The procedures in these staff and participant training manual/workshop are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
Abstract

Anxiety is a widespread mental health problem among adolescents that can lead to significant physical, mental, and personal impairments for the individual. To reduce anxiety and its associated problems, it is imperative for adolescents with anxiety to receive effective treatment. The literature suggests that group cognitive-behavioural therapy (CBT) and self-compassion training (SCT) are both effective treatment techniques for reducing anxiety. The goal of the present thesis was to develop client and therapist treatment manuals that would aid in facilitating group CBT combined with SCT for adolescent anxiety. These manuals were developed for use by professionals trained and experienced in delivering CBT and SCT. The target client population was adolescents (11 to 18 years of age) diagnosed with anxiety disorders (excluding obsessive compulsion disorder). The final treatment manuals were comprised of information on CBT and anxiety, session outlines and handouts corresponding to treatment, additional tips for group facilitators, and a feedback form. These materials reflected suggestions from group facilitators at the agency of interest, as well as research literature. Future research should aim to directly test the benefits of combining SCT with group CBT to treat adolescent anxiety.
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Chapter I: Introduction

Adolescent Anxiety

Anxiety is a widespread mental health problem among adolescents, with a prevalence rate of approximately 8% to 22% (Briesch, Sanetti, & Briesch, 2010). Anxiety has manifestations that are cognitive (e.g., difficulty concentrating), physical (e.g., racing heart, fatigue), emotional (e.g., fear), and behavioural (e.g., escape/avoidance behaviours) in nature (Lindsay, Paulhus, & Nairne, 2006, p. 572). It can lead to significant physical, mental, and personal impairments for the individual, and often co-occurs with depression (Kessler, Ruscio, Shear, & Wittchen, 2009; Skrove, Momundstad, & Indredavik, 2013). Further, anxiety can burden an individual’s direct support system, as well as the public health system at large (Kessler et al., 2009). To reduce anxiety and its associated problems, it is imperative for effective treatment to be available and provided to adolescents experiencing anxiety. It is also essential that adolescents struggling with anxiety receive treatment as early as possible to prevent exacerbated symptoms during adulthood (Kessler et al., 2009).

Anxiety Treatment

Cognitive-behavioural therapy (CBT) is widely recognized as an effective treatment for anxiety (Seligman and Ollendick, 2011). According to Petrocelli (2002), group CBT, which is defined as treatment that uses group dynamics along with common CBT strategies to change maladaptive thoughts, behaviours, and attitudes, has also been found to be effective in reducing adolescent anxiety. While group CBT is generally a sufficient treatment for anxiety, it is suggested that its effectiveness can be improved by combining it with other evidence-based practices (Zinbarg, Mashal, Black, & Flückiger, 2010). Self-compassion training (SCT), for example, might be a beneficial addition to standard group CBT practices. Several recent studies have suggested that SCT leads to reduced anxiety and improved well-being by encouraging individuals to: practice self-kindness over self-criticism; be mindful instead of avoiding or escaping aversive events; and accept suffering and failure as aspects of common humanity rather than as abnormal, isolated events (Germer & Neff, 2013; Gilbert & Procter, 2006).

Rationale

The present thesis involved the development of client and therapist treatment manuals to facilitate group CBT combined with SCT for adolescent anxiety. The manuals were developed by the student researcher in partial fulfillment of the requirements for an applied thesis in the Bachelor of Applied Arts Behavioural Psychology degree program. There is a need for the development of improved treatment strategies for adolescent anxiety. The aforementioned problems associated with anxiety, and the demonstrated effectiveness of CBT and SCT as effective interventions for anxiety, provide justification for the present thesis. Finally, the purpose for addressing this topic through the development of treatment manuals was to benefit the agency which requested the manuals.
Hypothesis/Goals

Due to research limitations and time constraints, the effects of combining group CBT with SCT could not be directly tested. However, it was hypothesized that combining these interventions will lead to improved treatment outcomes (i.e., further reductions in anxiety and increased self-compassion), and, at the very worst, be merely innocuous. The goal of the present thesis was to develop manuals for facilitating group CBT combined with SCT to treat adolescent anxiety. The treatment manuals were evaluated through feedback from group CBT facilitators, who were asked to critique the treatment manuals based on usefulness, organization, completeness, and content. It was anticipated that the feedback received through these evaluative procedures would allow for improvements in the treatment manuals that might increase their usefulness and effectiveness in facilitating future treatment.

Overview of Treatment Manuals

The client and therapist treatment manuals are developed for use with CBT groups for adolescent anxiety held at an outpatient psychiatric setting. The manuals may also be used as part of a pilot study to directly test the impact of incorporating SCT with group CBT for adolescents with anxiety. Each treatment manual contains a table of contents, instructions for each session, worksheets, handouts, and information on anxiety and the type of treatment implemented. All information included in the treatment manuals corresponds with the content taught during group CBT and SCT sessions. The addressed topics include: the CBT model (i.e., the relationship between thoughts, emotions, physical body, and behaviour); thought monitoring (i.e., recording automatic thoughts during anxiety provoking situations); goal setting/behavioural challenges (i.e., engaging in behaviours that are typically avoided in lieu of anxiety); cognitive challenges (i.e., testing or challenging the accuracy of anxious thoughts); relaxation exercises (e.g., deep breathing and progressive muscle relaxation); mindfulness techniques (i.e., recognizing and attending to unpleasant thoughts and emotions); and self-compassion strategies (e.g., mindful meditation).

Overview of Thesis

The present thesis includes a review of literature that builds the rationale for developing treatment manuals to facilitate group CBT combined with SCT to treat adolescent anxiety. Several key studies and their findings will be summarized, and relationships, trends, and gaps in the literature will be addressed and compared. The literature review will be followed by an explanation of the methodology used to complete the client and therapist treatment manuals, as well as a description of their intended use. The results section will present and summarize the final products of this thesis, as well as the data collected through evaluative procedures. Finally, further research recommendations and the limitations of the developed treatment manuals will be discussed.
Chapter II: Literature Review

Overview of Adolescent Anxiety

Briesch, Sanetti, and Briesch (2010) reported that between eight and 22% of youth are diagnosed with an anxiety disorder. Many anxiety disorders, especially tic disorders, specific phobias, social phobia, and obsessive-compulsive disorder, typically begin during adolescence or early adulthood (Kessler, Ruscio, Shear, & Wittchen, 2009). Although the onset of anxiety is usually in adolescence, initial treatment often does not occur until adulthood (Kessler et al., 2009). In fact, adolescents with anxiety are one of the least likely client populations to present in clinical services for adolescent mental health (Dadds, Heard, & Rapee as cited in Briesch et al., 2010). This is problematic given that anxiety is associated with a number of cognitive and psychosocial difficulties that can negatively impact an individual’s physical and mental health (Skrove, Momundstad, & Indredavik, 2013). According to Cartwright-Hatton, Richards, Chitabesan, Fothergill, and Harrington (2004), these difficulties are likely to exacerbate in early adulthood if an adolescent’s anxiety persists. Further, untreated anxiety in adolescence is associated with an increased risk for the development of substance abuse and depression in adulthood (Kessler et al., 2009).

There are some key differences in treating adolescent and adult anxiety. Unlike adults, some anxiety experienced by youth develops relative to normal age-specific experiences (Seligman and Ollendick, 2011). However, non-normative (or clinical) anxiety exists when fear and apprehension exceed what could be considered age–appropriate and cause an adolescent to avoid developmentally significant events, such as separating from parents and developing peer relationships (McLoone, Hudson, & Rapee as cited in Briesch et al., 2010; Seligman and Ollendick. 2011). Accordingly, psychological treatment for adolescent anxiety requires attention to an individual’s stage of development (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Further, psychological treatment must take into account the intricate relationships between the adolescent, his or her family, and their environment, and how they impact the adolescent’s development and psychological well-being. It is also important to construct a treatment plan that will be supported by the family, especially if caregivers need to deliver treatment strategies in the adolescent’s home environment. This might also pertain to care providers in the adolescent’s school environment (e.g., teachers). Attention to these factors is critical to developing successful treatment strategies for adolescents, especially when altering interventions used with adults to suit the needs of adolescents.

Sources of Anxiety

Protective factors and risk factors. The current literature suggests that there are factors that increase adolescents’ resilience against anxiety (protective factors), as well as factors that put adolescents at increased risk for developing anxiety (risk factors). According to Skrove et al., family connectedness and peer relations are considered to be protective factors. Adolescents who live with both parents, have a good or very good relationship with family members, and have at least two friends are less likely to develop symptoms of anxiety. In contrast, van Oort, Greaves-Lord, Ormel, Verhulst, and Huizink (2011) found that having decreased self-competence, being a victim of bullying, and having rejecting or overprotective parents were associated with a greater presence of anxiety symptoms in adolescents. Additionally, increased substance use (i.e.,
cigarette, alcohol, or illicit drug use) seems to be linked to a higher likelihood of developing symptoms of anxiety and depression (Skrove et al, 2013). Although the causes of anxiety are complex, knowledge of the aforementioned risk and protective factors provides some insight into how adolescent anxiety may develop.

Genetic factors. There are a number of genetic research methods used that allow estimation of the extent to which genetic factors contribute to the development of anxiety disorders (Domschke & Decker, 2009). Some genetic methods focus on family studies, twin studies, and adoption studies (i.e., clinical genetics), while other methods seek to identify specific genes associated with the genetic risk of anxiety (i.e., molecular genetics). Converging evidence from these research modalities supports the view that biological, environmental, and psychological factors influence the development of anxiety disorders. It has been proposed that the contribution of genetic factors is significant, with heritability of anxiety estimated to be as high as 67%. Based on correlational research, it is presumed that specific genes contribute to the development of anxiety. However, on a functional level, it is unknown how these genes cause the development of anxiety disorders. While genetic risk factors do not hold diagnostic value, knowledge of them facilitates an understanding of the pathophysiology of anxiety.

Neural processes in learning. Recent research has also focused on identifying the neural basis of fear and anxiety (Canteras, Resstel, Bertoglio, Carobrez, & Guimaraes, 2009). One of the main experimental approaches used to investigate brain systems underlying the anxiety response is Pavlovian fear conditioning. Rodents acquire a conditioned fear response (e.g., avoidance or escape) to a neutral stimulus (conditioned fear stimulus) when they are repeatedly presented with an unconditioned fear stimulus. In other words, rodents learn to engage in a fear response in the presence of non-life-threatening stimuli. Brain imaging in rodents has revealed that the amygdala is likely the locus for the learning, storage, and expression of conditioned fear. The acquisition and retention of the association between the unconditioned and conditioned stimuli seem to occur in the lateral nucleus of the amygdala. Since the brain systems responsible for evoking or inhibiting the fear response are similar in rodents and humans, it is believed that humans also develop a fear response to non-life-threatening situations through associative learning. This might be one explanation as to why humans develop anxiety disorders.

Pharmacotherapy

In America, a significant proportion of adolescents with mental health disorders are treated with psychotropic medications. A study by Olfson, He, and Merikangas (2013) examined data from a national survey in 2003 with a sample of 10,123 adolescents who were between 13 and 18 years of age. Participants received a list of 215 names of psychotropic drugs and were asked to specify medications they had been treated with during the previous 12 months. Of the participants, 7% reported that they had been treated with a psychotropic medication in the past year. The most commonly used class of psychotropic medication was antidepressants (3.9%). Among the participants who used antidepressants, 48.8% had been diagnosed with an anxiety or depressive disorder within the past year, and 20.3% had a lifetime anxiety or depressive disorder. Like CBT, psychotropic medication is a commonly used treatment for anxiety disorders in adolescents.
The effectiveness of pharmacotherapy and CBT has been evaluated in recent literature. A six-year, six-site randomized controlled trial was conducted by Compton et al. (2010) to compare the impact of CBT and sertraline (a widely-used antidepressant for anxiety) on the severity of anxiety disorders. The participants in this study were 488 children and adolescents (seven to 17 years of age) who were diagnosed with separation anxiety disorder, social phobia, or generalized anxiety disorder. Participants were randomized to receive monotherapy (individual CBT or sertraline), combination therapy (individual CBT and sertraline), or a placebo pill for 12 weeks. The results indicated that all active treatments were superior to the placebo pill, that combination treatment was more effective than monotherapy, and that CBT and sertraline had equivalent effects in reducing anxiety. Using data from this study, Ginsburg et al. (2011) also found that combination treatment produced significantly higher rates of remission (i.e., reaching an absence or near absence of anxiety symptoms) than other treatment conditions. However, remission rates for all participants were significantly lower than response rates (i.e., achieving a clinically significant improvement in anxiety symptoms). In other words, most of the participants experienced residual symptoms of anxiety following treatment.

