Using Cognitive Behavioural Therapy to Manage Anxiety and Depression in Female Offenders Residing In a Half-Way House

by

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The procedures in this workshop are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
Dedication

I wish to dedicate this thesis to my friends and family who have been with me throughout my four years of BPSYC. Without your love and amazing support, this would be an impossible dream that could not have been reached.
Abstract

Cognitive behavioural therapy (CBT) techniques have been demonstrated to be very effective for helping women with mental health disorders, and particularly those who have come in conflict with the law. CBT highlights thought processing skills that benefit people with mental health disorders to overcome their symptoms, and uses methods and practices to significantly reduce these automatic negative thoughts toward the self. The current intervention focused on a CBT group format which was established with three women residing in a half-way house who suffered from symptoms of anxiety and depression. The Beck Depression Inventory-II, Beck Anxiety Inventory, and an individual participant questionnaire were used to establish a pre- and post-group level of functioning for each participant. Four sessions were used in this program over a period of four weeks, containing an explanation of CBT, recognizing automatic thoughts, identifying and distinguishing cognitive errors and schemas, as well as symptom management. The results illustrated that CBT was effective in slightly reducing the symptoms of anxiety and depression in these women, and also provides techniques that they can use for future difficulties they may face.
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To my parents, sisters, brother, and other family members who gave me the strength and will to continue with this process even when I thought it was not possible, this is solely dedicated to the never-ending love you’ve always shown.

A big thank you to my friends and boyfriend for their words of wisdom and hugs when I needed them, I am appreciative of everything you have given. Thank you for always listening when I needed to vent, which sometimes was very often.
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Chapter I: Introduction

Mental health is an increasing concern among the general population and especially among women. With over 2 million Canadians diagnosed with a mood disorder in 2012, almost 1.5 million of those were women (Statistics Canada, 2013). Depression and anxiety are two of the highest occurring mood disorders, affecting 8 and 12 percent of the population, respectively (Centre for Addiction and Mental Health, 2012). Individuals with severe mental health are likely to negatively affect the criminal justice system further and longer than individuals without mental health concerns (Solomon, Draine, & Marcus, 2002). Most incarcerated women serve shorter prison terms than their male counterparts (Tye & Mullen, 2006). The time that women spend imprisoned provides an opportunity for the individuals who greatly need mental health assistance to receive an assessment and possible treatment. This option, unfortunately, tends to be seldom used. These women are discharged into society with mental health problems that are untreated, and frequently intensified (Tye & Mullen, 2006).

There are many techniques to manage depression and anxiety; one that has proven to be particularly effective is cognitive behavioural therapy (CBT). Created by Aaron Beck in the 1960s, CBT is centred on two principles: emotions and behaviour are governed by thoughts and cognitions, and also how behaviour affects emotions (Wright, Basco, Thase & Gabbard, 2006). CBT highlights skills to help clients become aware of and alter their negative thoughts within; specifically those particular thoughts that are correlated with negative symptoms like anxiety, depression and anger. The approaches outlined within CBT can be used to treat many disorders, with depression and anxiety being two of the most prevalent. Wright et al. (2006) also state that the CBT model is used to guide the therapist’s attention to the connection between thoughts, emotions, behaviours, and to direct an intervention for treatment. The goal of CBT is to ultimately have the client convey self-directed cognitions into mindfulness understanding and control. The projected result when using CBT to manage mental health symptoms is that an individual who is experiencing an increase in anxiety provoking thoughts will in fact decrease in force and amount (Newman, & Fisher, 2013).

The focus of this present study is to determine if the use of cognitive behavioural therapy techniques in a group setting with female offenders, specifically residing in a half-way house will aid in their ability to manage their depression and anxiety.

This study is important to further investigate and expand the research in this area of mental health with female offenders, as it is an increasing problem both inside and outside the walls of institutions. This thesis provides a review of the literature as it pertains to CBT techniques associated with depression and anxiety in a group format. It will also describe the specific needs of women offenders with mental health disorders, specifically those suffering from anxiety and depression. A literature review is provided to support the use of CBT techniques with this particular population, as well as its use with anxiety, depression, and the differences in mental health experienced by female offenders. The methodology section of this thesis provides a description of the participants who contributed in the study and the selection
procedures that were used by the researcher and student. The materials are listed, as well as the setting the group took place in, and the evaluation measures that were used with the clients. The results section provides a summary of the CBT group, as well as the numerical data collected from each measure used. The discussion section provides the strengths and limitations of this study, along with recommendations for future research, and contributions to the field of Behavioural Psychology.
Chapter II: Literature Review

The emphasis of this literature review will be placed on the increasing mental health concerns that occur while experiencing anxiety and depression. Also, using cognitive behaviour therapy (CBT) practises in an affirmative manner whilst in a group format will be highlighted, as well as using these accordingly with women who are experiencing anxiety and/or depression symptoms. CBT will also be discussed based on its support and advantageous efforts in managing many mental health disorders. Since the population being utilized for this thesis will be women who have come in conflict with the law, literature regarding women offenders with mental health concerns will also be addressed.

Anxiety

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) states that generalized anxiety disorder causes the individual to experience substantial anguish in social or other important areas of their life (“Anxiety UK”, n.d.). It is also characterized by excessive fear and worry about numerous activities in a person’s life and, individuals with anxiety often find it problematic to manage these feelings. The symptoms of anxiety and depression are often interchangeable, which makes a difficult task of distinguishing if a client has either anxiety, depression or both. A study completed by Tye and Mullen (2006) investigated the rates of various mental disorders, including anxiety, in Australian correctional facilities, and compare these rates with community figures. The instruments used to gather this information from the 103 female prisoners were a demographics questionnaire, the Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 1997), as well as the Personality Disorder Questionnaire 4+ (Hyler, Reider, Williams, Spitzer, Hendler, & Lyons, 1988). Women who were included in the incarceration sample showed a much higher probability of meeting the criteria for a mental disorder in the past 12 months compared to those women in the community sample. Therefore, women who are imprisoned arrive with elevated levels of numerous mental disorders comparative to women within the community. This imprisonment gives the women an opportunity to receive psychological aid for their symptoms, which they will hopefully continue when released back into a community setting. After they are released from prison, however, it is essential for these women to continue with treatment and seek community based support and groups generated to serving this increasing population.

Depression

The DSM-5 expresses depression as a reduced interest in everyday activities virtually every day, and a loss of general energy throughout the day (Alere Cares, 2011). A decrease or increase in appetite which is out of the norm for the individual is usually an indication of depression; and these symptoms of depression usually cause substantial anguish and impair many aspects of everyday functioning. According to Hara Estroff Marano (2003), 60 to 70% of those diagnosed with depression usually have anxiety and in general, mood disorders appear as a blend of anxiety and depression symptoms. Depression is often accompanied by a multitude of
adverse consequences, like self-harm or suicidal ideations which can indirectly manifest co-occurring mental health disorders which can result in an increase in the cost of specific health care needs (Kroner, Kang, Mills, Harris & Green, 2011). Depression is usually brought about from a combination environmental and psychological influences, as well as genetics (National Institute of Mental Health, n.d.). Recidivism rates for women in conflict with the law with regards to criminal activity have an emotional element often linked with depression (Zust, 2009). Therefore, when minimizing depressive symptoms during the CBT therapy process, a specific focus on issues that are parallel with recidivism rates, such as mental health symptoms and positive community resources, would be beneficial to the specific needs of women offenders.

