The Effectiveness of Gradual Exposure Therapy and Goal Setting in Managing Anxiety: A Case Study Involving an Older Adult Client

by

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Dedication

I dedicate this to my family and friends, without your constant love and support the past four years would not be possible.
Abstract
Anxiety disorders have a high prevalence rate and can have a significant impact on daily functioning. Therefore, finding ways to help clients manage their anxiety is needed, particularly in community mental health settings. There are many individuals who experience anxiety and with the long waitlists helping those in timely manner would be beneficial. Based on the existing literature, gradual exposure is identified as an effective way to treat those with anxiety. The current study sought to test the efficacy of gradual exposure with goal setting in an older adult woman with anxiety, specifically around the goal of leaving the area of her apartment. Therefore, gradual exposure, goal setting, and coping skills were used together with the client. The results showed that these strategies were effective in decreasing symptoms of anxiety and depression. Symptoms of anxiety were monitored through the Hamilton Anxiety Rating Scale (HAM-A) and depression though the Beck Depression Inventory (BDI). This study focused on one client who benefitted from the treatment, therefore future studies could be explored further with a larger sample as different populations could have a different impact.
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Chapter I: Introduction

Generalized Anxiety Disorder (GAD) has a high prevalence rate as it can impact one’s daily activities by an inability to function in some areas such as social interactions, work, family, friends, or school (Wells, 2016). The Diagnostic and Statistical Manual of Mental Disorders-5th Edition (DSM-5) associates the following symptoms with GAD: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance (American Psychiatric Association, 2013).

There have been multiple treatments that have been developed to help treat anxiety. As well there have been medications that have been known to be effective but as for this thesis and based on the client’s needs behavioural change will be focused on. Exposure therapy has been known to be effective in treating those with anxiety (Wiederhold & Wiederhold, 2010). Exposure therapy involves gradual exposure, which is also known as systematic desensitization (SD), combined with goal setting to be practiced within a set time (Wiederhold & Wiederhold, 2010). Goal setting is when there are smaller set goals that lead up to the ultimate end goal. It relates to gradual exposure as small incremental steps are taken to expose the client to the stimuli which then works towards the end goal. Clients that set goals showed increased levels of performance and positive attitudes towards the task given (Bryan & Locke, 1967).

Those who access mental health support in the community struggle more than those who have access to private mental health supports as waitlists as especially long for access to mental health support in the community. Due to such waitlists, clients have to wait long periods to access support or would pull out of the list because the wait is too long. This study was developed as a client in the community mental health agency wanted to achieve the end goal of being comfortable leaving her apartment and there was limited time to do so with the Behavioural Psychology student therefore exposure therapy was chosen as it can be done short term or long term depending on the severity of the disorder. In community mental health short term intervention is beneficial in helping the clients through treatment effectively and quickly due to long waitlists.

The current study aims to monitor the effectiveness of using gradual exposure and goal-setting techniques to reduce symptoms of anxiety with a client who is an older adult woman. The client has identified that anxiety levels are high around leaving her apartment and she has difficulty leaving the area in which she lives. Due to the client's symptoms and her responses to the triggers, exposure therapy and goal setting would be the best approach for the treatment. By exposing her to the elements that trigger anxiety, she can use learned coping strategies to handle the situation better. The hypothesis is that by helping the client develop coping skills when feeling high levels of anxiety when walking longer distances, she will be able to meet the goal of being able to leave her apartment comfortably.
Chapter II: Literature Review

Anxiety

The DSM-5 classifies GAD as excessive worry and difficulty controlling worry over six months about multiple events or activities which affects one’s functioning, not related to use of drugs nor relating to a medical disorder (American Psychiatric Association [APA], 2013). The DSM-5 also relates GAD with symptoms such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance (APA, 2013).

Anxiety and avoidance go together and are not always negative; they protect, motivate, and teach us by looking towards the future if anxiety was no longer a part of the participant’s life (Tompkins, 2013). Anxiety is the fear response which causes one to believe they are in danger (Tompkins, 2013). Avoidance triggers the flight response and does not only involve avoiding the physical object, activities, or situation; but also the thoughts and images surrounding what is provoking anxiety (Tompkins, 2013). Avoiding limits daily activities by avoiding the anxiety-provoking stimuli which can cause difficulty to enjoy living a meaningful life (Tompkins, 2013).

Treatment effectiveness is important; therefore client feedback is essential to what does or does not work for them. Glock, Hilsenroth, and Curtis (2018) looked at the effectiveness of multiple treatment approaches for anxiety. They found that participants believed it was useful when they were informed information or facts about the symptoms of anxiety, the different disorders, and the treatment. Participants also found it helpful when the origin of the trigger is established in order to have a better understanding of their feelings (Glock et al., 2018). Participants found that having another outlook from others on their situation was also beneficial as they can think of the situation in a way they had not previously thought of, a different outlook from their original maladaptive thoughts (Glock et al., 2018). By understanding the problem, it allows the participants to know what to change or work on during treatment (Glock et al., 2018).

Exposure Therapy

Exposure therapy is one approach that has been shown to effectively help those with anxiety (Wiederhold & Wiederhold, 2010). When using exposure therapy, small goals are set so that they are manageable. The goal of the therapy is to engage in the anxiety-provoking experiences that have been previously avoided to then change that behaviour. This is when gradual exposure, also known as systematic desensitization (SD), can be utilized. When using SD, the client is gradually introduced to the situation which caused them to be uncomfortable until they then become comfortable with that situation (Wiederhold & Wiederhold, 2010). SD has shown to be effective in treating anxiety due to the constant exposure that the client receives (Sajadi, Goudarzi, Khosravi, Farahani & Mohammadbeig, 2017). The client becomes accustomed to the trigger (a situation or stimuli that evokes anxiety) that caused them anxiety and learns ways to adapt to the trigger (Sajadi et al., 2017). Part of SD is helping the client with developing coping mechanisms, which help change the maladaptive behaviour such as avoidance, that arise from the trigger (Sajadi et al., 2017). An example of a coping mechanism would be relaxation techniques. Relaxation techniques are an excellent coping strategy when dealing with the trigger (Sajadi et al., 2017). Results showed that both methods were effective in treating traits and symptoms of anxiety (Sajadi et al., 2017). Both methods of treatment were found to be equally effective in treatment for anxiety; therefore, if both methods are used together, they should be found to be more effective in treatment for anxiety.