While CBT and pharmacotherapy are both well-established and effective treatments for adolescent anxiety, these modalities have divergent conceptualizations and approaches to treatment (Brown, Deacon, Abramowitz, Dammann, & Whiteside, 2007). Pharmacotherapy is consistent with biological models of anxiety that emphasize the role of neurotransmitter dysregulation. CBT originated from cognitive and learning models that stress the role of learned behaviour and erroneous appraisals of threat in the development of anxiety. Understandably, these modalities provide different therapeutic experiences, and parents may prefer that their child receive one modality rather than the other. Brown et al. (2007) conducted a study that consisted of 71 parents of children (7 to 18 years of age) with anxiety disorders to evaluate their perceptions of pharmacotherapy and CBT. Parents generally viewed both pharmacotherapy and CBT as acceptable treatments for child anxiety. However, they perceived CBT as more acceptable and effective overall than pharmacotherapy. Also, children’s history of medication use was associated with parents’ perceptions of the acceptability of pharmacotherapy (i.e., no history of use was associated with unfavourable views of pharmacotherapy). These findings have important implications to clinical practice given that caregiver support can be crucial to treatment success.

In general, CBT and pharmacotherapy are widely used and shown to be equally effective treatments for adolescent anxiety. However, while symptomatic improvement is a valuable treatment outcome, achieving remission is the preferred goal of treatment. With this being said, there is a need to improve evidence-based treatments for adolescent anxiety. Further, there is some evidence to support that parents hold more favourable perceptions of CBT than pharmacotherapy for adolescent anxiety. With attention to these issues, one way to optimize evidence-based treatment for adolescent anxiety might be to combine CBT with other psychotherapeutic techniques, such as SCT.

**Cognitive-Behavioural Therapy**

According to Seligman and Ollendick (2011), cognitive-behavioural therapy (CBT) is regarded as the treatment of choice for adolescent anxiety. CBT differs from other psychotherapeutic techniques in that practitioners use a combination of cognitive and
behavioural interventions to deliver problem-focused and skill-building treatment. A core procedure in CBT involves the client and therapist working collaboratively to set goals for the client to strive toward throughout treatment. An extensive review of literature conducted by Petrocelli (2002) revealed that adolescents with anxiety also benefit from CBT conducted through a group format, and that individual and group CBT are equally effective. The main difference between the two treatment formats is that group CBT is influenced by the relationships and social climate among group members. Additionally, potential benefits of group treatment include participants’ exposure to social engagement and time and cost-effectiveness (Liber, Van Widenfelt, Utens, Ferdinand, Van der Leeden, Gastel, & Treffers, 2008). Some common strategies implemented in group CBT for adolescent anxiety include: psychoeducation, cognitive restructuring, repeated exposure, and relaxation training (Petrocelli, 2002).

**Psychoeducation.** An essential process in CBT for anxiety is to educate adolescents and caregivers on how anxiety and fear are developed and maintained, as well as to provide them with the rationale for various treatment strategies (Velting, Setzer, & Albano, 2004). This information is usually relayed through didactic instruction and assigned readings. The goal of psychoeducation is to improve adolescents’ and caregivers’ understanding of anxiety and treatment protocols. This might increase their support for treatment strategies, which could facilitate treatment success.

**Cognitive restructuring.** Cognitive restructuring involves the modification of maladaptive cognitions (Seligman and Ollendick, 2011). This technique is based on cognitive theory, which asserts that maladaptive thoughts are linked to anxious feelings and behaviours. To modify these problematic thoughts, clients typically answer a series of questions or engage in behavioural experiments to discover, evaluate, and challenge anxious thoughts. The goal is for clients to continuously practice these strategies, and eventually become independent in identifying thinking errors and developing more adaptive thoughts. Cognitive theory asserts that positive changes in cognitions promote more adaptive and less disruptive behaviour and emotions.

**Repeated exposure.** A central component of CBT for adolescent anxiety is repeated exposure to anxiety-provoking stimuli (Seligman and Ollendick, 2011). According to Chorpita et al. (as cited in Seligman and Ollendick, 2011), treatments that use exposure techniques to reduce anxiety often yield the largest effect sizes. Typically, exposure therapy includes the development of a fear hierarchy, which involves a ranking of feared stimuli from least to most anxiety-provoking. The goal is for adolescents to be systematically exposed to the identified stimuli, either during or between therapy sessions, until anxiety dissipates. Exposure may occur through direct contact with anxiety-provoking stimuli or through imagery (i.e., imagining a feared object or situation), which allows for indirect confrontation of feared stimuli (Tiwari, Kendall, Hoff, Harrison, & Fizur, 2013). Regardless of the strategy used, animal learning theory provides one explanation as to why repeated exposure reduces anxiety (Hofmann, 2008). In the same way that humans might acquire a conditioned fear response, repeated exposure to a conditioned fear stimulus in the absence of an unconditioned fear stimulus could lead to fear extinction. In other words, frequent exposure to anxiety-provoking stimuli might alter an adolescent’s expectations or perceived control of unconditioned fear stimuli.
Relaxation training. Progressive muscle relaxation (PMR) and deep breathing are relaxation strategies that aid in the management of somatic symptoms of anxiety (Velting et al., 2004). PMR involves systematically tensing and relaxing major muscle groups to induce a state of overall bodily relaxation. The primary task of deep breathing is to inhale slowly and deeply to counteract shallow and rapid breathing that induces panic-like symptoms. PMR and deep breathing prevent somatic symptoms of anxiety by reducing oxygen consumption and metabolic rate (Nickel et al., 2005; Mohan, Sharma, & Bijlani, 2011). This heightens activation of the parasympathetic nervous system while reducing activity of the sympathetic nervous system. Meditation seems to produce a similar physiologic relaxing effect; even short meditation practices (i.e., 20 minutes) appear to result in significantly decreased sympathetic reactivity (Jerath, Edry, Barnes, & Jerath, 2006). The application of these strategies can depend on the severity and function of a client’s anxiety.

Self-Compassion

According to Neff and Germer (2013), self-compassion is a relatively new concept to Western psychology that has been adopted from Buddhist philosophy. Self-compassion can be defined as an individual noticing and being open to his or her experience of suffering, while generating self-kindness in attempts to alleviate that suffering (Neff, 2003). According to Neff, the three central components of self-compassion are self-kindness, mindfulness, and a sense of common humanity. Self-kindness involves being understanding and compassionate towards oneself while experiencing failure, suffering, or feelings of inadequacy. Being kind to oneself might mean acknowledging one’s shortcomings or failures without engaging in critical or judgemental self-talk. Maintaining a sense of common humanity entails that one recognizes failure and suffering as part of the human condition, rather than as abnormal, isolated events. Finally, mindfulness involves recognizing and attending to unpleasant thoughts and emotions, without suppressing or avoiding them. Germer and Neff (2013) assert that self-compassion only occurs when each of the aforementioned elements exist.

SCT targets the essential elements of self-compassion through the teaching and practice of self-compassion skills and mindfulness, typically in a group-based treatment format (Neff & Germer, 2012). Formal meditation practices, such as loving-kindness meditation or affectionate breathing, are commonly used to facilitate mindfulness. Strategies targeting self-compassion include a combination of informal exercises (e.g., repeating self-compassionate phrases during moments of emotional pain), interpersonal activities (e.g., sharing experiences to foster a sense of common humanity), and self-monitoring homework (e.g., recording pleasant events). SCT participants are typically instructed to perform formal and informal strategies outside of treatment. Educating SCT participants on the significance of self-compassion is also important to treatment, as the concept is unfamiliar to many people.

Recent research suggests that self-compassion positively contributes to the psychological well-being of adolescents and adults. Neff and McGehee (2010) conducted a study to assess self-compassion, anxiety, depression, and social connectedness in 235 adolescent participants and 287 young adult participants. Individuals completed eight standardized self-report questionnaires as measures of these target variables. Self-compassion was found to be negatively correlated with depression and anxiety, and positively correlated with social connectedness. In other words, self-compassion was associated with improved psychological well-being in adolescent and adult
participants. Unfortunately, these relationships are correlational, and it cannot be said for certain that self-compassion causes or is caused by changes in other variables. A pre-test post-test study could contribute towards clarifying causal relationships among self-compassion and positive emotional states. Controlled trials have been conducted to test the effects of SCT programs, but research limitations (e.g., small sample sizes and limited generalizability) make it difficult to assess the overall contribution of self-compassion to psychological well-being. Regardless, it is suggested that self-compassion might serve as an alternative treatment model to self-esteem, which is a commonly used but problematic treatment target for adolescent anxiety.

Self-Compassion versus Self-Esteem

Self-esteem is a construct that refers to the degree to which a person places value on him or herself, or how favourably (high self-esteem) or unfavourably (low self-esteem) an individual evaluates him or herself (Baumeister, Campbell, Krueger, & Vohs, 2003). For decades, Western psychologists and educators have focused on developing programs to increase adolescents’ self-esteem to combat negative self-perceptions (Mecca, Smelser, & Vasconcellos as cited in Neff & McGehee, 2010). Despite its widespread use, self-esteem has also been a controversial and problematic target in mental health interventions. Baumeister et al. concluded that while self-esteem is positively correlated with happiness, academic performance, and interpersonal functioning, there is little to no empirical evidence to support that self-esteem is causal in these relationships. Further, self-esteem is seemingly associated with unstable and contingent feelings of self-worth (i.e., fluctuations due to external circumstances). Finally, high self-esteem has been found to contribute to problematic behaviours like narcissism, aggression, bullying, and self-enhancement bias (Baumeister, Bushman, & Campbell; Baumeister, Smart, & Boden; Crocker & Park as cited in Neff & McGehee, 2010).

Neff and Vonk (2009) conducted correlational research to assess whether or not problems associated with self-esteem were redundant with self-compassion. To do so, they compared self-esteem and self-compassion relative to a number of factors, including various emotional states and aspects of self-concept. A battery of 12 questionnaires measuring different variables were completed by 2,187 adult participants over an eight month period. Using data from completed assessments, the researchers found that that unlike self-esteem, self-compassion was negatively correlated with: unstable and contingent self-worth, social comparison, public self-consciousness, anger, and self-rumination. Additionally, Neff and Vonk evaluated the association between self-compassion and positive emotional states. Analyses of five self-report questionnaires completed by a group of 167 undergraduate university students indicated that self-esteem and self-compassion were equivalently correlated with positive emotional states (i.e., happiness, optimism, and positive affect). Further, they found that the positive emotional states associated with self-compassion tended to be less conditional on perceptions of self-worth and more contingent on acceptance of self and external conditions as they are. These findings support the notion that self-compassion might be a more plausible and desirable treatment for adolescent anxiety than boosting self-esteem. Although a causal relationship has not yet been established between self-compassion and improved emotional states or self-concept, the results of these studies warrant further investigation of self-compassion as an alternative treatment target to self-esteem.
Self-Compassion Training

There is little research examining SCT, as the idea of targeting self-compassion in treatment is novel to Western psychology. Pilot studies and controlled trials have used within-subject and between-subjects research designs to demonstrate the benefits of SCT for adults with and without mental health problems; however, there have not been any studies using control groups that have assessed the direct impact of SCT on anxiety in adolescents. For the purpose of the present thesis, it is important to discuss two studies in particular.

**Mindful self-compassion.** Neff and Germer (2013) established a structured 8-week group treatment program called Mindful Self-Compassion (MSC). According to Germer and Neff (2013), this program consisted of several mindful meditation practices and informal self-compassion strategies to be used in everyday life. When practicing meditation, participants were encouraged to be mindful by focusing their attention on an object in the present moment (e.g., their breath) or by repeating self-compassionate phrases (e.g., “may I be kind to myself”). Participants were also asked to practice compassionate language in place of critical self-talk. Additionally, participants identified their core values and beliefs, and then assessed how consistent their typical behaviour was with their values and beliefs. These strategies were taught and practiced in sessions with the expectation that participants would use the techniques between sessions so that self-compassion would become habitual.

