shabby looking people
18. Contracting an unspecified illness
19. Contracting a specific illness: ________________________
20. Spreading illness to, or contaminating others
21. Hospitals, doctor's offices and health care workers
22. Leaving or spreading an essence or trace of yourself behind on objects or others
23. Being contaminated by thoughts of harm happening to yourself or others
24. A specific person, or place felt to be contaminated in some nonspecific way
25. Being contaminated by certain words: ________________________
26. Being contaminated by the names of certain illnesses
27. Being contaminated by seeing an ill or disabled person
28. Being contaminated by the memory of a person who has died
OBSESSIVE CONCERNS CHECKLIST

IV. RELIGIOUS OBSESSIONS

1. Being deliberately sinful or blasphemous
2. Doubtful thoughts as to whether you acted sinfully or blasphemously in the past
3. Fears of having acted sinfully or unethically
4. Doubting your faith or beliefs
5. Unacceptable thoughts about religious figures, religion, or deities
6. Thoughts of being possessed
7. Thoughts of having to be perfectly religious
8. Other:

V. OBSESSIONS OF HARM, DANGER, LOSS, OR EMBARRASSMENT

1. Having an accident, illness or being injured
2. An accident, illness or injury happening to someone else
3. Accidentally losing control and harming others
4. Accidentally losing control and harming self
5. Causing harm to others through your own negligence or carelessness
6. Causing harm to others through my thoughts
7. Causing harm to self through your own negligence or carelessness
8. Causing harm to self through my thoughts
9. Never being able to be happy, or never being able to get what you want in life
10. Doubt about whether you somehow harmed or injured others in the past
11. Being deliberately harmed by others
12. Being rejected by a loved one
13. Being cheated or taken advantage of by others
14. Having somehow cheated or taken advantage of others
15. Having insulted or offended others
16. Objects in the environment having been moved or changed in unexplainable ways
17. Damage or theft of property
18. Losing or misplacing property
OBSESSIVE CONCERNS CHECKLIST

19. Forgetting information (memories, facts, appointments, etc.)
20. Being trapped in an unsatisfactory life or relationship
21. Being looked at or noticed by others in a critical way
22. Acting inappropriately in public
23. Your own mortality
24. The mortality of your family and friends
25. Your children not being your own
26. Other: ____________________________

VI. SUPERSTITIOUS OR MAGICAL OBSESSIONS

1. Having bad luck
2. Bad luck happening to someone else
3. Lucky or unlucky numbers or their multiples
4. Lucky or unlucky colors
5. Lucky or unlucky objects or possessions
6. The possibility that thinking or hearing of bad events can make them occur to yourself or others
7. Certain words, names, or images being able to cause bad luck
8. Certain actions or behaviors being able to cause bad luck
9. Being possessed
10. Places, objects or people associated with unlucky occasions causing bad luck by contact
11. The need to perform certain activities a special number of times
12. Lucky or unlucky mental arrangements of things
13. Other: ____________________________

VII. HEALTH AND BODY-FOCUSED OBSESSIONS

1. Parts of your body are ugly or disfigured in some way
2. Your body gives off a bad odor (e.g., breath, armpits, genital, etc)
3. Your body has scars or marks
4. Question how certain parts of your body work or function
5. A part of your body does not work properly or functions differently than it used to
6. Parts of your body are asymmetrical
7. Part(s) of your body is (are) too large or small
8. You are overweight or underweight
9. You will choke or vomit accidentally
10. You are going bald or have thinning hair
ST. LAWRENCE COLLEGE: BEHAVIOURAL PSYCHOLOGY

OBSESSIVE CONCERNS CHECKLIST

11. Part(s) of your body is (are) aging prematurely
12. Clothing does not fit certain parts of your body correctly (too loose or too tight)
13. You have brain damage or your mental faculties are impaired
14. You have undiagnosed serious illnesses. Which ones:__________________________
15. Other:__________________________

VIII. PERFECTIONISTIC OBSESSIONS

1. Questioning whether you have said, done, or thought certain things perfectly
2. Questioning whether others perfectly understand what you have said
3. Wanting to do, think, or say everything (or certain things) perfectly
4. Wanting to have a perfect appearance
5. Wanting your clothes to fit perfectly
6. Questioning whether you have told the truth perfectly
7. Making or keeping your home or possessions perfectly clean or pristine
8. Keeping your possessions in perfect order
9. Ordering things or making them symmetrical
10. Wanting to know everything about a specific subject or topic
11. Perfectly understanding what you have read
12. Perfectly communicating your thoughts through writing
13. Other:__________________________

IX. NEUTRAL OBSESSIONS

1. Sounds, words, or music
2. Nonsense or trivial images
3. Counting for no special reason
4. Repetitive questions for which there are no answers or which are unimportant
5. The excessive awareness of your own thought processes
6. The awareness of specific things in your environment (sounds, colors, objects, etc.)
7. Excessive awareness of normal body functioning (breathing, eyes blinking, heart, etc.)
8. Excessive awareness of abnormal body functioning (ringing in ears, aches, stiffness, pains, etc.)
9. Other:__________________________

Obsessional Beliefs Questionnaire (OBQ-44)

This inventory lists different attitudes or beliefs that people sometimes hold. Read each statement carefully and decide how much you agree or disagree with it.

For each of the statements, choose the number matching the answer that best describes how you think. Because people are different, there are no right or wrong answers.

To decide whether a given statement is typical of your way of looking at things, simply keep in mind what you are like most of the time.

Use the following scale:

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>agree</td>
<td>disagree</td>
<td>disagree</td>
<td>disagree</td>
<td>neither agree</td>
<td>agree</td>
<td>agree</td>
<td>agree</td>
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<tr>
<td>very much</td>
<td>moderately</td>
<td>a little</td>
<td>nor disagree</td>
<td>a little</td>
<td>moderately</td>
<td>very much</td>
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</table>

In making your ratings, try to avoid using the middle point of the scale (4), but rather indicate whether you usually disagree or agree with the statements about your own beliefs and attitudes.

1. I often think things around me are unsafe. 
2. If I am not absolutely sure of something, I am bound to make a mistake.
3. Things should be perfect according to my own standards.
4. In order to be a worthwhile person, I must be perfect at everything I do.
5. When I see any opportunity to do so, I must act to prevent bad things from happening.
6. Even if harm is very unlikely, I should try to prevent it at any cost.
7. For me, having bad urges is as bad as actually carrying them out.
8. If I don’t act when I foresee danger, then I am to blame for any consequences.
9. If I can’t do something perfectly, I shouldn’t do it at all.
10. I must work to my full potential at all times.
11. It is essential for me to consider all possible outcomes of a situation.
12. Even minor mistakes mean a job is not complete.
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<th></th>
<th>disagree</th>
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<th>disagree</th>
<th>neither agree</th>
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<th>moderately</th>
<th>very much</th>
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<tr>
<td>13.</td>
<td>If I have aggressive thoughts or impulses about my loved ones, this means I may secretly want to hurt them.</td>
<td>1 2 3 4 5 6 7</td>
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<td>14.</td>
<td>I must be certain of my decisions.</td>
<td>1 2 3 4 5 6 7</td>
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<td>15.</td>
<td>In all kinds of daily situations, failing to prevent harm is just as bad as deliberately causing harm.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>16.</td>
<td>Avoiding serious problems (for example, illness or accidents) requires constant effort on my part.</td>
<td>1 2 3 4 5 6 7</td>
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<td>17.</td>
<td>For me, not preventing harm is as bad as causing harm.</td>
<td>1 2 3 4 5 6 7</td>
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<td>18.</td>
<td>I should be upset if I make a mistake.</td>
<td>1 2 3 4 5 6 7</td>
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<td>19.</td>
<td>I should make sure others are protected from any negative consequences of my decisions or actions</td>
<td>1 2 3 4 5 6 7</td>
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<td>20.</td>
<td>For me, things are not right if they are not perfect.</td>
<td>1 2 3 4 5 6 7</td>
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<td>21.</td>
<td>Having nasty thoughts means I am a terrible person.</td>
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<td>22.</td>
<td>If I do not take extra precautions, I am more likely than others to have or cause a serious disaster.</td>
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<td>23.</td>
<td>In order to feel safe, I have to be as prepared as possible for anything that could go wrong.</td>
<td>1 2 3 4 5 6 7</td>
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<td>24.</td>
<td>I should not have bizarre or disgusting thoughts.</td>
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<td>25.</td>
<td>For me, making a mistake is as bad as failing completely.</td>
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<td>26.</td>
<td>It is essential for everything to be clear cut, even in minor matters.</td>
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<td>27.</td>
<td>Having a blasphemous thought is as sinful as committing a sacrilegious act.</td>
<td>1 2 3 4 5 6 7</td>
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<td>28.</td>
<td>I should be able to rid my mind of unwanted thoughts.</td>
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<td>29.</td>
<td>I am more likely than other people to accidentally cause harm to myself or to others.</td>
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30. Having bad thoughts means I am weird or abnormal.  
31. I must be the best at things that are important to me.  
32. Having an unwanted sexual thought or image means I really want to do it.  
33. If my actions could have even a small effect on a potential misfortune, I am responsible for the outcome.  
34. Even when I am careful, I often think that bad things will happen.  
35. Having intrusive thoughts means I'm out of control.  
36. Harmful events will happen unless I am very careful.  
37. I must keep working at something until it's done exactly right.  
38. Having violent thoughts means I will lose control and become violent.  
39. To me, failing to prevent a disaster is as bad as causing it.  
40. If I don’t do a job perfectly, people won’t respect me.  
41. Even ordinary experiences in my life are full of risk.  
42. Having a bad thought is morally no different than doing a bad deed.  
43. No matter what I do, it won’t be good enough.  
44. If I don't control my thoughts, I'll be punished.

# Yale-Brown Obsessive Compulsive Scale (Y-BOCS) *

Questions 1 to 5 are about your obsessive thoughts.

Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger; extreme concern with order, symmetry, or exactness; fear of losing important things.

Please answer each question by writing the appropriate number in the box next to it.

### 1. **Time Occupied by Obsessive Thoughts**

**Q.** How much of your time is occupied by obsessive thoughts?

<table>
<thead>
<tr>
<th></th>
<th>0 = None.</th>
<th>1 = Less than 1 hr/day or occasional occurrence.</th>
<th>2 = 1 to 3 hrs/day or frequent.</th>
<th>3 = Greater than 3 and up to 8 hrs/day or very frequent occurrence.</th>
<th>4 = Greater than 8 hrs/day or nearly constant occurrence.</th>
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### 2. **Interference Due to Obsessive Thoughts**

**Q.** How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don’t do because of them?

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<thead>
<tr>
<th></th>
<th>0 = None.</th>
<th>1 = Slight interference with social or other activities, but overall performance not impaired.</th>
<th>2 = Definite interference with social or occupational performance, but still manageable.</th>
<th>3 = Causes substantial impairment in social or occupational performance.</th>
<th>4 = Incapacitating.</th>
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### 3. **Distress Associated with Obsessive Thoughts**

**Q.** How much distress do your obsessive thoughts cause you?

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<th></th>
<th>0 = None.</th>
<th>1 = Not too disturbing.</th>
<th>2 = Disturbing, but still manageable.</th>
<th>3 = Very disturbing.</th>
<th>4 = Near constant and disabling distress.</th>
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### 4. **Resistance Against Obsessions**

**Q.** How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

<table>
<thead>
<tr>
<th></th>
<th>0 = Try to resist all the time.</th>
<th>1 = Try to resist most of the time.</th>
<th>2 = Make some effort to resist.</th>
<th>3 = Yield to all obsessions without attempting to control them, but with some reluctance.</th>
<th>4 = Completely and willingly yield to all obsessions.</th>
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### 5. **Degree of Control Over Obsessive Thoughts**

**Q.** How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?

<table>
<thead>
<tr>
<th></th>
<th>0 = Complete control.</th>
<th>1 = Usually able to stop or divert obsessions with some effort and concentration.</th>
<th>2 = Sometimes able to stop or divert obsessions.</th>
<th>3 = Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty.</th>
<th>4 = Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking.</th>
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*This adaptation of the Y-BOCS is abridged from the original version with permission from Wayne Goodman. For additional information on the Y-BOCS, please contact Dr. Wayne Goodman at the University of Florida, College of Medicine, Gainesville, Florida 32610. The original version was published by: Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale I: Development, use, and reliability. *Arch Gen Psychiatry* 1989;46:1006-1011.
The next several questions are about your compulsive behaviors. Compulsions are urges that people have to do something to lessen feelings of anxiety or other discomfort. Often they do repetitive, purposeful, intentional behaviors called rituals. The behavior itself may seem appropriate but it becomes a ritual when done to excess. Washing, checking, repeating, straightening, hoarding and many other behaviors can be rituals. Some rituals are mental. For example thinking or saying things over and over under your breath.

### 8. DISTRESS ASSOCIATED WITH COMPULSIVE BEHAVIOR

Q. How would you feel if prevented from performing your compulsion(s)? How anxious would you become?

- 0 = None.
- 1 = Only slightly anxious if compulsions prevented.
- 2 = Anxiety would mount but remain manageable if compulsions prevented.
- 3 = Prominent and very disturbing increase in anxiety if compulsions interrupted.
- 4 = Incapacitating anxiety from any intervention aimed at modifying activity.

### 6. TIME SPENT PERFORMING COMPULSIVE BEHAVIORS

Q. How much time do you spend performing compulsive behaviors? How much longer than most people does it take to complete routine activities because of your rituals? How frequently do you do rituals?

- 0 = None.
- 1 = Less than 1 hr/day, or occasional performance of compulsive behaviors.
- 2 = From 1 to 3 hrs/day, or frequent performance of compulsive behaviors.
- 3 = More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors.
- 4 = More than 8 hrs/day, or near constant performance of compulsive behaviors (too numerous to count).

### 9. RESISTANCE AGAINST COMPULSIONS

Q. How much of an effort do you make to resist the compulsions?

- 0 = Always try to resist.
- 1 = Try to resist most of the time.
- 2 = Make some effort to resist.
- 3 = Yield to almost all compulsions without attempting to control them, but with some reluctance.
- 4 = Completely and willingly yield to all compulsions.

### 10. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR

Q. How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?

- 0 = Complete control.
- 1 = Pressure to perform the behavior but usually able to exercise voluntary control over it.
- 2 = Strong pressure to perform behavior, can control it only with difficulty.
- 3 = Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty.
- 4 = Drive to perform behavior experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity.

---

Appendix H: Measures for Aggression

Name: _____________________   AQ
Date : ____________________

Instructions:
Using the 5 point scale shown below, indicate how uncharacteristic or characteristic each of the following statements is in describing you. Place your rating on the line next to the statement.