Exposure therapy can work either by gradual exposure or by flooding, which is exposing the client to the anxiety-provoking stimuli in its most extreme form. Gradual exposure is
preferred over flooding, and depending on what the target behaviour is, one method can be more
effective than the other (Suarez, Adams, & McCutcheon, 1976).

SD is a type of exposure therapy that has been effective in treating anxiety (Wiederhold
& Wiederhold, 2010). Buggs (1972) stated that behavioural therapy assumes that anxiety
responses to stimuli are behaviours that are learned and may change due to relearning a more
appropriate response. If that new appropriate response is more pleasant, that behaviour will over
time replace the old maladaptive behaviour (Buggs, 1972). Buggs describes SD as a three-part
process: 1) teaching muscle relaxation techniques, 2) creating a list of a hierarchy of anxiety
stimuli, and 3) replacing relaxation in place of the anxiety stimuli. Similarly, Fischer (1973)
states the same method for SD; Fischer (1973), also adds that one can identify the effectiveness
of treatment by identifying the cause of the problem behaviour and what maintains the behaviour
so that it is then easier to resolve. Fischer’s (1973) method of SD uses imaginal exposure first
before exposing the participant directly to the stimuli. The belief is that by introducing the
stimuli visually in a controlled setting, the participant will then be able to face the stimuli
physically (Fischer, 1973).

SD is effective in treating different types of anxiety, Kuhlman (1982) conducted a study
with participants who had test anxiety and would forget all studied material when it came time to
write the exam, regardless of how much they had previously studied. SD was chosen as a
treatment to proceed in combination with muscle relaxation. A fear hierarchy (a list of things
feared from least to most) was made weekly at each appointment starting at two weeks before the
day of the exam to the morning of the exam (Kuhlman, 1982). In this case, they began with
visual SD of what the situation would look like which progressed to then being able to write the
exam (Kuhlman, 1982). This study showed effectiveness as the participant completed tests
throughout treatment and was able to finish with average grades (Kuhlman, 1982).

Shelton and Madrazo-Peterson, (1978) compared the effectiveness of delivering SD
between newly trained professionals and those more experienced professionals. Newly trained
professionals delivering the treatment of SD were seen to be as effective in reducing test anxiety
in the study sample as the more experienced professionals (Shelton & Madrazo-Peterson, 1978).
This shows that more people with anxiety who seek SD as treatment do not have to wait for a
more experienced professional and those professionals can be relieved of those duties for other
tasks (Shelton & Madrazo-Peterson, 1978).

Hekmat, Lubitz, and Deal (1984) looked at instructional desensitization (ID), which is
similar to SD, it shows images rather than the physical trigger, on the effectiveness with speech
anxiety. The study had a control group which received a placebo treatment and a group receiving
ID for those with speech anxiety; results showed an increase in both groups although ID had
better results (Hekmat et al., 1984). Sajadi et al. (2017) tested two types of treatment in
decreasing anxiety in nurses. These were 1) systematic desensitization and 2) Benson’s
relaxation techniques. Benson’s relaxation techniques includes a physical state of deep relaxation
which aids the other parts of the nervous system (Benson, & Klipper, 1975).

These studies show the effectiveness of SD across multiple populations. Any professional
trained in SD can then help treat those with anxiety. SD helps to reduce the symptoms of anxiety
and replaces the maladaptive behaviours with adaptive behaviours.

Goal Setting

In order for exposure therapy to be effective, finding the appropriate steps to take when
goal setting is required to succeed in helping the client. Bryan and Locke (1967) compared two
groups: those who were told to set specific goals they wanted to achieve and those who were told to ‘do their best.’ Bryan and Locke (1967) found that the group who set specific goals achieved better results, and reported more interest than the ‘do your best’ group. The set goals create motivation for participants who have low motivation (Bryan & Locke, 1967). Clients that have goals showed increased levels of performance and participants showed positive attitudes to the task (Bryan & Locke, 1967). The highly motivated participants who were told to do their best showed a minimum performance increase and poor attitudes towards the goal (Bryan & Locke, 1967). As such positive reinforcement can also be effective when motivating participants to work towards their goals. DeMartini et al. (2018) found that having another party present to give encouragement and praise seemed to be reinforcing towards goal attainment.

A study by Beckman (2018) outlines two dimensions to goal setting. Dimension one is called "the way." Dimension one highlights how skills, capabilities, and knowledge come in to play in changed behaviour. The goal is planned step-by-step, and attention, inhibitors, and working memory are tested. Dimension two is called "the will." It requires desire and recognizing the importance of behaviour. This dimension looks at why the goal is to be achieved, prioritization of the goal and what are the motivating factors to complete the goal. Beckman (2018) also mentions two steps to behaviour change. The first step is to find where the hesitation originates, finding why there is a need for behaviour change, and how the new behaviour differs from the old (Beckman, 2018). The second step looks at motivation and skill; do skills need to be developed, or how to push through to the extra mile to achieve the goal (Beckman, 2018).

Coping Strategies

Coping strategies are defined as something that aids one in a stressful situation (Po-Chi Kao & Craigie, 2013). Social supports include anyone in which there is a close bond; family, friends, and peers. Some examples of coping strategies are deep breathing techniques and progressive muscle relaxation (PMR). Deep breathing techniques include inhaling for five seconds and releasing that breath for another five (Perciavalle et al. 2017). PMR is defined as tensing and releasing one muscle at a time in order to feel the change between the two (Klein, 2003).

Coping strategies are used to adapt to anxiety-provoking stimuli. Po-Chi Kao and Craigie (2013) monitored how students coped with stressors in the classroom setting. These authors state that choosing which strategy to use when feeling stressed determines how stressful the situation is for the individual, and therefore the better the strategy, the less stress (Po-Chi Kao & Craigie, 2013). They also determined that social support contributes to lower levels of stress and that avoidance was also found to be the leading cause of stress in students (Po-Chi Kao & Craigie, 2013). Those who use less avoidance in their coping had better results in being able to handle stress (Po-Chi Kao & Craigie, 2013).