The MSC program was evaluated through a randomized control design that compared the results of a treatment group consisting of 24 adult participants to a waitlist control group with 27 adult participants (Neff & Germer, 2013). In comparison to the control group, MSC participants demonstrated significantly improved self-compassion, compassion for others, mindfulness, and life satisfaction, as well as decreased stress, anxiety, depression, and maladaptive avoidance behaviours. These results suggest that individuals experiencing anxiety and/or depression may benefit from receiving SCT. Further, SCT might be a useful addition to standard group CBT for individuals with anxiety, as it may promote further reductions in targeted problems. However, there were limitations to this study that reduce its generalizability. The researchers used a small sample size consisting of well-educated females, most of whom had prior experience with meditation. To be effective with a wider-range of client sub-types, treatment modifications would likely be necessary, which should be explored by further controlled research.

**Compassionate-mind training.** Gilbert and Procter (2006) developed a program called compassionate-mind training (CMT) as a treatment for various mental health problems in adults. The main objective of this program was to decrease participants’ self-criticism while increasing compassion and self-compassion. CMT used procedures similar to CBT, including psychoeducation, guided discovery, Socratic questioning, thought monitoring, imagery, and behavioural practices. In the first few sessions of CMT, participants discussed the nature of self-criticism. They were also introduced to the concepts of compassion and self-compassion, as well as the intention of therapy. The following sessions involved further exploration of the qualities of self-compassion and possible fears associated with being self-compassionate. In the final sessions, participants discussed exemplary triggers and consequences of self-attacking and self-criticism.
The CMT program was assessed through an uncontrolled trial conducted by Gilbert and Procter (2006). Six adult participants (aged 39 to 51 years) who were diagnosed with personality disorders and/or severe mood disorders underwent 12 CMT sessions that were two hours long. The participants were current patients of an inpatient psychiatric setting who were already receiving CBT. They received CMT through a group format in the hospital setting, and reported significant decreases in anxiety, depression, and self-criticism following CMT. A potential strength of CMT is that it blends concepts of CBT and SCT, which also makes it highly applicable to the present thesis. However, given that this study was an uncontrolled trial with a small sample, confounding variables (e.g., time effects) may have impacted the results. Further, the extent to which participants benefited from initial CBT sessions was not assessed. While CMT likely provided additional benefits over standard group CBT, a more accurate estimate of its effects could be made through a stricter research methodology.

The Present Thesis

Given that self-compassion is associated with psychological well-being among adolescents, it might be useful to incorporate SCT with other evidence-based treatment strategies, such as CBT. Research on this combination of interventions is lacking, and it merits investigation. The present thesis involved the development of client and therapist treatment manuals to facilitate group CBT combined with SCT for adolescents diagnosed with anxiety disorders. It is hypothesized that the addition of SCT to group CBT will strengthen the overall success of treatment, leading to further reductions in anxiety and increases in psychological well-being. Although the direct benefits of combining these techniques to treat adolescent anxiety have not been tested, research suggests that this treatment hybrid would be harmonious and, at the very worst, merely innocuous. Further, it is important to note that the manuals may be used to guide treatment in a pilot study that seeks to directly assess the impact of combining group CBT and SCT for adolescent anxiety. Due to the aforementioned problems and risks associated with adolescent anxiety, if this treatment hybrid is found to be beneficial, further development of SCT for adolescents would be of value to the field of Behavioural Psychology.
Chapter III: Method

Rationale for Developing Manuals

The treatment manuals were developed by the student researcher in partial fulfillment of the requirements for an applied thesis in the Bachelor of Applied Arts Behavioural Psychology degree program. A manual format was selected for several reasons. First, the aforementioned literature supports further research on effective treatment for adolescent anxiety. Due to time constraints and research limitations, the student researcher was not able to directly assess the impact of combining group CBT and SCT to treat adolescent anxiety. However, the manuals may be used to guide treatment in a controlled study in the future to directly examine the outcome of combining these treatment modalities. The treatment manuals were also developed at the request of the agency that they are intended to serve. Existing manuals for adolescent anxiety CBT groups were out-of-date, and the new manuals were intended to complement current practices at the agency. The updated manuals might also help to ensure that group facilitators implement practices based on the most recent evidence in the literature. Group facilitators are responsible for selecting and implementing appropriate methods of content delivery (i.e., readings, audio CDs, group discussion), as well providing clients with further explanations for group activities. Therefore, the student researcher’s intention was to create manuals for group facilitators that can effectively guide the treatment process, rather than providing detailed instructions for treatment delivery.

Description of Services at Target Agency

The client and therapist treatment manuals were developed for use at an outpatient psychiatric setting that serves children and adolescents of a small city. This agency provides services to children and adolescents between the ages of four and 18 who are diagnosed with various psychiatric disorders. The agency is staffed by numerous professionals of various disciplines and specialities, such as psychiatrists, behaviour therapists, social workers, dieticians, nurse practitioners, psychologists, and occupational therapists. This multidisciplinary team allows for a range of outpatient services, including: neuro-developmental services, community classrooms, urgent care consultation, and a variety of individual and group-based interventions for mood disorders, eating disorders, and anxiety disorders.

Intended Treatment Format

The client and therapist treatment manuals were developed for use by the behaviour therapist and social worker who facilitate adolescent anxiety CBT. There are typically three separate CBT groups conducted simultaneously at the agency to serve different age groups (i.e., 11-12, 13-15, and 16-18 years of age). Each group provides treatment to approximately five to 10 participants, who are expected to attend 10 weekly 90-minute group sessions. The first seven sessions are reserved for the delivery of group CBT, while the final three sessions are focused on SCT. Each session includes a combination of didactic instruction and group discussion. This treatment protocol may vary depending on the preferences of group facilitators and needs of specific groups of clients.
**Target Population**

The adolescent anxiety CBT groups are intended to serve youth who are 11 to 18-years-old, male or female, and diagnosed with an anxiety disorder specified by the Diagnostic and Statistical Manual of Mental Disorders. To be offered treatment, an individual must obtain a diagnosis and referral from a psychiatrist. Individuals who are referred to the groups may have a co-occurring depressive disorder; however, depression should not be the primary disorder of concern. Further, adolescents included in the groups must be able to comprehend the material they are taught and independently complete assigned homework. The treatment outlined in the manuals is not appropriate for individuals who have cognitive impairments that would inhibit homework comprehension.

In addition to the aforementioned requirements, group facilitators must use their clinical judgement to determine if an individual is well-suited for group CBT. For example, it may not be beneficial to place an individual with poor social skills into group-based treatment. Further, participants must verbally agree to receive group-based CBT. When the individual is under 16 years of age, formal written consent must be obtained from his or her legal guardian prior to treatment; individuals who are 16 years of age or older may provide their own written consent. If an individual is not well-suited for group CBT, or does not agree to receive group-based treatment, he or she can be offered individual CBT or be referred to more appropriate services.

The treatment manuals were also developed for use by the professionals who provide treatment to the target client population. Since SCT is a relatively new practice, it would not be reasonable to expect that professionals would have a great deal of experience in the delivery of SCT. It is recommended that group facilitators are familiar with mindfulness training, as well as the CBT strategies included in the treatment manuals, as they are standard evidence-based practices. In other words, the intervention strategies outlined in the manuals should only be provided by individuals who are competent in delivering group CBT and in treating adolescents who have anxiety.

**Composition of Manuals**

To develop the treatment manuals, the student researcher conducted an extensive review of the literature and observed the adolescent anxiety CBT groups held at the agency. Also, the group facilitators provided the student researcher with past session outlines and handouts, along with new SCT materials to be modified for use in the treatment manuals. Based on suggestions from the literature and group facilitators, the following major topics were incorporated into the treatment manuals: the CBT model, thought monitoring, goal setting/behavioural challenges, cognitive challenges, relaxation exercises, mindfulness techniques, and self-compassion strategies. The first two sessions focus on the CBT model and steps to establishing behavioural goals. Sessions three and four are mainly concerned with the introduction of thought monitoring, while cognitive challenges are outlined in sessions five through seven. Finally, mindfulness and self-compassion strategies are the focus of sessions eight through ten. Relaxation strategies and behavioural challenges are covered intermittently throughout treatment. Although these topics are not explained in great length in the manuals, there are somewhat detailed outlines of content to be covered in each session, as well as handouts to be included in each session.
The therapist treatment manual includes an additional list of tips for facilitators to provide more effective treatment, which was gathered from the literature and suggestions from group facilitators. The client treatment manual also contains two informative brochures regarding CBT and anxiety, as well as the Self-Compassion Scale (SCS) (Neff, 2003) (Appendix A), which is a 26-item questionnaire used to measure self-compassion in individuals 14 years of age and older. In terms of reliability, the SCS has been found to have an internal consistency of .92 and test-retest reliability of .93 (Neff, 2003). In a test of construct validity, the SCS was found to have a significant negative correlation with the Self-Criticism subscale of the Depressive Experiences Questionnaire (DEQ) (.65), a significant positive correlation with the Social Connectedness scale of the DEQ (.41), and a significant positive correlation with the Trait-Meta Mood Scale (.55).

Group facilitators at the agency also require clients to complete the Beck Youth Inventories (BYI) (Beck, Beck, Jolly, & Steer, 2005) as a measure of their anxiety, depression, self-concept, anger, and disruptive behaviour before and after treatment. The BYI is a 100-item, norm-referenced diagnostic scale appropriate for assessing youth seven to 18 years of age (Community-University Partnership for the Study of Children, Youth, and Families, 2011). In terms of reliability, the BYI has yielded an internal consistency correlation coefficient ranging from .86 to .96, and a test-retest reliability correlation coefficient in the ranges of .74 to .93 depending on age (i.e., reliability increased as age of test completers increased). Validation studies have found the BYI to have strong convergent validity with: the Children’s Depression Inventory (correlation coefficient of .67 to .76); the Revised Children’s Manifest Anxiety Scale (.64 to .70); and the Piers-Harris Children’s Self-Concept Scale (.61 to .77). Because the BYI is a restricted test (i.e., can only be purchased and used by an individual with a master’s degree in a field closely related to the intended use of the test), it was not included the client manual. A description of the BYI can be found in Appendix B. In composing the treatment manuals, the student researcher’s overall aim was to ensure that the manuals would suit the needs of the agency and its clients, while including the most up-to-date evidence-based practices.

Operational Definitions

The strategies outlined in the manuals are meant to target increased self-compassion and reduced anxiety. Descriptions of each of these target behaviours are provided below.

Anxiety (decelerate). Anxiety (Lindsay, Paulhus, & Nairne, 2006, p. 572) involves persistent and pervasive worry, fear, and apprehension that manifest into: negative thoughts (i.e., thoughts of apprehension, fearful anticipation of worst possible outcomes, etc.); negative emotions (i.e., depression, fear, frustration, etc.); maladaptive behaviours (i.e., avoidance or escape of feared stimuli, self-harm, etc.); and/or physiological symptoms (i.e., shallow breathing, muscle tension, fatigue, etc.). To be considered manifestations of anxiety, the aforementioned symptoms must have no other explained origins (i.e., medical condition), should not be isolated events, and need to result in some impairment in everyday functioning (i.e., poor school attendance).

Self-compassion (accelerate). Self-compassion is the act of being compassionate towards one’s self during perceived occurrences of failure or states of general suffering (Germer & Neff, 2013). Self-compassion involves: practicing self-kindness versus self-criticism; being
mindful by accepting aversive events as they are, instead of avoiding or escaping them; and recognizing suffering and failure as aspects of common humanity rather than as abnormal, isolated events (Germer & Neff, 2013; Gilbert & Procter, 2006). To be self-compassionate does not mean to suppress or avoid negative emotions or thoughts, or to replace them with unrealistic positive emotions or thoughts.

**Evaluation of Manuals**

The treatment manuals were evaluated through feedback provided by the group facilitators who lead the targeted adolescent anxiety CBT groups. This feedback was obtained on an ongoing basis throughout the treatment process. The facilitators were asked to critique the content, comprehensiveness, usability, and organization of the treatment manuals. Unfortunately, due to time and research constraints, the treatment manuals could not be formally evaluated. Appendix C contains a brief questionnaire that can be completed by future group participants to provide facilitators with some insight regarding their perceptions of the value and usefulness of the manuals. It would be beneficial for group facilitators to make changes to the treatment manuals based on client feedback. Modifications may also be necessary depending on the overall impact of treatment on clients’ levels of anxiety and self-compassion. If clients do not demonstrate significant increases in self-compassion or reductions in anxiety, the content may be altered to allow for more effective treatment. This matter will likely be further explored in a controlled pilot study conducted to directly assess the effects of this treatment protocol.
Chapter IV: Results

The ‘Adolescent Anxiety CBT and SCT Group: Therapist Manual’ can be found in Appendix C. The therapist manual includes session outlines along with corresponding handouts, a list of resources, a treatment manual feedback form, and a list of tips for group facilitators to guide more effective intervention. The manual incorporates a number of cognitive-behavioral and self-compassion strategies aimed at reducing adolescent anxiety and increasing self-compassion. Such strategies include: thought monitoring, goal setting, cognitive challenges, relaxation exercises, mindfulness techniques, and self-compassion strategies.