A study on the mental health literacy of depression completed by Viren Swami (2012) conveys gender-based distinctions toward the attitudes of awareness and opinions the general population has in regards to mental health, specifically depression. The author uses the term “mental health literacy” to refer to the understanding and view the community may have about mental health and the deterrence of these disorders. People in the general population who are experiencing depression symptoms might not be willing to seek help in regards to the behaviour symptoms associated with depression if there is a failure to identify the symptoms of depression themselves. Samples of both male and female participants from the general population were randomly assigned a vignette recounting either a female or male who meets DSM-5 diagnostic conditions for major depression. The participants were asked if they believed the described individual in the vignette experienced a mental health disorder, to specify which disorder they thought was present, and if they thought they would recommend they proceed with treatment opportunities. The participants showed distinct variations in opinions regarding depression and “mental health literacy”. Male participants assessed the female case vignette as more troubling and experiencing further difficulties toward treatment than the male vignette. The results indicate that principle gender role beliefs form distinct attitudes toward mental health. Also, negative attitudes with regards to seeking psychological aid or psychiatry helped to forecast thoughts and opinions toward the vignettes of individuals experiencing depression. Additional education about mental health disorders, specifically depression, is needed in the community to promote positive help-seeking behaviour and to prevent the negative stigma that is often associated with depression in the general population.

Difficulties in managing emotions are one obstruction that individuals face when coping with symptoms of anxiety and depression (D’Avanzato, Joormann, Siemer & Gotlib, 2013). The variety of treatments that operate best for depression also help battle anxiety, with CBT being the most prominent and positive therapy used for both mental health disorders (Estroff Marono, 2003). Anxiety and depression have similar characteristics and traits, which makes CBT the perfect fit to aid in reducing the shared symptoms between both mental health disorders.

Mental Health and Female Offenders

Even though mental health concerns are a prevalent and significant topic in today’s culture, mental health is an increasing issue in the offender population. Information from
Correctional Service of Canada show that difficulties with mental health are two to three times more frequent in the correctional institutions of Canada than the broad Canadian population alone (Gabora, 2009). The capability to concentrate on the specific needs of offenders coping with mental health difficulties is a universal issue that needs further investigation to better understand specific concerns regarding offenders (Derkzen, Booth, Taylor & McConnell, 2013). Female offenders are twice as likely as male offenders to have diagnoses in mental health at the time of their admission into an institution (Public Safety, 2009). Currently 21.8% of the female population is diagnosed with a mental illness, compared to 10.4% of the male population.

Female offenders with ongoing mental health difficulties would benefit from treatment in the community, wherever it is available (Scott, McGilloway, & Donnelly, 2009). Most women offenders, post-incarceration, experience homelessness and economic difficulties, which can be a major factor in not being able to successfully access mental health services and aid. These services might not be a priority when compared to daily necessities, like food and shelter; so women offenders in the community are often left untreated and experience many negative symptoms of mental health (Scott et al., 2009). Female offenders may also experience various hardships from the problems they face with when managing their mental health compared with male offenders. The manifestation of mental health symptoms varies between male and female offenders, as well as the difference in a perceived susceptibility to stressors in the environment of an institution (Covington, 2003).

An analysis of mental health needs completed by Derkzen, Booth, Taylor, and McConnell (2013) examined the needs of woman offenders with mental health difficulties throughout the correctional system. Roughly 25 to 35% of the sample met the criteria for suffering from a generalized anxiety disorder. This concludes that the familiarity of anxiety-related symptoms is something with which women offenders regularly face. Of those who participated, 69% of the sample had been subjected to a major depressive occurrence at one point in time in their life. Anxiety disorders are found all throughout the incarceration system and women who are being released from these systems are suffering from anxiety disorders even after they have received treatment while incarcerated. It has been suggested by Derkzen et al. (2013) that these women who suffer with anxiety symptoms, and who are seeking treatment while incarcerated, should continue to inquire about other forms of treatment in the community. This will aid in the continued reduction of anxiety symptoms and management, and will also aid in managing different situations that they face outside of the institutions.

A risk assessment that pertains to mental health which is centred on effective risk measures should be performed on women in the offender population, even if an imminent risk is less likely to occur (Eisenbarth et al., 2012). These assessments will help institutions with specific programming individual women need to aid in managing their mental health symptoms, both in the institution and when they are released in the community. Healing and improvement for women is a process, and requires a profound bond with the self and others that are experiencing similar difficulties (Bloom & Covington, 2008). Experiencing group therapy
sessions with other women who have experienced similar hardships can aid in the recovery of one’s own personal difficulties.

**Cognitive Behaviour Therapy**

An essential goal for CBT psychotherapies is to help in reducing negative cognitions while enhancing the clients’ adaptive feelings among their negative symptoms experienced (Wright et al., 2013). The most basic model of CBT holds that CBT approaches to alter these maladaptive thoughts lead to a decrease in levels of emotional difficulty as well as challenging negative behaviours. CBT has been found to be particularly effective in the treatment of anxiety and mood disorder symptoms (Nathan & Gorman, 2007). CBT utilizes many different aspects of treatment, and is based on the specific needs of the client and the specialties of the practitioner administering the treatment (Somers, 2007). CBT is helpful in a short-term setting to treat the symptoms of depression, and when compared with longer term therapies, it can often be exceptional in nature (Watkins & Williams, 1998). CBT uses many learning practices aimed at instructing the client to assess misunderstandings and maladaptive assumptions (Beck, Rush, Shaw & Emery, 1979). CBT has several theoretical views one recognizes before administering such a therapy; short-term therapies designed to rapidly have further positive outcomes, and it focuses on having clients encounter innovative ways of thinking (Somers, 2007).

Self-monitoring is a particularly helpful practise that is taught during CBT interventions, and it continues to be an essential portion of this type of therapy (Beck, 2011). Self-monitoring incorporates tracking a specific pattern of behaviour to assess progress and any problems the client faces during the therapeutic process (Muench, 2010). It can aid with creating realistic and manageable goals for the client, as well as create an observation of what possible stressors and negative aspects of one’s life can be discussed throughout therapy. This technique can assist the client in communicating daily cognitions and emotions to the group, which can help the participants to obtain an understanding of their responses to particular events that occur throughout their day (Beck, 2011). Clients should be educated on self-monitoring techniques as well as the benefits of self-monitoring while experiencing symptoms of anxiety and depression.

Possel, Martin, Garber, and Hautzinger (2013) examined cognitive sessions which focused on grasping the associations between behaviours, emotions, and cognitions. These CBT sessions taught the client how to recognize and overcome negative thoughts and the most effective techniques to combat depression when used early in life. When implemented, these methods of recognizing behaviours, emotions and cognitions can effectively assist both adolescents and adults in overcoming their depression symptoms. Recognizing and overcoming negative thoughts is paramount to the premise of CBT, and when utilized can aid in the reduction of many negative symptoms that would cause distress otherwise.

