Research Project Reports and

Professional and Ethical Issues Report

By

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Three thematically linked placement project reports and one report addressing areas of professional and ethical issues in the practice of Clinical Psychology submitted in partial fulfillment of the requirements for the degree of

Doctor of Psychology (Clinical)

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June 2004

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Statement of Authorship

Except where explicit reference is made in the text of this document, this body of work contains no material published elsewhere are extracted in whole or part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgement in the main text or reference lists of these four reports.

Signature: M. Molloy

Date: 4th June 2024

Preamble

The following is an account of 200 days of unpaid experience gained over a three-year period across four clinical placements. This document contains reports from three of these placement in addition to a fourth report on the professional and ethical issues I encountered over the course of these clinical placements.

My first placement was within the Psychology Department of the Queen Elizabeth Centre attached to the Ballarat Base Hospital in Ballarat, Victoria. In this placement I was exposed to working within a hospital environment with both inpatient and outpatient clients. I gained experience also in working within a multidisciplinary setting, having many experiences of working within as a member of a team alongside doctors, surgeons, nurses, and many other allied health professionals. The experience of working therapeutically in this environment was both frustrating and challenging and required me to draw on my own coping skills and knowledge in order to make this a valuable learning experience.

My second placement was within a Community Health Service located in the suburb of Corio in Geelong, Victoria. This service was located within a severely disadvantaged population with high levels of immigrants, unemployment, and low socio-economic status. Many of the clients I worked with did not speak English, and this placement provided me with the opportunity to gain experience is working therapeutically with clients through the use of interpreters for whom. Additionally, it also enhanced my awareness of cultural issues and sensitivities involved in the delivery of therapeutic work with people of different nationalities.

Mt third placement was within Primary Care and Mental Health Services at Barwon Health's Community Health Services located in Newcomb, Geelong,

Victoria. Barwon Health is the major provider of health services for the Barwon Region of Victoria. In this placement I gained experience in providing treatment to clients who were experiencing severe mental health problems, such as schizophrenia, bi-polar, post traumatic stress and personality disorders, within the mental health service of this agency. I gained experience in treatment planning and case management through my liaison with the psychiatrists, general practitioners and mental health case management teams. Within the primary care setting, I was able to further develop my ability to provide group treatment through involvement in the development and delivery of a 10-week program for treating anxiety. I also saw my own clients for counselling and treatment for issues ranging from grief, trauma, anger management, marriage breakdown, anxiety and depression

My final placement was within Pomegranate House psychology Services, Ballarat, Victoria. Within this placement I gained experience in working with children and adolescents and the particular challenges that working with this particular client group. This was a newly opened service initiated and funded through a collaboration between four Ballarat organisation: St John of God Hospital, the University of Ballarat, the Division of General Practitioners, and Centacare to provide affordable psychological services to disadvantage members of the Ballarat community. The children and adolescents I worked presented with issues such as conduct disorders, developmental disorders, trauma, grief, and behaviour problems. Therapeutic work with these clients involved family therapy, play therapy, cognitive and emotional assessments and case and treatment planning.

The thematic link within each of the individual reports arising from three of these placements is that of anxiety and depression. This linking served to further enhance and develop both my knowledge and skill in the recognition of the impact

these conditions have on the developmental stages of life and their link to the development of mental health and psychological problems. The reports also demonstrate the relevance of the Scientist-Practitioner Model in the training of clinical psychologists through its emphasis of ensuring clinicians are well educated and competent in discerning quality in the assessment, diagnosis and treatment options available for the treatment of individuals experiencing mental health problems. AS an example, the reports presented here reflect the knowledge I have acquired in relation to the importance of early intervention whenever possible in order to prevent or minimize the longer term and often life-long impact of psychological illness.

Placement Report 1

Clinical Case Study Of

Panic Disorder With Agoraphobia

Acknowledgements:

To Corio Community Health Centre for allowing their data and resources to be used in the production of this research report.

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Preamble

Panic disorder affects 3.5% of the general population and creates serious personal and social repercussions such as depression, substance abuse and suicidal tendencies. Panic attacks are a singular feature of panic disorder and are defined as the sudden onset of a period of intense fear and/or discomfort. Panic is characterized by a cluster of physical and cognitive symptoms, which occur unexpectedly and recurrently such as palpitations and persistent worry about future attacks. Further, panic disorder is often associated with phobic disorders such as agoraphobia. Research suggests that Cognitive-Behavioural Therapy (CBT) is an effective treatment for Panic Disorder with Agoraphobia. The following case study reviews the treatment of an individual with panic disorder with agoraphobia using cognitive-behavioural therapy.