1 = extremely uncharacteristic of me
2 = somewhat uncharacteristic of me
3 = neither uncharacteristic nor characteristic of me
4 = somewhat characteristic of me
5 = extremely characteristic of me

____ 1. Some of my friends think I am a hothead
____ 2. If I have to resort to violence to protect my rights, I will.
____ 3. When people are especially nice to me, I wonder what they want.
____ 4. I tell my friends openly when I disagree with them.
____ 5. I have become so mad that I have broken things.
____ 6. I can’t help getting into arguments when people disagree with me.
____ 7. I wonder why sometimes I feel so bitter about things.
____ 8. Once in a while, I can’t control the urge to strike another person.
____ 9. I am an even-tempered person.
____ 10. I am suspicious of overly friendly strangers.
____ 11. I have threatened people I know.
____ 12. I flare up quickly but get over it quickly.
____ 13. Given enough provocation, I may hit another person.
____ 14. When people annoy me, I may tell them what I think of them.
____ 15. I am sometimes eaten up with jealousy.
____ 16. I can think of no good reason for ever hitting a person.
____ 17. At times I feel I have gotten a raw deal out of life.
____ 18. I have trouble controlling my temper.
____ 19. When frustrated, I let my irritation show.
____ 20. I sometimes feel that people are laughing at me behind my back.
____ 21. I often find myself disagreeing with people.
____ 22. If somebody hits me, I hit back.
____ 23. I sometimes feel like a powder keg ready to explode.
____ 24. Other people always seem to get the breaks.
____ 25. There are people who pushed me so far that we came to blows.
____ 26. I know that “friends” talk about me behind my back.
____ 27. My friends say that I’m somewhat argumentative.
____ 28. Sometimes I fly off the handle for no good reason.
____ 29. I get into fights a little more than the average person.

Buss-Perry Aggression Questionnaire Excel Scoring Sheet

**Patient Name:** Sample person

**File #**

**Date:**

**Subscales** | **Scores** | **Scale Range** | **Construct Categories**
--- | --- | --- | ---
Physical Aggression | 33 | 9 - 45 | Low: 9 - 24
Verbal Aggression | 16 | 5 - 25 | Average: 5 - 10
Physical | 26 | 7 - 35 | High: 7 - 18
Hostility | 26 | 8 - 40 | Low: 8 - 20
Total Score: | 101 | 29 - 145 | Average: 21 - 32

**Buss Perry AQ Scores**

<table>
<thead>
<tr>
<th>% Scores</th>
<th>Phys Aggr</th>
<th>V Aggr</th>
<th>Anger</th>
<th>Hostility</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>73%</td>
<td>64%</td>
<td>74%</td>
<td>68%</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>

**Subscale Codes**

- Physical (P1)
- Verbal (V1)
- Anger (A1)
- Hostility (H1)
- Physical (P2)
- Verbal (V2)
- Anger (A2)
- Hostility (H2)
- Physical (P3)
- Verbal (V3)
- Anger (A3)
- Hostility (H3)
- Physical (P4)
- Verbal (V4)
- Anger (A4)
- Hostility (H4)
- Physical (P5)
- Verbal (V5)
- Anger (A5)
- Hostility (H5)
- Physical (P6)
- Verbal (V6)
- Anger (A6)
- Hostility (H6)
- Physical (P7)
- Verbal (V7)
- Anger (A7)
- Hostility (H7)
- Physical (P8)
- Verbal (V8)
- Anger (A8)
- Hostility (H8)
- Physical (P9)

* Reverse Scored Items

<table>
<thead>
<tr>
<th>Item #</th>
<th>Raw Score</th>
<th>Edited Score</th>
<th>SubScale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Physical P1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>3</td>
<td>Verbal V1</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>Anger A1</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
<td>Hostility H1</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>5</td>
<td>Physical P2</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>4</td>
<td>Verbal V2</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
<td>4</td>
<td>Anger A2</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>4</td>
<td>Hostility H2</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>4</td>
<td>Physical P3</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>1</td>
<td>Verbal V3</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>4</td>
<td>Anger A3</td>
</tr>
<tr>
<td>12</td>
<td>4</td>
<td>4</td>
<td>Hostility H3</td>
</tr>
<tr>
<td>13</td>
<td>4</td>
<td>4</td>
<td>Physical P4</td>
</tr>
<tr>
<td>14</td>
<td>4</td>
<td>4</td>
<td>Verbal V4</td>
</tr>
<tr>
<td>15*</td>
<td>5</td>
<td>1</td>
<td>Anger A4</td>
</tr>
<tr>
<td>16</td>
<td>4</td>
<td>4</td>
<td>Hostility H4</td>
</tr>
<tr>
<td>17</td>
<td>4</td>
<td>4</td>
<td>Physical P5</td>
</tr>
<tr>
<td>18</td>
<td>4</td>
<td>4</td>
<td>Verbal V5</td>
</tr>
<tr>
<td>19</td>
<td>4</td>
<td>4</td>
<td>Anger A5</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>1</td>
<td>Hostility H5</td>
</tr>
<tr>
<td>21</td>
<td>4</td>
<td>4</td>
<td>Physical P6</td>
</tr>
<tr>
<td>22</td>
<td>4</td>
<td>4</td>
<td>Anger A6</td>
</tr>
<tr>
<td>23</td>
<td>4</td>
<td>4</td>
<td>Hostility H6</td>
</tr>
<tr>
<td>24*</td>
<td>3</td>
<td>3</td>
<td>Physical P7</td>
</tr>
<tr>
<td>25</td>
<td>4</td>
<td>4</td>
<td>Anger A7</td>
</tr>
<tr>
<td>26</td>
<td>1</td>
<td>1</td>
<td>Hostility H7</td>
</tr>
<tr>
<td>27</td>
<td>4</td>
<td>4</td>
<td>Physical P8</td>
</tr>
<tr>
<td>28</td>
<td>4</td>
<td>4</td>
<td>Hostility H8</td>
</tr>
<tr>
<td>29</td>
<td>4</td>
<td>4</td>
<td>Physical P9</td>
</tr>
</tbody>
</table>

* Reverse Scored Items

**Subscales**

- Physical P1
- Verbal V1
- Anger A1
- Hostility H1
- Physical P2
- Verbal V2
- Anger A2
- Hostility H2
- Physical P3
- Verbal V3
- Anger A3
- Hostility H3
- Physical P4
- Verbal V4
- Anger A4
- Hostility H4
- Physical P5
- Verbal V5
- Anger A5
- Hostility H5
- Physical P6
- Verbal V6
- Anger A6
- Hostility H6
- Physical P7
- Verbal V7
- Anger A7
- Hostility H7
- Physical P8
- Verbal V8
- Anger A8
- Hostility H8
- Physical P9

**File #**

**Date:**

**Subscales** | **Scores** | **Scale Range** | **Construct Categories**
--- | --- | --- | ---
Physical Aggression | 33 | 9 - 45 | Low: 9 - 24
Verbal Aggression | 16 | 5 - 25 | Average: 5 - 10
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**Buss Perry AQ Scores**

<table>
<thead>
<tr>
<th>% Scores</th>
<th>Phys Aggr</th>
<th>V Aggr</th>
<th>Anger</th>
<th>Hostility</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>73%</td>
<td>64%</td>
<td>74%</td>
<td>68%</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>

**Subscale Codes**

- Physical (P1)
- Verbal (V1)
- Anger (A1)
- Hostility (H1)
- Physical (P2)
- Verbal (V2)
- Anger (A2)
- Hostility (H2)
- Physical (P3)
- Verbal (V3)
- Anger (A3)
- Hostility (H3)
- Physical (P4)
- Verbal (V4)
- Anger (A4)
- Hostility (H4)
- Physical (P5)
- Verbal (V5)
- Anger (A5)
- Hostility (H5)
- Physical (P6)
- Verbal (V6)
- Anger (A6)
- Hostility (H6)
- Physical (P7)
- Verbal (V7)
- Anger (A7)
- Hostility (H7)
- Physical (P8)
- Verbal (V8)
- Anger (A8)
- Hostility (H8)
- Physical (P9)

* Reverse Scored Items

**Subscales**

- Physical P1
- Verbal V1
- Anger A1
- Hostility H1
- Physical P2
- Verbal V2
- Anger A2
- Hostility H2
- Physical P3
- Verbal V3
- Anger A3
- Hostility H3
- Physical P4
- Verbal V4
- Anger A4
- Hostility H4
- Physical P5
- Verbal V5
- Anger A5
- Hostility H5
- Physical P6
- Verbal V6
- Anger A6
- Hostility H6
- Physical P7
- Verbal V7
- Anger A7
- Hostility H7
- Physical P8
- Verbal V8
- Anger A8
- Hostility H8
- Physical P9

* Reverse Scored Items
**Appendix I: Measures for Bi-Polar Disorders**

**THE MOOD DISORDER QUESTIONNAIRE**

**Instructions:** Please answer each question to the best of your ability.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has there ever been a period of time when you were not your usual self and...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you were so irritable that you shouted at people or started fights or arguments?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you felt much more self-confident than usual?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you got much less sleep than usual and found you didn’t really miss it?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you were much more talkative or spoke much faster than usual?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...thoughts raced through your head or you couldn’t slow your mind down?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you were so easily distracted by things around you that you had trouble concentrating or staying on track?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you had much more energy than usual?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you were much more active or did many more things than usual?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you were much more interested in sex than usual?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>...spending money got you or your family into trouble?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only.
   - No Problem
   - Minor Problem
   - Moderate Problem
   - Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? ☐ ☐

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ☐ ☐
SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.1

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. “Yes” to seven or more of the 13 items in question number 1;

AND

2. “Yes” to question number 2;

AND

3. “Moderate” or “Serious” to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke’s Medical Center.

Appendix J: Measures for Depression

Patient Health Questionnaire—PHQ-9

Name: __________________________ Date of Birth: ________________ Today’s Date: ____________

Fill in the boxes with pen or pencil to mark your answers.

A. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Trouble falling/staying asleep, sleeping too much</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>__________ and your family down.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>__________ or watching television.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Or the opposite — being so fidgety or restless that you have been</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>__________ moving around a lot more than usual.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>__________ yourself in some way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score _____ = _____+ _____+ _____+ _____

B. If you have been bothered by any of the 9 problems listed above, please answer the following:

**How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

This health survey was adapted from the PRIME-MD® Patient Health Questionnaire © 1998, Pfizer Inc. Reproduced with permission. For research information, contact Dr. Robert L. Spitzer at rls@columbia.edu.

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The Patient Health Questionnaire (PHQ-9) Scoring

Use of the PHQ-9 to Make a Tentative Depression Diagnosis:
The clinician should rule out physical causes of depression, normal bereavement and a history of a manic/hypomanic episode

Step 1: Questions 1 and 2
Need one or both of the first two questions endorsed as a “2” or a “3”
(2 = “More than half the days” or 3 = “Nearly every day”)

Step 2: Questions 1 through 9
Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count. (Questions 1-8 must be endorsed as a “2” or a “3”; Question 9 must be endorsed as “1” a “2” or a “3”)

Step 3: Question 10
This question must be endorsed as “Somewhat difficult” or “Very difficult” or “Extremely difficult”

Use of the PHQ-9 for Treatment Selection and Monitoring

Step 1
A depression diagnosis that warrants treatment or a treatment change, needs at least one of the first two questions endorsed as positive (“more than half the days” or “nearly every day”) in the past two weeks. In addition, the tenth question, about difficulty at work or home or getting along with others should be answered at least “somewhat difficult”

Step 2
Add the total points for each of the columns 2-4 separately
(Column 1 = Several days; Column 2 = More than half the days; Column 3 = Nearly every day. Add the totals for each of the three columns together. This is the Total Score
The Total Score = the Severity Score

Step 3
Review the Severity Score using the following TABLE.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
<th>Patient Preferences should be considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal Symptoms*</td>
<td>Support, educate to call if worse, return in one month</td>
<td></td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ++</td>
<td>Support, watchful waiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dysthymia*</td>
<td>Antidepressant or psychotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Major Depression, mild</td>
<td>Antidepressant or psychotherapy</td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
<td></td>
</tr>
<tr>
<td>&gt;20</td>
<td>Major Depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
<td></td>
</tr>
</tbody>
</table>

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask “In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?”)
++ If symptoms present ≥ one month or severe functional impairment, consider active treatment
Appendix K: Measures for Insomnia

### PSSQ_1

<table>
<thead>
<tr>
<th>ID____ __ __ __ __ __ __ __ __ __ Date __ __ __ __ / __ __ / __ __ __ __ m m d d y y y</th>
<th></th>
</tr>
</thead>
</table>

**Instructions:** Below is a list of common sleep complaints. *During the past month*, how many nights or days per week have you had, or been told you had, the following symptoms? If you have experienced any of these symptoms please indicate how long it has lasted in weeks, months or years.

<table>
<thead>
<tr>
<th>During the past month...</th>
<th>Never</th>
<th>Do not know</th>
<th>Rarely less than once per week</th>
<th>Sometimes 1-2 times per week</th>
<th>Frequently 3-4 times per week</th>
<th>Always 5-7 times per week</th>
<th>How long has the symptom lasted? (# of weeks, months or years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty falling asleep.</td>
<td>0 1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>wks mos yrs</td>
</tr>
<tr>
<td>2. Difficulty staying asleep.</td>
<td>0 1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>wks mos yrs</td>
</tr>
<tr>
<td>3. Frequent awakenings from sleep.</td>
<td>0 1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>wks mos yrs</td>
</tr>
<tr>
<td>4. Feeling that your sleep is not sound.</td>
<td>0 1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>wks mos yrs</td>
</tr>
<tr>
<td>5. Feeling that your sleep is unrefreshing.</td>
<td>0 1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>wks mos yrs</td>
</tr>
</tbody>
</table>

If you checked “never” or “do not know” for all of these symptoms YOU MAY STOP.

If you checked “rarely” to “always” for any of these symptoms please continue with questions 6-13.
### PSSQ_I

**Instructions:** If you have experienced any sleep symptoms during the past month please circle the appropriate number to let us know how your sleep is affecting your daily life.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. How much do your sleep problems bother you?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Have your sleep difficulties affected your work?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Have your sleep difficulties affected your social life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Have your sleep difficulties affected other important parts of your life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Have your sleep difficulties made you feel irritable?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Have your sleep problems caused you to have trouble concentrating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Have your sleep difficulties made you feel fatigued?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. How sleepy do you feel during the day?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Pittsburgh Sleep Symptom Questionnaire-Insomnia (PSSQ-I)
(also known as the Insomnia Symptom Questionnaire (ISQ))

References and Scoring

Reference

Scores – reportable in publications
Pittsburgh Sleep Symptom Questionnaire – Insomnia (PSSQ-I) has 13 self-rated questions. Only questions 1, 2 or 5 are used to determine the presence, frequency AND duration of sleep symptom criteria. Questions 6-13 are used to identify significant daytime consequences of the sleep complaint. Please answer the following questions based on the participants responses to determine if they meet the case definition of insomnia.

Scoring proceeds as follows:

<table>
<thead>
<tr>
<th>Sleep symptom criterion</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the answer to at least one of Questions 1, 2, or 5 &quot;Frequently&quot; or &quot;Always&quot;?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

| Duration criterion                                                                       | ☐   | ☐  |
| Is the answer to at least one of Questions 1, 2, or 5 "≥ 4 weeks"?                       |     |    |

| Daytime impairment criterion                                                              | ☐   | ☐  |
| Is the answer to at least one of Questions 6-13 "Quite a bit" or "Extremely"?            |     |    |

If the answer to each question above is "Yes," assign a diagnosis of insomnia disorder. Insomnia disorder

If the answer to one or more of the questions above is "No," do not assign a diagnosis of insomnia disorder. No insomnia disorder
Appendix L: Measures for Posttraumatic Stress Disorder (PTSD)

PTSD Checklist Scoring

While this instrument alone is not sufficient to diagnose PTSD, it gives you a sense of whether the individual is experiencing PTSD symptoms and how severe his or her symptoms are.