Newman and Fisher (2013) found that CBT techniques such as reducing automatic thoughts and responses to insignificant external prompts, as well as minimizing body tension can result in a healthier lifestyle in the community when managing anxiety symptoms. They also taught coping skills to aid in the routine practices of the clients’ everyday activities and to instill
an alternate thinking process for maladaptive thoughts, which were very effective with persons who were experiencing symptoms of an anxiety disorder. When assisting clients to overcome their symptoms of depression, the counselor must encourage the client to both identify and challenge negative thoughts in order to consider a more genuine view of their experiences (Somers, 2007). Returning to a positive and enjoyable daily routine is crucial for someone experiencing depression, as well as transferring their focus from their adverse symptoms and mood.

**Group Cognitive Behaviour Therapy**

In a pilot study completed by Cramer, Salisbury, Conrad, Eldred, and Araya (2011), group cognitive behavioural therapy was utilized to aid women with depression who were residing in socially dispossessed regions of the United Kingdom. The authors used a variety of baseline and follow-up questionnaires, including the Beck Anxiety Inventory and the Automatic Thoughts Questionnaire to gather pre- and post- intervention data on each client. The participants were assessed at baseline, as well as three and six months after the start of the group. The content of the group sessions was based on negative thoughts, managing anxiety, relaxation techniques, and discovering new ways to solve problems. The results from the intervention data in this study indicate that a CBT group based within the community was effective in women with depression. The authors also noted the accessibility to people in disadvantaged areas was a positive attribute to this study, as well as the group support given throughout the therapy process.

A group setting assists women in developing the feeling of fitting in and a connection to other women, which can act as a motivation to aid the participants to continue with the group process (Bloom & Covington, 2008). A group comprised of only women also gives an opportunity for these participants to relate and associate their emotions regarding difficult situations they might have encountered throughout their life to other women with similar difficulties. Group members can also suggest other ideas of feelings, and perceiving situations in a different light. This can help each of the participants gain knowledge through other women on how to positively manage their emotions and other ways they can deal with situations that might arise in the future.

It is important for clients participating in CBT to take part in programs that offer encouragement and rehabilitation, as these can be successful in decreasing recidivism rates of offenders that are recently released from prison (Trotter, McIvor & Sheehan, 2012). Gender specific programs are utilized to direct the needs of female offenders toward methods that specify the multifaceted pathways into criminal activity that women face.

**Community-Based Therapy**

A study completed by Trotter et al. (2012) compared many community-based services that were available to women offenders that were incarcerated between 2003 and 2005. These services were established in the community to aid women newly released from the prison system with support, housing opportunities, community groups, and any therapies they may need and
could not acquire on their own. There were 58 women who participated in both the interviews while incarcerated and during post-release. The aim of each interview was to establish what services were available, the positive attributes of each service, and whether they contributed to their rate of recidivism. Throughout the follow-up phase 52% of the participants did commit an offence. Most of the participants that were interviewed throughout follow-up stated that features of the services they had utilized assisted in reducing the likelihood of recidivism. Services that specify their intentions and role with the participant maximize their use with each client, and provide the best assistance possible. Women respond best to treatments with the intention to encourage self-efficacy and empowerment.

Services which are positive in nature and provide a comforting and welcome environment are more likely to work positively with each participant. Women-centred programs are more distinct and specifically focus on recidivism rates and decreasing mental health symptoms which often contribute to an increase in offending. These program facilitators should introduce their role in the clients’ rehabilitation process in advance to client participation as this will reassure the client that these programs are the right fit for them and will help to keep them focused on treatment.

Summary

The current literature is based on the premise of utilizing cognitive behavioural therapy techniques to aid in the management of anxiety and depression symptoms often experienced by female offenders, specifically those who live in a halfway house. This literature illustrates that the needs of women offenders in regards to mental health issues is high, and if possible, it should be addressed at best while they are incarcerated so they are not faced with the same symptoms when they have been released from the prison system. Having these women reside in a halfway house will give them ample opportunity to utilize the many resources that are available in the community, especially for assistance with mental health symptoms and symptom management. These resources that will be accessible to them while they are in the community can help reduce depression and anxiety symptoms, as well as any other co-occurring disorders that they might be faced with.

These findings emphasize some of the prevalent mental health issues that are experienced by female offenders, and makes clear that the need for dependable and adequate mental health aid is crucial, both in the institutions and community alike. Community resource groups which focus on the specific mental health needs of women offenders outside of the institutions will aid in managing symptoms which are explicit to those in the community. Ongoing support outside of the prison system guides the transitional process into the community, and encourages positive performance and help with successful reintegration into the community.

CBT is the most suitable therapy for this population as it is easily accessible by each of the women, and has been shown to have many positive effects on mental health disorders, primarily anxiety and depression. The components which will be utilized in this study will aid in the management of automatic negative thoughts, noticing and working with cognitive errors and
schemas, and finding ways of controlling anxiety and depression symptoms when they arise. CBT as a short-term therapy is most beneficial for this specific population because of the limits to time and money with this population, and will be utilized in this group therapy. This duration is best suited for this type of population and the location that the group will be held in. Because the women who are participating in this group are offenders, the therapy sessions will be tailored to their specific needs as well as encourage them to become actively involved, if they so choose, in other forms of therapy and ways of managing their depression and anxiety symptoms.

This study concentrates on providing community mental health services in the form of group sessions, and encourages positive coping skills and strategies for the clients to use in the future while in the community and managing their symptoms of anxiety or depression. This group is also a way for women who are in conflict with the law to reflect on their own and other group members’ past experiences, and gather ways of managing their mental health symptoms. This CBT group will focus on different struggles each of the participants has had to face as well as coping skills and strategic skills that will be taught to manage their emotions and difficulties that come with experiencing anxiety and depression. The results of the measures, pre- and post-intervention, provided by each of the participants will demonstrate that cognitive behaviour therapy is useful to women with depression and anxiety and will help to reduce these symptoms felt by women who were in conflict with the law.

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Chapter III: Methodology

Setting

All of the group sessions were held at the agency, next door from the halfway house where the participant reside, so that each session was easily accessible to each participant. The agency is a non-profit organization to aid women who are in conflict with the law re-integrate themselves into the community after they are released from the prison system. The room in the agency was equipped with one large rectangular table with seating for twelve people, as well as a basket with pens for use by the participants during the sessions. The student facilitator and agency supervisor used this room for each group session, and each participant was seated at the table with the student facilitator. The agency supervisor and student facilitator chose this room because it was a quiet and large seating area where the participants would be comfortable; and, it was within walking distance for each participant so there was no concern about travel expenses or rides.

Facilitators

The agency supervisor was the director of residential services for the halfway house. The student facilitator, a fourth year behavioural psychology student, led all sessions with guidance from the agency facilitator. A second student, a second year corrections student, sat in on each meeting but was not facilitating the sessions. The agency supervisor also helped with gathering volunteers to participate in the group sessions, as well as support and management to the student facilitator and second student when needed.

Participants

The CBT group was comprised of three women, between the ages of 30 and 63 who were living in the halfway house at the time of this study. Two resided at the house on probation and one was a community client. Each participant volunteered to participate in this group. They had all experienced symptoms of anxiety or depression in their recent past, and all agreed to contribute to the group to aid with the reduction of these symptoms.