In addition, the ‘My Anxiety Group Manual’ can be found in Appendix D. This manual is intended for use by participants of adolescent anxiety CBT and SCT groups. The client manual includes session outlines, handouts, and further information regarding CBT for adolescent anxiety. Although the information in the client manual is less detailed, the materials included in the client manual correspond to the content of the therapist manual.
Chapter V: Discussion

Overview

Anxiety is a highly prevalent and problematic mental health disorder among adolescents. Without effective treatment, adolescent anxiety is likely to continue into adulthood, and the associated social, physical, and cognitive symptoms may exacerbate. For these reasons, continued research on effective treatment for adolescent anxiety is of importance. Based on support from the literature, combining group CBT with SCT may lead to improved treatment outcomes for adolescent anxiety. For years, CBT has been considered the gold-standard treatment for anxiety. However, CBT alone usually does not lead to a cessation of symptoms (Ginsburg et al., 2011). Therefore, adolescents with anxiety might further benefit from treatment that combines CBT with other evidence-based strategies, such as SCT. In other words, combining standard group CBT with SCT may strengthen the overall success of treatment.

The goal of this thesis was to develop corresponding client and therapist treatment manuals that would aid professionals in the facilitation of group CBT combined with SCT for adolescent anxiety. These manuals were requested and intended for use by facilitators of adolescent anxiety CBT groups at a specific outpatient psychiatric setting. The final treatment manuals are a reflection of materials and feedback provided by the group facilitators, as well as recent research. It was important for the student researcher to develop manuals that outlined strategies consistent with evidence-based research, while meeting the specific needs of group facilitators and participants at the agency.

Contribution to the Behavioural Psychology Field

In addition to implementing the manuals at the agency, they might also be used to facilitate treatment in a pilot study that directly tests the effects of combining group CBT with SCT for adolescent anxiety. The findings of such a study could have important implications for the field of behavioural psychology. If the results were to indicate that SCT is a beneficial addition to group CBT, it would likely promote further research on the application of this treatment protocol. Such advancements could bring about improved treatment for individuals with mental health disorders in the future.

Strengths

The greatest strength of the present thesis is that the treatment manuals have attempted to be consistent with empirical literature, which asserts that group CBT and SCT are both effective strategies for reducing anxiety and improving psychological well-being. Further, the manuals combine two evidence-based strategies that have not previously been integrated as treatment for anxiety. Combining treatment techniques may improve outcomes for adolescents with anxiety while meeting a growing need for effective treatments with adolescents. Although this thesis did not directly test the effects of group CBT combined with SCT for adolescent anxiety, the development of the treatment manuals can be considered a preliminary step towards research in this area.

Another strength of the present thesis is the direct benefits that the treatment manuals can provide to the agency for which they were developed. In addition to providing a guide for the
delivery of group CBT combined with SCT, the manuals should aid group facilitators in delivering consistent treatment across client groups. Further, the client manual can provide group participants with portable treatment information that can be applied during therapy sessions and in everyday life. Having treatment materials available at home might increase participants’ use of therapeutic strategies across a variety of settings, facilitating a more enriching treatment experience.

There are also strengths to the specific treatment plan outlined in the manuals. First, the treatment plan includes a wide range of activities and strategies, such as videos, group discussions, experiential exercises, readings, and games. Having a variety of activities might help to increase and maintain group participants’ interest and engagement during the treatment process. A second strength of the treatment plan is the inclusion of an initial parent session. As noted, therapy tends to be more effective when adolescents’ parents support treatment and have some involvement in the process.

**Limitations**

Despite its strengths, there are several limitations to this thesis. The most significant limitation is the lack of formal research on the effectiveness and usability of the treatment manuals. The student research initially planned to obtain feedback from group participants at the agency of interest, as well as from an expert in the field of CBT. However, this was not possible due to time and research constraints. Without this information, it is difficult to assess the overall usefulness and effectiveness of the manuals, or determine specific areas for improvement.

There are also some weaknesses in the treatment plan outlined in the manuals. First, the treatment plan does not include strategies for evaluating group participants’ comprehension of mindfulness and self-compassion. While participants’ understanding of CBT concepts can be assessed through a review of completed homework, this would be difficult for SCT because it is experiential in nature. Another weakness of the outlined treatment is that it only includes three SCT sessions, whereas previous successful SCT programs included eight to 10 sessions. While the number of CBT sessions might be sufficient to reduce group participants’ anxiety, three SCT sessions may not be adequate to significantly improve the effects of standard group CBT. Unfortunately, it might be impractical to include additional sessions due to time and financial constraints faced by group facilitators. It is possible that it would be more advantageous to combine both modalities into each treatment session.

A final limitation is that while the strategies included in the manuals are based on empirical findings, much of the available literature uses adult participants. The SCT activities included in the treatment manuals are based on strategies that have been successfully implemented with adults, but not with adolescents. Therefore, even if SCT is a beneficial addition to group CBT for adolescent anxiety, the techniques outlined in the manuals may require further modification. These challenges to the practicality of the manuals highlight the significant need for this treatment approach to be evaluated through a controlled study.
Multilevel Challenges

There are several challenges involved in developing treatment manuals and delivering group therapy for adolescents with anxiety. At the client level, a challenge common to any type of treatment is the client’s motivation to participate. No matter what modality is implemented, without client involvement, treatment is unlikely to be effective. While there are strategies for increasing motivation, it is possible that clients will continue to resist treatment. Another challenge specific to providing treatment in a group format is the inability to tailor treatment to each participant. This increases the risk of individual participants’ needs not being met, as well as the potential for drop-out. Another challenge is that although adolescents might be close in age, they may be at varying stages of development. This often requires facilitators to conduct several treatment groups to minimize developmental differences between participants. Additionally, the social climate among group participants can vary between treatment groups. Social climate can be impacted by several factors, such as the level of group participation, the male to female participant ratio, or the climate of the therapeutic relationship. These differences among group members and between treatment groups make it necessary for therapeutic strategies to be modified for each group of participants. Unfortunately, the demands of modifying strategies for every group can be challenging for group facilitators. Mental health agencies often face challenges related to funding and staffing despite a high volume of clients. These challenges limit the time and resources that group facilitators have to adequately modify treatment between groups, which can pose a threat to the overall success of treatment.

Recommendations

The hypothesis of the present thesis could not be directly tested due to time limitations. It would be of value for a pilot study to be conducted to determine how beneficial the addition of SCT is to standard group CBT for adolescent anxiety, and specifically what SCT strategies are effective with adolescents. A between-group experimental research design would likely be the strongest method for testing this treatment. An ideal study would involve a comparison between the outcomes of participant groups that either receive the combination treatment, CBT or SCT alone, or no treatment (control group). It would also be helpful for a future study to evaluate the acceptability and feasibility of this combination treatment. Given that SCT is a relatively new practice in Western psychology, it would be useful to know how favourably (or unfavourably) it is perceived by group participants, facilitators, and parents, especially since this view can directly influence treatment effectiveness. Additionally, it would be beneficial to determine how many SCT sessions are necessary for treatment to show significant improvements over standard group CBT, as this could directly impact the feasibility of this combination treatment.

To improve the treatment manuals, it is also recommended that future research include the collection of participant and facilitator feedback. A participant feedback survey, for example, could be a simple and cost-effective method for collecting feedback on the manuals, but verbal feedback could be useful as well. Further, it would be valuable to have group participants report how often they use their treatment manual outside of therapy sessions. Group facilitators may use this information to determine if the client manual is useful to participants outside of sessions, and assess the maintenance and generalization of treatment effects. Participant feedback could help facilitators modify the manual to promote its use and application in everyday life.
References


Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles?. *Psychological Science in the Public Interest, 4*(1), 1-44.


Appendix A: Self-Compassion Scale

**HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES**

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost</th>
<th>Always</th>
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<tr>
<td>never</td>
<td>always</td>
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<td>1</td>
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1. I’m disapproving and judgmental about my own flaws and inadequacies.
2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I’m feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I’m intolerant and impatient towards those aspects of my personality I don’t like.
12. When I’m going through a very hard time, I give myself the caring and tenderness I need.
13. When I’m feeling down, I tend to feel like most other people are probably

---

happier than I am.

14. When something painful happens I try to take a balanced view of the situation.

15. I try to see my failings as part of the human condition.

16. When I see aspects of myself that I don't like, I get down on myself.

17. When I fail at something important to me I try to keep things in perspective.

18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.

19. I'm kind to myself when I'm experiencing suffering.

20. When something upsets me I get carried away with my feelings.

21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

22. When I'm feeling down I try to approach my feelings with curiosity and openness.

23. I'm tolerant of my own flaws and inadequacies.

24. When something painful happens I tend to blow the incident out of proportion.

25. When I fail at something that's important to me, I tend to feel alone in my failure.

26. I try to be understanding and patient towards those aspects of my personality I don't like.
Appendix B: Description of Beck Youth Inventories

Early Childhood Measurement and Evaluation Tool Review

Early Childhood Measurement and Evaluation (ECME), a portfolio within CUP, produces Early Childhood Measurement Tool Reviews as a resource for those who conduct screening, assessment, and evaluation. To learn more about ECME and CUP, provide feedback, or to access additional reviews, visit our website at www.cup.ualberta.ca or email us at cup@ualberta.ca

Beck Youth Inventories – For Children and Adolescents 2nd Edition (BYI-II)

Measurement Areas and Purpose:
The Beck Youth Inventories 2nd Edition (BYI-II) is a set of norm-referenced diagnostic scales designed to assess children and youth between the ages of 7 and 18, in five areas:

1) Depression
2) Anxiety
3) Anger
4) Disruptive behavior
5) Self-concept

Length and Structure:
Each inventory in the BYI-II takes approximately 5-10 minutes to administer. The full “combination” inventory that includes all five scales takes approximately 30-60 minutes to administer. Each inventory consists of 20 items that are self-rated on a 4-point scale of 0 to 3. Total raw scores can range from 0 to 60 for each scale, and converted to T-scores, cumulative percentages, descriptive classifications, and scale profiles.

Materials:
The publisher classifies the BYI-II as a “C-level” qualification. The publisher requires the purchaser to fit into one of the following categories: (a) trained and certified by a recognized institution in a relevant area of assessment (with or without a Master’s degree), (b) a member of the American Speech-Language-Hearing Association or the American Occupational Therapy Association, or (c) possess a Master’s (or Doctorate) degree in psychology, education, or relevant field with training in assessment.

C-Level tests require verification of a doctorate in psychology, education, or a related field or licensure. If you have certification by a provincial College of Psychology (College of Alberta Psychologists) or are a member of a provincial or national organization, such as the Canadian Psychological Association (CPA), the Canadian Register of Health Service providers in Psychology, or a member of the Canadian Association of Occupational Therapists or Canadian Association of

(Community-University Partnership for the Study of Children, Youth, and Families, 2011)
Appendix C: Treatment Manual Feedback Form

You are a (check one):

☐ Therapist/ CBT Group Facilitator

☐ Researcher

☐ CBT Group Participant

Was the treatment manual you were provided easy to use or follow?

☐ Yes

☐ No

☐ Somewhat

Was the treatment manual you were provided organized and complete?

☐ Yes

☐ No

☐ Somewhat

Was the information and instructions contained in the manual clear and comprehensive?

☐ Yes

☐ No

☐ Somewhat

Do you think that the treatment manual was useful and helpful?

☐ Yes

☐ No

☐ Somewhat

Please suggest any improvements that might make the manual more useful or helpful.

____________________________________________  __________________________________
Appendix D: Adolescent Anxiety CBT and SCT Group: Therapist Manual

Disclaimer: This manual was created in partial fulfilment of an applied thesis. The manual should not be implemented without permission from the author.
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Introduction

The Adolescent Anxiety CBT Group Treatment Manuals were developed at the request of professionals who facilitate cognitive-behavioural therapy (CBT) groups for adolescent anxiety in an outpatient psychiatric setting. Given the increasing prevalence of anxiety in adolescents and the problems associated with the disorder, there is a need for enhanced treatment for this client population. Thus, the manuals outline treatment that combines standard group CBT practices with a relatively new evidence-based technique, self-compassion training (SCT). The treatment manuals serve as guides for the delivery of group CBT and SCT for adolescents (11 to 18-years-old) diagnosed with anxiety disorders. The manuals contain outlines of 10 1.5-hour therapy sessions, as well as corresponding handouts for session activities. The therapist manual also contains facilitator tips and resources (i.e., suggested materials and further instructions for group activities). Treatment should be implemented by professionals who are trained and experienced in the delivery of CBT and SCT. If procedures outlined in the manuals are outside a professional’s scope of competent practice, further training and professional consultation should be obtained, or treatment should be modified. In some cases, treatment modification might also be necessary to suit the needs of the group.