For your purposes, add up your patient’s scores on the 17 items. If the total score is 45 or above, refer him or her for a PTSD assessment/evaluation, if needed, for confirmation of the diagnosis. You can track your patient’s scores by plotting them on the PCL graph.

There are two versions of the PCL-S:

1) The PCL-S MONTHLY is administered before the start of Session 1 of CPT. It uses the past month as the time frame reference.

2) The PCL-S WEEKLY is used during CPT starting from Session 2 and for all other sessions. Remind the patient to use only the preceding week as the time frame for each item. The therapist should score it immediately upon receipt and ask the patient for any clarifications needed.

If the patient’s scores have not dropped significantly by Session 6, the therapist should explore whether the patient is still avoiding affect, has been engaging in self-harm or other therapy-interfering behavior, or has not changed his assimilated beliefs about the traumatic event. Processing the lack of improvement with the patient will be important at that point.

A reliable amount of change on the PCL is 5 points. Thus, if your patient has an increase or decrease in his total score of fewer than 5 points, this change is likely due to normal variation in symptoms. A clinically significant amount of change is approximately 10 points [5 * 1.96 (equivalent to \( p < .05 \) significance)] on the PCL. If your patient’s scores increase or decrease 10 or more points, this is a clinically significant amount of improvement or exacerbation.

Initial of Patient Last Name: ___________  Last 4 digits of SSN: ___________
Therapist Initials: ___________  Date: ___________  Session: ___________

Format of CPT: Individual □  Group □  CPT-C □  CPT □

**PCL-S: MONTHLY**

**Instructions:**

1. Consider the most stressful experience you have experienced ______________________ (event).

2. Here is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then indicate, using the numbers to the right, how much you have been bothered by that problem in the past month.

<table>
<thead>
<tr>
<th>1. Repeated, disturbing memories, thoughts, or images, of the stressful experience?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Repeated, disturbing dreams of the stressful experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Suddenly acting or feeling as if the stressful experience was happening again (as if you were reliving it)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Feeling very upset when something reminded you of the stressful experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Avoiding activities or situations because they reminded you of the stressful experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Trouble remembering important parts of the stressful experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Loss of interest in activities that you used to enjoy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Feeling distant or cut off from other people?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Feeling emotionally numb or being unable to have loving feelings for those close to you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Feeling as if your future will somehow be cut short?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. Trouble falling or staying asleep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. Feeling irritable or having angry outbursts?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. Having difficulty concentrating?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. Being “super-alert” or watchful or on guard?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. Feeling jumpy or easily startled?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*PCL-S for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD – Behavioral Science Division*
BODY SENSATIONS QUESTIONNAIRE

Below is a list of specific body sensations that may occur when you are nervous or in a feared situation. Please mark down how afraid you are of these feelings. Use the five-point scale below and mark the corresponding number for each item.

1. Not frightened or worried by this sensation
2. Somewhat frightened by this sensation
3. Moderately frightened by this sensation
4. Very Frightened by this sensation
5. Extremely frightened by this sensation

How frightened of these sensations?

___ 1) Heart palpitations
___ 2) Pressure or a heavy feeling in chest
___ 3) Numbness in arms or legs
___ 4) Tingling in the fingertips
___ 5) Numbness in another part of your body
___ 6) Feeling short of breath
___ 7) Dizziness
___ 8) Blurred or distorted vision
___ 9) Nausea
___ 10) Having “butterflies” in your stomach
___ 11) Feeling a knot in your stomach
___ 12) Having a lump in your throat
___ 13) Wobbly or rubber legs
___ 14) Sweating
___ 15) A dry throat
___ 16) Feeling disoriented and confused
___ 17) Feeling disconnected from your body: only partly present
___ 18) Other (describe)______________________________

Please stop here.

Total: 
Mean: 

© 1984 Diane L. Chambless.

Panic Frequency Questionnaire

Name: ___________________________  Date: ___________________________

**Instructions:**
A panic attack is a period of intense fear or discomfort that begins suddenly and peaks in 10 minutes or less. Panic attacks must be accompanied by at least 4 of the following:

1. racing or pounding heart
2. sweating
3. trembling/shaking
4. shortness of breath
5. chest pain/discomfort
6. choking feeling
7. nausea/abdominal discomfort
8. dizzy, unsteady, lightheaded, faintness
9. feeling unreal or detached
10. numbness/tingling sensations
11. chills/hot flashes
12. fear of dying
13. fear of going crazy/losing control

1a. In the past month, approximately how many panic attacks (see above definition) have you had out of the blue or when you did not expect to have a panic attack? (Please provide the number of attacks, not a range or percentage). __________

1b. If you haven’t had an unexpected or out of the blue panic attack in the past month, have you ever experienced one? Please circle either Yes OR No.

   **NO**  \[ ]  \[ ]
   **YES** \[ ]  \[ ]

2. In the past month, approximately how many attacks did you have that were triggered by a specific situation or occurred when you expected to have a panic attack? (Please provide the number of attacks, not a range or percentage). __________

   What were these situations or places? ____________________________________________
   ____________________________________________________________________________

3. During the past month, how worried or concerned were you about having more panic attacks? Estimate your average level of concern by circling a number on the scale below from 0 to 8, where 0 = no worry or concern about panicking and 8 = constantly worried about having a panic attack over the past month.

   1  | 2  | 3  | 4  | 5  | 6  | 7  | 8

   Not at all worried  |  Mildly worried  |  Moderately worried  |  Very worried  |  Constantly worried

4. During the past month, how worried or concerned were you about something bad happening (e.g., dying, going crazy, losing control, being embarrassed, vomiting, fainting, losing bowel control, etc.) during your panic attack? Estimate your level of concern by circling a number on the scale below from 0 to 8, where 0 = no worry or concern about something bad happening during panic and 8 = constantly worried about something bad happening during panic.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all worried</td>
<td>Mildly worried</td>
<td>Moderately worried</td>
<td>Very worried</td>
<td>Constantly worried</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. During the past month, to what extent have you behaved differently (e.g., avoiding situations, avoiding activities, using drugs or alcohol to reduce anxiety, carrying certain objects with you, etc.) because of your panic attacks? Estimate the degree to which your panic attacks affect your behaviour by circling a number on the scale below from 0 to 8, where 0 = no change in behaviour related to panic and 8 = very extreme changes in behaviour related to panic.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>No changes</td>
<td>Mild changes</td>
<td>Moderate changes</td>
<td>Extreme changes</td>
<td>Very extreme changes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. During a typical panic attack in the past month, how intensely do you feel each of the following symptoms? Please circle the number that best corresponds to the intensity you feel each symptom.

<table>
<thead>
<tr>
<th>a) Racing or pounding heart</th>
<th>Not at all</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Sweating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c) Trembling/Shaking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d) Shortness of breath</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e) Chest pain/discomfort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f) Choking feeling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g) Nausea/Abdominal Discomfort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h) Dizzy, unsteady, lightheaded, faintness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i) Feeling unreal or detached</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j) Numbness/tingling sensations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>k) Chills/Hot flashes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>l) Fear of Dying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>m) Fear of going crazy/Losing control</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Appendix N: Measures for Substance Use

CAGE Adapted to Include Drugs (CAGE-AID)

Please circle “yes” or “no” for each question.

Have you felt you ought to cut down on your drinking or drug use? .............................................. Yes No

Have people annoyed you by criticizing your drinking or drug use? .............................................. Yes No

Have you felt bad or guilty about your drinking or drug use? .............................................. Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? .............................................. Yes No

Scoring: Item responses on the CAGE-AID are scored 0 for "no" and 1 for "yes" answers. A higher score is an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.


Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

During the past 6 months:

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) ........................................ Yes No

2. Have you felt that you use too much alcohol or other drugs? ........................................ Yes No

3. Have you tried to cut down or quit drinking or using drugs? ........................................ Yes No

4. Have you gone to anyone for help because of your drinking or drug use? (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program) Yes No

5. Have you had any of the following?
   Put a check mark next to any problems you have experienced.
   ○ Blackouts or other periods of memory loss?
   ○ Injury to your head after drinking or using drugs?
   ○ Convulsions or delirium tremens (DTs)?
   ○ Hepatitis or other liver problems?
   ○ Felt sick, shaky, or depressed when you stopped drinking or using drugs?
   ○ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   ○ Injury after drinking or using?
   ○ Used needles to shoot drugs?

Circle "yes" if at least one of the eight items above is checked ........................................ Yes No

6. Has drinking or other drug use caused problems between you and your family or friends? ....... Yes No

7. Has your drinking or other drug use caused problems at school or at work? .......................... Yes No

8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession) ............................................. Yes No

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? ...... Yes No

10. Do you need to drink or use drugs more and more to get the effect you want? ......................... Yes No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? .................... Yes No

12. When drinking or using drugs, are you more likely to do something you wouldn’t normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ................................................. Yes No

13. Do you feel bad or guilty about your drinking or drug use? ................................................. Yes No

continued on other side
The next questions are about lifetime experiences.

14. Have you ever had a drinking or other drug problem? ................................................. Yes  No

15. Have any of your family members ever had a drinking or drug problem?................................. Yes  No

16. Do you feel that you have a drinking or drug problem now?................................................. Yes  No
### Appendix O: Other Measures

#### PBQ Belief Questionnaire

Name: ___________________________ Date: ___________________________

Please read the statements below and rate HOW MUCH YOU BELIEVE EACH ONE. Try to judge how you feel about each statement MOST OF THE TIME.

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Believe it</td>
<td>I Believe it</td>
<td>I Believe it</td>
<td>I Believe it</td>
<td>I Don’t Believe</td>
</tr>
<tr>
<td>Totally</td>
<td>Very Much</td>
<td>Moderately</td>
<td>Slightly</td>
<td>it at all</td>
</tr>
</tbody>
</table>

### Example

1. The world is a dangerous place.
   (Please circle)

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally</td>
<td>Very Much</td>
<td>Moderately</td>
<td>Slightly</td>
<td>Not at All</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

2. Other people are potentially critical, indifferent, demeaning, or rejecting.
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

3. I cannot tolerate unpleasant feelings.
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

4. If people get close to me, they will discover the “real” me and reject me.
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

5. Being exposed as inferior or inadequate will be intolerable.
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

6. I should avoid unpleasant situations at all cost.
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

7. If I feel or think something unpleasant, I should try to wipe it out or distract myself (for example, think of something else, have a drink, take a drug, or watch television).
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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</tr>
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<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
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</tbody>
</table>

8. I should avoid situations in which I attract attention, or be as inconspicuous as possible.
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
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<th>1</th>
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<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
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</table>

9. Unpleasant feelings will escalate and get out of control.
<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
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<tbody>
<tr>
<td>4</td>
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<td>0</td>
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</tbody>
</table>

(c) 1995 by Aaron T. Beck, M.D. and Judith S. Beck, Ph.D.
<table>
<thead>
<tr>
<th></th>
<th>HOW MUCH DO YOU BELIEVE IT?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Totally</td>
</tr>
<tr>
<td>10. If others criticize me, they must be right.</td>
<td>4</td>
</tr>
<tr>
<td>11. It is better not to do anything than to try something that might fail.</td>
<td>4</td>
</tr>
<tr>
<td>12. If I don’t think about a problem, I don’t have to do anything about it.</td>
<td>4</td>
</tr>
<tr>
<td>13. Any signs of tension in a relationship indicate the relationship has gone bad; therefore, I should cut it off.</td>
<td>4</td>
</tr>
<tr>
<td>14. If I ignore a problem, it will go away.</td>
<td>4</td>
</tr>
<tr>
<td>15. I am needy and weak.</td>
<td>4</td>
</tr>
<tr>
<td>16. I need somebody around available at all times to help me to carry out what I need to do or in case something bad happens.</td>
<td>4</td>
</tr>
<tr>
<td>17. My helper can be nurturing, supportive, and confident -- if he or she wants to be.</td>
<td>4</td>
</tr>
<tr>
<td>18. I am helpless when I’m left on my own.</td>
<td>4</td>
</tr>
<tr>
<td>19. I am basically alone -- unless I can attach myself to a stronger person.</td>
<td>4</td>
</tr>
<tr>
<td>20. The worst possible thing would be to be abandoned.</td>
<td>4</td>
</tr>
<tr>
<td>21. If I am not loved, I will always be unhappy.</td>
<td>4</td>
</tr>
<tr>
<td>22. I must do nothing to offend my supporter or helper.</td>
<td>4</td>
</tr>
<tr>
<td>23. I must be subservient in order to maintain his or her good will.</td>
<td>4</td>
</tr>
<tr>
<td>24. I must maintain access to him or her at all times.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>HOW MUCH DO YOU BELIEVE IT?</td>
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<tr>
<td></td>
<td>Totally</td>
</tr>
<tr>
<td>25. I should cultivate as intimate a relationship as possible</td>
<td>4</td>
</tr>
<tr>
<td>26. I can’t make decisions on my own.</td>
<td>4</td>
</tr>
<tr>
<td>27. I can’t cope as other people can.</td>
<td>4</td>
</tr>
<tr>
<td>28. I need others to help me make decisions or tell me what to do.</td>
<td>4</td>
</tr>
<tr>
<td>29. I am self-sufficient, but I do need others to help me reach my goals.</td>
<td>4</td>
</tr>
<tr>
<td>30. The only way I can preserve my self-respect is by asserting myself indirectly; for example, by not carrying out instructions exactly.</td>
<td>4</td>
</tr>
<tr>
<td>31. I like to be attached to people but I am unwilling to pay the price of being dominated.</td>
<td>4</td>
</tr>
<tr>
<td>32. Authority figures tend to be intrusive, demanding, interfering, and controlling.</td>
<td>4</td>
</tr>
<tr>
<td>33. I have to resist the domination of authorities but at the same time maintain their approval and acceptance.</td>
<td>4</td>
</tr>
<tr>
<td>34. Being controlled or dominated by others is intolerable.</td>
<td>4</td>
</tr>
<tr>
<td>35. I have to do things my own way.</td>
<td>4</td>
</tr>
<tr>
<td>36. Making deadlines, complying with demands, and conforming are direct blows my pride and self-sufficiency.</td>
<td>4</td>
</tr>
<tr>
<td>37. If I follow the rules the way people expect, will inhibit my freedom of action.</td>
<td>4</td>
</tr>
<tr>
<td>Statement</td>
<td>How Much Do You Believe It?</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td></td>
<td>Totally</td>
</tr>
<tr>
<td>38. It is best not to express my anger directly but to show my displeasure by not conforming.</td>
<td>4</td>
</tr>
<tr>
<td>39. I know what's best for me and other people shouldn't tell me what to do.</td>
<td>4</td>
</tr>
<tr>
<td>40. Rules are arbitrary and stifle me.</td>
<td>4</td>
</tr>
<tr>
<td>41. Other people are often too demanding.</td>
<td>4</td>
</tr>
<tr>
<td>42. If I regard people as too bossy, I have a right to disregard their demands.</td>
<td>4</td>
</tr>
<tr>
<td>43. I am fully responsible for myself and others.</td>
<td>4</td>
</tr>
<tr>
<td>44. I have to depend on myself to see that things get done.</td>
<td>4</td>
</tr>
<tr>
<td>45. Others tend to be too casual, often irresponsible, self-indulgent, or incompetent.</td>
<td>4</td>
</tr>
<tr>
<td>46. It is important to do a perfect job on everything.</td>
<td>4</td>
</tr>
<tr>
<td>47. I need order, systems, and rules in order to get the job done properly.</td>
<td>4</td>
</tr>
<tr>
<td>48. If I don't have systems, everything will fall apart.</td>
<td>4</td>
</tr>
<tr>
<td>49. Any flaw or defect of performance may lead to a catastrophe.</td>
<td>4</td>
</tr>
<tr>
<td>50. It is necessary to stick to the highest standards at all times, or things will fall apart.</td>
<td>4</td>
</tr>
<tr>
<td>51. I need to be in complete control of my emotions.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>HOW MUCH DO YOU BELIEVE IT?</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>Totally</td>
</tr>
<tr>
<td>52. People should do things my way.</td>
<td>4</td>
</tr>
<tr>
<td>53. If I don’t perform at the highest level, I will fail.</td>
<td>4</td>
</tr>
<tr>
<td>54. Flaws, defects, or mistakes are intolerable.</td>
<td>4</td>
</tr>
<tr>
<td>55. Details are extremely important.</td>
<td>4</td>
</tr>
<tr>
<td>56. My way of doing things is generally the best way.</td>
<td>4</td>
</tr>
<tr>
<td>57. I have to look out for myself.</td>
<td>4</td>
</tr>
<tr>
<td>58. Force or cunning is the best way to get things done.</td>
<td>4</td>
</tr>
<tr>
<td>59. We live in a jungle and the strong person is the one who survives.</td>
<td>4</td>
</tr>
<tr>
<td>60. People will get at me if I don’t get them first.</td>
<td>4</td>
</tr>
<tr>
<td>61. It is not important to keep promises or honor debts.</td>
<td>4</td>
</tr>
<tr>
<td>62. Lying and cheating are OK as long as you don’t get caught.</td>
<td>4</td>
</tr>
<tr>
<td>63. I have been unfairly treated and am entitled to get my fair share by whatever means I can.</td>
<td>4</td>
</tr>
<tr>
<td>64. Other people are weak and deserve to be taken.</td>
<td>4</td>
</tr>
<tr>
<td>65. If I don’t push other people, I will get pushed around.</td>
<td>4</td>
</tr>
<tr>
<td>66. I should do whatever I can get away with.</td>
<td>4</td>
</tr>
<tr>
<td>67. What others think of me doesn’t really matter.</td>
<td>HOW MUCH DO YOU BELIEVE IT?</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td></td>
<td>Totally</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