Another effective coping strategy is deep breathing techniques. Perciavalle et al. (2017) studied levels of stress, mood, and physiological effects (heart rate) in college students. They found that there was a significant improvement between pre and post-treatment when using these techniques. It was concluded that deep breathing techniques have a positive effect on those who experience stress in daily life and this, therefore, can generalize to being effective in other stressors students may experience (Perciavalle et al., 2017). PMR has also found to be effective as a coping strategy (Klein, 2003). PMR is the concentration of relaxing one muscle group at a time comparing tension versus relaxation in each muscle group (Klein, 2003). It also works as imagining the tense muscles and imagining the muscles relax; it has the same effectiveness as physically comparing the relaxation between the tense and relaxed muscles (Klein, 2003).
Current Study

The current study aims to decrease symptoms of anxiety in an older adult woman through SD. SD was used by exposing the client to the anxiety-provoking stimuli of leaving her apartment and teaching coping strategies (deep breathing, PMR, challenging irrational thoughts, and imagery) when the stimuli occur. The studies show that SD is effective in treating those with anxiety. SD was chosen to be used for the client in this study due to the positive outcomes from previous studies as well the client has had positive results from previously trying SD. Positive reinforcement was also given when she was successful in meeting the goals. The client had previously worked with a different worker who began working on expanding the distance travelled which triggers her anxiety and has successfully been able to travel short distances and needs further support in expanding further distances. The Behavioural Psychology student worked alongside the previous distance travelled.
Chapter III: Methods

Participants
There was one participant in this study: an older adult client of the case management team at Addictions Mental Health Services-Kingston Frontenac Lenox & Addington (AMHS-KFLA). The participant was referred to intensive case management by the transitional case management team; and has some other social groups that operated by the agency. The participant has a diagnostic history of post-traumatic stress disorder (PTSD), generalized anxiety disorder, and has also reported experiencing situational panic attacks. The participant has reported experiencing high levels of anxiety when placed in unfamiliar or unexpected situations and identified difficulty leaving her house as a particularly distressing consequence of her anxiety.

The inclusion criteria required the participant be a client on the case management team who experience anxiety and would likely benefit from gradual exposure, the criteria to be referred to case management can be seen in Appendix B.

Consent Procedures
Before the client was able to participate in this study, a signed consent form was completed. The consent form (Appendix A) was created by the Behavioural Psychology student and was approved by the college and agency supervisor, as well as the Research Ethics Board at St. Lawrence College. The form was read and explained to the client, who had the opportunity to ask questions and seek clarification. The consent form outlines what the research includes, such as, foreseeable risks, potential benefits, and how confidentiality will be kept (e.g., by not using any identifying information, securely storing data on a locked computer). At any time, the participant was able to ask questions regarding the study, as well as withdraw consent without any consequence. This study was approved by the St Lawrence College Research Ethics Board.

Research Design
The study compares baseline ratings of anxiety on the Hamilton Anxiety Rating Scale (HAM-A), and baseline ratings on the Beck Depression Scale (BDI) to ratings at session five. Additionally, the study measures the change in distance that the client is able to comfortably walk from her apartment from the time of first measurement (one block) to session five. The goal of one block around her apartment was established based on the client not being able to get out for the past three weeks; there was discomfort with continuing from the previous distance she was able to achieve. The BDI is being utilized due to self-report that the client’s anxiety symptoms have an impact on her depression symptoms. The independent variable is defined as engagement in treatment with the case management team, and the dependent variable is defined as the frequency and severity of the client’s anxiety and depression symptoms, as measured by scores on BDI and HAM-A and achievement of behavioural goals (i.e., walking a certain distance from her house).

Setting and Materials
This study took place in the community as well as at the AMHS building. The client travels to appointments within close proximity to the area that she lives. The goal is for the client to expand further than the appointment to apartment radius; therefore, there is no set parameter. The participant was asked to fill in the BDI and HAM-A scale at home after being exposed to the new parameter. Materials consist of a pencil and note pad to monitor progress, which will then be transferred to a computer, as well as both scales printed out and ready for the participant to fill out weekly.
Measures

**Behavioural Measure.** This data represents the behavioural aspects of the client’s goal setting, i.e., the distance that the client travels each week. The client's distance was monitored in a chart (Appendix C). The distance was monitored to ensure that the client is meeting the goals each week. Each week the client discussed whether or not the increase was met for the week; if the goal was met, it was marked with a check mark on the chart. If the increase was not met, it was marked with an ‘x’. At the end of the five weeks, a graph will be made to represent the physical distance travelled.

**The Beck Depression Inventory (BDI).** The client filled out the Beck Depression Inventory (Beck et al., 1961; Appendix D). The BDI is a 21-item self-report rating inventory that measures symptoms of depression. Each question on the BDI is rated from 0-4, zero being not symptomatic and four being very symptomatic. Therefore, the goal is to get a lower score each week. Each week, the scores from the BDI will be recorded (Appendix F) and graphed (Appendix H) to show whether or not the symptoms are decreasing.

**The Hamilton Anxiety Rating Scale (HAM-A).** The HAM-A (Hamilton, 1959; Appendix E) is a 14-item self-reporting scale to measure the severity of anxiety symptoms. Similar to the BDI, the HAM-A is rated from 0-4, zero being not symptomatic and four being very symptomatic. The goal is to obtain a lower score each week. The scores from the HAM-A will be recorded (Appendix F) and graphed (Appendix I) to show whether or not there is a symptom decrease.

Procedures

Gradual exposure through goal setting took place over five weeks of working with the client. The goal was to decrease anxiety relating to leaving the apartment in order to increase the distance she can comfortably travel from her apartment. This was done by gradually extending the physical distance travelled from her apartment. She will have met the goal if she has travelled the new parameter twice that week. In conjunction with this exposure, the participant learned, developed, and practiced coping strategies to apply when feeling anxious. Coping strategies such as deep breathing, PMR, thought records, and imagery (Appendix F) was taught for the client to utilize when feelings of anxiousness arise. Each week the expected distance to travel increased and a new goal was established. Each meeting the client, the Behavioural Psychology student and agency supervisor, work together to set a goal for the following week, based on feedback provided from the previous week. With the increase of distance each week the client was prompted to practice coping strategies to find out which works best when feelings of anxiety arise. The goal is that when feelings of anxiousness arise when travelling new distances, the client will utilize coping strategies to achieve the set distance for the week. Each meeting the Behavioural Psychology student checked in with the client and discuss whether or not the new increase was met. If the client did not complete the goal that was agreed upon from the previous week, the client, Behavioural Psychology student, and agency supervisor worked collaboratively to identify barriers, practice coping strategies, and adjust goals, if needed. As well in each meeting, the BDI and HAM-A was reviewed to ensure the scales were decreasing and if the symptoms were increasing to discuss what may have changed from the previous week.
Chapter IV: Results

The intervention was delivered over a four-week period with a one-week baseline collected before the intervention. The weekly goals were met when the client completed the set distance twice per week. The client and the Behavioural Psychology student agreed to begin the distance at one block around her apartment. This was chosen as the first distance travel due to previous work with the transitional case manager stopped before working with the Behavioural Psychology student, and the client was not comfortable starting where she left off. Each week, the distance was increased by one block. Over the four-week intervention, the client achieved all weekly exposure goals, increasing the distance travelled from one to four blocks.