Information was passed on to each of the women in the halfway house by means of word of mouth regarding the group therapy and the subject matter of reducing anxiety and depression symptoms. Suggestions were also made by the director of residential services. The student facilitator directly invited each of the women living in the house to participate in the group sessions, and gave a brief explanation of what these sessions would entail to each individual. Other than the three participants, the fourth year behavioural psychology student facilitated the group, and was overseen by the director of residential services.

Design

A group format was chosen specifically for this thesis for its usefulness in applying these specific cognitive behavioural therapy techniques effectively to this population. The group
dynamic was also an important support system to each of the participants, as they could provide encouragement and positive reinforcement to one another. The act of sharing experiences amongst the group was also useful in gaining an understanding of how to apply the techniques that were taught in a variety of situations that each participant may be faced with in the future. The participants also showed an eagerness to participate and share experiences within the group dynamic, which would have been arduous if the therapy sessions were given in a one-on-one setting.

The primary goal of the group was to assist in managing anxiety and depression symptoms by promoting tools and relaxation techniques that could be useful in promoting positive cognitions. The dependent variable throughout this thesis was the level of anxiety or depression that each participant experiences before and after the conclusion of the group sessions. The independent variable was the diverse CBT techniques used throughout the sessions. Each of the four group sessions were 60 minutes in length, allowing adequate time for group discussions and group activities. The sessions involved discussions around managing automatic thoughts, distinguishing and avoiding cognitive errors and schemas, and teaching techniques to help manage symptoms of anxiety and depression. Peer support was encouraged, as some topics that were discussed were somewhat difficult for clients to share. The group met on Thursdays in the afternoon for four consecutive weeks with the necessary space and materials needed. The flow of the sessions was the same each week; an introduction to the group was given, a review of last week’s material, a strategy to present the current material, and a discussion portion of the strategies given at any time throughout the session. Any materials that were required for each session were handed out by the student facilitator, and included the “recognizing automatic thoughts” handout, the “thought record” sheet, the “cognitive errors and schemas” handout, and any materials needed to complete these handouts.

Consent

A consent form (Appendix A), drafted by the student facilitator and approved by the agency supervisor was given to each of the participants prior to the initiation of the first session. This consent form outlined why the study was being done, the benefits of taking part in the group sessions, risks involved, as well as contact information for the student’s school supervisor. Each form was willingly signed and dated by the participant as well as the student facilitator and given back to the student facilitator to keep. Each consent form and all pertinent information relating to each of the participants and personal information will be kept at the agency in a locked filing cabinet for ten consecutive years.

Measures

There were two questionnaires used during this study, as well as two inventories given out for each participant to complete. The pre-group questionnaire and inventories were given prior to the start of the sessions, and the post-group questionnaire and inventories were given after the sessions had commenced.
The first questionnaire was created by the student facilitator and called the “Pre-group Questionnaire” (Appendix B). This is a five question, multiple choice and 5-point Likert scale used to gain information from each client about their symptoms of anxiety and depression before the group sessions have begun. The Likert scale consisted of 5 points; “1” never, “2” rarely (1-2 days), “3” often (3-4 days), “4” sometimes (5-6 days), and “5” always (7 days). This measured the feelings and symptoms of anxiety and depression within the last seven days. There was also a multiple choice question asking to circle the techniques that they might have used to cope with anxiety and depression, as this was the basis for the topics that were presented throughout each of the sessions. For example, two of the questions on the “Pre-group Questionnaire” asks “how many times within the last week have you felt anxious”, as well as “how many times within the last week have you felt depressed”.

The second questionnaire created by the student facilitator, called the “Post-group Questionnaire” (Appendix C) has the same Likert scale as the pre-group questionnaire to assess changes in the symptom severity of anxiety or depression before and after the group sessions. It consists of nine questions. It also has three “yes” or “no” questions to determine whether the group was helpful, and two open-ended questions at the end for comments about the group. This will help the facilitators make any necessary changes to the group sessions, dynamics or content for future use within the agency. For example, one of the “yes” or “no” questions consists of “do you think you will use any of the strategies taught in this group in the future for your anxiety/depression symptoms?”

There are also two inventories given to each of the participants, along with the consent form, before the start of the group sessions. The consent form was given to each of the participants individually, one week before the beginning of the group, at the half-way house where the women resided. Each inventory was given to each of the participants in a group format in the agency room where the group sessions were held. The Beck Depression Inventory –II (BDI-II) is a twenty-one question self-report evaluation used to measure depression severity. This was given to each of the participants before the start of the group sessions, and at the conclusion of the group sessions. This is the second revision of the original Beck Depression Inventory, and statements are weighted from “0” to “3” on a four-point Likert scale, scored and compared to a normative population provided by the instrument’s manual. A score of 30 to 63 indicates the individual is at risk for severe depression. The Beck Anxiety Inventory (BAI) is a twenty-one question self-report evaluation of the severity of each anxiety symptom listed on the evaluation. The columns are then added together, and the total score is the interpretation of the amount of anxiety a person experiences within a monthly period of time. A sum that exceeds 36 is interpreted as very high and persistent anxiety.

Procedure

The group focus for each of the four sessions was dedicated to anxiety and depression, and how to manage these symptoms with positive coping skills and techniques. Prior to the start of the first session, the participants were informed of the consent procedures and given the
consent form to sign (Appendix A). The pre-group questionnaire (Appendix B) was completed and the BDI-II or BAI will be administered.

During the first session, a brief explanation of cognitive behavioural therapy was given, as well as an outline of each topic that will be covered in subsequent sessions was presented. Any questions regarding the layout or the topics of the group sessions and what to expect from each session were answered. Confidentiality was reviewed with each of the participants, and any questions or concerns regarding privacy was discussed.

The second session began with an overview of what was discussed during the first session, and any questions or concerns posed were answered then. The second session was based around the topic of recognizing automatic thoughts, and how to eliminate these from a person’s internal reasoning. This included a handout titled “Recognizing Automatic Thoughts” (Appendix D), created by the student facilitator, which explained what automatic thoughts are and four ways to eliminate these thoughts. The handout also contained a section on “crushing your automatic negative thoughts” which presents different points of view a person can use and think of to eliminate automatic thoughts. There was also a discussion of the different types of automatic thoughts each of the participants has used in the past, and ways to help eradicate those thoughts as well as positive thoughts that can be utilized instead. During this discussion, the “Thought Record Sheet” (Appendix E) was utilized, and each of the participants completed one pertaining to any automatic thoughts they have experienced within the last week. A discussion pertaining to the content of the thought record sheet was encouraged, and the participants also guided each other toward a more positive thought they could think of instead of the negative thought that occurred. This session concluded with an overview of what was talked about throughout the hour, and utilizing the skills learned for future automatic negative thoughts that might occur.

The third session began with a summary of the automatic thoughts learned in the previous meeting, and a discussion regarding if any of the participants have had to use these techniques since the last session and how they overcame those thoughts. The focus of this session was on identifying and distinguishing cognitive errors, schemas, and how to avoid these thoughts while managing the client’s anxiety or depression. A handout was given to each of the participants named “cognitive errors and schemas” (Appendix F) created by the student facilitator. This included a list of the different cognitive errors and techniques that can be used to eliminate these errors, and a discussion was presented about cognitive errors that each of the participants have experienced. The student facilitator also explained reason’s for avoiding each of the cognitive errors, and presented the question “what techniques have you tried in the past to be rid of your cognitive errors?” along with a discussion period with the group.