<p>| 68. If I want something, I should do whatever is necessary to get it. | 4 | 3 | 2 | 1 | 0 |
| 69. I can get away with things so I don’t need to worry about bad consequences. | 4 | 3 | 2 | 1 | 0 |
| 70. If people can’t take care of themselves, that’s their problem | 4 | 3 | 2 | 1 | 0 |
| 71. I am a very special person. | 4 | 3 | 2 | 1 | 0 |
| 72. Since I am so superior, I am entitled to special treatment and privileges. | 4 | 3 | 2 | 1 | 0 |
| 73. I don’t have to be bound by the rules that apply to other people. | 4 | 3 | 2 | 1 | 0 |
| 74. It is very important to get recognition, praise, and admiration. | 4 | 3 | 2 | 1 | 0 |
| 75. If others don’t respect my status, they should be punished. | 4 | 3 | 2 | 1 | 0 |
| 76. Other people should satisfy my needs. | 4 | 3 | 2 | 1 | 0 |
| 77. Other people should recognize how special I am. | 4 | 3 | 2 | 1 | 0 |
| 78. It’s intolerable if I’m not accorded my due respect or don’t get what I’m entitled to. | 4 | 3 | 2 | 1 | 0 |
| 79. Other people don’t deserve the admiration or riches they get. | 4 | 3 | 2 | 1 | 0 |
| 80. People have no right to criticize me. | 4 | 3 | 2 | 1 | 0 |
| 81. No one’s needs should interfere with my own. | 4 | 3 | 2 | 1 | 0 |</p>
<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Totally</th>
<th>Very Much</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>Since I am so talented, people should go out of their way to promote my career.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>83</td>
<td>Only people as brilliant as I am understand me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>84</td>
<td>I have every reason to expect grand things.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>85</td>
<td>I am an interesting, exciting person.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>86</td>
<td>In order to be happy, I need other people to pay attention to me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>87</td>
<td>Unless I entertain or impress people, I am nothing.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>88</td>
<td>If I don’t keep others engaged with me, they won’t like me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>89</td>
<td>The way to get what I want is to dazzle or amuse people.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>90</td>
<td>If people don’t respond very positively to me, they are rotten.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>91</td>
<td>It is awful if people ignore me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>92</td>
<td>I should be the center of attention.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>93</td>
<td>I don’t have to bother to think things through -- I can go by my “gut” feeling.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>94</td>
<td>If I entertain people, they will not notice my weaknesses.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>95</td>
<td>I cannot tolerate boredom.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>96</td>
<td>If I feel like doing something, I should go ahead and do it.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>97</td>
<td>People will pay attention only if I act in extreme ways.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<tr>
<td></td>
<td>HOW MUCH DO YOU BELIEVE IT?</td>
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<tr>
<td></td>
<td>Totally</td>
<td>Very Much</td>
<td>Moderately</td>
<td>Slightly</td>
<td>Not at all</td>
<td></td>
</tr>
<tr>
<td>98. Feelings and intuition are much more important than rational thinking and planning.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>99. It doesn’t matter what other people think of me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>100. It is important for me to be free and independent of others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>101. I enjoy doing things more by myself than with other people.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>102. In many situations, I am better off to be left alone.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>103. I am not influenced by others in what I decide to do.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>104. Intimate relations with other people are not important to me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>105. I set my own standards and goals for myself.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>106. My privacy is much more important to me than closeness to people.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>107. What other people think doesn’t matter to me.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>108. I can manage things on my own without anybody’s help.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>109. It’s better to be alone than to feel “stuck” with other people.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
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<tr>
<td>110. I shouldn’t confide in others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>111. I can use other people for my own purposes as long as I don’t get involved.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>112. Relationships are messy and interfere with freedom.</td>
<td>HOW MUCH DO YOU BELIEVE IT?</td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td>Very Much</td>
<td>Moderately</td>
<td>Slightly</td>
<td>Not at all</td>
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<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

| 113. I cannot trust other people.                     | 4   | 3   | 2   | 1   | 0   |

| 114. Other people have hidden motives.                | 4   | 3   | 2   | 1   | 0   |

| 115. Others will try to use me or manipulate me if I don’t watch out. | 4   | 3   | 2   | 1   | 0 |

| 116. I have to be on guard at all times.              | 4   | 3   | 2   | 1   | 0   |

| 117. It isn’t safe to confide in other people.        | 4   | 3   | 2   | 1   | 0   |

| 118. If people act friendly, they may be trying to use or exploit me. | 4   | 3   | 2   | 1   | 0 |

| 119. People will take advantage of me if I give them the chance.     | 4   | 3   | 2   | 1   | 0   |

| 120. For the most part, other people are unfriendly.              | 4   | 3   | 2   | 1   | 0   |

| 121. Other people will deliberately try to demean me.             | 4   | 3   | 2   | 1   | 0   |

| 122. Oftentimes people deliberately want to annoy me.             | 4   | 3   | 2   | 1   | 0   |

| 123. I will be in serious trouble if I let other people think they can get away with mistreating me. | 4   | 3   | 2   | 1   | 0   |

| 124. If other people find out things about me, they will use them against me. | 4   | 3   | 2   | 1   | 0   |

| 125. People often say one thing and mean something else.           | 4   | 3   | 2   | 1   | 0   |

<p>| 126. A person whom I am close to could be disloyal or unfaithful.   | 4   | 3   | 2   | 1   | 0   |</p>
<table>
<thead>
<tr>
<th>PBQ Scale</th>
<th>Raw Score</th>
<th>Z-score</th>
<th>Patients with corresponding PD</th>
<th>Patients with no PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidant</td>
<td>Sum of items 1-14</td>
<td>(Raw score - 18.8)/10.9</td>
<td>.62</td>
<td>-.69</td>
</tr>
<tr>
<td>Dependent</td>
<td>Sum of items 15-28</td>
<td>(Raw score - 18.0)/11.8</td>
<td>.83</td>
<td>-.49</td>
</tr>
<tr>
<td>Passive-Aggressive</td>
<td>Sum of items 29-42</td>
<td>(Raw score - 19.3)/10.5</td>
<td>No data</td>
<td>-.38</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>Sum of items 43-56</td>
<td>(Raw score - 22.7)/11.5</td>
<td>.31</td>
<td>-.51</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Sum of items 57-70</td>
<td>(Raw score - 9.3)/6.8</td>
<td>.31</td>
<td>-.18</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Sum of items 71-84</td>
<td>(Raw score - 10.0)/7.6</td>
<td>1.10</td>
<td>-.38</td>
</tr>
<tr>
<td>Histrionic</td>
<td>Sum of items 85-98</td>
<td>(Raw score - 14.0)/9.3</td>
<td>No data</td>
<td>-.29</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Sum of items 99-112</td>
<td>(Raw score - 16.3)/8.6</td>
<td>No data</td>
<td>-.14</td>
</tr>
<tr>
<td>Paranoid</td>
<td>Sum of items 113-126</td>
<td>(Raw score - 14.6)/11.3</td>
<td>.51</td>
<td>-.55</td>
</tr>
<tr>
<td>Borderline</td>
<td>Sum items 4, 9, 13, 15, 16, 18, 27, 60, 97, 113, 116, 119, 125, and 126</td>
<td>(Raw score - 15.8)/10.5</td>
<td>.77</td>
<td>-.65</td>
</tr>
</tbody>
</table>

Note: Z-scores are based on a sample of 756 psychiatric outpatients with mixed diagnoses.


<table>
<thead>
<tr>
<th>Items</th>
<th>Score</th>
<th>Scale</th>
<th>Raw Score</th>
<th>Z-Score</th>
<th>Criterion Z-Scores for patient with corresponding PD</th>
<th>Criterion Z-Scores for patient with no PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Avoidant</td>
<td>0</td>
<td>-1.72</td>
<td>0.62</td>
<td>-0.69</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Dependent</td>
<td>0</td>
<td>-1.53</td>
<td>0.83</td>
<td>-0.49</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Passive-Aggressive</td>
<td>0</td>
<td>-1.84</td>
<td>No data</td>
<td>-0.38</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Obsessive-Compulsive</td>
<td>0</td>
<td>-1.97</td>
<td>0.31</td>
<td>-0.51</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Antisocial</td>
<td>0</td>
<td>-1.37</td>
<td>0.31</td>
<td>-0.18</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Narcissistic</td>
<td>0</td>
<td>-1.32</td>
<td>1.1</td>
<td>-0.38</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Histrionic</td>
<td>0</td>
<td>-1.51</td>
<td>No data</td>
<td>-0.29</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Schizoid</td>
<td>0</td>
<td>-1.90</td>
<td>No data</td>
<td>-0.14</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Paranoid</td>
<td>0</td>
<td>-1.39</td>
<td>0.51</td>
<td>-0.55</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Borderline</td>
<td>0</td>
<td>-1.50</td>
<td>0.77</td>
<td>-0.65</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Total item answered</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Total item answered</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See Dropbox for full document – Home and Community Based Programming- Intake Measures- Additional Intake Measures (by problem area)- Personality Belief Questionnaire- PBQ Scoring.xlsx
**Work and Social Adjustment Scale**

Name: ___________________________  Date: ___________________________

**Instructions:** People’s problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems, look at each section and determine on the scale provided how much your problem affects your ability to carry out the activity. Once you have decided upon a number, circle it. Then proceed to the next stage.

**WORK**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>Definitely</td>
<td>Markedly</td>
<td>Very severely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I cannot work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOME MANAGEMENT**

Cleaning, tidying, shopping, cooking, looking after home/children, paying bills, etc...

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>Definitely</td>
<td>Markedly</td>
<td>Very severely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOCIAL LEISURE ACTIVITIES**

With other people, e.g., parties, pubs, outings, entertaining, etc...

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>Definitely</td>
<td>Markedly</td>
<td>Very severely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PRIVATE LEISURE ACTIVITIES**

Done alone, e.g., reading, gardening, sewing, hobbies, etc...

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>Definitely</td>
<td>Markedly</td>
<td>Very severely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY AND RELATIONSHIPS**

Form and maintain close relationships with others including the people I live with.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>Definitely</td>
<td>Markedly</td>
<td>Very severely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using the following 5-point scale, please circle the number that best represents your opinion for this group:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

My learning and treatment objectives were met:

*Learning Objectives:*

1. Understand the Principles of Exposure Therapy .................................................. 1  2  3  4  5
2. Set up a clear hierarchy for feared sensations................................................. 1  2  3  4  5
3. How to expose self to feared situations in a systematic manner...................... 1  2  3  4  5

The content of the program has been relevant to my needs ...................................... 1  2  3  4  5

I feel supported by my therapist during my exposure tasks....................................1  2  3  4

The team involved in my treatment feels unified and cohesive and it appears that adequate communication has been facilitated between all individuals involved in my care at OICBT .........1  2  3  4  5

My therapist was reachable and followed up with me no later than 48 hours upon me reaching out to them.......1  2  3  4

I feel understood by the the treatment team involved in my care (psychologist, social worker, behavioral aide)........................................1  2  3  4  5
For me, the “pearls” that I learned in this program were:

1. _____________________________________________________________
2. _____________________________________________________________

These sessions/this program helped me to make the following changes:

1. _____________________________________________________________
2. _____________________________________________________________

Overall Comments about this program: 1 – Poor    2 – Fair    3 – Good    4 – Excellent

Therapist

1  2  3  4

1  2  3  4

Organization

1  2  3  4

Additional Comments: _____________________________________________

____________________________________________________________________

____________________________________________________________________

Are there other suggestions you have to improve the program?