BDI scale was given before beginning intervention to achieve a baseline score to compare to the end of treatment. The client's baseline BDI score was 22. Throughout the intervention, the client saw a decrease in this score except week three. During week three, the client reported personal factors which impacted this score. At the end of the intervention, the client's BDI score was nine.

HAM-A scale was also given before beginning intervention to compare to the end score after treatment. The client's baseline HAM-A score was 39. Throughout the intervention, the client found that the scores were decreasing but not as much compared to the BDI scores. Similar to the BDI score week three the HAM-A score increased as there were outside factors that were impacting this score. At the end of the intervention, the client's HAM-A score was 25.

The client met with the Behavioural Psychology student during week one and went over the consent form with the client. A copy was signed and kept by the Behavioural Psychology student, and a copy was kept for the client to refer to if needed. The Behavioural Psychology student also explained further the role of the client in the project. BDI and HAM-A were reviewed and explained that each week the scale would be given for the client to complete to monitor progress. Scales were given to show baseline. It was also established that each week the client and the Behavioural Psychology student would determine the new set goal for the following week and the client would monitor the progress during the week and report back to the Behavioural Psychology student.

Week two the client and Behavioural Psychology student met and reviewed the set goal from the previous week and how often the client was able to get out. Barriers were discussed, and the client shared feelings of having a fear of the unknown. She described this as where her anxiety springs from, and which occurs when she travels distance, she is unfamiliar with. The Behavioural Psychology student then taught the client four coping strategies (deep breathing, PMR, challenging irrational thoughts, and imagery) to use when these feelings of anxiety arise. The client was tasked to practice each at least once during the week. The BDI and HAM-A were also reviewed, and new scales were given to fill out for the following week. Collectively the goal of two blocks around her apartment was agreed upon for the next week.

Week three the client and Behavioural Psychology student met and reviewed the set goal from the previous week and how often the client was able to get out. The Behavioural Psychology student reviewed coping strategies and followed up on if they were practiced once each during the week and the client was prompted to continue to use those strategies when feelings of anxiety arise. The BDI and HAM-A were also reviewed and compared to the week before. The client had already noticed a decrease in anxiety symptoms. New scales were given to fill out for the following week. The Behavioural Psychology student then suggested setting the goal for three blocks around her apartment. The client was initially hesitant, but following positive reinforcement, she did agree to aim for that goal.
Week four the client and Behavioural Psychology student met and reviewed the set goal for the previous week and how often the client was able to leave her apartment. The Behavioural Psychology student and the client discussed which of the coping strategies used was most beneficial. The client identified that deep breathing exercises were the most beneficial for her to manage anxiety, and so these exercises were identified as the coping strategy she would use. The BDI and HAM-A were also reviewed, and new scales were given to fill out for the following week. During this week the client described personal emotional stressors that impacted how often she was able to get out of the apartment and also how they affected her mental state for the week. The client set the goal for four blocks around their apartment.

Week five the client and Behavioural Psychology student met and reviewed the set goal for the previous week and how often the client was able to get out. The BDI and HAM-A were also reviewed, and the final round of scales was given to fill out. The placement supervisor addressed that although the Behavioural Psychology student would no longer be working with the client. The placement supervisor planned to continue working with the client on continuing to expand travel distance, and instead of filling out the scales it was agreed they would verbally discuss issues that arise so that the client can continue to work on decreasing levels of anxiety.

After all the data was collected and scored it was found that the client met the distance goal each week. The client was able to leave her apartment and meet the goals that had been set. As well, the scores from the BDI and HAM-A scales showed a decrease except for one week which spiked. The client did clarify that this was due to other personal stressors and were not directly related to the study. The results from the scores from the scales can be seen in the following graphs.
Figure 2. Beck Depression Inventory Scores
Chapter V: Discussion

Summary

This thesis attempted to determine the effectiveness of gradual exposure for a client who experiences anxiety when leaving her house. Throughout four weeks, behavioural goals of walking a specified radius from her apartment were chosen, and the distance increased each week to monitor the rate of anxiety and depression. Anxiety was measured using the HAM-A scale, and the depression was measured using the BDI. Each week as the behavioural goal increased which was the distance around her apartment, increased coping skills were taught. As well the client practiced those coping skills when feelings of anxiety arose when she went out on her walk. Throughout the intervention, there was a steady decrease in her anxiety and depression rate. For this client, her levels of anxiety around leaving the house impacted daily functioning and therefore it was motivating for her to set goals and engage in the exposure exercises.

The goal of the study was to use gradual exposure through goal setting and coping mechanisms to decrease levels of anxiety. Through the course of the intervention, gradual exposure was successful in decreasing the client’s levels of anxiety and depression. As well, she learned how to manage feelings of anxiety when they arise by practicing coping skills that were taught by the Behavioural Psychology student.

During the intervention, the Behavioural Psychology student and placement supervisor planned to learn more about why, where, and when feelings of anxiety arise and what could be the potential trigger to the anxiety. Exploring triggers of anxiety, including maladaptive thoughts, is beneficial for clients to identify and troubleshooting different situations (Glock et al., 2018). This was seen to be true when the client was practicing coping strategies. Some strategies challenged her thinking patterns, and the client found the activities to be beneficial. Glock et al. (2018) also believed that the effectiveness of treatment was best determined by the client being able to give feedback on what worked for them and what did not. When working with the client, she was supported in trying each new coping strategy and was able to identify which were most beneficial to her. The client was honest in reporting what worked and what did not.

Buggs (1972) described gradual exposure by a three-step process of teaching relaxation skills; creating a list of anxiety-provoking stimuli and replacing the skills with the stimuli. This was used with the client in the study as she was taught coping skills to use when feelings of anxiety arose. Behaviourally, the client benefited from having a set goal each week rather than allowing her to see how far she can achieve. This correlates with what Bryan and Locke (1967) found in their study when those who were told to do their best achieved less than those who had set goals.