The final session included an overview of all the material that was given throughout each of the previous sessions, and praise and encouragement was given to each of the participants to continue to use the techniques that have been taught. The emphasis of the final session was based upon symptom management and learning different strategies the participants can use to utilize in the future to help manage their anxiety and depression symptoms. Relaxation techniques including meditation and progressive muscle relaxation were discussed, and other positive
techniques were discussed amongst the participants and encouraged in the place of the negative techniques often used. Discussion was based on trying to use the different techniques that have been taught in the future, and difficulties that one might be presented with while managing anxiety and depression symptoms. The post-group questionnaire as well as the BDI-II and BAI were distributed amongst the participants and completed, and received by the student facilitator.
Chapter IV: Results

The hypothesis that was proposed before the commencement of the program was that the involvement in the CBT group would help reduce the symptoms of anxiety and depression in the participants. Each Likert scale of the “Pre-group Questionnaire” and “Post-group Questionnaire” were compared to evaluate the effectiveness of the group sessions on symptom reduction for anxiety and depression. The scores of both the Beck Depression Inventory (BDI-II) and the Beck Anxiety Inventory (BAI) were analyzed to depict a change in the level of each, which every participant was feeling before and after the group sessions. They were also used to investigate the effectiveness of symptom reduction. Both the questionnaire’s and the inventories were the means of evaluating the results from the group sessions. The raw data is presented in Appendix G, Table 1 and Table 2 for both the pre- and post-test scores of each of the tests that were administered to the three participants.

Individual Participant Questionnaire Results

Participant 1 was administered the “Participant Information Form” before the group sessions had begun. She circled that she has been diagnosed with either anxiety or depression in the past, and she does experience the symptoms of both. When asked which coping techniques she has used in the past three months to cope with her anxiety or depression, she checked that she has used nine of the possible twelve listed examples. Participant 1’s score on the final “Post-Group Questionnaire Participant Information Form” increased by one point from the pre-group participant information form.

Participant 2 was given the “Participant Information Form” prior to the start of the group sessions to complete. She circled that she has not been diagnosed with either anxiety or depression in the past, and she does not experience symptoms of either. She circled three out of the possible twelve coping technique examples she uses that were listed on the form. Participant 2’s final score on the “Post-Group Questionnaire Participant Information Form” increased by two points from the initial participant information form score.

Participant 3 was administered the “Participant Information Form” prior to the beginning of the first session. She circled that she has been diagnosed with anxiety or depression in the past, and she answered yes to the question “Do you ever feel as though you experience the symptoms of anxiety or depression?” She also circled five out of a possible twelve examples of coping techniques that she has used within the past three months to cope with her anxiety or depression. Participant 3’s final score on the “Post-Group Questionnaire Participant Information Form” remained the same as her pre-group score.

BDI-II and BAI Individual Results

Participant 1 was administered the Beck Depression Inventory and the Beck Anxiety Inventory prior to the start of the first group session, and the student facilitator was in close proximity in case of any questions she might have had. Her total pre-group score was 24 which
indicated that she was experiencing moderate depression at the time the BDI-II was administered. When given the BDI-II after the group sessions had commenced, her total score was 18 and signified borderline clinical depression. Her total pre-group score for the BAI was 31 and indicated that she was experiencing moderate anxiety at the time this test was administered. When her total BAI score was calculated post-group, her score decreased by two points from her initial score during pre-group.

Participant 2 was administered the Beck Depression Inventory and the Beck Anxiety Inventory prior to the beginning of the group sessions, with the student facilitator nearby in case of any questions or concerns. Her pre-group score for the BDI-II she was administered was 45 and indicated that she was experiencing extreme depression at the time of the pre-group meeting. When given the BDI-II inventory to complete after the group sessions had finished, her total score was 28 and indicated moderate depression. Her pre-group score for the BAI she completed was 25 and indicated that she was experiencing moderate anxiety. Participant 2’s post-group BAI score specified moderate anxiety still. Her total score increased by two points from pre-group to post-group measures.

Participant 3 was administered the Beck Depression Inventory and the Beck Anxiety Inventory prior to the beginning of the group sessions, with the student facilitator in close proximity to the participant in case of any questions or concerns. Her pre-group score for the BDI-II was 44 and indicated that she was experiencing extreme depression. When given the post-group BDI-II inventory to complete, her final score was 43 and indicated that she was still in the extreme depression range. Participant 3’s pre-group score when completing the BAI during pre-group was 49 which indicated that she was experiencing extreme anxiety. When given the BAI to complete during post-group, her final score was 37 and suggested extreme anxiety as well.

Table 2 is presented to show the mean and standard deviation for each of the three participants’ scores on the Beck Anxiety Inventory, prior to the start of the first session (pre) and following the last session (post). These findings suggest that the average score for all participants did decrease slightly. This aims to propose that on average the anxiety felt by the participants before the group sessions began decreased after the sessions had commenced. The standard deviation of the mean scores also decreased when comparing the pre- and post-intervention scores. This shows that there is less of a variation between the mean scores for each of the participants.

The average score for the BDI-II, shown in Table 2, during the pre-intervention decreased when compared to the post-intervention scores. Comparisons of the pre-intervention and post-intervention mean suggest that the group sessions assisted in the decrease of overall scoring. The standard deviation increased between the pre-intervention and post-intervention scores, which is a useful observed variance that was noted between pre- and post-group therapy.
Participant Evaluation Results

During the post-group evaluation portion, participants were each given a participant information form in which they were asked to complete and hand into the student facilitator. Three “yes” or “no” questions were asked about the overall experience of the group sessions, and two questions were also given to gain feedback on what they liked and did not like. Overall, the participants generally responded positively and emphasised that the group sessions were very helpful in gaining knowledge about different aspects of anxiety and depression symptoms. When asked “do you feel as though this group was helpful in gaining an understanding of anxiety and/or depression?” two out of three participants answered with a “yes” response. When asked “do you think you will use any of the strategies taught in this group in the future for your anxiety/depression symptoms?” all three participants answered “yes” to this question. Although one participant did not complete the two questions on the opposite side of the page, the other two participants seemed to respond very positively to the group. They both enjoyed the different techniques used throughout the sessions, as well as the handouts were found to be useful. When asked if there was anything about the group that you would change, one participant did state that the sessions were too fast-paced for her and she wanted more detail regarding examples of situations that had been used. Overall, there was positive feedback from each of the participants and the staff of the agency and all participants stated that they would recommend this group to others.

The overall mean shown in Table 2 minimally increased from pre- to post-intervention, while the standard deviation decreased slightly. This slight increase in the mean could have been caused by having one participant not fully complete the questionnaire, as she did not complete two questions on the back page.