1. _____________________________________________________________
2. _____________________________________________________________

Thank you for completing this evaluation form.
# EVALUATION FORM:
## Family Group For Depression

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>Behavioural Activation in the Treatment of Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator:</td>
<td>Connie Dalton and Dianne Blackburn</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
</tbody>
</table>

Using the following 5-point scale, please circle the number that best represents your opinion for this group:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

My group **learning and treatment objectives** were met:

**Learning Objectives:**

1. Understand the Role of Behaviors in Depression .................................. 1 2 3 4 5  
2. More aware of behavioural strategies for treatment .................................. 1 2 3 4 5  
3. Better Understand my loved ones experience of Depression .......................... 1 2 3 4 5  

The **quality** of the education session is acceptable (facilitator clarity, maintaining quality of interactions in group) .......................................................... 1 2 3 4 5  

The content of the session has been relevant to my needs .................................. 1 2 3 4 5  

I felt like I belonged in this session ................................................................. 1 2 3 4 5  

There is adequate time and quality in questioning and interactive aspects of the session .......................................................... 1 2 3 4 5  

The time spent in the group is adequately managed ............................................ 1 2 3 4 5  

I feel understood by the group leader ............................................................... 1 2 3 4 5  
Appendix P: Screening Call Template

Ottawa Institute
Of Cognitive
Behavioural Therapy

L'institut de thérapie
cognitivo-comportementale
d'Ottawa

The OICBT Supervision and Training Program
411 Roosevelt Ave., Suite 200, Ottawa, Ontario, K2A 3X9, Tel. 613-820-9931

Telephone Screening

Date: ____________________  Screening completed by: ____________________

Hello, my name is _______________, may I please speak with ____________________.

Hello, my name is _______________. I’m calling from the Ottawa Institute of Cognitive Behavioural Therapy. As you know, I’m calling today to do a screening call. This is a short phone call to make sure that the student training program at the OICBT is a good fit for your needs. I will be asking you some basic questions for approximately 20-30 minutes. Then I will be able to give you an idea about the next steps. Do you have any questions?

Confidentiality

Before we begin the screening, I would like to review the limits of confidentiality to make sure that you are entirely clear about these.

Everything that you share with us during the screening, assessment, or treatment sessions is confidential and will not be discussed beyond the supervision relationship. We safeguard your anonymity, so that no one knows you are receiving services if you don’t want them to know. In addition, nothing that you talk about will be repeated to others unless you give us your explicit permission to do so.

However, there are five very special circumstances under which we may be required to break confidentiality. First, if we are concerned that you are at risk of harming yourself or another person, we may have to break confidentiality. Second, if you tell us that a child under the age of 16 is being abused or neglected, is at risk of being abused or neglected, or has been abused or neglected, we are required by law to report this to the Children’s Aid Society. Third, if you tell us that you have been sexually abused by a regulated health professional and you give us the name of that person, we are required by law to report the abuse to that professional’s regulatory college. Fourth, if you are involved in a legal case, your file could be subpoenaed and we may be forced to release information from your file to the court. Finally, assessors from the College of Psychologists of Ontario may have access to client records during professional quality assurance reviews. These are the only limits to your confidentiality.

Do you have any questions about the limits of confidentiality? Are you ready to begin the screening?
SUMMARY INFORMATION

Basic Demographics:

Client Name: Sex:
Age: DOB:
Address:
Phone (Home): Phone (Work):
Phone (Cell): Can leave message (Y/N)
Email:
Referral Source:

Medical Information:

Do you have a GP? ___ (y/n)
IF YES, Who?: _________________________________________
IF NO, Where do you receive your primary medical care? (e.g., walk-in clinic including name):

Do you have any diagnosed medical conditions or a physical disability? ___ (y/n), and
Have you ever been diagnosed with a psychiatric illness? ___ (y/n)
IF YES to diagnosed with medical condition, disability, or psychiatric illness, complete table (continue on back if necessary):

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>When was this diagnosed? (year or, if in last year, month)</th>
<th>Is this related to why you are seeking treatment? (y/n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Have you ever been hospitalized for a physical or a psychiatric illness?

IF YES, complete table (continue on back if necessary):

<table>
<thead>
<tr>
<th>When</th>
<th>Where</th>
<th>For what</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Presenting Problem** (Try to keep this a brief as possible. Remember, there will be lots of time to flesh out the details during the assessment)

Now, I’d like to ask a bit about why you contacted the OICBT. What is the main problem you need help with (e.g., anxiety, depression, coping with illness/disability, attention difficulties)?

What are the main symptoms you are experiencing (e.g., panic attacks, low mood/anhedonia, physical symptoms, grief/loss, behavioural avoidance, distractibility)?

**Risk/Suitability**

1) Sometimes when people are struggling, they think a lot about death or that they would be better off dead. Have you had any thoughts like that recently? ___ (y/n) (IF YES, get details about thoughts, intent, plan, availability of means to execute plan, past attempts, current substance use and history of impulsive behaviour).

IF AT RISK (i.e., endorses thoughts), say, “I know that things can get really difficult sometimes. I’d like to give you some information about staying safe if things get to that point again. Do you have a pen and paper? If you’re having a crisis and need someone to talk to, you can call the Ottawa Distress Centre at 613-238-3311. If you don’t think you can keep yourself safe at any time, you should go to the emergency room at the nearest hospital or call 911.” Continue with 2) below.

IF AT HIGH RISK (i.e., thoughts, specific plan, means, and current intent), say “I hear you saying that things are so difficult right now that you don’t know whether you can keep yourself safe. I would like to do everything I can to keep you safe. Can I put you on hold while I call a supervisor to come help me with this?” IF YES, Seek immediate supervision: Use a cell phone or put the client on hold to call your immediate
supervisor (i.e., your assessment/diagnosis supervisor) followed by the emergency coverage supervisor,
followed by Lisa (who can get a supervisor for you). Keep the client on the phone until a supervisor arrives. If
the client hangs up, see below. IF NO, see instructions about imminent risk below.

IF AT IMMINENT RISK (i.e., threatening to kill self immediately, cannot commit to staying safe while on
hold), follow Suicide Risk Assessment protocol:

- If you don’t know where the client is calling from, get that information. (Do not assume they are calling
  from home address). “I hear you saying that, as soon as we get off the phone, you’re going to kill
  yourself. I would like to do everything I can to keep you safe. Please tell me where you are right
  now.”
- Use a cell phone or put the client on hold to call 911. If the client has refused to provide their location,
call 911 anyway. It may be possible to track where phone call is coming from. Try to keep the client on
  the line but, if he/she hangs up, call 911 anyway.
- Seek immediate supervision: Use a cell phone or put the client on hold to call your immediate supervisor
  (i.e., your assessment/diagnosis supervisor) followed by the emergency coverage supervisor, followed
  by Lisa (who can get a supervisor for you). Try to keep the client on the phone until a supervisor arrives.

2) Has there ever been a period of time when you had unusual experiences such as seeing or hearing things
other people could not see or hear? Or when you strongly believed something that others thought did not make
sense? (IF YES, get details about number of episodes, most recent episode, and current status. IF CURRENT,
get details about current severity and impact. Discuss with supervisor before booking assessment).

3) How much alcohol do you drink in a week? (Get details of total number of drinks, number of drinks per day,
and serving size)

Do you use any street drugs or use any prescription medications in ways other than how they were prescribed?
(Get details of what, how much and how often)

(IF POSSIBLE EXCESSIVE USE, Does drinking/drug use cause any problems for you? Does anyone object to
your drinking/drug use?)
IF DRINKING/DRUG USE IS CURRENT, EXCESSIVE AND PROBLEMATIC, discuss with supervisor before booking assessment.

4) Recently (in the past month) has there been a period of time when you were so high, excited, or hyper that other people thought you were not your normal self? ___ (y/n) Or when you were consistently irritable, angry, or short-tempered, much more so than usual? ___ (Y/N) (IF YES, get details about when, for how long, did they get in trouble or where they hospitalized, and current status.)

IF CLIENT IS CURRENTLY IN A MANIC EPISODE, end the interview, let them know that the OICBT training program is not the best place for them to get services at this time, and tell them that you will get back to them with some referrals.

5) Have you ever been involved in any legal proceedings?

<table>
<thead>
<tr>
<th>What for? (e.g., divorce, custody/access, assault)</th>
<th>When? (year and, if in last year, month)</th>
<th>Is it ongoing? (y/n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Presenting Problem Differentiation**

Now I’m going to ask you some specific questions that require only a yes or no answer. If it is important, we will get more details at a later time. **(DON’T ASK ITEMS FOR WHICH THE CLIENT HAS ALREADY INDICATED THE PROBLEM IS PRESENT)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently bothered by panic attacks, when you suddenly feel frightened or anxious or suddenly develop a lot of physical symptoms?</td>
<td></td>
</tr>
<tr>
<td>Are you very anxious about or afraid of situations like going out of the house alone, being in crowds, going to stores, standing in lines, or travelling on buses or planes?</td>
<td></td>
</tr>
<tr>
<td>Are you especially anxious about or afraid of being separated from people you are attached to like your parents, your children, your partner, or others, including pets?</td>
<td></td>
</tr>
<tr>
<td>Are you especially nervous or anxious in social situations that involve people that you don’t know very well?</td>
<td></td>
</tr>
<tr>
<td>Is there anything that you are afraid to do or feel very uncomfortable doing in front of other people, like speaking, eating, or going to the bathroom?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Are there any other things that make you especially anxious or afraid, like flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects?</td>
<td></td>
</tr>
<tr>
<td>Over the last 6 months, have you been feeling nervous or anxious a lot of the time?</td>
<td></td>
</tr>
<tr>
<td>Are you bothered by thoughts that don’t make sense and keep coming back to you even when you don’t want them to, like being exposed to germs or dirt or needing everything lined up in a certain way?</td>
<td></td>
</tr>
<tr>
<td>How about having images pop into your head that you don’t want, like violent or horrible scenes or something of a sexual or blasphemous nature?</td>
<td></td>
</tr>
<tr>
<td>How about having urges that keep coming back to you even though you don’t want them to, like the urge to harm a loved one?</td>
<td></td>
</tr>
<tr>
<td>Is there anything that you have to do over and over again and can’t resist doing, like washing your hands again and again, repeating something over and over again until it “feels right”, counting up to a certain number, or checking something many times to make sure that you’ve done it right?</td>
<td></td>
</tr>
<tr>
<td>Do you find it difficult to throw out or give away things?</td>
<td></td>
</tr>
<tr>
<td>Are you very concerned that there is something wrong with the way your body or part of your body looks?</td>
<td></td>
</tr>
<tr>
<td>Do you repeatedly pull out hair from anywhere on your body?</td>
<td></td>
</tr>
<tr>
<td>Do you repeatedly pick at your skin with your fingernails, tweezers, pins, or other objects?</td>
<td></td>
</tr>
<tr>
<td>Do you often have trouble sleeping?</td>
<td></td>
</tr>
<tr>
<td>Do you often feel sleepy despite having slept for at least 7 hours?</td>
<td></td>
</tr>
<tr>
<td>Over the past six months, have you often been easily distracted or disorganized?</td>
<td></td>
</tr>
<tr>
<td>Over the past six months, have you often had a lot of difficulty being patient or sitting still?</td>
<td></td>
</tr>
<tr>
<td>Do you weigh much less than other people think you ought to weigh?</td>
<td></td>
</tr>
<tr>
<td>Do you often have times when your eating is out of control?</td>
<td></td>
</tr>
<tr>
<td>Are you bothered by any physical symptoms? That is, do you spend a lot of time thinking about them, feel very anxious about them, or spend more time and energy on them than most people would?</td>
<td></td>
</tr>
<tr>
<td>Do you spend a lot of time thinking that you have or will get a serious illness?</td>
<td></td>
</tr>
<tr>
<td>Is there any aspect of your sexual functioning that is of concern to you? (e.g., delayed or premature ejaculation, erectile disorder, female orgasmic or interest/arousal disorder, genito-pelvic pain) (IF YES, identify and note the issue)</td>
<td></td>
</tr>
</tbody>
</table>
Do you frequently lose control of your temper and end up yelling or getting into arguments with others?

IF YES, Have you lost control of your temper and physically hurt a person or an animal, or damaged something?

IF YES, Have you lost control so that you shoved, hit, kicked, or threw something at a person, an animal, or an object without causing any physical damage or injury?

**Closing**

Thank you. That’s all the questions I have for you. Do you have any questions for me?

Finally, I would like to ask what you thought of this screening phone call. Do you have any feedback? We would like to make sure that this process is as easy and comfortable for our clients as possible.
INTAKE AND FOLLOW UP NEEDED:

1) Scheduling Assessment: Please determine if the screening needs to be discussed in supervision prior to scheduling an intake session.
   • If they seem appropriate and there are no contraindications for their involvement, you can schedule an intake session for those that may be appropriate for group and/or individual therapy with a student.
   • If they seem appropriate for a more intensive diagnostic assessment, including assessment of ADHD, and have been referred for this purpose, please schedule this session.
   • If the client is seeking services in the context of an illness or disability, please schedule them with a student who is interested in health/rehabilitation cases.
   These options should be available and clearly indicated in google calendar.

Please make sure you have reviewed all financial and location information included below.

2) Accessibility: (IF not already clear, ask) Do you have any mobility issues? ___ (y/n) (IF YES, DISCUSS CONSTRAINTS IN OUR BUILDING):
   • In winter, access to front door: might have to come along sidewalk from Danforth Ave.
   • Double set of doors at front, no push buttons.
   • Elevators, OK
   • Door to Suite 305 has push down handle and door opens inward. Heavy door.
   • Washrooms are locked (require key obtained from reception) and have round turn handle. Narrow entrance. In women’s, one larger stall, no handrail. In men’s average sized stall, no handrail).

Appointment Scheduled:   Yes_____No______

When:   ________________________________   With whom: ________________________

Other Follow Up: ________________________

When Booking Time ensure you review the following:
   _____ Address (411 Roosevelt Avenue – Suite 305)
   _____ Call 24 hours in advance to cancel session (cancellation fee applicable – half fee)
   _____ Parking (in residential area and not in building)
   _____ Directions and Suite number (Corner of Richmond Road and Roosevelt Ave)
   _____ Telephone Numbers for contact and cancel (613) 820-9931, ext 0
Ensure you reviewed Financial Issues:

- [ ] No OHIP coverage and insurance plan
- [ ] Referral by physician before first session in order to be reimbursed by insurance
- [ ] Session Cost and Length
- [ ] Inform about Fees ($120 for the first intake session)
- [ ] Review of Payment Method (Pay at the end of session by cheque, credit or debit)
### COMMUNITY AND HOME-BASED CBT SERVICE SCREENING FORM

<table>
<thead>
<tr>
<th>Client’s Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent form reviewed with client?</td>
<td>Yes [ ] No [ ]</td>
</tr>
<tr>
<td>Intervention requested</td>
<td></td>
</tr>
<tr>
<td>Intervention location(s)</td>
<td></td>
</tr>
<tr>
<td>Full address of intervention location</td>
<td></td>
</tr>
</tbody>
</table>

**IF INTERVENTION WILL TAKE PLACE IN THE HOME, PLEASE COMPLETE THE FOLLOWING:**

<table>
<thead>
<tr>
<th>Type of residence</th>
<th>House</th>
<th>Apartment</th>
<th>Boarding home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parking</td>
<td>Driveway</td>
<td>Designated visitor parking</td>
<td>Street (if so, time restriction?)</td>
</tr>
<tr>
<td>Pets? Yes [ ] No [ ]</td>
<td>If yes, please describe (including how they might react to strangers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does anyone smoke in the home? Yes [ ] No [ ]</td>
<td><em>If yes, please request that they not smoke during – or one hour before – session</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who lives in the home?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any history of violence?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who else would be present during a home visit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private space for the session?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix Q: Intake Assessment

Therapy Intake Session: Mental Health Stream

Name of Patient: _____________________    Date:______________

REVIEW OF ADMINISTRATION:

1) Review of Purpose of the Intake: _____Yes      ____  No
   (To complete a 75-minute initial assessment of primary area of target for treatment and determine best fit in our program – individual or group therapy. Describe the program if more detail needed)

2) Review of Consent form (in file): _____Yes      ____  No
   (Including limits of confidentiality, late payment form, and fee structure)

3) Confirm demographic information (i.e., name, age, DOB, contact information) on screening form. Correct if necessary.