Limitations

Throughout the intervention, some limitations arose that made it difficult to proceed. A limitation of this study is that when working with clients, it can be unpredictable as to when clients attend meetings. This was especially difficult as during intervention there was a week where the client had a personal crisis and was unable to meet. This set back the goal setting that was to be monitored every week.

Client caseload was another limitation to the study. Due to caseload demands, if a meeting was missed, it was difficult to reschedule, and on three occasions the meeting would be pushed a week, or the placement supervisor meet with the client without the behavioural psychology student. Another limitation was that due to not being able to have direct contact with the client outside of weekly meetings, it was difficult to communicate on next steps for intervention as everything had to be communicated through the placement supervisor to the client.
Another limitation arose in regard to the measure used for the client to collect behavioural data. The client was to keep track of the distance travelled each day, but at each meeting, the client reported based on memory. In addition, when a week was missed the client did not have the HAM-A or BDI scale to monitor the rate of anxiety and depression but instead wrote down points as to what they experienced during the walks. Therefore, when filling out the scales based on the previous week, the data could be skewed. It would be more beneficial if the client filled out the scales directly after the behaviour so that the data would be more accurate.

Another limitation is when working with one client, it would not be an accurate representation to address that it can be generalized to the population of people who have anxiety. To say it worked with one client; therefore, it will work for others would not be an accurate representation, the study would then have to be tested among a larger group.

**Strengths**

A strength was that due to a successful intervention this adds to the hypothesis that gradual exposure and goal setting can be an effective treatment method to those who have anxiety. Having the client set her own goals was effective as it helped to provide motivating factors to push the client to want to achieve that goal. By building rapport and being able to identify further what is the underlying emotions behind the anxiety finding what motivates the client will benefit how the process of the intervention goes. By doing this, the Behavioural Psychology student was able to identify what was motivating for the client to have a successful intervention.

Another strength was that the client found that the use of coping strategies was beneficial when feelings of anxiety arose when the client was out walking the set distances. The client struggled with leaving the property of her building due to feelings of anxiety and by allowing to substitute the fears with the skills learned she was able to attempt to travel those distances.

The final strength was that the client identified her own goals therefore there was increased motivation to achieving the goal because they were goals she wanted to achieve.

**Multilevel challenges**

**Client.** At the client level when creating the intervention, the client was still new to the placement supervisor. Therefore, there was minimal information available about the client. This was a challenge as there were minimal time and less of a rapport with the client before building the intervention plan and there were still a few questions as to what is impacting the client's anxiety as well as what were the motivating factors.

**Program.** At the program level, client participation is voluntary; therefore, when the client did not want to meet for a scheduled meeting, there was little to be done. This caused difficulty during intervention as there was no data that was able to be collected at that time. Further direction with intervention could not proceed until discussion occurred with the client. This was also dependent on when it was possible to communicate with her, as all client communication had to be supervised by the placement supervisor.

**Organization.** At the organization level communications outside of meetings with the client must go through the placement supervisor. This made things difficult when a message needed to be passed on, as things can often times be lost in translation. If further explanation was needed the placement supervisor would have to provide this or the client would have to wait for the placement supervisor to communicate with the Behavioural Psychology student for further direction.
Society. At the societal level, there is a constant stigma around those who wish to attend treatment. People are afraid that if others know that they wish to attend treatment that their peers will judge them. Therefore, those who want treatment to feel embarrassed or ashamed and do not reach out for help due to being afraid of what others may think of them.

Implications for the Behavioural Psychology field
This thesis is significant to the Behavioural Psychology field as it provided support for the effectiveness of gradual exposure through goal setting in decreasing symptoms of anxiety. As previously mentioned, anxiety has a high prevalence rate (Wells, 2016). Due to the high prevalence rate of anxiety (Wells, 2016), identifying treatments that can help those who experience anxiety is essential. This benefits clients to be able to change their maladaptive thoughts. By changing those thoughts, one may be able to change the behaviours that follow. Maladaptive thoughts are what impacts a person to want to change. By focusing on the maladaptive thoughts and behaviours and effecting change, individuals who suffer from anxiety will be able to do things they would often be held back in doing such as daily living activities. In relation to this, this study was successful in decreasing symptoms of anxiety in a client with anxiety. As this study was found to be successful, it can be used to help others who have anxiety also to decrease the prevalence rate.

Recommendations for future research
Working with clients can be difficult as they can be unpredictable. In order for an accurate outcome to occur, the client needs to put in the work. When working with clients with mental health issues, there are often negative symptoms that allow for little motivation to change behaviour. It is therefore important to find something that will motivate them to work towards their goal. Allowing for more time to build a rapport and learn about the reasons behind their emotions, and why or where their anxiety may be coming from would also be beneficial. From this information, one may be able to identify what are their triggers as well as why they want to make the change. As well for interventions that require clients to monitor their behaviour or emotions, it may be helpful to give them a self-monitoring data sheet to have to monitor more accurately than memory alone. This study was limited due to time and sample size; however, it does show the effectiveness of gradual exposure therapy and goal setting with an adult woman. Expanding sample size, maintaining the set time period trial, and allowing for a larger demographic would be extremely beneficial in furthering this hypothesis.
References
Appendix A

Consent Form

Project Title: Gradual Exposure Therapy through Goal Setting with Older Adult Woman with Anxiety

Principal Investigator: Cindy Chong

Name of Agency Supervisor: Lindsay Shaddock

Name of College Supervisor: Rachel Williamson

Name of Institution: St. Lawrence College

Name of Institution/Agency: AMHS-KFLA

Invitation

You are being invited to take part in a research study. I am a student in my 4th year of the Honours Behavioural Psychology program at St. Lawrence College. I am currently on placement at AMHS-KFLA. As a part of this placement, I am completing a research project on the effectiveness of gradual exposure for anxiety related to a specific client goal (i.e., increasing the distance travelled from the apartment). The information in this form will help you understand my project. Please read the information carefully and ask all the questions you might have before you decide if you want to take part.

Why is this research study being done?