Summary

Overall, the scores depicted from each of the participants and the overall mean of each of the instruments used decreased in amount from pre-intervention to post-intervention. These findings suggest that this intervention was useful in decreasing the amount of anxiety and depression each of the clients were experiencing. Positive feedback was also given to the administrator depicting helpful suggestions for future groups, and ideas that each client found to be beneficial were noted in the Individual Participant Questionnaire.
Chapter V: Discussion

Thesis Summary

The current program aimed to decrease the symptoms of anxiety and depression often felt by women who have been in conflict with the law and who are residing in a halfway house. The primary goal of the group was to aid women in managing anxiety and depression symptoms, by promoting the tools and techniques that could be useful in encouraging positive cognitions. A group format was chosen to encourage peer support and independence. From the mean scores during pre- and post-intervention, there was a noticeable decrease in scores of each of the three inventories which supports the hypothesis.

As mentioned by Estroff and Marono (2003), CBT is the most positive and respected therapy for both anxiety and depression. The CBT therapy used in this intervention supports that notion, and the scores from each of the inventories decreased noticeably suggesting that the CBT treatment did aid in the reduction of anxiety and depression symptoms. Female offenders with ongoing mental health difficulties benefit from available treatment in the community wherever available (Scott, McGilloway, & Donnelly, 2009). The current group utilized community resources to give each participant the specific skills to face their anxiety and depression symptoms. It is important to continue treatment after a woman is released from prison, as this will solidify what she has learned in group sessions within the prison system as well as help with different issues they are facing while in the community that she did not think would transpire. Bloom and Covington (2008) stated that group therapy sessions with other women who have experienced similar hardships can aid in the recovery of one’s own personal difficulties. The CBT group sessions did aid in the reduction of depression and anxiety symptoms in the clients who participated in this program. The women residing in the halfway house who were chosen for this program do experience similar difficulties, and completing group therapy sessions can help with problem-solving techniques and peer support.

Participant 1 was very engaged throughout the entire program, and often added experiences and events that occurred throughout her lifetime to the group for discussion. She was very willing to learn during each of the group sessions, and when filling out the “post-group questionnaire” she indicated that she thought the group was helpful in gaining an understanding of anxiety and depression symptoms.

Throughout the three group sessions, it was difficult to keep Participant 2 focused on the task at hand. She would often drift from discussions that the rest of the group was having, and would talk with Participant 3 about irrelevant information to what each session was teaching. She was going through a lot of issues pertaining to her family, which could be one reason why she was not as engaged in the group discussions as hoped. She did, however, mention in the post-group questionnaire that she enjoyed the group and found it helpful toward her symptoms of depression and anxiety. Her scores on the Beck Depression Inventory-II and Beck Anxiety Inventory were the most surprising to the student and agency supervisor, as both facilitators did not believe that she was suffering from major depression or anxiety like her scores portrayed.
Participant 3 did extremely well throughout the group sessions, and often stated that she enjoyed what she was learning and she would use all of the techniques that were taught in her personal life for problems that may arise in the future. She was very interested in each of the topics covered, and provided a lot of feedback and personal experiences when asked for discussion purposes. Her scores on the BDI-II and BAI were troublesome for the student facilitator and agency supervisor, as they reported to be very high before the start of the group sessions. The student facilitator expressed these findings to the agency supervisor, which monitored Participant 3 throughout the group sessions.

Strengths

A major strength of this study was that the material was based on empirical information that was strongly integrated into the functioning and overall justification of this program. A review of several articles based on cognitive behaviour therapy, anxiety, depression, and incarcerated persons were integrated in the literature review portion of this program and the specific CBT techniques were used to strengthen the cognitive behavioural therapy.

This program was also successful in reducing the amount of anxiety and depression experienced by each of the participants based on their BDI-II and BAI inventories they completed before and after the program. All of the participants’ scores decreased by at least two points on each BDI-II and BAI inventory, which suggested that the group therapy sessions were a factor in decreasing the scores from pre- to post-intervention.

Each participant also gave very positive feedback about the group and the overall success of the cognitive behavioural therapy toward reducing the anxiety and depression through the use of the “Post-group Questionnaire”. Although there were some minor suggestions for future programs, most of the comments on the “Post-group Questionnaire” and given verbally to the student facilitator were very encouraging and confirmed that the group members enjoyed the sessions and the information they were taught. They were also very pleased with the peer support they received during each group session, and liked the feedback from each member about their own difficulties.

Limitations

Due to limited time constraints and deferred approval by the research ethics board, five original sessions had to be condensed into four sessions. This lead to having rushed sessions which could have impacted the results of the BDI-II, BAI, and individual participant questionnaire. Having more sessions could have been very beneficial toward the additional reduction of anxiety and depression symptoms, as the clients could have been taught more about how to manage these symptoms and more in-depth techniques could have been used when experiencing these symptoms.

Another limitation of this study was that there were only three participants who agreed to participate in the therapy sessions by the commencement of the group. The difficulty in acquiring participants could account for this limitation as well. This was probably because all of
the women who were residing in the halfway house at the time of this study were involved in community programming, including therapy groups, and psychology appointments. This mandatory involvement might have turned them away from this group compared to another therapy group that was voluntary to the conditions of their parole or house arrest.

An additional limitation of this study was that it was often difficult to encourage some of the participants in each of the sessions to participate in group discussions or give feedback to each other when needed. The student facilitator would ask for participation in each of the group sessions in various ways, with some discussions gaining more participation than others. This could be because some of the women did not feel comfortable in sharing these often very personal events with one another, or that some of the women did not trust in sharing these with one another due to past experiences with others.

Future Research Directions

As the cognitive behavioural therapy group was a brief study developed to aid in the reduction of depression and anxiety symptoms, further development is needed for the continued success. To continue the positive attributes toward the decrease of anxiety and depression symptoms for women in a halfway house, expansion of the CBT techniques and sessions is needed.

Multilevel Challenges to Service Implementation

Client level

The ultimate goal of a group counselling program with a focus on the reduction of anxiety and depression is to provide each client with the necessary tools to enhance their awareness of their symptoms, and to manage them in a positive and helpful manner. With this particular population, however, it can be difficult to battle these symptoms as women who have been in conflict with the law experience many different and often more difficult hardships than the societal norm. Also, because of the age of this population, most of the participants likely have been suffering from anxiety and depression for an extensive period of time. This can make it difficult to reverse those adverse behaviours and thoughts to make them manageable for each woman in their particular situation. It can also make it challenging for the clients to participate in these sessions, as they might think that these strategies will not work for them, or they have tried them before without any success. Women who were living in the halfway house at the time of the group sessions might not have wanted to participate in the group because most of them have already been assigned community and agency programming as a stipulation of their release into the community. Some of the women also had to participate in group sessions while incarcerated in prison and could have a negative outlook toward counselling or group interventions, which may be the reason that they did not volunteer to participate in this particular CBT group.
**Program Level**

Barriers that occur at a program level can be an issue pertaining to the implementation and success of the program itself. The number of sessions that were presented to the clients did present a problem, as five sessions were originally planned and had to be condensed into three sessions. This meant that the material had to be reduced which could have affected the outcome of the post-group scores. The total number of participants was also a concern, as only three women from the halfway house agreed to participate in the group sessions. This could have been because the topic of the sessions might not have been appealing to each of the women or they did not feel comfortable participating in this type of group. The encouragement toward the topics that were covered in each session was also a difficulty between some of the participants, especially during discussion times. Keeping all of the women on-task and focused on each of the sessions was challenging at times and this was particularly so when the women were asked to complete a task such as a group sheet that was being discussed during the session, or discussing experiences with one another.