For more information, please contact:

Courtney Jackson [B.A.A Psychology]
Email: courtney.jackson@hotmail.com
Parent Session

**Purpose:** Invite parents of group members to attend an information session to provide psychoeducation and an overview of treatment.

**Materials Required:** Presentation materials (e.g., slideshow presentation, projector, pamphlets, etc.)

1. **Psychoeducation.**
   - Educate parents on:
     a) What anxiety is and how it manifests
     b) The cycle of experience (“CBT Model”)
     c) Common cognitive distortions

2. **Overview of Treatment.**
   - Review goals of treatment (i.e., improving management of anxiety and performance during stressful situations)
   - Review roles and expectations of parents and group members (i.e., weekly attendance, homework completion)

3. **Questions.**
   - Address parents’ questions and concerns and provide contact information for further questions/concerns.
Session One

Materials required: Group binders with handouts (Getting to know you, Why I get Anxious, Cognitive Behavioural Therapy (CBT) Model, Body Map, Behaviour Report, Autonomic Nervous System, SMART Goals), pencils, Cognitive Behavioural Therapy Group Contract, Beck Youth Inventory, Self-Compassion Scale, body scan CD, CD player deep breathing CD, reinforcers (i.e., stickers)

1. Assessment.
   - Each group member required to complete Beck Youth Inventory (Beck, Beck, Jolly, & Steer, 2005) and Self-Compassion Scale (Neff, 2003)

2. Contract.
   - Review “Group Contract” and ask group members to sign contract

3. Introductions (Ice Breaker).
   - Form dyads and have each group member take a turn interviewing his or her partner by using and completing the “Getting to know you” handout

4. Review CBT anxiety model.
   - Introduce CBT, explaining premise and application to treatment
   - Discuss handouts “Why I get Anxious” and “The Cognitive Model”

5. Body Map Exercise.
   - Explain physical manifestations of anxiety using “Body Map” handout and “Autonomic Nervous System” diagram

6. Smart Goals.
   - Explain importance and process of goal setting using “SMART Goals” handout

7. Body Scan
   - Brief guided body scan (Vidyamala, 2008)

8. Assigned Homework.
   - Practice deep breathing technique using provided audio CD (Weil, 2001)
     - Briefly explain importance of practicing deep breathing daily
   - “Behaviour Report” handout
   - Identify two potential goals for treatment using “Smart Goals” criteria

Cognitive Behavioural Therapy
Group Contract

I understand and agree to the following:

1. I plan to attend every session and if I cannot attend, I will inform the group leader in advance.

2. I will maintain strict confidentiality regarding what I hear from others in the group, including the identity of group members.

3. I will contribute to a climate of support and respect.

4. Group sessions will begin and end on time.

5. I will complete the homework as assigned each week. I understand that working outside the group is an essential component in making changes.

Name of group member: _____________________________

Date: ___________________________
Getting to Know You!

Interview your partner to find out the answers to the following questions.

1. How old are you?

2. What school do you go to?

3. What is your favourite subject?

4. What do you like most about your school?

5. What do you like least about your school?

6. Do you have any hobbies?

7. What kind of music do you like?

8. What is your favorite band?

9. What is your favorite TV show?

10. What is your favourite food?
Cognitive Behavioural Therapy (CBT) Model
Why I get Anxious

Causes

Biological:
- Genetics
- Biochemical irregularities
- Sensitivity

Environmental:
- Negative experiences
- Learning by example
- Misinformation

Misperceptions of Threat:
- Exaggerations of probability and severity

Maladaptive Coping:
- Avoidance
- Worry
- Self-Preoccupation

Maintenance

FEAR SOMETHING BAD MIGHT HAPPEN
Circle the words that describe how you feel when you are anxious.

- Headache
- Tearful
- Breathless
- Sweaty
- Dizzy
- Nauseous
- Sore stomach
- Faint
- Racing heart
- Dizzy
- Tingly
- Cold
- Hot
- Weak
- Tense

Put an X where you feel physical symptoms when you are anxious.
Thought

Autonomic Nervous System

DANGER

Sympathetic Nervous System

Fight/Flight Response

SAFE

Parasympathetic Nervous System

Relaxation Response

Break-In

Hide

Heart racing, sweating

Anxious, Scared

Cat

Sleep

Heart racing → Relaxed

Annoyed

BREATHE
SMART Goals

Once you have decided what you want to change, the first step is to develop your goals. Goals clarify exactly what it is that you want to change. Goals act like a road map, guiding you where you want to go. However, it is important to set SMART goals.

*This means that the goals are:*

**S**- specific, significant, stretching

**M**- measurable, meaningful, motivational

**A**- agreed upon, attainable, achievable, acceptable, action-oriented

**R**- realistic, relevant, reasonable, rewarding, results-oriented

**T**- time-based, timely, tangible, trackable

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Agreed Upon</th>
<th>Realistic</th>
<th>Time-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Well defined</td>
<td>• Know if the goal is attainable and how far away completion is</td>
<td>• Discussed with anyone required to assist with its completion</td>
<td>• Within the availability of resources, time, and knowledge</td>
<td>• Adequate time to achieve goal</td>
</tr>
<tr>
<td>• Clear to anyone</td>
<td>• Know when goal has been achieved</td>
<td></td>
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</tbody>
</table>
Behaviour Report

Recall a time when you did something you were proud of. Reflect using the following questions:

- How did you manage to do it?

- What strengths or skills did you use to accomplish it?

- Why was this important to you?

- How did you feel before you did it?

- What did you think about yourself afterwards?
Session Two

Materials required: Group handouts (Small Steps, Steps to Completing Goal, Steps to Completing Goal example), pencils, yoga mats, CD player, Body Scan CD, COMP assessment (“My Anxiety Group Goals”), reinforcers (i.e., stickers)

1. Check-In.
   - Each group member required to say one thing about his or her day or week
   - Any new members should complete contract and assessments from first session

2. Homework Review.
   - Review deep breathing, asking each group member to demonstrate proper technique
   - Provide feedback and corrections on breathing technique (based on instructions provided by audio CD)

   - Discuss the principles of goal setting, as well as expectations for group members in working toward their goals
   - Ask each group member to rate his or her goals using COMP assessment (“My Anxiety Group Goals” handout)
   - Introduce “Small Steps” handout, discussing importance of breaking goals down into small steps
   - Discuss exemplary “Steps to Completing Goal” handout
   - Have group members complete “Steps to Completing Goal” handout in dyads

   - Ask group members to brainstorm and identify coping strategies (as a group)

5. Relaxation Exercise
   - Brief guided body scan (Vidyamala, 2008)
   - Follow with a discussion of what group members noticed during the body scan

6. Assigned Homework.
   - Practice focused breathing with shortened body scan using provided audio CD
   - Practice coping strategies identified in session (once daily)
   - Complete step one of goal developed in session
   - Complete “Steps to Completing Goal” handout for one additional goal

7. Close.
# My Anxiety Group Goals

<table>
<thead>
<tr>
<th>Goals</th>
<th>How important is this to me?</th>
<th>How well do I think I perform this behaviour?</th>
<th>How satisfied am I with how I perform this behaviour?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
<td>Before</td>
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</table>
Small Steps

Sometimes starting a new activity can seem like too large of a step to tackle in one go.

* At these times it might be useful to break down the task into smaller steps
* Smaller steps can make your goal feel more manageable
* This increases your chances of success

Rebecca wanted to get her driver’s licence

Rebecca has been wanted to get her driver’s licence for a while, but over the past year she has felt too anxious to take the necessary steps. In fact, when she thought about it, she realized that there are a number of things she hasn’t done over the past while because she has felt anxious. Rebecca listed all of the things she would like to achieve and chose getting her driver’s licence as her top priority. Although she wanted to do it, the thought of getting her licence seemed like a really big challenge. Rebecca decided to break this task down into a number of small steps that she felt she could handle.
**Steps to Completing Goal**

Break down your CBT group goal into as many small steps as possible. Rate the level of anticipated anxiety for the completion of each step.

**My goal is to:**

<table>
<thead>
<tr>
<th>Steps</th>
<th>Activity/Situation</th>
<th>Anticipated Anxiety Level (0-10)</th>
<th>Coping Strategies Used</th>
<th>Actual Anxiety Level (0-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<td>10</td>
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</table>
Steps to Completing Goal Example

Break down your CBT group goal into as many small steps as possible. Rate the level of anticipated anxiety for the completion of each step.

**My goal is to:** Get my driver’s licence

<table>
<thead>
<tr>
<th>Steps</th>
<th>Activity/Situation</th>
<th>Anticipated Anxiety Level (0-10)</th>
<th>Coping Strategies Used</th>
<th>Actual Anxiety Level (0-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Purchase driver’s handbook</td>
<td>1</td>
<td>Positive self-talk</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Study driver’s handbook</td>
<td>3</td>
<td>Positive self-talk Deep breathing</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Take practice tests</td>
<td>4</td>
<td>Deep breathing</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Take written test</td>
<td>9</td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>Take driver’s ed course (in-class)</td>
<td>9</td>
<td></td>
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<tr>
<td>6</td>
<td>Practice driving in parking lot with parents</td>
<td>8</td>
<td></td>
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<tr>
<td>7</td>
<td>Practice driving on rural roads with parents</td>
<td>8</td>
<td></td>
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<tr>
<td>8</td>
<td>Practice driving with instructor (in-car)</td>
<td>9</td>
<td></td>
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<tr>
<td>9</td>
<td>Make road-test appointment</td>
<td>4</td>
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</tr>
<tr>
<td>10</td>
<td>Take road test</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Celebrate!</td>
<td>0</td>
<td></td>
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</tr>
</tbody>
</table>
Session Three

Materials required: Handouts (Single Incident Records), pencils, guided meditation CD, CD player, yoga mats, reinforcers (i.e., stickers)

Materials to collect: Goal sheets (to be photocopied)

1. Check-In.
   • Each group member required to say one thing about his or her day or week

2. Homework Review.
   • Each group member is asked to report progress on established behavioural goal

   • Each group member will identify a behavioural challenge for the upcoming week
   • Goal should be rated for anticipated anxiety
   • Provide support if necessary

   • Introduce and review importance and completion of “Single Incident Records” (SIRs)
   • Use guided group discussion to complete one SIR as an example

5. Relaxation Exercise.
   • Short guided meditation (Kabat-Zinn, 2007)

6. Assigned Homework.
   • Continue practicing coping skills
   • Practice Guided Meditation using audio CD
   • Complete SIRs for at least 4 events
   • Continue to complete challenges toward established behavioural goal

7. Close.
Single Incident Record

**Situation:** (What were you doing? Who were you with? What was happening?)
______________________________________________________________________________
______________________________________________________________________________

**Feelings:** (What emotions were you experiencing and how intense were they? [1-10])
______________________________________________________________________________
______________________________________________________________________________

**Negative Thought:** (What were you thinking and how much did you believe it? [1-10])
______________________________________________________________________________
______________________________________________________________________________

**Physical Body:** (What physical symptoms were present and how intense were they? [1-10])
______________________________________________________________________________
______________________________________________________________________________

**Behaviour:** (What did you do?)
______________________________________________________________________________
Session Four

**Materials required:** Handouts (Weekly Mood Records, Checklist of Cognitive Distortions, Can You Identify the Thinking Error?), pencils, reinforcers (i.e., stickers)

**Materials to collect:** Single Incident Records

**Prep work:** Prepare exemplary Mood Record

1. **Check-In.**
   - Each group member required to say one thing about his or her day or week

2. **Homework Review.**
   - Have each group member discuss progress toward behavioural goal and identify anticipated anxiety rating vs. actual anxiety rating
   - Collect Single Incident Records and provide feedback and corrections on their completion

3. **Behavioural Challenges.**
   - Each group member will develop a behavioural challenge for the upcoming week
   - Each member should rate challenge for anticipated anxiety
   - Provide support if necessary