The purpose of this study is to assess the effectiveness of gradual exposure in decreasing symptoms of anxiety. This study aims to use gradual exposure therapy through goal setting as a means to decrease anxiety around leaving the apartment. This will be assessed in two ways: first, the physical distance traveled each week will be monitored and recorded, and second, self-reported ratings of depressions and anxiety symptoms will be monitored through the BDI and HAM-A scales.

What will you need to do if you take part?

As part of the planned intervention, you will be meeting with the Behavioural Psychology student Cindy Chong, and Lindsay Shaddock, Case Manager at AMHS-KFLA once a week for 30-60 minute sessions for 10 weeks to gradually increase the distance from your apartment. You then will be asked to attempt to achieve the set goal for the week. During these meetings, you will also be learning, developing, and practicing coping strategies to apply when feeling anxious. At the next scheduled appointment, you will review briefly (15mins) with the behavioural psychology student whether or not the goal was met during that week and discuss difficulties and identify coping strategies to use in the future. During each appointment, you will also be asked to complete the Beck Depression Inventory and the Hamilton Anxiety Rating Scale.

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

The potential benefits of participating in this research study is that you might learn new coping skills to manage anxiety, and you might be able to increase the distance you are comfortable travelling from your apartment. By learning these coping techniques you might find that you are more capable of participating in more activities in the community.
**GOAL SETTING**

**What are the potential disadvantages or risks of taking part?**

Inherent in this intervention approach is the experience of some anxiety when attempting to overcome one’s fears; however, the behavioural goals are created collaboratively with you and will be identified as manageable. Additionally, throughout the course of the intervention, coping strategies will be practiced during meetings and their effectiveness outside of meetings will be continuously reviewed and adjusted as needed. At any point during the course of the intervention, changes can be made to the goals and/or the intervention plan to reduce any feelings of anxiousness.

**What happens if something goes wrong?**

If you feel uncomfortable at any time you may tell the behavioural psychology student or Lindsay Shaddock (case manager). You may ask for changes to be made or stop participating. We will not proceed unless you are comfortable in this process.

**Will the information you collect from me in this project be kept private?**

If you chose to participate in this project, the information collected from the two scales will not be marked with your name. All data collected will be kept on a password protected computer. Any information with identifiers will be blacked out or shredded after use. You will only be identified as an older adult woman and there will be no mention of identifying information, including the agency, in any reports or presentations. Consent Forms will be stored in a locked filing cabinet in Dr. Rachel Williamson’s office at St. Lawrence College for 7 years. The consent form will be stored securely on the agency’s electronic chart for 10 years, after which time the data will be destroyed. The results from the research are part of my thesis and will be made available at the St. Lawrence College library. They may also be published in professional journals or presented at professional conferences, but any such presentations will be of general findings and will never breach individual confidentiality. Limits of confidentiality arise if you disclose that you are a harm to self or harm to others. Confidentiality will have to be breached to ensure safety to all parties.

**Do you have to take part?**

Taking part is voluntary. It is up to you to decide whether or not to take part in this research project. If you do decide to take part, you will be asked to sign this consent form. If you do decide to take part in this research project, you are still free to withdraw at any time, without giving any reason. You can withdraw without it negatively impacting your relationship or the services that you receive at the agency.

**Contact for further information**

This research project has received ethical clearance from the Research Ethics Committee for Behavioural Psychology (REC-P) under the authority of the St. Lawrence College Research Ethics Board (SLC-REB). The project was developed under the supervision of Rachel Williamson, my supervisor from St. Lawrence College. I appreciate your cooperation and if you have any additional questions, feel free to ask me, Cindy Chong (cchong30@student.sl.on.ca). You can also contact my agency supervisor Lindsay Shaddock (lshaddock@amhs-kfla.ca). You can also contact my College Supervisor Rachel Williamson (rwilliamson@sl.on.ca). If you have concerns about the way this research is being conducted or about your rights as a participant you may contact the St. Lawrence College Research Ethics Board (SLC-REB) Chair at reb@sl.on.ca.
Consent
If you agree to take part in this research project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. The original will be retained at the agency.

By signing this form, I agree that:

☐ The study has been explained to me.
☐ All my questions were answered.
☐ Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
☐ I understand that I have the right not to participate and the right to withdraw at any time.
☐ I am free now, and in the future, to ask any questions I have about the study.
☐ I have been told that my personal information will be kept confidential.
☐ I understand that no information that would identify me will be released or printed without asking me first.
☐ I understand that I will receive a signed copy of this consent form.
☐ I understand that the data from this study will be presented at the St. Lawrence College Behavioural Psychology Poster Gala, and may be reported at other conferences or published in a scientific journal. No identifying information will be included in these reports.

I hereby consent to take part.
Participant Name Signature of Participant Date
Student Printed Name Signature of Student Date

***Participants should be informed to retain a copy of the consent form for their personal records.***
## Appendix B

### Intensive Case Management Suitability Criteria Checklist

<table>
<thead>
<tr>
<th>Meets Intensive Case Management Criteria:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Has a diagnosis of an Axis 1 serious mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Requires ongoing and long term support from service providers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Requires assistance to achieve goals in more than one life domain.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Has concerns in 2 or more of the following criteria:**

|☐ Is socially or geographically isolated |     |    |
|☐ Experiences barriers due of race, culture or ethnicity |     |    |
|☐ Has multiple and complex needs and is at risk for repeated or prolonged institutionalization in health care or correctional facilities |     |    |
|☐ Has had 3 or more psychiatric admissions within the last 2 years, or has been detained in an inpatient facility for 60 days or more within this period |     |    |
|☐ Has been subject to 2 or more police complaints/interventions in the last 12 months, or has been incarcerated in a correctional facility for 30 days or more within this period |     |    |
|☐ Has been recently evicted from housing, or is homeless or living in shelters |     |    |
|☐ Has current problems with drugs and/or alcohol |     |    |
|☐ Consistently uses crisis services in the community |     |    |
|☐ Requires frequent contacts with support systems |     |    |

In addition to the admission criteria above, the individual being referred for service must also meet one or more the following criteria:

|☐ Is planning to move or is imminently moving to an independent living setting in the community |     |    |
|☐ At risk for high use of psychiatric services even when being followed by the support systems within the setting |     |    |
|☐ At risk for high level of involvement with police or repeated complaints by community members even when being followed by support systems within the setting |     |    |
|☐ At risk for putting other resident’s safety at risk |     |    |
|☐ At risk of being evicted from the residential setting |     |    |