**Organizational Level**

Within the organization, challenges may exist when it comes to coordinating and incorporating this CBT group into a group that is widely used within the agency. This could be because the agency does not have the funds or resources to continue this program with a staff member or community member who are willing to dedicate the time that is needed. Also, having enough participants from the half-way house and community who are willing to participate in this therapy group will be difficult for this organization to gather. Because of the population this organization manages, it could be challenging to find women that are willing to participate in such an open and honest manner to make the CBT group the most successful.

**Societal Level**

The incarcerated population is a challenging population to work with, and many stigmas are in place within these individuals that counselling and group therapy will not be beneficial to their lives. Also, there are many programs available for incarcerated women within the prison system, and some might believe that they should be ‘cured’ after they are released from prison from any mental illness they may have been diagnosed with. There is also still a stigma with individuals who suffer from anxiety and depression in that they should be able to fix themselves and therapy might be a waste of resources and money. This might have a negative impact on if women feel comfortable participating in a group therapy session at all.

**Contributions to the Behavioural Psychology Field**

The behavioural psychology field, more specifically cognitive behavioural therapy aims to reduce the symptoms of mental health and to suggest ways of decreasing those symptoms or eliminating them all together. These findings can aid in the continuing education and
development of cognitive behavioural therapy techniques toward the reduction of anxiety and depression symptoms.

**Recommendations for Further Development**

It is recommended that for future CBT groups this agency develops, more participants should be included to promote increased variation as well as better group dynamic and social interaction between group members. Having more group members participate in the sessions would be beneficial to both the facilitator and each of the group members for discussion purposes. Ensuring that there are at least five sessions in future groups will aid in increasing the clients knowledge about anxiety and depression symptoms, and go in depth about ways that they can manage these.
References


Zust, B. L. (2009). Partner violence, depression, and recidivism: The case of incarcerated women and why we need programs designed for them. *Issues in Mental Health Nursing. 30*, 246-251. doi: 10.1080/01612840802701265
Appendices
Appendix A: Consent Form

Project title: Using Cognitive Behavioural Therapy techniques to manage anxiety and depression in female offenders residing in a halfway house

Principal Investigator: Sarah Pearce
Name of supervisor: Lana DiFazio
Name of Institution: St. Lawrence College
Name of part partnering institution/agency: Elizabeth Fry Society

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

Why is this study being done?
This study is being done with women, ages 19 and older, who are living in a halfway house and who have either been diagnosed with anxiety or depression, or they believe that they are suffering with anxiety or depression. I will be teaching you different techniques and strategies you can use to reduce the symptoms, as well as coping strategies you can use in the future. This will hopefully help you to gain an understanding of your symptoms, and what the causes are of you being anxious and depressed.

What will you need to do if you take part?
If you choose to take part in this study you will be asked to take part in 4 sessions which will last about one hour in length. Everyone will share their experiences in managing their anxiety and depression, and make suggestions for others on healthy coping strategies. You will also learn many approaches to help with managing your anxiety and depression. There will be a couple of questionnaires you will need to fill out during the first session which will take approximately twenty minutes to complete. These relate to your depression and anxiety levels, as well as demographic information and coping strategies that you use already. These sessions will be run by me and with a supervisor from Elizabeth Fry, and should take a total of one hour to complete. At the end of the four counseling sessions, you will also be asked to fill these same questionnaires out again.

What are the potential benefits of taking part?
Taking part in this research study may help you to gain an understanding of anxiety...
and depression, as well as different healthy coping strategies that can be used. This will also help us to gain an understanding if these group sessions work with women who are living in the halfway house. You may also be able to share your experiences with other women if you feel comfortable doing so, and listen to different strategies that others use and may find healthy and effective.

What are the potential benefits of this research study to others?
This study may benefit you as a participant by learning different thoughts and actions about anxiety and depression, and different ways you might be thinking while under stress and how to manage these.

What are the potential disadvantages or risks of taking part?
Risks from taking part in this research study are minimal but may include experiencing an increase in emotions such as fear, anger, and sadness during the group sessions that you could find challenging. There could also be a sense of re-experiencing some traumatic events when you are explaining these experiences to the group, which can lead to other negative emotions.

What happens if something goes wrong?
There should not be anything that will go wrong with you or with the other participants. If anything unexpected occurs, I or my supervisor will handle the situation to the best of our abilities to ensure the safety of both you and the other party. If an unexpected situation occurs, you can seek support from me or the supervisor at any time during the sessions or after the group has finished. If you have any questions or concerns, please do not hesitate to contact me or my supervisor.

Will my information you collect from me in this project be kept private?
I will take special precautions to make sure that your information is kept private and confidential, unless required by law to report, such as significant harm to self, or an objective to harm others around you. You will be assigned a code name for the information that is gathered, and only my supervisor and I will be looking at the data we have gathered. The data will only be kept on a memory stick that is password protected, or in a locked filing cabinet at the Elizabeth Fry Society building to ensure that this information is safe. You will not be identified by name on any reports or presentations written, and any data gathered will be kept up to seven years for research purposes at the Elizabeth Fry Society building after which time it will be destroyed.

Do you have to take part?
Taking part is completely voluntary. It is up to you to decide whether or not to take part in this research project. If you do decide to take part, you will be asked to sign this consent form. If you do decide to take part in this research project, you are still free to withdraw at any time, without giving any reason, and without incurring any penalty, or
negative effects.

Contact for further information
This project has been approved by the Research Ethics Board at St. Lawrence College. The project will be developed under the supervision of Lana DiFazio, my College Supervisor, from St. Lawrence College, and [redacted], my placement supervisor from [redacted]. I really appreciate your cooperation and if you have any additional questions or concerns, feel free to ask me, Sarah Pearce, at spearce28@student.sl.on.ca. You can also contact my College Supervisor, Lana DiFazio at Lana.Difazio@csc-scc.gc.ca, or you may also contact the Research Ethics Board at reb@sl.on.ca.

Consent
If you agree to take part in this research project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency [and in a secure location at St. Lawrence College, if applicable].

By signing this form, I agree that:

✓ The study has been explained to me.
✓ All my questions were answered.
✓ Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
✓ I understand that I have the right not to participate and the right to stop at any time.
✓ I am free now, and in the future, to ask any questions I have about the study.
✓ I have been told that my personal information will be kept confidential.
✓ I understand that no information that would identify me will be released or printed without asking me first.
✓ I understand that I will receive a signed copy of this consent form.
I hereby consent to take part.

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Signature of Participant</th>
<th>Date</th>
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<tr>
<th>Student Printed Name</th>
<th>Signature of Student</th>
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Appendix B: Pre-Group Questionnaire
Participant Information Form

Code Name: ______________________

Age: ____________________________

When did you arrive at the Joyce Detweiler House? _______________________

Have you been diagnosed with anxiety or depression? (Please circle) Yes No

Do you ever feel as though you experience the symptoms of anxiety or depression? __________

Please circle the correct response as it relates to you and your feelings within the past week.