4) Get name and contact information for emergency contact person.
   Name: ________________ Relationship to client: __________________
   Phone number: __________________

5) Review list of medications: _____Yes      ____  No
   (Clients have been asked to complete this and bring it in with them. If client does not have list with them get names and dosages of all medications.)

6) Confirm Resources Involved in Care using the screening form:
   Family physician :   ____ yes      ____ No ;  Who __________________________
   Psychiatrist:        ____ yes      ____ No ;  Who __________________________
   Psychologist:        ____ yes      ____ No;   Who __________________________
   Other:               ____ yes      ____ No;   Who __________________________

7) Indicate who we may send back a letter of contact when completing intake - outlines the general plan for treatment:
   Family physician :   ____ yes      ____ No ;  Clinic Name ______________________
   Psychiatrist:        ____ yes      ____ No ;  Clinic Name ______________________
   Psychologist:        ____ yes      ____ No;   Clinic Name ______________________
   Other:               ____ yes      ____ No;   Clinic Name ______________________

If client does not want a contact form sent back please indicate the reason identified:

____________________________________________________________________________
1) PRESENTING PROBLEM AND REASON FOR REFERRAL: First, I’d like to start by asking some questions about your current situation. I see from your phone screen that you are coming to see us for __________. Tell me a more about that.

Main Problem Area:
______________________________________________________________________________
______________________________________________________________________________

Secondary Problem Area:
______________________________________________________________________________
______________________________________________________________________________

What impact are these problems having on your life? (i.e., interpersonal, family, personal time, work performance)
______________________________________________________________________________
______________________________________________________________________________

2) CURRENT SYMPTOM PRESENTATION: OK, I’d like to take a closer look at some of your current symptoms.

Review questionnaires (with client as necessary) to identify main symptoms/treatment issues.
______________________________________________________________________________
______________________________________________________________________________
**3) BACKGROUND INFORMATION:** Now, I’d like to ask some questions about the history of these problems and your personal background.

**a) Psychiatric History:** (Review screening and confirm past diagnoses, hospitalizations and contact with mental health professionals, family history of mental illness)

Now, I’d like to ask you about some things that may have happened to you and that may have been extremely upsetting. I am asking because people often find that talking about these experiences can be helpful. Have you ever been exposed to a life-threatening situation (e.g., major disaster, fire, combat, or accident), serious injury or physical or sexual violence? You might have experienced something like this yourself, witnessed it happening to someone else, or learned about it happening to a close family member or friend. ___Yes ___ No

IF YES, Is this something that continues to bother you? ___Yes ___ No

IF YES, Please tell me briefly what happened.

IF EVENT IS A TRAUMATIC EVENT AS DEFINED IN DSM 5, Thank you for telling me about that. (Administer PCL-S).

**b) Medical History:** (Review screening and confirm diagnoses. Onset, course, and treatments received for current medical condition/disability.)
c) Developmental History: Where did you grow up? How would you describe your childhood? What was school like for you? How far did you get in school? What did you do after you finished school?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Current employment situation: Are you currently employed? ___Yes ___No

IF YES, By whom? For how long? What kind of work do you do? Do you like it?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

IF NO, What is your current source of income?

______________________________________________________________________________

______________________________________________________________________________

Insurance: Do you have insurance for psychological services? ___Yes ___No

IF YES, Which company?

______________________________________________________________________________

______________________________________________________________________________

d) History of Bullying/Abuse: Have you ever experienced any bullying or abuse? ___Yes ___No (IF YES, get details of type, by whom, when, and for how long). IF NOT CLEAR, Is this something that continues to affect you? ___Yes ___No

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

e) Interpersonal Functioning: I’d like to know a bit about your relationships with other people. (Relationships with family members, past and current; quality and quantity of friendships growing up and
currently; quality and quantity of romantic relationships; interpersonal conflict, relationships ending, fear of abandonment)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4) FACTORS THAT MAINTAIN OR ALLEVIATE SYMPTOMS

a) Behavioural Factors (helpful and unhelpful behaviours): When you feel (sad/anxious/etc.) what do you do? (Unhelpful behaviors: withdrawal, escape, over-activation, drinking, excessive reassurance seeking, the use of safety behaviors to cope)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Avoidance: Are there things you used to do that you don’t do anymore because of these problems? (Avoidance of places, people, things, tasks, memories, thoughts, feelings and internal bodily sensations)

______________________________________________________________________________
______________________________________________________________________________

b) Cognitive Factors (helpful and unhelpful thinking patterns): What kinds of thoughts do you have about your problems? (Unhelpful thinking patterns: negative thoughts and beliefs, cognitive biases, thought suppression, rumination, catastrophizing, hopelessness, excessive focus on body sensations)

______________________________________________________________________________
______________________________________________________________________________

b) Cognitive Factors (helpful and unhelpful thinking patterns): What kinds of thoughts do you have about your problems? (Unhelpful thinking patterns: negative thoughts and beliefs, cognitive biases, thought suppression, rumination, catastrophizing, hopelessness, excessive focus on body sensations)

______________________________________________________________________________


c) Emotional/Physiological Factors (helpful and unhelpful emotion management strategies): What kinds of feelings or emotional reactions do you have to your problems? How do you manage these emotions? What does that feel like in your body? (Unhelpful emotion management strategies: Emotion dysregulation, fear/avoidance of emotional experiences, flattened affect)

______________________________________________________________________________
d) Environmental Factors (relationship distress/violence, social support, financial problems, employment issues, housing issues, legal involvement, access to medical services): Ask about these if you don’t already have the information.

5) GOALS FOR TREATMENT: What are your goals for treatment? What might be different that would let you know treatment had worked?

Goal 1: _____________________________________________________
Goal 2: _____________________________________________________
Goal 3: _____________________________________________________

6) CONCLUSION

a) Anything Missed? Is there anything I haven’t asked that you think I should know about?

______________________________________________________________________________

b) Concerns: Do you have any concerns about being involved in the student training program?

______________________________________________________________________________

c) Group vs. Individual: Do you have a preference with respect to participating in a group or being seen individually? (Provide any necessary details about the two options, e.g., wait times, financial considerations)

______________________________________________________________________________

d) Questions: Do you have any questions for me?

______________________________________________________________________________
7) NEXT STEPS (Review next steps with the client regarding the development of a collaborative treatment plan based on the assessment – give some suggestions if you can regarding the next steps)

Feedback Session Scheduled on (Date): ________________________________

BEHAVIOURAL OBSERVATIONS: (Appearance; behaviour/psychomotor activity; attitude towards the interviewer; affect (content, range and duration, appropriateness, depth or intensity) and mood; speech (rate, volume, and amount) and thought (process and content); perceptual disturbances; orientation (person, time, and place) and consciousness; apparent memory and intelligence; apparent reliability, judgment, and insight)

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Ph.D. Student ___________________________ Date ___________________________

Supervising Psychologist ___________________________ Date ___________________________
ASSESSMENT TASK LIST

___ Left questionnaires for scoring at the admin office

___ Prepared all documentation needed for the initial intake session (complet intake folder, consent form and payment receipts)

___ Administered and looked through all questionnaires

___ Complete the informed consent form and gave client a copy of the signed form

___ Used screening form in which to base some of the interview questions

___ Completed the intake form

___ Completed and Reviewed case conceptualisation/treatment planning form

___ Reviewed the intake form with supervisor and signed all documents (name printed clearly)

___ Signed and dated all forms and documentation in the clinical file

___ Completed the physician contact form, reviewed with supervisor and signed
Basic Demographics:

Patient Name: _________________ Referral Source: _________________

Age _________________________ DOB: __________________________

Address: ________________________________________________

Phone (Home): _________________ Phone (Work) _________________

Phone (Cell): _________________ Can leave message (Y/N)________

Emergency Contact _________________ Phone _________________

Background Information:

Marital Status and children ______________________________________

Current living situation _________________________________________

Place of Employment ___________________________________________

Insurance provider _____________________________________________

Medical History and Medications:

Resources Involved in Care:

Family physician:    ____ yes   ____ No; Who_________________________
Psychiatrist:        ____ yes   ____ No; Who_________________________
Psychologist:        ____ yes   ____ No; Who_________________________
Other:               ____ yes   ____ No; Who_________________________

Current Medications
Medical History

Past Psychiatric hospitalizations

Past Treatment History

**Communciation with Treatment Team:**

Indicate who may be sent back a letter of contact when the intake is completed - outlines initial contact and the general plan for treatment:

- **Family physician**: [ ] yes [ ] No; Clinic Name
- **Psychiatrist**: [ ] yes [ ] No; Clinic Name
- **Psychologist**: [ ] yes [ ] No; Clinic Name
- **Other**: [ ] yes [ ] No; Clinic Name

*If client does not want a contact form sent back please indicate the reason identified:*
<table>
<thead>
<tr>
<th>Session #</th>
<th>Date</th>
<th>Assignment</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>6</td>
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</table>
Activity Monitoring Worksheet: Monitor all the activities you participate in during the week. This includes cooking, cleaning, grocery shopping, sleeping, eating, etc. For each activity rate the amount of pleasure and enjoyment received from completing the activity (0 being no pleasure/no enjoyment to 10 being very pleasurable/enjoyable)

<table>
<thead>
<tr>
<th>Time</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<tr>
<td>5 a.m. - 6 a.m.</td>
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<td>6 a.m. - 7 a.m.</td>
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<td>7 a.m. - 8 a.m.</td>
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<td>9 a.m. - 10 a.m.</td>
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<td>11 a.m. - 12 p.m.</td>
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<td>12 p.m. - 1 p.m.</td>
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<td>1 p.m. - 2 p.m.</td>
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<td>2 p.m. - 3 p.m.</td>
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<td>4 p.m. - 5 p.m.</td>
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<tr>
<td>6 p.m. - 7 p.m.</td>
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<tr>
<td>8 p.m. - 9 p.m.</td>
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<tr>
<td>10 p.m. - 11 p.m.</td>
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<tr>
<td>11 p.m. - 12 a.m.</td>
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</tbody>
</table>
Behavioral Experiment

Prediction
What is your prediction?
What do you expect will happen?
How would you know if it came true?
Rate how strongly you believe this will happen (0-100%)

Experiment
What experiment could test this prediction? (where & when)
What safety behaviors will need to be dropped?
How would you know your prediction had come true?

Outcome
What happened?
Was your prediction accurate?

Learning
What did you learn?
How likely is it that your predictions will happen in the future?
Rate how strongly you agree with your original prediction now (0-100%)
**Behavioral Experiment**

**Prediction**
What is your prediction?
What do you expect will happen?
How would you know if it came true?

*If I speak in public I will shake so much that people will notice and laugh at me*

Rate how strongly you believe this will happen (0-100%)

90%

**Experiment**
What experiment could test this prediction? (where & when)
What safety behaviors will need to be dropped?
How would you know your prediction had come true?

*Speak up at the next meeting on Monday - I could present some of the data that I have been meaning to show.  
Would need to gesture with my hands, and not hold on to the table  
I could ask my friends if they noticed me shaking when I talk*

**Outcome**
What happened?
Was your prediction accurate?

*I was really nervous and was very aware of my hands  
My friends said I spoke well and that they could not see me shake*

**Learning**
What did you learn?
How likely is it that your predictions will happen in the future?

*Although I feel nervous when speaking it’s not as obvious to other people*

Rate how strongly you agree with your original prediction now (0-100%)

50%
Exposure & Response Prevention (EX/RP)

Exposure and Response Prevention is about exposing yourself to a situation that triggers your obsessions or compulsions (exposure), and then deliberately resisting the urge to carry out the compulsion that would normally relieve your anxiety (response prevention).

**Situation / Trigger**
What situations trigger my obsession?

**Obsession**
What is the thought, image, urge or impulse that bothers me?

**Compulsion**
What do I do to make myself feel better when I get the obsession?

**EX/RP Instructions:**
1. Expose yourself to the trigger
2. Resist performing the compulsion
3. Record how distressed you feel over time using the graph below
4. If you do perform the compulsion, expose yourself to the trigger again

![Graph showing the Subjective Units Of Distress (SUDS) over time.](http://psychology.tools)
Exposure & Response Prevention (EX/RP)

Exposure and Response Prevention is about exposing yourself to a situation that triggers your obsessions or compulsions (exposure), and then deliberately resisting the urge to carry out the compulsion that would normally relieve your anxiety (response prevention).

<table>
<thead>
<tr>
<th>Situation / Trigger</th>
<th>Obsession</th>
<th>Compulsion</th>
</tr>
</thead>
<tbody>
<tr>
<td>What situations trigger my obsession?</td>
<td>What is the thought, image, urge or impulse that bothers me?</td>
<td>What do I do to make myself feel better when I get the obsession?</td>
</tr>
<tr>
<td>Seeing dirty things – worst things are used diapers or band-aids</td>
<td>Image of my family getting ill – it would be my fault</td>
<td>Clean myself and anything my family might touch</td>
</tr>
</tbody>
</table>

EX/RP Instructions:
1. Expose yourself to the trigger  – Hold a used diaper
2. Resist performing the compulsion – Not wash my hands
3. Record how distressed you feel over time using the graph below
4. If you do perform the compulsion, expose yourself to the trigger again
Exposure Summary Sheet

Name: ___________________________  Date: ___________________________  Therapist: ___________________________

Theme of scenario: ______________________________________________________________

To complete before exposure:

1. Time ____:____

2. What is the level of distress associated with your thought right now? (circle the number that best corresponds to your level of distress before the beginning of the exposure session).

0  1  2  3  4  5  6  7  8
none  a little  moderate  considerable

To complete after exposure:

1. Time ____:____

2. What is the level of distress associated with your thought right now? (circle the number that best corresponds to your level of distress before the beginning of the exposure session).

0  1  2  3  4  5  6  7  8
none  a little  moderate  considerable

3. What was the maximum level of distress that was associated with your thought? (circle the number that best corresponds to your maximum level of distress during the exposure session).

0  1  2  3  4  5  6  7  8
none  a little  moderate  considerable

4. Did you neutralize your thought while you were listening?

Yes: _____  No: ______;  If yes, in what way
____________________________________________________________________________
____________________________________________________________________________
Guidelines for Emotion Exposure

1. Choosing your task
   - Pick something that is going to challenge you, but don't try to do a task that is too difficult.
   - The purpose of the exercise is to learn that you can master the situation, even in the face of very intense anxiety, fear, or depression.
   - Always complete exposures without emotional avoidance strategies, so do something that is manageable.
   - The more difficult exposures you can complete, the better you will do in the long-term.