(Continued on reverse)
Please indicate if individual is currently in a supported living environment:  ☐ Yes  ☐ No

If yes, please specify: ____________________________

Possible Exclusionary Criteria:
☐ Primary diagnosis of borderline personality disorder-primary Axis 2 diagnosis that consists of cluster B & C traits or features consistently indicative of B & C traits
☐ Demonstrates recent risk for unpredictable violence or assaultive behaviours
☐ Diagnosis of acquired brain injury
☐ Requires short term, intensive support to achieve goals in one life domain
☐ Primary diagnosis of developmental disability

Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
<table>
<thead>
<tr>
<th>Distance</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
</tr>
</thead>
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<tr>
<td>1 block</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 blocks</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 blocks</td>
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<td>√</td>
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</tr>
<tr>
<td>4 blocks</td>
<td></td>
<td></td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>
## Appendix D

**BECK DEPRESSION INVENTORY**

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Date: __________________________</th>
</tr>
</thead>
</table>

Please circle the number next to the sentence which best describes your symptoms for the past seven days. Choose only one sentence under each letter.

### A. 0 1 2 3
1. I do not feel sad.
2. I feel sad.
3. I am sad all the time and I can't snap out of it.
4. I am so sad or unhappy that I can't stand it.

### B. 0 1 2 3
1. I am not particularly discouraged about the future.
2. I feel discouraged about the future.
3. I feel that the future is hopeless and that things cannot improve.

### C. 0 1 2 3
1. I do not feel like a failure.
2. I feel I have failed more than the average person.
3. As I look back on my life, all I can see is a lot of failure.
4. I feel I am a complete failure as a person.

### D. 0 1 2 3
1. I get as much satisfaction out of things as I used to.
2. I enjoy things the way I used to.
3. I don't get real satisfaction out of anything anymore.
4. I am dissatisfied or bored with everything.

### E. 0 1 2 3
1. I don't feel particularly guilty.
2. I feel guilty a good part of the time.
3. I feel guilty most of the time.
4. I feel guilty all the time.

### F. 0 1 2 3
1. I don't feel I am being punished.
2. I feel I may be punished.
3. I expect to be punished.
4. I feel I am being punished.

### G. 0 1 2 3
1. I don't feel disappointed in myself.
2. I am disappointed in myself.
3. I am disgusted with myself.
4. I hate myself.

### H. 0 1 2 3
1. I don't feel I am any worse than anybody else.
2. I am critical of myself for my weaknesses or mistakes.
3. I blame myself all the time for my faults.
4. I blame myself for everything that happens.

### I. 0 1 2 3
1. I don't have any thoughts of killing myself.
2. I have thoughts of killing myself but I would not carry them out.
3. I would like to kill myself.
4. I would kill myself if I had the chance.

### J. 0 1 2 3
1. I don't cry anymore than usual.
2. I cry more now than I used to.
3. I cry all the time now.
4. I used to be able to cry, now I can't cry even though I want to.

### K. 0 1 2 3
1. I am no more irritated now than I ever am.
2. I get annoyed or irritated more easily than I used to.
3. I don't get irritated at all by the things that used to irritate me.

### L. 0 1 2 3
1. I have not lost interest in other people.
2. I have lost most of my interest in other people.
3. I have lost all of my interest in other people.

### M. 0 1 2 3
1. I make decisions about as well as I ever could.
2. I put off making decisions more than I used to.
3. I have greater difficulty in making decisions than before.
4. I can't make decisions at all anymore.

### N. 0 1 2 3
1. I don't feel I look any worse than I used to.
2. I am worried that I am looking old and unattractive.
3. I feel that there are permanent changes in my appearance that make me look unattractive.
4. I believe that I look ugly.

### O. 0 1 2 3
1. I can work about as well as before.
2. It takes an extra effort to get started at doing something.
3. I can't do any work at all.

### P. 0 1 2 3
1. I can sleep as well as usual.
2. I don't sleep as well as I used to.
3. I wake up 1 to 2 hours earlier than usual and find it hard to get back to sleep.
4. I wake up several hours earlier than I used to and cannot get back to sleep.

### Q. 0 1 2 3
1. I don't get tired more than usual.
2. I get tired more easily than I used to.
3. I get tired from doing almost anything.
4. I am too tired to do anything.

### R. 0 1 2 3
1. My appetite is no worse than usual.
2. My appetite is no better than usual.
3. My appetite is not as good as it used to be.
4. I have no appetite at all anymore.

### S. 0 1 2 3
1. I have lost much weight, if any, lately.
2. I have lost more than 5 pounds.
3. I have lost more than 10 pounds.
4. I am purposely trying to lose weight by eating less.

### T. 0 1 2 3
1. I have not noticed any recent change in my interest in sex.
2. I am less interested in sex than I used to be.
3. I have lost interest in sex completely.
### Appendix E