Feeling anxious:

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<th>4</th>
<th>5</th>
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<tr>
<td>never (0 days)</td>
<td>rarely (1-2 days)</td>
<td>often (3-4 days)</td>
<td>sometimes (5-6 days)</td>
<td>always (7 days)</td>
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Feeling depressed:

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<tr>
<td>never (0 days)</td>
<td>rarely (1-2 days)</td>
<td>often (3-4 days)</td>
<td>sometimes (5-6 days)</td>
<td>always (7 days)</td>
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Using healthy coping strategies to manage your anxiety/depression:

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<td>never</td>
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Using unhealthy coping strategies to manage your anxiety/depression:

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<tbody>
<tr>
<td>never</td>
<td>rarely</td>
<td>often</td>
<td>sometimes</td>
<td>always</td>
</tr>
</tbody>
</table>

Circle one or more coping technique you have used in the past 3 months to cope with anxiety/depression:
- Medication
- Seeking help from peers
- Cutting and/or self-harm
- Journaling
- Sleep
- Exercise
- Listening to music
- Relaxation techniques
- Support groups
- Substance use
- Drug use
- Counselling
Appendix C: Post-Group Questionnaire
Participant Information Form

Name: ________________________________

Age: ________________________________

When did you arrive at the Joyce Detweiler House? _________________

Please circle the correct response as it relates to you and your feelings within the past week.

Feeling anxious:

1 never (0 days) 2 rarely (1-2 days) 3 often (3-4 days) 4 sometimes (5-6 days) 5 always (7 days)

Feeling depressed:

1 never (0 days) 2 rarely (1-2 days) 3 often (3-4 days) 4 sometimes (5-6 days) 5 always (7 days)

Using healthy coping strategies to manage your anxiety/depression:

1 never 2 rarely 3 often 4 sometimes 5 always

Using unhealthy coping strategies to manage your anxiety/depression:

1 never 2 rarely 3 often 4 sometimes 5 always

Do you feel as though this group was helpful in gaining an understanding of anxiety and/or depression? (Please circle) Yes No

Do you think you will use any of the strategies taught in this group in the future for your anxiety/depression symptoms? (Please circle) Yes No

Do you think you will use any of the healthy coping strategies taught in this group in the future for your anxiety/depression symptoms? (Please circle) Yes No
Please list one positive aspect that you found helpful about this group.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Is there anything about this group that you would change?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Recognizing Automatic Thoughts

Automatic Thoughts are...

- Typically private and unspoken
- Occur in a “rapid fire” manner
- Preconscious thoughts
- Believable but not necessarily true, accurate or helpful

People with depression and/or anxiety experience floods of Automatic Thoughts that are maladaptive or distorted

These thoughts can generate painful emotional reactions and dysfunctional behaviours

4 Ways to Eliminate Automatic Negative Thoughts

1. Recognize the automatic negative thought(s)
2. Once recognized, you can either:
   - Challenge them
   - Ignore them
3. If you choose to challenge the automatic negative thoughts...
   - Look at the situation where the negative thought occurred
   - What is the negative thought?
   - What is the consequence of the thought?
   - What is the actual fact of the situation?
4. Ignore the automatic negative thoughts (awareness and letting them be) involving different thinking...
- Awareness of the thought
- Acknowledging the thought
- Acknowledging that resisting the thought will give it power
- Knowing that it is a negative thought
- Letting it go

**CRUSHING Your Automatic Negative Thoughts**

- Notice how *negative* thoughts affect your body
- Notice how *positive* thoughts affect your body
- Think of negative thoughts as pollution
- Understand that your automatic thoughts don’t always tell the truth
- Challenge your automatic thoughts
- Take away their power over you
- Don’t live in the past (in your mind) the rest of your life
- If you can’t stop the negative thoughts, try replacing them with positive ones
- Important not to get caught in minor details, look at the bigger picture
### Appendix E: Thought Record Sheet

<table>
<thead>
<tr>
<th>Situation</th>
<th>Feelings</th>
<th>Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who, What, When Where?</td>
<td>Rate emotion 0-100%</td>
<td>What was going through your mind as you started to feel this way?</td>
</tr>
</tbody>
</table>

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</table>
Cognitive Errors & Schemas

*Cognitive Errors* (or distortions) are common mistakes in internal thinking one might experience when managing their anxiety and depression symptoms.

There are 6 common cognitive errors:

**Selective Abstraction** “ignoring the evidence”
→ An assumption that is made after looking at a small amount of the information

**Arbitrary Inference**
→ An assumption is made because of conflicting evidence or the lack of evidence

**Overgeneralization**
→ An assumption is made about one or several specific incidents, but is used to cover bigger areas of a person's performance

**Magnification and Minimization**
→ A significant event, feeling or quality that is inflated or minimized

**Personalization**
→ Outside events that you relate to yourself when there is little or no reason for doing so

**Absolutistic “all or nothing” Thinking**
→ Judgements about yourself, experiences you’ve had, or others are placed only into two categories (ex. Bad and good, success or failure)
**Schemas** are basic rules for handling information that are deeper than automatic thoughts

- Values/morals/standards of thinking that develop in early childhood and are affected by many life experiences (education, trauma, success, etc.)

There are 3 main groups of schemas:

**Simple Schemas**
- Rules about the environment, managing everyday tasks that usually have little to no effect on thinking/reasoning
  - “take shelter during a thunderstorm”

**Intermediary (Middle) Beliefs and Assumptions**
- Conditional rules that influence self-esteem and emotions (usually “if-then” statements)
  - “I must be perfect to be accepted”

**Core Beliefs about the Self**
- Global rules for understanding information coming from society that is related to self-esteem
  - “I’m stupid”
  - “I am a good friend”

Important to note that ALL people have a mixture of healthy and unhealthy beliefs; the goal then is that balance between the two and building up the healthy beliefs while changing or getting rid of the unhealthy beliefs ...
Appendix G: Pre- and Post-Test Scores for the BAI, BDI-II, and the Individual Participant Questionnaire

Table 1

Pre- and Post- Test Scores: Beck Anxiety Inventory, Beck Depression Inventory II and Individual Participant Questionnaire

<table>
<thead>
<tr>
<th>Test Scores</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Anxiety Inventory</td>
<td>Pre 31</td>
<td>Post 29</td>
<td>Pre 25</td>
</tr>
<tr>
<td>Beck Depression Inventory II</td>
<td>Pre 24</td>
<td>Post 18</td>
<td>Pre 45</td>
</tr>
<tr>
<td>Individual Participant Questionnaire</td>
<td>Pre 18</td>
<td>Post 19</td>
<td>Pre 8</td>
</tr>
</tbody>
</table>

Table 2

Mean and Standard Deviation of Pre- and Post-Intervention Scores

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<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Beck Anxiety Inventory</td>
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<td>31</td>
</tr>
<tr>
<td>Beck Depression Inventory II</td>
<td>34.3</td>
<td>29.7</td>
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<tr>
<td>Individual Participant Questionnaire</td>
<td>13.3</td>
<td>14.3</td>
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<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
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<td>Beck Anxiety Inventory</td>
<td>12.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Beck Depression Inventory II</td>
<td>10</td>
<td>12.6</td>
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<tr>
<td>Individual Participant Questionnaire</td>
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<td>4.5</td>
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