2. BEFORE the exposure
   - As you notice yourself getting nervous before the task, use some of the cognitive reappraisal strategies you learned to reappraise the situation in order to complete the full exposure.
   - Remind yourself that facing your emotions is the only way to make them more manageable.
   - Similarly, if you find that you “just don't want to do it” because you feel depressed or anxious, THIS IS THE MOMENT TO PUSH YOURSELF EVEN HARDER. You cannot trust your emotions in this moment – remember that what goes up, must come down.

3. DURING the exposure
   - Practice awareness of your thoughts, feelings, behavioral urges, and the situation around you.
   - Prevent yourself from engaging in any emotional avoidance strategies. Don't try to push away uncomfortable thoughts and feelings – they are there and must be experienced head on in order to change and to break the cycle.
   - Notice any EDBs you might have the urge to engage in and don’t engage in them. You will be reinforcing the negative cycle of emotions if you do.

   - STAY IN THE SITUATION until your emotional distress has reduced. Notice what it's like when your emotions are reducing on their own. See how you are able to make a choice about how you respond, instead of being driven by your feelings.

4. AFTER the exposure.
   - Look back and evaluate how the exposure went.
   - Did what you fear would happen actually happen
■ Did you do anything to prevent your emotions from becoming too intense?
■ Did you stay in the exposure long enough?
■ What could you have done to challenge yourself even more?

*IF YOU FIND YOURSELF AVOIDING THE EXPOSURE,*
reevaluate your fears by answering some of these questions:

■ What did you fear would happen?
■ What do you imagine happening that would be so terrible?
■ What would be so bad about that happening
  ■ If you could be sure that *that* is all that would happen, would you still be as afraid of it?
### Emotion Exposure Hierarchy

Describe situations you are currently avoiding in order to prevent uncomfortable emotions from occurring, starting with the worst or most distressing situation. Rate the degree to which you avoid each of the situations you describe, and the degree of distress they cause. For each, write the applicable number in the space provided.

<table>
<thead>
<tr>
<th>Do Not Avoid</th>
<th>Hesitate To Enter But Rarely Avoid</th>
<th>Sometimes Avoid</th>
<th>Usually Avoid</th>
<th>Always Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>No Distress</td>
<td>Slight Distress</td>
<td>Definite Distress</td>
<td>Strong Distress</td>
<td>Extreme Distress</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
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<table>
<thead>
<tr>
<th>Description</th>
<th>Avoid</th>
<th>Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 WORST</td>
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<td></td>
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<td>2</td>
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</table>
Positive Activities for Behavioral Activation

Create a list of activities that you find rewarding. Rate each activity in two categories: How easy the activity will be for you to complete, and how rewarding it is (with 1 being very easy or rewarding, and 10 being difficult or not at all rewarding).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Ease (1-10)</th>
<th>Reward (1-10)</th>
</tr>
</thead>
<tbody>
<tr>
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Record of Emotional Exposure Sheet:

Exposure Task: ____________________________________________________________

Prior to the task:

Anticipatory Distress (0 – 8): ____________________________________________

Thoughts, Feelings, and Behaviors you noticed before the task:

____________________________________________________________________
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Reevaluate your automatic appraisals about the task:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

After completing the task:

Thoughts, Feelings, and Behaviors you noticed during the task:

____________________________________________________________________
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____________________________________________________________________

Number of minutes you did the task: _______ Distress at the end of the task (0 – 8): ______

Maximum distress during the task (0 – 8): ______

Any attempts to avoid your emotions (distraction, safety signals, etc.)?

____________________________________________________________________
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What did you take away from this exposure task? Did your feared outcomes occur? If so, how were you able to cope with them

____________________________________________________________________
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Treatment Goal Setting Worksheet

Research has consistently shown that one of the most effective ways to achieve successful behavior change is goal setting. When we talk about goals, we are referring to future states or events that we are interested in making happen or hoping to prevent from happening. These can include more immediate things, such as: “going to the gym tonight” or “finishing my treatment homework” and more distant things, such as: “making more friends” and “feeling happier.” Research has also shown that setting specific, concrete, and manageable goals for behavior change greatly improves our chances of successfully changing. Although you might have a general sense of what your goals for treatment are, it will be helpful to explicitly record these goals on this worksheet. Next, you will outline a series of smaller goals or steps that will help you to achieve your larger, more distant treatment goals. Take a moment to think about your most important goal that you have for yourself during treatment.

My #1 goal for treatment is: ______________________________________________________

Making it More Concrete

Now, let’s take a moment to make this goal more concrete. What would it look like once you have achieved this goal? What things would you be doing, or not doing? What behaviors would you be engaging in? What behaviors would you not be engaging in? Try to be as concrete as possible here.

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Taking the Necessary Steps

Next, think about some small manageable steps that you can take towards reaching the specific treatment goals you’ve listed above. These steps should take anywhere from a few days or a week up to a month to achieve. What steps will you need to take? It can be helpful to work backwards from your goal to help identify specific steps you will need to take to get there. Use the behaviors you listed above to help come up with your steps to achieving your treatment goal.

Step 5: ____________________________________________________________

______________________________________________________________________________

Step 4: ____________________________________________________________

______________________________________________________________________________

Step 3: ____________________________________________________________

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Step 2: ____________________________________________________________

______________________________________________________________________________
Step 1:

______________________________________________________________________________

People often have at least a few goals for treatment. Let’s take a moment to list at least two more treatment goals you have. You might find it helpful to repeat this process for additional goals as well.

My 2nd goal for treatment is: _____________________________________________________

Making it More Concrete

Take a moment to make this goal more concrete. What would it look like once you have achieved this goal? What things would you be doing, or not doing? What behaviors would you be engaging in or not engaging in? Again, be as concrete as possible here, try to list specific behaviors.

______________________________________________________________________________
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Taking the Necessary Steps

Next, think about some small manageable steps that you can take towards reaching the specific treatment goals you’ve listed above. These steps should take anywhere from a few days or a week up to a month to achieve. What steps will you need to take? It can be helpful to work backwards from your goal to help identify specific steps you will need to take to get there. Use the behaviors you listed above to help come up with your steps to achieving your treatment goal.

Step 5:
______________________________________________________________________________

Step 4:
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Step 3:
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Step 2:
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Step 1:
______________________________________________________________________________
My 3rd goal for treatment is: _____________________________________________________

Making it More Concrete

Take a moment to make this goal more concrete. What would it look like once you have achieved this goal? What things would you be doing, or not doing? What behaviors would you be engaging in or not engaging in? Again, be as concrete as possible here, try to list specific behaviors.

________________________________________________________________________________
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Taking the Necessary Steps

Next, think about some small manageable steps that you can take towards reaching the specific treatment goals you’ve listed above. These steps should take anywhere from a few days or a week up to a month to achieve. What steps will you need to take? It can be helpful to work backwards from your goal to help identify specific steps you will need to take to get there. Use the behaviors you listed above to help come up with your steps to achieving your treatment goal.

Step 5:________________________________________________________________________

Step 4:________________________________________________________________________

Step 3:________________________________________________________________________

Step 2:________________________________________________________________________

Step 1:________________________________________________________________________

EXAMPLES OF COMPLETED GOAL SHEETS

#1 Goal for Treatment: Get more physically active.

Concrete goal (what it would look like if goal is achieved):

- Get out of the house every day.
- Walk for 30 minutes every day.

Necessary steps (working backwards from the goal):

5. Select a time of day to walk and select a start date.
4. Remind myself that getting active will help me feel better, even if I don’t feel like it.
3. Start walking every other day for 15-20 minutes for one week.
2. Walk everyday for 20-25 minutes for one week.
1. Walk everyday for 30 minutes.

#2 Goal for Treatment: Address negative thinking patterns.

Concrete goal (what it would look like if goal is achieved):

- Be able to identify unhelpful/negative thoughts and counter them (e.g., self-criticism, tendency to expect the worst, etc.).

Necessary steps (working backwards from the goal):

5. Practice taking note of shifts in my mood (big or small).
4. When I notice a shift in my mood that is negative, write down what I was doing, what my emotions were, and what I was thinking about as soon as possible or before going to bed.
3. Identify “traps” in my thinking by learning about unhelpful thinking traps in group.
2. Spend 10 minutes/day considering the evidence for/against my negative automatic thoughts and identify a more helpful and accurate alternative thought.
1. If my alternative thought is not believable to me or if it is in fact supported by the evidence, consider doing a behavioural experiment or carrying out an action plan (strategies to be learned about in group).
#3 Goal for Treatment: Enjoy life more.

Concrete goal (what it would look like if goal is achieved):

- Spend more time doing activities that are enjoyable/fun.

Necessary steps (working backwards from the goal):

5. Make a list of activities that I enjoy or have enjoyed in the past before I became depressed.

4. Select at least one activity and decide on a time to fit it into my schedule (e.g., daily, weekly, etc.).

3. Identify any potential barriers and do some problem solving – consider asking the group or someone else for ideas if I struggle with this.

2. Identify and address any unhelpful thoughts about scheduling fun activities into my week. Remind myself that even if it is not as fun as before I became depressed, I may still get something out if it that helps my mood.

1. Engage in the enjoyable activity of my choice. If I find it to be a positive experience, great! Consider adding on. Alternatively, if after a few times I am not finding it beneficial, go back to my list and try again with a different activity.
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PHQ-9 Monitoring Form –
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**Depressed Mood Rating Before and After Exercise (10 Highly depressed - 0 Low levels of depression)**
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Energy Rating Before and After Exercise (10 High energy- 0 Low Energy)
Anxiety Curve (2 Minute Intervals)

Anxiety Rating During Exercise (10- extremely anxious- 0- not at all anxious)
## Anxiety Curve

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Anxiety Rating Before and After Exercise (10- extremely anxious- 0- not at all anxious)
# THOUGHT RECORD

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<tr>
<td>Who were you with?</td>
<td>Describe each mood in one word.</td>
<td>Rate intensity of mood (0-100%).</td>
<td>Answer some or all of the following questions:</td>
<td>Circle hot thought in previous column for which you are looking for evidence. Write factual evidence to support this conclusion. (Try to avoid mind-reading and interpretation of facts).</td>
<td>Ask yourself the questions in the Hint Box (p. 70) to help discover evidence that does not support your hot thought.</td>
<td>Ask yourself the questions in the Hint Box (p. 95) to generate alternative or balanced thoughts. Write an alternative or balanced thought. Rate how much you believe in each alternative or balanced thought (0-100%).</td>
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## Example of a Thought Record

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<td>I had an argument with my boss.</td>
<td>Anxiety (80%).</td>
<td>He’s so stupid.</td>
<td>I was late for work 3 weeks ago. We had a disagreement about the current project last week.</td>
<td>I got an excellent performance review 2 weeks ago. Our argument was about how best to complete the current project. He always asks for my opinion.</td>
<td>Although we got into an argument, it was about how to complete a project and not about my work ethic. In fact, I recently had an excellent performance review. So there is no evidence I will be fired. (I believe this 90%).</td>
<td>Anxiety (20%). Relief (75%).</td>
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</table>

Who were you with? What were you doing? When was it? Where were you?

Describe each mood in one word. Rate intensity of mood (0-100%).

Circle hot thought in previous column for which you are looking for evidence. Write factual evidence to support this conclusion. (Try to avoid mind-reading and interpretation of facts).

Ask yourself the questions in the Hint Box (p. 70) to help discover evidence that does not support your hot thought.

Ask yourself the questions in the Hint Box (p. 95) to generate alternative or balanced thoughts.

Write an alternative or balanced thought.

Rate how much you believe in each alternative or balanced thought (0-100%)

Copy the feelings from Column 2. Rerate the intensity of each feeling from 0-100% as well as any new records.

---

QUESTIONS TO HELP FIND EVIDENCE THAT DOES NOT SUPPORT YOUR HOT THOUGHT

- Have I had any experiences that show that this thought is not completely true all the time?
- If my best friend or someone I loved had this thought, what would I tell them?
- If my best friend or someone who loves me knew I was thinking this thought, what would they say to me? What evidence would they point out to me that would suggest that my thoughts were not 100% true?
- When I am not feeling this way, do I think about this type of situation any differently? How?
- When I have felt this way in the past, what did I think that helped me feel better?
- Have I been in this type of situation before? What happened? Is there anything different between this situation and previous ones? What have I learned from prior experiences that could help me now?
- Are there any small things that contradict my thoughts that I might be discounting as not important?
- Five years from now, if I look back at this situation, will I look at it any differently? Will I focus on any different part of my experience?
- Are there any strengths or positives in me or in the situation that I am ignoring?
- Am I jumping to any conclusions in columns 3 and 4 that are not completely justified by the evidence?
- Am I blaming myself for something over which I do not have complete control?


QUESTIONS TO HELP ARRIVE AT ALTERNATIVE OR BALANCED THINKING

- Based on the evidence I have listed in columns 4 and 5 of the Thought Record, is there an alternative way of thinking about or understanding this situation?
- Write one sentence that summarizes all the evidence that supports my hot thought (column 4) and all the evidence that does not support my hot thought (column 5). Does combining the two summary statements with the word "and" create a balanced thought that takes into account all the information I have gathered?
- If someone I cared about was in this situation, had these thoughts, and had this information available, what would be my advice to them? How would I suggest that they understand the situation?
- If my hot thought is true, what is the worst outcome? If my hot thought is true, what is the best outcome? If my hot thought is true, what is the most realistic outcome?
- Can someone I trust think of any other way of understanding this situation?