#### HAMILTON ANXIETY RATING SCALE (HAM-A)

**Classification of symptoms:**
- 0 - absent
- 1 - mild
- 2 - moderate
- 3 - severe
- 4 - incapacitating

**HAM-A score level of anxiety:**
- < 17 mild
- 18 - 24 mild to moderate
- 25 - 30 moderate to severe

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Date: ___________</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxious mood</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• worries</td>
<td></td>
</tr>
<tr>
<td>• anticipates worst</td>
<td></td>
</tr>
<tr>
<td>2. Tension</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• startles</td>
<td></td>
</tr>
<tr>
<td>• cries easily</td>
<td></td>
</tr>
<tr>
<td>• restless</td>
<td></td>
</tr>
<tr>
<td>• trembling</td>
<td></td>
</tr>
<tr>
<td>3. Fears</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• fear of the dark</td>
<td></td>
</tr>
<tr>
<td>• fear of strangers</td>
<td></td>
</tr>
<tr>
<td>• fear of being alone</td>
<td></td>
</tr>
<tr>
<td>• fear of animal</td>
<td></td>
</tr>
<tr>
<td>4. Insomnia</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• difficulty falling asleep or staying asleep</td>
<td></td>
</tr>
<tr>
<td>• difficulty with nightmares</td>
<td></td>
</tr>
<tr>
<td>5. Intellectual</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• poor concentration</td>
<td></td>
</tr>
<tr>
<td>• memory impairment</td>
<td></td>
</tr>
<tr>
<td>6. Depressed Mood</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• decreased interest in activities</td>
<td></td>
</tr>
<tr>
<td>• anhedonia</td>
<td></td>
</tr>
<tr>
<td>• insomnia</td>
<td></td>
</tr>
<tr>
<td>7. Somatic complaints - Muscular</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• muscle aches or pains</td>
<td></td>
</tr>
<tr>
<td>• bruxism</td>
<td></td>
</tr>
<tr>
<td>8. Somatic complaints - Sensory</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• tinnitus</td>
<td></td>
</tr>
<tr>
<td>• blurred vision</td>
<td></td>
</tr>
<tr>
<td>9. Cardiovascular Symptoms</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• tachycardia</td>
<td></td>
</tr>
<tr>
<td>• palpitations</td>
<td></td>
</tr>
<tr>
<td>• chest pain</td>
<td></td>
</tr>
<tr>
<td>• sensory of feeling faint</td>
<td></td>
</tr>
<tr>
<td>10. Respiratory Symptoms</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• chest pressure</td>
<td></td>
</tr>
<tr>
<td>• choking sensation</td>
<td></td>
</tr>
<tr>
<td>• shortness of breath</td>
<td></td>
</tr>
<tr>
<td>11. Gastrointestinal Symptoms</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• dysphagia</td>
<td></td>
</tr>
<tr>
<td>• nausea or vomiting</td>
<td></td>
</tr>
<tr>
<td>• constipation</td>
<td></td>
</tr>
<tr>
<td>• weight loss</td>
<td></td>
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<tr>
<td>12. Genitourinary Symptoms</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• urinary frequency or urgency</td>
<td></td>
</tr>
<tr>
<td>• dysmenorrhea</td>
<td></td>
</tr>
<tr>
<td>• impotence</td>
<td></td>
</tr>
<tr>
<td>13. Autonomic Symptoms</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• dry mouth</td>
<td></td>
</tr>
<tr>
<td>• flushing</td>
<td></td>
</tr>
<tr>
<td>• pallor</td>
<td></td>
</tr>
<tr>
<td>• sweating</td>
<td></td>
</tr>
<tr>
<td>14. Behavior at Interview</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>• fidgets</td>
<td></td>
</tr>
<tr>
<td>• tremor</td>
<td></td>
</tr>
<tr>
<td>• paces</td>
<td></td>
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</table>

**TOTAL SCORE: ___________**
## Appendix F

<table>
<thead>
<tr>
<th>Week</th>
<th>HAM-A (Out of 56)</th>
<th>BDI (Out of 63)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>39</td>
<td>22</td>
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<tr>
<td>2</td>
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</tr>
<tr>
<td>5</td>
<td>25</td>
<td>9</td>
</tr>
</tbody>
</table>
Appendix G

Coping Skills

Anxiety

Deep Breathing
Deep breathing is a simple technique that’s excellent for managing emotions. Not only is deep breathing effective, it’s also discreet and easy to use at any time or place.

Sit comfortably and place one hand on your abdomen. Breathe in through your nose, deeply enough that the hand on your abdomen rises. Hold the air in your lungs, and then exhale slowly through your mouth, with your lips puckered as if you are blowing through a straw. The secret is to go slow: Time the inhalation (4s), pause (4s), and exhalation (6s). Practice for 3 to 5 minutes.

Progressive Muscle Relaxation
By tensing and relaxing the muscles throughout your body, you can achieve a powerful feeling of relaxation. Additionally, progressive muscle relaxation will help you spot anxiety by teaching you to recognize feelings of muscle tension.

Sit back or lie down in a comfortable position. For each area of the body listed below, you will tense your muscles tightly, but not to the point of strain. Hold the tension for 10 seconds, and pay close attention to how it feels. Then, release the tension, and notice how the feeling of relaxation differs from the feeling of tension.

- **Feet**  Curl your toes tightly into your feet, then release them.
- **Calves**  Point or flex your feet, then let them relax.
- **Thighs**  Squeeze your thighs together tightly, then let them relax.
- **Torso**  Suck in your abdomen, then release the tension and let it fall.
- **Back**  Squeeze your shoulder blades together, then release them.
- **Shoulders**  Lift and squeeze your shoulders toward your ears, then let them drop.
- **Arms**  Make fists and squeeze them toward your shoulders, then let them drop.
- **Hands**  Make a fist by curling your fingers into your palm, then relax your fingers.
- **Face**  Scrunch your facial features to the center of your face, then relax.
- **Full Body**  Squeeze all muscles together, then release all tension.
Coping Skills

Anxiety

Challenging Irrational Thoughts
Anxiety can be magnified by irrational thoughts. For example, the thoughts that “something bad will happen” or “I will make a mistake” might lack evidence, but still have an impact on how you feel. By examining the evidence and challenging these thoughts, you can reduce anxiety.

Put thoughts on trial. Choose a thought that has contributed to your anxiety. Gather evidence in support of your thought (verifiable facts only), and against your thought. Compare the evidence and determine whether your thought is accurate or not.

Use Socratic questioning. Question the thoughts that contribute to your anxiety. Ask yourself:

- “Is my thought based on facts or feelings?”
- “How would my best friend see this situation?”
- “How likely is it that my fear will come true?”
- “What’s most likely to happen?”
- “If my fear comes true, will it still matter in a week? A month? A year?”

Imagery
Your thoughts have the power to change how you feel. If you think of something sad, it’s likely you’ll start to feel sad. The opposite is also true: When you think of something positive and calming, you feel relaxed. The imagery technique harnesses this power to reduce anxiety.

Think of a place that you find comforting. It could be a secluded beach, your bedroom, a quiet mountaintop, or even a loud concert. For 5 to 10 minutes, use all your senses to imagine this setting in great detail. Don’t just think fleetingly about this place—really imagine it.

- What do you see around you? What do you notice in the distance? Look all around to take in all your surroundings. Look for small details you would usually miss.
- What sounds can you hear? Are they soft or loud? Listen closely to everything around you. Keep listening to see if you notice any distant sounds.
- Are you eating or drinking something enjoyable? What is the flavor like? How does it taste? Savor all the tastes of the food or drink.
- What can you feel? What is the temperature like? Think of how the air feels on your skin, and how your clothes feel on your body. Soak in all these sensations.
- What scents are present? Are they strong or faint? What does the air smell like? Take some time to appreciate the scents.
Figure 1. Hamilton Anxiety Rating Scale Scores
Figure 2. Beck Depression Inventory Scores