Introduction

Through epidemiological studies, it is apparent that that 3.5% of the general population suffer from panic disorder (Kessler, et al., 1994) with serious personal and social repercussions, such as depression, substance abuse, and suicidal tendencies (Markowitz, Weissman, Ouellette, Lish, & Klerman, 1989). According to the DSM-IV (APA, 1994), the essential feature of Panic Disorder (PD) is the occurrence of panic attacks. Further, in its diagnostic criteria, the DSM-IV states that a panic attack is a sudden onset period of intense fear or discomfort associated with at least four symptoms that include: palpitations, breathlessness, dizziness, trembling, a feeling of choking, nausea, de-realization, chest pain, and paresthesias. The panic must also be characterised by a cluster of physical and cognitive symptoms, which occur unexpectedly and recurrently, such as pervasive apprehension about panic attacks; persistent worry about future attacks; worry about the perceived physical, social, or mental consequences of attacks; or major changes in behaviour in response to attacks.

PD is often associated with circumscribed phobic disorders such as specific phobias, social phobias, and especially with agoraphobia (Goisman, et al., 1994; Sanderson, DiNardo, Rapee, & Barlow, 1990). Agoraphobia is described separately from PD in the DSM-IV to highlight the occurrence of agoraphobic avoidance in individuals with or without a history of panic disorder (APA, 1994).

Agoraphobia consists of a group of fears of public places such as going outside, using public transportation, and being in public places (i.e., supermarkets, theatres, churches, football stadiums, shopping centers) that causes serious interference in daily life (Goisman, et al., 1994). Other fears may spring from this core phobia (such as going through tunnels, using lifts, and crossing bridges) as well as other internal fears, such as excessive worry about physical sensations (palpitations, vertigo, and dizziness)

or an intense fear of panic attacks, including the fear of social interaction (Morrison, 1995). The results of these psychopathological symptoms are that the individual tends to avoid the feared situation and, from then on, this avoidance carries over into other situations. Indeed, avoidance of public places in order to reduce fear or panic became the main cause of incapacity in individuals, who, in more serious cases, are confined to their homes (Barlow & Mavissakalian, 1981; Chambless & Goldstein, 1983).

The recognition of PD as a specific syndrome was introduced by Klein (1964; 1967). He disclosed that individuals with recurrent panic attacks responded to imipramine but not benzodiazapines, and vice versa for anxious patients without recurrent panic attacks. His studies were particularly influential in establishing PD as a separate diagnostic entity.

In the aetiopathology of PD, Barlow (1988) describes the initial panic attack as a misfiring of the 'fear system' under stressful life circumstances in physiologically vulnerable individuals. An isolated panic attack does not necessarily lead to the development of PD, as evidenced by the scientific literature (Kessler et al., 1994; Telch, Lucas, & Nelson, 1989). Individuals who develop PD have a physiological vulnerability, a sort of anxious apprehension conceptualized by Barlow as a set of danger-laden beliefs about the symptoms of panic and about the meaning of panic attacks. After the initial panic attack, the unrealistic interpretations persist because individuals engage in cognitive and behavioural strategies that are intended to prevent the feared events from occurring. As the fears are unrealistic, the main effect of these strategies is to prevent individuals from disconfirming their negative beliefs. Then, as in many anxiety disorders, the symptoms of anxiety are additional sources of perceived danger, and produce vicious circles that further contribute to the maintenance of the disorders (Barlow, 1988; Barlow & Craske, 1994). Clark et al (1988) clarify the

aetiopathogenetic model of PD by stating that individuals who experience recurrent panic attacks due to an enduring tendency to interpret bodily sensations as catastrophic. They note that these sensations are typically normal anxiety responses such as palpitations, dizziness and breathlessness and that individuals who catastrophise these sensations, perceive them as indicative of impending mental or physical disaster, for example, palpitations as heralding a heart attack,

Many studies have demonstrated the effectiveness of a multi-component cognitive-behavioural treatment strategy for PD with agoraphobia (Clark, Salkovskis, & Chalkley, 1985; Shear, et al., 1991). Clark, Salkovskis, Barlow, and other colleagues (Barlow, 1988; Barlow & Mavissakalian, 1981; Chambless & Goldstein, 1983; Clark, et al., 1985; Clark et al., 1988; 1994) have outlined the treatment for PD with agoraphobia. The traditional protocol involves a combination of cognitive and behavioural techniques that are intended to help the individual identify and modify their dysfunctional anxiety-related thoughts, beliefs, and behaviours. Emphasis is placed on reversing the maintaining factors identified in the cognitive and behavioural patterns. The treatment protocol includes exposure to the feared situation, interoceptive exposure, cognitive restructuring, breathing retraining, and applied relaxation. On average, the duration of treatment is 12-15 sessions. The following case study consists of the history of a 31 year-old male who experienced panic disorder with agoraphobia and is offered as a detailed illustration of the application and efficacy of this treatment approach.