4. **Cognitive Challenges.**
   - Introduce and explain thinking errors using “Checklist of Cognitive Distortions” handout
   - Have group members identify thinking errors on the “Can You Identify the Thinking Error?” handout (or example presented on flip-chart) through group discussion
   - Introduce Mood Records
   - Review exemplary Mood Record through guided group discussion

5. **Assigned Homework.**
   - Practice coping skills as needed
   - Use relaxation CDs as needed
   - Complete two Mood Record entries per day and identify thinking errors
   - Work toward established behavioural challenge

6. **Close.**
## Weekly Mood Records

<table>
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</tbody>
</table>

My emotional thermometer: describe the situation

1 - would be the saddest you could be ____________________________

4 - would be neutral __________________________________________

7 - would be the happiest could be ____________________________
### Checklist of Cognitive Distortions

<table>
<thead>
<tr>
<th>Distortion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All-or-nothing thinking</strong></td>
<td>Viewing things in absolute. Also known as “black-and-white” thinking.</td>
</tr>
<tr>
<td><strong>Over generalization</strong></td>
<td>Seeing a negative event as a never-ending pattern of defeat.</td>
</tr>
<tr>
<td><strong>Mental filter</strong></td>
<td>Dwelling on the negatives.</td>
</tr>
<tr>
<td><strong>Discounting the positives</strong></td>
<td>Insisting that positive qualities or accomplishments don’t matter or don’t count.</td>
</tr>
<tr>
<td><strong>Jumping to conclusions</strong></td>
<td>A) Mind-reading- Assuming that people are responding negatively to you without definite evidence.</td>
</tr>
<tr>
<td></td>
<td>B) Fortune-telling- Arbitrarily predicting negative outcomes.</td>
</tr>
<tr>
<td><strong>Magnification or minimization</strong></td>
<td>Blowing things out of proportion or shrinking their importance.</td>
</tr>
<tr>
<td><strong>Emotional reasoning</strong></td>
<td>Reasoning from how you feel: “I feel like a loser so I must be one.”</td>
</tr>
<tr>
<td><strong>“Should statements”</strong></td>
<td>Criticizing yourself (or others) with “shoulds”, “musts”, “oughts”, and “have tos”.</td>
</tr>
<tr>
<td><strong>Labelling</strong></td>
<td>Telling yourself, “I’m a jerk”, or “a loser”, or “stupid” instead of saying “I made a mistake”.</td>
</tr>
<tr>
<td><strong>Personalization and blame</strong></td>
<td>Blaming yourself for something that wasn’t entirely your responsibility, or blaming others and denying your role in the problem.</td>
</tr>
</tbody>
</table>

---

Can You Identify the Thinking Error?

Instructions: Each of the following maladaptive thoughts contains cognitive distortions. Can you guess the thinking error(s) for each thought?

I have to get 90% in Math this semester.

Something bad is going to happen.

I feel overwhelmed, therefore my problems are impossible to solve.

I’m not good at anything.

I’m the team captain. If I pushed the team harder we could have won the game.

I’m not in the mood to do anything, so I might as well just lie in bed all day.

My coach probably thinks I should quit the team.

I did well because it was an easy test.

My sister is the reason why my family can’t get along.

If I take the bus home I will have a headache for the rest of the night.

I’m a failure.

If my boyfriend/girlfriend breaks up with me my life will be empty.

If my friend was a better liar we wouldn’t have gotten caught.

I never go to the gym. People will think I’m weak or slow.

My anxiety will always get in the way.

My parents divorced because of me.

My teacher and peers said they liked my speech out of pity.

Only thin people are beautiful.
Session Five

Materials required: Handouts (Examining the Evidence, Weekly Mood Records, Mood Record Errors), pencils, reinforcers (i.e., stickers)

Materials to collect: Mood Records

Prep work: Prepare exemplary Mood Record common errors

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. Homework Review.
   - Each group member will discuss progress toward behavioural goal and identify anticipated anxiety rating vs. actual anxiety rating
   - Collect Mood Records and provide feedback and corrections on their completion
   - Have group members identify and discuss any errors on “Mood Record Errors” handout

   - Each group member will develop a behavioural goal for the upcoming week
   - Provide support if requested

   - Introduce challenges to thinking errors using “Examine the Evidence” handout
   - Form two groups and have one group identify evidence for a negative thought and the other group identify evidence against a negative thought

5. Assigned Homework.
   - Practice coping skills and use relaxation CDs as needed
   - Complete two Mood Record entries per day and identify thinking errors
   - Complete Examine the Evidence for two situations
   - Work toward established behavioural challenge

**Mood Record Errors**

Can you identify the errors in these mood record entries?

<table>
<thead>
<tr>
<th>Mood Rating (1-7)</th>
<th>Behaviour</th>
<th>Emotions</th>
<th>Physical Symptoms</th>
<th>What was I thinking about?</th>
<th>Thinking Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>B- Thinking</td>
<td>E- Anxious</td>
<td>PS- Headache</td>
<td>My future. School.</td>
<td>Fortune Telling, Overgeneralization, Mental Filter</td>
</tr>
<tr>
<td>2</td>
<td>B- Sitting at desk working on Math</td>
<td>E- Angry, anxious, sad</td>
<td>PS- Tense, shaky</td>
<td>Why do I always do stupid things? I’M SO ANNOYED!</td>
<td>Labeling</td>
</tr>
<tr>
<td>2</td>
<td>B- In French class receiving grade for group project</td>
<td>E- Angry</td>
<td>PS- Nothing</td>
<td>70% is an awful mark. My group members should have put more effort into their parts. This is really going to bring my grade down.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B- Looking at myself in the mirror</td>
<td>E- Crying</td>
<td>PS- Tears</td>
<td>I’m fat. Nobody will ever want me because I’m ugly. Only skinny people are beautiful.</td>
<td>Emotional Reasoning, Fortune Telling, All-or-Nothing</td>
</tr>
<tr>
<td>3</td>
<td>B- Walking into school alone</td>
<td>E- I’m stupid</td>
<td>PS- Shaky</td>
<td>I’m so embarrassed about falling in Gym class yesterday. Everyone must think I’m a loser.</td>
<td>Mind Reading, Labeling</td>
</tr>
</tbody>
</table>
Examining the Evidence

Negative Thought:
_________________________________________________

Thinking Error(s): _______________________

Belief in thought before (0-100%): __________

<table>
<thead>
<tr>
<th>Evidence For</th>
<th>Evidence Against</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Belief in thought after (0-100%): __________
Session Six

Materials required: Handouts (Weekly Mood Records, Independent Goal Setting, The Vertical Arrow Technique), pencils, reinforcers (i.e., stickers)

Materials to collect: Mood Records, Examine the Evidence

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. Discussion Dyads.
   - Group members will review progress towards goal in dyads and then report progress back to the group
   - Provide “Independent Goal Setting” handout to facilitate discussion between dyads

3. Homework Review.
   - Each group member will discuss progress toward behavioural goal and identify anticipated anxiety rating vs. actual anxiety rating
   - Collect Mood Records and provide feedback and corrections on their completion

   - Each group member will develop a behavioural goal for the upcoming week
   - Provide support if requested

   - Further discuss challenging thinking errors by introducing “Vertical Arrow” handout
   - Complete exemplary Vertical Arrow through group discussion

6. Assigned Homework.
   - Engage in relaxation exercises using CDs as required
   - Complete Mood Record entries once a day and identify thinking errors
   - Complete two Vertical Arrows
   - Work toward established behavioural goal

7. Close.
Independent Goal Setting

Last week, my goal was to:

__________________________________________________________________

Did I complete this goal? **YES or NO**

If no, why wasn’t I able to complete my goal?

__________________________________________________________________

What was my actual anxiety rating for this goal? **/10** (1=very easy 10=very difficult)

Did I use any relaxation techniques or coping strategies to reduce my anxiety? If yes, specify which techniques.

__________________________________________________________________

**With a partner**, brainstorm a new goal for this week. This goal could be an addition to last week’s challenge, or something new you would like to achieve.

My goal for this week is to:

__________________________________________________________________

My anticipated anxiety rating for this new goal is? **/10** (1=very easy 10=very difficult)
The Vertical Arrow Technique

Negative Automatic Thought:

How much do you believe this thought? ______ (0-100%)

Why would this be upsetting to me if it were true?

Why would this be upsetting to me if it were true?

Why would this be upsetting to me if it were true?

Why would this be upsetting to me if it were true?
Why would this be upsetting to me if it were true?

________________________________________________________________________

Why would this be upsetting to me if it were true?

________________________________________________________________________

Why would this be upsetting to me if it were true?

________________________________________________________________________

Why would this be upsetting to me if it were true?

________________________________________________________________________

How much do you believe this thought now? ______ (0-100%)
Session Seven

Materials required: Handouts (Pleasant Events Calendar, Independent Goal Setting, Double Standard), pencils, Beck Youth Inventory, Self-Compassion Scale, reinforcers (i.e., stickers)
Materials to collect: Mood Records, Vertical Arrow

1. Assessment.
   - Each group member required to complete Beck Youth Inventory (Beck, Beck, Jolly, & Steer, 2005) and Self-Compassion Scale (Neff, 2003)

2. Check-In.
   - Each group member required to say one thing about his or her day or week

3. Discussion Dyads.
   - Group members will review progress towards goal in dyads and then report progress back to the group
   - Provide “Independent Goal Setting” handout to facilitate discussion between dyads

   - Each group member will develop a behavioural goal for the upcoming week
   - Provide support if requested

5. Homework Review.
   - Collect Mood Records and provide feedback and corrections on their completion

   - Introduce “Pleasant Events Calendar” handout and explain its purpose
   - Further discuss challenging thinking errors by introducing “Double Standard” handout
   - Complete exemplary Double Standard through group discussion

7. Assigned Homework.
   - Engage in relaxation exercises using CDs as required
   - Complete daily Pleasant Events Calendar entries
   - Complete one Double Standard
   - Work toward established behavioural goal

8. Close
## PLEASANT EVENTS CALENDAR

**Instructions:** Over the next week, be aware of one pleasant event or occurrence each day. On this calendar record in detail what the event was and your experience of it.

<table>
<thead>
<tr>
<th>Day</th>
<th>Describe the experience/situation.</th>
<th>Did you notice pleasant feelings <em>while</em> the event was occurring?</th>
<th>How did your body feel during this experience? Describe physical sensations.</th>
<th>What feelings and thoughts did you experience while the event was happening?</th>
<th>What are your thoughts as you write this down?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONDAY</td>
<td></td>
<td></td>
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<tr>
<td>TUESDAY</td>
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<td>WEDNESDAY</td>
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<td>THURSDAY</td>
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<td>FRIDAY</td>
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<td>SATURDAY</td>
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<tr>
<td>SUNDAY</td>
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</tbody>
</table>
Instructions: Talk to yourself in the same compassionate way you might talk to your best friend who was upset.

Your Negative Thought:

________________________________________________________________________

Thinking Error(s):

________________________________________________________________________

How much do you believe your thought? _____ % (0-100%)

What could you say to a good friend if they had this thought? Remember to be honest.