## PROGRESS NOTE

### Client and Meeting Information

Name: __________________________ Date & Time: ___________________________ Session #: ________

Location: ____________________________

### Mood:

- Normal/Euthymic
- Anxious
- Depressed
- Elevated
- Anger

Substance use:

- None
- Alcohol
- Cannabis
- Tobacco
- Other: ____________________________

Suicide/Violence risk:

- None
- NKDA
- Idea only
- Threat
- Gesture

### Mental State:

- Alert/Engaged
- Disorganized
- Lessened awareness
- Memory impairments
- Vigilance
- Hallucinations

Sleep Quality:

- Well-rested
- Restless/broken
- Nightmares
- Difficulties with onset
- Oversleeping

Physical Activity:

- None
- Minimal
- Moderate
- Vigorous

Treatment participation:

- Active/eager
- Variable
- Only responsive

Response to treatment:

- As expected
- Better than expected
- Much better
- Poorer
- Very poor

### Homework from last week:

- Psychoeducation
- Core Beliefs
- Behavioural
- Cognitive Work
- Problem Solving
- Exposures
- Behavioural Activation
- Relaxation
- Workbook exercises

Completed: □ Yes □ No

- Mindfulness Exercise
- Goals/values
- Experiential

### Agenda and Session Content

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

### Target Problems/Cognitions/Behaviour

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

### Homework

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

### Supervision Notes

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

---

Ottawa Institute of Cognitive-Behavioural Therapy
Psychology Training Program
411 Roosevelt Avenue, Suite 200, Ottawa, Ontario, K2A 3X9 Canada
TEL: (613) 820-9931
Next Appointment

Name of Behavioural Aide
B.A.A., Behavioural Therapist

Dr. Connie Dalton, C.Psych
Appendix T: Termination Summary and Termination Note

Ottawa Institute of Cognitive Behavioral Therapy
411 Roosevelt Avenue, Suite 200, Ottawa, Ontario, K2A 3X9 Canada TEL: (613) 820-9931

Termination Summary

Client: ____________________________________________ Date: __________________

A. Main reason for termination
☐ The planned treatment was completed. ☐ The client refused to receive or participate in services.
☐ The client was unable to afford continued treatment or did not pay bills on time. ☐ Client moved.
☐ There was little or no progress in treatment. ☐ This is a planned pause in treatment.
☐ The client needs services not available here, and so was referred to: ____________________________
☐ Other: ________________________________________________________________________________

B. Source of termination decision
The decision to terminate was: ☐ Client-initiated ☐ Therapist-initiated ☐ A mutual decision ☐ Other: _________

C. Treatment sessions
Referred on date: _______________ Date of first contact: _______________ Date of last session: ____________
Number of sessions: Scheduled: _______ Attended: _______ Cancelled: _______ Did not show: _____________

D. Kinds of services rendered
☐ Individual psychotherapy, for _____ sessions ☐ Couple/family therapy, for _____ sessions
☐ Group therapy, for _____ sessions ☐ Other: ________________________________________________________________________________

E. Treatment goals and outcomes (Code outcomes as follows: N = no change, S = some or slight [about 25% to 35%], M = moderate [about 50%], V = very good [about 75% to 100%], E = exceeded expectation)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other notable aspects of treatment outcome, change, or progress:

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

_________________________________________  __________________________________________
Supervisor  Student therapist
Name, C. Psych  (CPO #)  Name, Degree

FORM 46. Termination summary form. From The Paper Office. Copyright 2008 by Edward L. Zuckerman. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).
TERMINATION NOTE

CLIENT: _____________________  PSYCHOLOGIST ________________
DATE: _______________________

Clients Mood and Affect:

________________________________________________________________________

Session Plan and Goals (Agenda):

________________________________________________________________________
________________________________________________________________________

Previous weeks assignment (progress, setbacks, lesson learned):

________________________________________________________________________
________________________________________________________________________

Patients Progress

________________________________________________________________________
________________________________________________________________________

Relapse Prevention Plan:

________________________________________________________________________

Client Feedback:

________________________________________________________________________
Appendix U: Internal Referral Form

411 Roosevelt Ave., Suite 200, Ottawa, Ontario, K2A 3X9, Tel. 613-820-9931

Referral to Community and Home-Based Intervention Stream

Name of Patient: ____________________      Date: ____________________________

Primary problem area ________________________________________________________

Secondary problem area_______________________________________________________

Client identified goals:
1)                                                                                     
2)                                                                                     
3)                                                                                     

Suggested areas of focus for sessions:

Approximately how many sessions do you estimate will be needed?     __________________

Are there any reservations or things to consider when working with this client:
______________________________________________________________________________
______________________________________________________________________________

Checklist:

1. Please attach intake note or assessment/report

2. Please attach client demographic form (can submit own or fill out version located on dropbox)

3. Hierarchy completed?       _______Yes           _______No

    *If yes, please attach completed hierarchy

4. Consent for disclosure form with client prior to initial meeting with Behavioural Aide and attach to this document.

______________________________________________________________________________

Psychologist      Date
Appendix V: Standard Fees, Invoice Template, Financial Monitoring, and Payment Form

2016 Fees

This is to inform you of the 2016 fees for the following services provided by clinical psychology students:

Intake Interview: .............................................. $120.00 (75 minute session)
Feedback Session.............................................. $70.00 (50 minute session)
Individual Therapy Sessions.............................. $70.00 (50 minute session)
Group Therapy Individual Sessions...................... $50.00 (50 minute session)
Home Visits....................................................... $80.00 (50 minute session – includes travel)
Letters/Reports................................................. $16.25 for every 15 minutes

Forty-eight hour notice is needed for cancellation of your appointment or a cancellation/missed session fee of half the standard rate will be charged by the clinic.
INVOICE

TO:  Client’s Name  Account #  

Date  17-Jan-14  

FROM  Therapist Name, Practicum Student under the supervision of Supervisor’s Name  

Ottawa Institute of Cognitive Behavioral Therapy Psychology Training Program  
411 Roosevelt Avenue, Suite 305  
Ottawa, Ontario  
K2A 3X9  
Phone: (613) 820-9931

Professional Services Rendered for:  Client’s Name (1 hour)

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Service</th>
<th>Fee</th>
<th>Paid</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-Jan-14</td>
<td>Intake Session</td>
<td>$65.00</td>
<td>$65.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Total Due  $0.00

Payable on receipt of statement. NSF cheques are subject to a $20.00 service charge. Please make all cheques payable to OICBT Supervision and Training Program.

Supervisors Name, C.Psych  
College of Psychologists #: 4246

Next Appointment: _________________________________

*Note this is an Invoice Template. All words underlined and in italics must be changed prior to administering. Remove this note after changes are made.
Home Based Intervention Payment Form

1. I understand that I will be required to pay for each individual session at the Ottawa Institute of Cognitive Behavioural Therapy ($80 – including travel costs)

2. I will be arranging my payment through Therapist’s Name on ________________________________.

3. I understand that I can reschedule my individual therapy sessions with no cost as long as I give 48-hours notice. If adequate notice is not given, the entire session fee (including associated travel cost) will be charged for this missed session.

4. If I do not show up for a session this is also considered a missed session without adequate notice and the entire session fee will be charged.

4. I understand that I am free to withdraw at any time if I do not find this treatment program helpful. I will need to give at least 48 hours notice prior to my next scheduled session.

5. I understand that payment will be processed for my individual therapy sessions following each of these scheduled appointments and that they are charged separately from any other sessions I am attending at the OICBT.

I will be paying for my individual sessions with Therapist’s Name with the Credit Card listed below:

Name On Card: ____________________________________________________________________
Credit Card #: ____________________________________________________________________
Expiry Date: _____________________________________________________________________
Security Code: ____________________________________________________________________

Printed Name __________________________  Signature __________________________  Date __________________________

*Note this is a Home Based Intervention Payment Form Template. All words underlined and in italics must be changed prior to administering. Remove this note after changes are made.*
## Excel Financial Monitoring Form Example

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Service</th>
<th>Professional Service Rendered</th>
<th>Rate</th>
<th>Total Hours</th>
<th>Client Billed</th>
<th>Client Paid</th>
<th>Third Party</th>
<th>Paid by</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Patient</td>
<td>January 6, 2014</td>
<td>Assessment</td>
<td>$120.00</td>
<td>1</td>
<td>January 6, 2014</td>
<td>January 6, 2014</td>
<td>NO</td>
<td>Moneris</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>January 20, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 20, 2014</td>
<td>January 20, 2014</td>
<td>NO</td>
<td>Moneris</td>
<td>$0.00</td>
</tr>
<tr>
<td>Patient #2</td>
<td>January 6, 2014</td>
<td>Assessment</td>
<td>$120.00</td>
<td>1</td>
<td>January 6, 2014</td>
<td>January 6, 2014</td>
<td>Bluecross</td>
<td>Moneris</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>January 14, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 14, 2014</td>
<td>January 14, 2014</td>
<td>Moneris</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>January 20, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 20, 2014</td>
<td>January 20, 2014</td>
<td>Cash</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>January 27, 2014</td>
<td>Missed Session</td>
<td>$40.00</td>
<td>1</td>
<td>January 27, 2014</td>
<td>February 3, 2014</td>
<td>Moneris</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Patient #3</td>
<td>January 6, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 6, 2014</td>
<td>January 6, 2014</td>
<td>NO</td>
<td>Moneris</td>
<td>$0.00</td>
</tr>
<tr>
<td>Patient #4</td>
<td>January 7, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 7, 2014</td>
<td>January 7, 2014</td>
<td>NO</td>
<td>Cheque</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>January 14, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 14, 2014</td>
<td>January 14, 2014</td>
<td>NO</td>
<td>Moneris</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>January 21, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 21, 2014</td>
<td>January 21, 2014</td>
<td>NO</td>
<td>Moneris</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>January 28, 2014</td>
<td>Therapy</td>
<td>$80.00</td>
<td>1</td>
<td>January 28, 2014</td>
<td>January 28, 2014</td>
<td>NO</td>
<td>Moneris</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**TOTALS**  
$920.00  
11.00  
$0.00
Appendix W: Resources for Implementing CBT Procedures

**Resources for Psychoeducation**

Good overall Sites with Information about Evidence Based Treatments, including CBT
http://www.cpa.ca/public/psychologyfactsheets/ Canadian Psychological Association—Fact Sheets on many different topics, including evidence based treatments.
http://www.apa.org/ see American Psychological Association
http://www.cci.health.wa.gov.au (Australian site—Centre for Clinical Innovation)
http://www.nice.org.uk/ (UK site for clinical practice guidelines, including mental disorders)
http://www.abct.org/home (ABCT is the largest and oldest CBT organization in the world)
http://academyofct.org/ see Consumers Section

Sites with Information about Mental Disorders
www.mentalhealthcommission.ca
www.calgary.cmha.ca
www.adaa.org/ Anxiety and Depression Association of America
www.anxiety.bc.com
www.socialphobia.org
www.anxietycanada.ca/
www.anxieties.com (Reid Wilson’s site)
www.hearing-voices.org
http://stepsforbpd.com (Borderline Personality Disorder)
iocdf.org (International OCD Foundation)
canadianocdnetwork.com
www.trich.org (Trichotillomania)

Sites for CBT Resources
http://www.get.gq/freedownloads2.htm (CBT Worksheets)
http://psychology.tools/download-therapy-worksheets.html (CBT Worksheets/Educational Handouts)
getselhelp.com
www.getselfhelp.co.uk
http://www.anxietyonline.org.au/
http://www.moodswings.net.au/ (for Bipolar Disorder)

Sites for Relaxation and Mindfulness
http://goodmedicine.org.uk
http://mindfulwaythroughanxietybook.com/exercises/
http://www.guidetopsychology.com/pmr.htm
http://wellness.mcmaster.ca/resources.relaxation.html
http://www.hws.edu/studentlife/counseling_relax.aspx
http://www.cancerbridges.ca/resources/local-resources/calgary/calgary-area/guided-mindfulness-meditation/ (MBSR guided audio tracks from the Tom Baker Cancer Centre Psychosocial Resources)
http://behavioraltech.org/resources/mindfulness.cfm (Marsha Linehan’s website—great resources for mindfulness)
Calmkeeper (anxiety management with breathing exercises, distractions, and customizable reframing
Mindfulness Meditation for Pain—Jon Kabat-Zinn

**Phone Apps**
- Mood Kit (available on iTunes for $4.99)
- Moving Forward (available on iTunes for free; Problem Solving Therapy)
- PTSD Coach (National Center for PTSD in the US—Canadian App available as well)—free from iTunes
- CBT Referee (from iTunes)
- Sleeping tips, using CBT (free from iTunes)
- Relax2breathe (free)
Guidelines for Conducting Exposure

Exposure occurs in a series of steps using the exposure hierarchy that you created prior to the start of treatment. Remember, YOU control the pace at which you move through your hierarchy. There are specific ways to conduct exposure using the guidelines described:

1. **Exposure practices should be planned, structured, and predictable.** Decide in advance what you will do in the situation and how long you will stay. Plan in advance when you will complete your practice and put it in your schedule. Have a back up plan in case the original plan doesn’t work out.

2. **Exposure pace can be gradual.** In other words, do not assume that you must do the most difficult thing you can imagine right away. On the other hand, be sure to choose practices that are challenging. The most difficult the items that you practice, the quicker you will learn to become more comfortable. Try to choose practices that are challenging but not so difficult that you will not complete them.

3. **Do not use subtle avoidance strategies during exposure practices.** In other words, try to complete the practices without the use of distraction, alcohol, leaving early, avoiding eye contact, and other such strategies.

4. **Rate your fear on a scale from 0 to 100.** When in the feared situation, it can be helpful to pay attention to how you are feeling and to notice the variables that make your anxiety go up and down during the practice.

5. **Try not to fight your fear.** Fighting the anxiety will have the effect of increasing your anxious feelings. Instead, just let it happen. The worst thing that is likely to happen is that you will feel uncomfortable.

6. **Exposure practices should be repeated frequently and spaced close together.** The more closely spaced the practices, the more fear reduction that you are likely to experience. It is a good idea to practice being in the same situation repeatedly until it becomes easier.

7. **Exposure practices should last long enough to experience a significant decrease in anxiety** (Sometimes this can take several hours).

8. **Use the cognitive coping strategies to counter anxious, automatic thoughts during exposure practices.**

9. **Expect to feel uncomfortable.** It is perfectly normal to feel awful during initial exposure practices. Also, these practices may leave you feeling tired and anxious afterwards. With repeated practices, these feeling will decrease. Success should not be judged by how you felt in the situation. Rather, success should be judged by whether you were able to stay in the situation despite the awful feeling.

10. **If you experience social anxiety, use specific exercises to enhance your anxiety and to draw attention to yourself in the feared situation.** For example, if you fear sweating, wear a heavy sweater. Or, if you fear having others notice your shaky hands, purposely shake your hand while holding a drink. If you are fearful of losing your train of thought, you can purposely allow yourself to have trouble finding the right words during a conversation.
Exposure Monitoring Form

Complete the following BEFORE your exposure:

<table>
<thead>
<tr>
<th>Describe the exposure (include duration)</th>
<th>List all safety behaviours that will not be used</th>
<th>Initial SUDS rating (0-100)</th>
<th>Automatic Thoughts and Predictions</th>
<th>Countering Statements (evidence based)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have difficulty, ask yourself the following questions:
What am I predicting will happen during the exposure?
What is the worst possible outcome? Best? Most likely?

Complete the following DURING your exposure

Throughout your exposure, graph your SUDS (subjective units of distress) score every few minutes, using the following graph:

<table>
<thead>
<tr>
<th>SUDS Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>80-100</td>
</tr>
<tr>
<td>60-80</td>
</tr>
<tr>
<td>40-60</td>
</tr>
<tr>
<td>20-40</td>
</tr>
<tr>
<td>0-20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIME (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Complete the following AFTER your exposure

<table>
<thead>
<tr>
<th>Describe the outcome</th>
<th>Final SUDS rating (0-100)</th>
<th>Post-Exposure Processing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>How does the outcome relate to the initial thoughts &amp; predictions?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What did you notice about how your anxiety changes over time? When did your anxiety peak?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What did you learn about the role of safety behaviours?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does this exposure provide you with any information that can be used in your future exposures?</td>
</tr>
</tbody>
</table>
**Behavioural Exposure**

Now that you have developed skills to counter your anxious thoughts, you are ready to move on to the next step in treatment – gradually confronting the situations that you fear or avoid using a strategy called EXPOSURE.

The longer you stay in an anxiety-provoking situation, the more your anxiety will reduce. As you repeatedly confront a specific situation, your anxiety will reduce more over each practice. Anxiety reduction happens for a number of reasons:

1. You learn that the consequences you fear do not come true.
2. You gain confidence that you can stay in the situation and ride out your anxiety.
3. You become more aware of your surroundings and things that you had not paid attention to because you were focused on your anxiety so that you are better able to process a stimulus accurately.
4. Your body gets used to the situation so your anxiety reduces through a process of habituation.

![Graph showing anxiety levels over time during different exposures]