Reason for Referral

Dennis (not his real name) was a divorced 31 year old, successful insurance salesman. He had experienced panic attacks on several occasions during the past 10 years, but did not seek psychological treatment until shortly after the last incident. This

had happened while Dennis and his fiancée, Elaine, were doing their Christmas shopping at a local shopping centre. Although he was usually uneasy in large crowds of people, Dennis was in a good mood when they first arrived at the centre and was looking forward to spending the Christmas bonus he had received from his company. Around 10 minutes after they began shopping, Dennis related that he suddenly felt very sick. His hands had begun to tremble uncontrollably, his vision blurred, and his body felt weak all over. He experienced tremendous pressure on his chest and began to gasp for breath, sensing he was about to smother. These dramatic physical symptoms were accompanied by an overwhelming sensation of apprehension. He was terrified but did not know why. Without saying anything to Elaine, he had dashed out of the centre, seeking refuge in their car, which was parked outside. Once there, he rolled down the windows to let in more air and lay back on the seat and closed his eyes. He continued to feel dizzy and short of breath for a further 10 minutes. This was the first panic attack he had experienced since he had begun dating Elaine several months previously. After they had returned to their home, he had explained what had happened and his past history of attacks in greater detail; Elaine had persuaded him to seek professional help.

Therapist Observations

The first interview was not very productive. Dennis began by cracking jokes and attempted to engage in an endless sequence of witty small talk and banter. In response to the psychologist's persistent but gentle queries, Dennis explained that he had promised his fiancée that he would seek some advice on his intermittent panic attacks. Nevertheless, he was reluctant to admit he had any serious problems, and he evaded many questions pertaining to his current adjustment. Dennis seemed intent on convincing the psychologist that he was not 'just another nutter'. He continued to chat

on a superficial level and, at one point, even began asking the psychologist if they had adequate insurance cover.

In subsequent sessions it became clear that the panic attacks, which never occurred more than two to three times a year, were simply the most dramatic of Dennis's problems. He was an extremely tense and anxious person between attacks. He frequently experienced severe headaches that sometimes lasted for several hours. These generally took the form of a steady diffuse pain across his forehead. Dennis sometimes felt as if a tight band were stretched around the top of his head. The headaches were accompanied by an aching sensation in his neck and shoulders. Dennis also complained that he could not relax, noting that he suffered from chronic muscle tension and occasional insomnia. His job often required him to work late in the evening, visiting people in their homes after dinner. When he returned home, he was always 'wound up' and on edge, unable to sleep. He had tried various distractions and popular remedies, but none had worked. His attempt at transcendental meditation had failed, and an expensive reclining armchair with an electric vibrator had only seemed to add to his discomfort.

Dennis was very self-conscious. Although he was an attractive man and one of the most successful salespersons in his company, he worried constantly about what others thought of him. This concern was obvious in his behaviour both before and after sessions at the clinic. At the end of every session, he seemed to make a point of joking loudly so that anyone outside the office would hear the laughter. He would then open the door, as he continued to chuckle, and say something like, 'Well Mari (the therapist's first name), that was a lot of fun. Lets get together again soon!' as he left the office. The most peculiar incident of this sort occurred prior to the fourth treatment session. Dennis had avoided the clinic waiting room on past visits, but this time it happened that

he and his therapist met at a location that required them to walk through the waiting room together in order to reach the therapist's office. Thinking nothing of it, the therapist set off across the room in which there were several other clients waiting, and Dennis quickly followed. When they reached the middle of the room, Dennis suddenly clasped his right arm around the therapist's shoulders, smiled, and in a voice that was slightly too loud said, 'Well' Mari, what's up? How can I help you today?' The therapist was taken completely by surprise but said nothing until they reached her office. Dennis quickly closed the door and leaned against the wall, holding his hand over his heart as he gulped for air. He was visibly shaken. Once he had caught his breath, he apologised profusely and explained that he did not know what had come over him. He said that he had always been afraid that the other people at the clinic, particularly the other clients, would realise he was a client and therefore think he was crazy. He had panicked as they walked across the waiting room and had been unable to resist the urge to divert attention from himself by seeming to be a therapist.