1. ______________________________________________________________________

2. ______________________________________________________________________

3. ______________________________________________________________________

4. ______________________________________________________________________

5. ______________________________________________________________________

If you said these same compassionate statements to yourself, how much would you believe the negative thought now? _____ % (0-100%)
Session Eight

Materials required: Handouts (Pleasant Events Calendar, 9-Dot Exercise), pencils, boxes of raisins, Guided Meditation CD, CD player, reinforcers (i.e., stickers)

Materials to collect: Pleasant Events Calendar, Double Standard

1. Check-In.
   - Each group member required to say one thing about his or her day or week and report progress toward behavioural goal

2. Homework Review.
   - Collect Pleasant Events Calendar and Double Standard
   - Ask each group member to report examples of recorded pleasant events and compare completion of this handout to Mood Records (i.e., differences in thoughts, feelings, overall mood, or difficulty of task)

3. Introduction to Mindfulness.
   - Show “The Monkey Business Illusion” video (Simons, 2010) and ask group members to report their experience while watching the video
   - Using the video as an example, explain to the group the difference between thinking and perceiving

   - Facilitate Raisin Eating Exercise (Williams, Teasdale, Segal, & Kabat-Zinn, 2007) and ask group members to report sensory experiences during the exercise
   - Using the Raining Eating Exercise as an example, define and explain the concept of mindfulness

5. Listening Exercise.
   - Ask group members to deliberately focus attention listen to background noise for 5 minutes, and ring a bell to indicate the onset and offset of the exercise
   - Prompt group members to report their experience during the exercise (i.e., what sounds were heard, difficulty of the task)

   - Reiterate and summarize important points regarding mindfulness
   - Explain relevance of mindfulness in overcoming anxiety

7. Relaxation Exercise.
   - 20-Minute guided mindful meditation exercise (Neff, 2013)
8. **Assigned Homework.**
   - Complete daily Pleasant Events Calendar entries
   - Complete “9-Dot Exercise” handout
   - Practice guided mediation CD daily
9-Dot Exercise

Using the image below, try to connect all 9 dots with 4 straight lines, without taking your pen off the paper.
Session Nine

**Materials required:** Handouts (Self-Compassion Exercise), pencils, reinforcers (i.e., stickers)

**Materials to collect:** Pleasant Events Calendar

1. **Check-In.**
   - Each group member required to say one thing about his or her day or week

2. **Homework Review.**
   - Ask each group member to report experience in recording pleasant events
   - Provide answer to 9-dot exercise and ask group members to discuss the message behind the exercise (Kershaw & Ohlsson, 2004)

3. **Introduction to Compassion.**
   - Define compassion and explain the 3 core steps involved in compassion (i.e., mindfulness, common humanity, desire to alleviate suffering)
   - Ask group members to discuss experience being compassionate to others compared to experience being compassionate to self

4. **Introduction to Self-Compassion.**
   - Define self-compassion and discuss obstacles to being self-compassionate (i.e., culture, motivation, self-indulgence, weakness)
   - Contrast self-compassion and self-criticism (using examples), and explain difference between self-correction and self-criticism

5. **Assigned Homework.**
   - Practice self-compassion using “Self-Compassion Exercise” handout
   - Engage in relaxation exercises using CDs as required
Self-Compassion Exercise

When something happens over the next week that makes you feel sad or uncomfortable with yourself, see if you can take a few moments to extend to yourself some self-compassion. This exercise should take about 10-15 minutes to complete.

First, find a quiet place where you won’t be disturbed and turn off any possible distractions. Assume a comfortable upright position and simply let yourself settle into your body. Close your eyes. Take some deep breaths and with each exhalation, let go of any stress and bring your attention to the present moment.

Begin by imagining someone who cares deeply about you. If there is no one who comes to mind, you can think of a pet or a higher spiritual power. Notice what it is like to be with this person. Notice your thoughts and any physical sensations that emerge when you are thinking of this being.

Now imagine that this person begins to tell you that the same event that has made you sad or uncomfortable has happened to them. What would you do or say to them in response to what they are telling you? Come up with words or gestures that might make them feel better. Allow yourself to get a sense of what it is like to extend kindness and compassion to them.

Now imagine that your friend tells you that he or she feels much better and has to leave. As you watch them depart, you recall that you have also had this experience. See if you can allow yourself to continue to extend kindness to yourself. Try saying the same words to yourself or making small gesture that you gave to your friend - possibly giving yourself a soothing touch or engaging in a comforting behaviour. Notice how this makes you feel.

When you are ready, open your eyes and consider these questions:

* How is this experience different than how you usually respond to yourself?
* How did you feel physically and emotionally in your body as you did this?
* Which experience do you prefer?

---

Session Ten

1. **Check-In.**
   - Each group member required to say one thing about his or her day or week

2. **CBT and SCT Review.**
   - Summarize core principles and strategies of CBT
   - Review importance of continued use of coping strategies after treatment
   - Discuss steps for moving forward with behavioural goals
   - Summarize core components and significance of mindfulness and self-compassion

3. **Assessments.**
   - Each group member required to complete Beck Youth Inventory (Beck, Beck, Jolly, & Steer, 2005) and Self-Compassion Scale (Neff, 2003)

4. **“CBT Jeopardy”.**
   - Facilitate interactive game for review of core components of CBT and SCT

5. **Feedback.**
   - Each group member will complete written feedback form
   - Request each group member to report to the group one thing he or she gained from attending the group

6. **Close.**
   - Inform group members of individual feedback sessions and request attendance from group members and their parent(s).
Group Facilitator Tips

- Provide reinforcement for brave behaviour (e.g., volunteering to speak first or challenging anxiety) and homework completion.
- Use reinforcers such as stickers or stamps as tokens for more valuable reinforcers to increase participation.
- Hold a separate session for parents to introduce self, explain the type of therapy being provided, inform on the importance of attendance and homework completion, and answer any questions or concerns parents might have.
- While teaching strategies, ask group members to provide examples when possible and take turns reading handouts to encourage active involvement.
- Tailor activities and treatment structure to the climate and needs of the group. This might involve modifying the pace of treatment delivery, or incorporating different types of activities.
- Make group ‘fun’ by including art activities, interesting videos or readings, partner tasks, games, or role-plays.
- Refer to check-in as “Brag Time” to encourage members to report positive experiences.
- Have food and drink available to group members during sessions.
- Ask group members to provide advice or suggestions to one another when appropriate, or problem-solve as a group.
Resources


Treatment Manual Feedback Form

You are a (check one):

☐ Therapist/ CBT Group Facilitator
☐ Researcher
☐ CBT Group Participant

Was the treatment manual you were provided easy to use or follow?

☐ Yes
☐ No
☐ Somewhat

Was the treatment manual you were provided organized and complete?

☐ Yes
☐ No
☐ Somewhat

Was the information and instructions contained in the manual clear and comprehensive?

☐ Yes
☐ No
☐ Somewhat

Do you think that the treatment manual was useful and helpful?

☐ Yes
☐ No
☐ Somewhat

Please suggest any improvements that might make the manual more useful or helpful.

_________________________________________________________________________________
Disclaimer: This manual was created in partial fulfilment of an applied thesis. The manual should not be implemented without permission from the author.
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Introduction to CBT

What is CBT?
CBT stands for Cognitive Behavioural Therapy (cognitive being a fancy word for thoughts). CBT is focused on the interaction between a person’s thoughts, emotions, physical body, and behaviour. There is no exact formula to illustrate how they influence each other, but we do know that positive change in one area can lead to positive change in other areas. In other words, when a person experiences more accurate thoughts, engages in healthier behaviours, and takes care of his or her physical body, they tend to feel better in turn!

How can CBT help me?
It can be challenging to change the way we feel, think, and behave, which is why CBT aims to teach skills and strategies that can help individuals make positive change. These skills and strategies can be used in everyday life, beyond treatment. It would be unreasonable to expect that you would never experience anxiety again after receiving CBT (some anxiety is important for survival); but you might find that the anxiety you experience is more manageable with the skills and strategies you learn.

Does it work for everyone?
For years, CBT has been considered the “gold-standard” treatment for anxiety. There have been numerous studies conducted to test the effectiveness of CBT and the research has consistently demonstrated that individuals who undergo CBT often experience a significant reduction in anxiety. Of course, no treatment is the right fit for everyone. If you have questions or concerns, it is important to consult a health professional who is familiar with CBT, such as your psychiatrist or therapist.
Session One


11. Review and sign group contract.

12. Introductions (Ice Breaker).

13. Review CBT anxiety model.
   - Introduction to CBT premise and application

   - Explanation of physical manifestations of anxiety

15. Smart Goals.

16. Body Scan.

17. Assigned Homework.

18. Close.

Notes
Cognitive Behavioural Therapy
Group Contract

I understand and agree to the following:

6. I plan to attend every session and if I cannot attend, I will inform the group leader in advance.

7. I will maintain strict confidentiality regarding what I hear from others in the group, including the identity of group members.

8. I will contribute to a climate of support and respect.

9. Group sessions will begin and end on time.

10.I will complete the homework as assigned each week. I understand that working outside the group is an essential component in making changes.

Name of group member: ____________________________

Date: ____________________________
Getting to Know You!

*Interview your partner to find out the answers to the following questions.*

1. How old are you?

2. What school do you go to?

3. What is your favourite subject?

4. What do you like most about your school?

5. What do you like least about your school?

6. Do you have any hobbies?

7. What kind of music do you like?

8. What is your favorite band?

9. What is your favorite TV show?

10. What is your favourite food?
Cognitive Behavioural Therapy (CBT) Model
Why I get Anxious

**Causes**

**Biological:**
- Genetics
- Biochemical irregularities
- Sensitivity

**Environmental:**
- Negative experiences
- Learning by example
- Misinformation

**Misperceptions of Threat:**
- Exaggerations of probability and severity

**Maladaptive Coping:**
- Avoidance
- Worry
- Self-Preoccupation

**Maintenance**
Circle the words that describe how you feel when you are anxious.

Headache
Tearful
Breathless
Sweaty
Dizzy
Nauseous
Sore stomach
Faint
Racing heart
Dizzy
Tingly
Cold
Hot
Weak
Tense

Put an X where you feel physical symptoms when you are anxious.
Thought

Autonomic Nervous System

DANGER
Sympathetic Nervous System
Fight/Flight Response

SAFE
Parasympathetic Nervous System
Relaxation Response

BREATHE

Break-In
Hide
Heart racing, sweating
Anxious, Scared

Cat
Sleep
Heart racing → Relaxed
Annoyed
SMART Goals

Once you have decided what you want to change, the first step is to develop your goals. Goals clarify exactly what it is that you want to change. Goals act like a road map, guiding you where you want to go. However, it is important to set SMART goals.

This means that the goals are:

S- specific, significant, stretching
M- measurable, meaningful, motivational
A- agreed upon, attainable, achievable, acceptable, action-oriented
R- realistic, relevant, reasonable, rewarding, results-oriented
T- time-based, timely, tangible, trackable

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Agreed Upon</th>
<th>Realistic</th>
<th>Time-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Well defined</td>
<td>• Know if the goal is attainable and how far away completion is</td>
<td>• Discussed with anyone required to assist with its completion</td>
<td>• Within the availability of resources, time, and knowledge</td>
<td>• Adequate time to achieve goal</td>
</tr>
</tbody>
</table>
Behaviour Report

Recall a time when you did something you were proud of. Reflect using the following questions:

- How did you manage to do it?

- What strengths or skills did you use to accomplish it?

- Why was this important to you?

- How did you feel before you did it?

- What did you think about yourself afterwards?
Session Two

8. Check-In.
   • Each group member required to say one thing about his or her day or week

9. Homework Review.

10. Setting Goals.
    • Discuss the principles of goal setting and brainstorm possible behavioural goals

    • Brainstorm and identify coping strategies for anxiety (as a group)

12. Relaxation Exercise.
    • Brief guided body scan


Notes
### My Anxiety Group Goals

<table>
<thead>
<tr>
<th>Goals</th>
<th>How important is this to me?</th>
<th>How well do I think I perform this behaviour?</th>
<th>How satisfied am I with how I perform this behaviour?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
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</tbody>
</table>
Small Steps

Sometimes starting a new activity can seem like too large of a step to tackle in one go.

* At these times it might be useful to break down the task into smaller steps
* Smaller steps can make your goal feel more manageable
* This increases your chances of success

Rebecca wanted to get her driver’s licence

Rebecca has been wanted to get her driver’s licence for a while, but over the past year she has felt too anxious to take the necessary steps. In fact, when she thought about it, she realized that there are a number of things she hasn’t done over the past while because she has felt anxious. Rebecca listed all of the things she would like to achieve and chose getting her driver’s licence as her top priority. Although she wanted to do it, the thought of getting her licence seemed like a really big challenge. Rebecca decided to break this task down into a number of small steps that she felt she could handle.
Steps to Completing Goal

Break down your CBT group goal into as many small steps as possible. Rate the level of anticipated anxiety for the completion of each step.

My goal is to: ____________________________

<table>
<thead>
<tr>
<th>Steps</th>
<th>Activity/Situation</th>
<th>Anticipated Anxiety Level (0-10)</th>
<th>Coping Strategies Used</th>
<th>Actual Anxiety Level (0-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2</td>
<td></td>
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<td>3</td>
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<td>10</td>
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</tbody>
</table>
Steps to Completing Goal Example

Break down your CBT group goal into as many small steps as possible. Rate the level of anticipated anxiety for the completion of each step.

**My goal is to:** Get my driver’s licence

<table>
<thead>
<tr>
<th>Steps</th>
<th>Activity/Situation</th>
<th>Anticipated Anxiety Level (0-10)</th>
<th>Coping Strategies Used</th>
<th>Actual Anxiety Level (0-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Purchase driver’s handbook</td>
<td>1</td>
<td>Positive self-talk</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Study driver’s handbook</td>
<td>3</td>
<td>Positive self-talk</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Take practice tests</td>
<td>4</td>
<td>Deep breathing</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Take written test</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Take driver’s ed course (in-class)</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Practice driving in parking lot with parents</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Practice driving on rural roads with parents</td>
<td>8</td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>Practice driving with instructor (in-car)</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Make road-test appointment</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Take road test</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Celebrate!</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session Three

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. Homework Review.

   - Each group member will identify a behavioural challenge for the upcoming week

   - Introduction of “Single Incident Records” (SIRs)

5. Relaxation Exercise.
   - Short guided meditation

6. Assigned Homework.

7. Close.

Notes
Single Incident Record

Situation: (What were you doing? Who were you with? What was happening?)
__________________________________________________________________________
______________________________________________________________________________

Feelings: (What emotions were you experiencing and how intense were they? [1-10])
______________________________________________________________________________
______________________________________________________________________________

Negative Thought: (What were you thinking and how much did you believe it? [1-10])
______________________________________________________________________________
______________________________________________________________________________

Physical Body: (What physical symptoms were present and how intense were they? [1-10])
______________________________________________________________________________
______________________________________________________________________________

Behaviour: (What did you do?)
______________________________________________________________________________
______________________________________________________________________________
Session Four

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. Homework Review.

   - Each group member will develop a behavioural challenge for the upcoming week

   - Introduce to thinking errors and “Mood Records”

5. Assigned Homework.

## Weekly Mood Records

<table>
<thead>
<tr>
<th></th>
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<tbody>
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</tbody>
</table>

**My emotional thermometer: describe the situation**

1 - would be the saddest you could be __________________________

4 - would be neutral __________________________

7 - would be the happiest you could be __________________________
### Checklist of Cognitive Distortions

<table>
<thead>
<tr>
<th>Cognitive Distortion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All-or-nothing thinking</strong></td>
<td>Viewing things in absolute. Also known as “black-and-white” thinking.</td>
</tr>
<tr>
<td><strong>Over generalization</strong></td>
<td>Seeing a negative event as a never-ending pattern of defeat.</td>
</tr>
<tr>
<td><strong>Mental filter</strong></td>
<td>Dwelling on the negatives.</td>
</tr>
<tr>
<td><strong>Discounting the positives</strong></td>
<td>Insisting that positive qualities or accomplishments don’t matter or don’t count.</td>
</tr>
<tr>
<td><strong>Jumping to conclusions</strong></td>
<td>A) Mind-reading- Assuming that people are responding negatively to you without definite evidence.&lt;/br&gt;B) Fortune-telling- Arbitrarily predicting negative outcomes.</td>
</tr>
<tr>
<td><strong>Magnification or minimization</strong></td>
<td>Blowing things out of proportion or shrinking their importance.</td>
</tr>
<tr>
<td><strong>Emotional reasoning</strong></td>
<td>Reasoning from how you feel: “I feel like a loser so I must be one.”</td>
</tr>
<tr>
<td><strong>“Should statements”</strong></td>
<td>Criticizing yourself (or others) with “shoulds”, “musts”, “oughts”, and “have tos”.</td>
</tr>
<tr>
<td><strong>Labelling</strong></td>
<td>Telling yourself, “I’m a jerk”, or “a loser”, or “stupid” instead of saying “I made a mistake”.</td>
</tr>
<tr>
<td><strong>Personalization and blame</strong></td>
<td>Blaming yourself for something that wasn’t entirely your responsibility, or blaming others and denying your role in the problem.</td>
</tr>
</tbody>
</table>

---

Can You Identify the Thinking Error?

**Instructions:** Each of the following maladaptive thoughts contains cognitive distortions. Can you guess the thinking error(s) for each thought?

I have to get 90% in Math this semester.

Something bad is going to happen.

I feel overwhelmed, therefore my problems are impossible to solve.

I’m not good at anything.

I’m the team captain. If I pushed the team harder we could have won the game.

I’m not in the mood to do anything, so I might as well just lie in bed all day.

My coach probably thinks I should quit the team.

I did well because it was an easy test.

My sister is the reason why my family can’t get along.

If I take the bus home I will have a headache for the rest of the night.

I’m a failure.

If my boyfriend/girlfriend breaks up with me my life will be empty.

If my friend was a better liar we wouldn’t have gotten caught.

I never go to the gym. People will think I’m weak or slow.

My anxiety will always get in the way.

My parents divorced because of me.

My teacher and peers said they liked my speech out of pity.
Session Five

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. Homework Review.

   - Each group member will develop a behavioural goal for the upcoming week

   - Introduction to “Examine the Evidence”

5. Assigned Homework.

## Mood Record Errors

Can you identify the errors in these mood record entries?

<table>
<thead>
<tr>
<th>Mood Rating (1-7)</th>
<th>Behaviour</th>
<th>Emotions</th>
<th>Physical Symptoms</th>
<th>What was I thinking about?</th>
<th>Thinking Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>B- Thinking</td>
<td>E- Anxious</td>
<td>PS- Headache</td>
<td>My future. School.</td>
<td>Fortune Telling Overgeneralization Mental Filter</td>
</tr>
<tr>
<td>2</td>
<td>B- Sitting at desk working on Math</td>
<td>E- Angry, anxious, sad</td>
<td>PS- Tense, shaky</td>
<td>Why do I always do stupid things? I’M SO ANNOYED!</td>
<td>Labeling</td>
</tr>
<tr>
<td>2</td>
<td>B- In French class receiving grade for group project</td>
<td>E- Angry</td>
<td>PS- Nothing</td>
<td>70% is an awful mark. My group members should have put more effort into their parts. This is really going to bring my grade down.</td>
<td>Emotional Reasoning Fortune Telling All-or-Nothing</td>
</tr>
<tr>
<td>2</td>
<td>B- Looking at myself in the mirror</td>
<td>E- Crying</td>
<td>PS- Tears</td>
<td>I’m fat. Nobody will ever want me because I’m ugly. Only skinny people are beautiful.</td>
<td>Emotional Reasoning Fortune Telling All-or-Nothing</td>
</tr>
<tr>
<td>3</td>
<td>B- Walking into school alone</td>
<td>E- I’m stupid</td>
<td>PS- Shaky</td>
<td>I’m so embarrassed about falling in Gym class yesterday. Everyone must think I’m a loser.</td>
<td>Mind Reading Labeling</td>
</tr>
</tbody>
</table>
Examine the Evidence

Negative Thought:

_________________________________________________________________

Thinking Error(s): ______________________

Belief in thought before (0-100%): __________

<table>
<thead>
<tr>
<th>Evidence For</th>
<th>Evidence Against</th>
</tr>
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<tbody>
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</tbody>
</table>

Belief in thought after (0-100%): __________
Session Six

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. Discussion Dyads.
   - Group members will review progress towards goal in dyads and then report progress back to the group
   - Each group member will develop a behavioural goal for the upcoming week

3. Homework Review.

   - Introduction to “Vertical Arrow”

5. Assigned Homework.


Notes
Independent Goal Setting

Last week, my goal was to:
__________________________________________________________________
__________________________________________________________________

Did I complete this goal? YES or NO
If no, why wasn’t I able to complete my goal?
__________________________________________________________________

What was my actual anxiety rating for this goal? /10 (1=very easy 10=very difficult)

Did I use any relaxation techniques or coping strategies to reduce my anxiety? If yes, specify which techniques.
__________________________________________________________________

With a partner, brainstorm a new goal for this week. This goal could be an addition to last week’s challenge, or something new you would like to achieve.

My goal for this week is to:
__________________________________________________________________

My anticipated anxiety rating for this new goal is? /10 (1=very easy 10=very difficult)
The Vertical Arrow Technique

Negative Automatic Thought:

________________________________________________________________________

How much do you believe this thought? ________ (0-100%)

Why would this be upsetting to me if it were true?

________________________________________________________________________

Why would this be upsetting to me if it were true?

________________________________________________________________________

Why would this be upsetting to me if it were true?

________________________________________________________________________

Why would this be upsetting to me if it were true?
Why would this be upsetting to me if it were true?
________________________________________________________________________

Why would this be upsetting to me if it were true?
________________________________________________________________________

Why would this be upsetting to me if it were true?
________________________________________________________________________

Why would this be upsetting to me if it were true?
________________________________________________________________________

Why would this be upsetting to me if it were true?
________________________________________________________________________

How much do you believe this thought now? _______ (0-100%)
Session Seven

1. **Complete assessment questionnaires.**

2. **Check-In.**
   - Each group member required to say one thing about his or her day or week

3. **Discussion Dyads.**
   - Group members will review progress towards goal in dyads and then report progress back to the group
   - Each group member will develop a behavioural goal for the upcoming week

4. **Homework Review.**

5. **Cognitive Challenges.**
   - Introduction to “Pleasant Events Calendar” and “Double Standard”

6. **Assigned Homework.**

7. **Close.**

**Notes**
PLEASANT EVENTS CALENDAR

Instructions: Over the next week, be aware of one pleasant event or occurrence each day. On this calendar record in detail what the event was and your experience of it.

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>Describe the experience/situation.</th>
<th>Did you notice pleasant feelings while the event was occurring?</th>
<th>How did your body feel during this experience? Describe physical sensations.</th>
<th>What feelings and thoughts did you experience while the event was happening?</th>
<th>What are your thoughts as you write this down?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TUESDAY</td>
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<tr>
<td>WEDNESDAY</td>
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<td>THURSDAY</td>
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<td>FRIDAY</td>
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<tr>
<td>SATURDAY</td>
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<td></td>
</tr>
<tr>
<td>SUNDAY</td>
<td></td>
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</tbody>
</table>
The Double Standard

*Instructions:* Talk to yourself in the same compassionate way you might talk to your best friend who was upset.

**Your Negative Thought:**

________________________________________________________________________

**Thinking Error(s):**

________________________________________________________________________

How much do you believe your thought? ____ % (0-100%)

What could you say to a good friend if they had this thought? *Remember to be honest.*

1.  
   ______________________________________________________________________

2.  
   ______________________________________________________________________

3.  
   ______________________________________________________________________

4.  
   ______________________________________________________________________

5.  
   ______________________________________________________________________

If you said these same compassionate statements to yourself, how much would you believe the negative thought now? ____ % (0-100%)
Session Eight

1. **Check-In.**
   - Each group member required to say one thing about his or her day or week and report progress toward behavioural goal

2. **Homework Review.**

3. **Introduction to Mindfulness.**

4. **Mindfulness Exercise.**

5. **Listening Exercise.**

6. **Review Mindfulness.**

7. **Relaxation Exercise.**
   - 20-Minute guided mindful meditation exercise

8. **Assigned Homework.**

9. **Close.**

**Notes**
9-Dot Exercise

Using the image below, try connecting all 9 dots with 4 straight lines, all without taking your pen off the paper.
Session Nine

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. Homework Review.

3. Introduction to Compassion.

4. Introduction to Self-Compassion.

5. Assigned Homework.


Notes
Self-Compassion Exercise

When something happens over the next week that makes you feel sad or uncomfortable with yourself, see if you can take a few moments to extend to yourself some self-compassion. This exercise should take about 10-15 minutes to complete.

First, find a quiet place where you won’t be disturbed and turn-off any possible distractions. Assume a comfortable upright position and simply let yourself settle into your body. Close your eyes. Take some deep breaths and with each exhalation, let go of any stress and bring your attention to the present moment.

Begin by imagining someone who cares deeply about you. If there is no one who comes to mind, you can think of a pet or a higher spiritual power. Notice what it is like to be with this person. Notice your thoughts and any physical sensations that emerge when you are thinking of this being.

Now imagine that this person begins to tell you that the same event that has made you sad or uncomfortable has happened to them. What would you do or say to them in response to what they are telling you? Come up with words or gestures that might make them feel better. Allow yourself to get a sense of what it is like to extend kindness and compassion to them.

Now imagine that your friend tells you that he or she feels much better and has to leave. As you watch them depart, you recall that you have also had this experience. See if you can allow yourself to continue to extend kindness to yourself. Try saying the same words to yourself or making small gesture that you gave to your friend- possibly giving yourself a soothing touch or engaging in a comforting behaviour. Notice how this makes you feel.

When you are ready, open your eyes and consider these questions:

* How is this experience different than how you usually respond to yourself?
* How did you feel physically and emotionally in your body as you did this?
* Which experience do you prefer?

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Session Ten

1. Check-In.
   - Each group member required to say one thing about his or her day or week

2. CBT and SCT Review.

3. Complete assessment questionnaires.

4. “CBT Jepordy”.

5. Feedback.


Notes