This preoccupation with social evaluation was also evident in Dennis' work. He explained that he became extremely tense whenever he would call on a prospective client. Between the point at which the appointment was made and his arrival at their home, Dennis worried constantly. Would they like him? Could he make the sale? His anxiety became most exaggerated as he drove his car to the person's home. In an effort to cope with his anxiety, Dennis had constructed a 45-minute tape that he played to himself in the car. The tape contained a long 'pep talk' recorded in his own voice in which he constantly reassured and encouraged himself. Unfortunately, the net effect of the tape was that it increased his anxiety. Despite this anxiety, he managed to perform effectively in his sales role, just as he was able to project an air of confidence in the clinic. But on the inside, he was miserable. He was worried constantly about his

performance and what others thought of him. Every few months he would become convinced that he could no longer stand the tension and decide to quit his job. Then he would make a big sale or receive a bonus for exceeding his quota for that period and change his mind.

Family and Social History

Dennis was an only child. His father was an accountant and his mother was a primary school teacher. No one else in his family had ever been treated for serious adjustment problems.

Dennis and his mother got along well, but his relationship with his father had always been difficult. Dennis described his father as a demanding perfectionist who held very high expectations for Dennis. When Dennis was in primary school, his father had always wanted him to be the best athlete and the best student in his class. Although Dennis was adequate in both of these areas, he did not excel in either. His father frequently expressed the hope that Dennis would become an engineer when he grew up. Now that Dennis was working as an insurance salesman, his father never missed an opportunity to express his disapproval and disappointment. He was also unhappy about Dennis' previous divorce. Most times when his parents came to visit, Dennis and his father ended up in an argument.

Dennis remembered being shy as a child. Nevertheless, he enjoyed the company of other children and always had a number of friends. When he reached adolescence, he was particularly timid around girls. In an effort to overcome his shyness, he joined the drama club and took part in a number of school productions. This involvement provided him with an easy avenue for meeting other students with whom he became friends. He also learned that he could speak in front of a group of people without

making a fool of himself, but he continued to feel uncomfortable in public speaking and social situations.

After completing high school, Dennis attended university undertaking an arts degree. Although he had been a reasonably good student at high school, he began to struggle at university. Dennis attributes his sporadic performance to test anxiety. In his own words he 'froze' during examinations. He recounted that shortly after entering the examination room, the palms of his hands would begin to sweat profusely, his breathing would become shallow and his mouth would become very dry. He sometimes found himself constantly checking both his watch and the clock in the room, worrying about the mark he would get and unable to concentrate on the test. On the worst occasions, his mind would go completely blank. At the end of his first year, Dennis was placed on academic probation.

During the second year, he began to have gastrointestinal problems. He always seemed to have a 'sensitive' stomach and avoided rich or fried foods that often led to excessive flatulence or nausea. He suffered intermittently from constipation, cramping, and diarrhea. Medical investigations at this time were unable to find any evidence of pathology and diagnosed Dennis' problems as irritable bowel syndrome. While medications provided some relief, Dennis continues to suffer from intermittent bowel problems.

At the end of his second year, Dennis decided to leave university due to continual pressure from his parent to improve his marks. An older friend had recently commenced working for an insurance company and was earning good money so Dennis decided to follow a career in this field. His first job required him to relocate to another state. During his first few years in this position, Dennis met and married his first wife, Beth, a real estate agent.

Dennis and Beth were reasonably happy for the first three years of their marriage. However over time, their busy work schedules saw them spend less and less time together. Dennis describes Beth as a very social person who liked to go out and socialize with friends frequently, while he preferred to stay and home and watch television.

Dennis' first real panic attack occurred when he was 24 years old. He and Beth were out to dinner with three other couples, including Beth's boss and his wife. The dinner had been planned for weeks, in spite of his repeated objections to going. He was self-conscious about eating in public and felt awkward among Beth's colleagues, but had finally agreed to accompany her because it was so important for her. During the meal, Dennis began to feel increasingly uncomfortable. He was concerned he might experience one of his gastrointestinal attacks during dinner and end up spending the rest of the night in the men's room. He did not want to have to explain his problem to Beth's friends if this happened. In an attempt to prevent this he had taken extra medication prior to leaving for the dinner and ate sparingly. Just as everyone was finishing dessert, Dennis began to experience a choking sensation in his throat and chest. He could not catch his breath and believed he was going to faint on the spot. Unable to speak, he had remained 'frozen' in his seat in terror. His dinner companions realising something was wrong, began to pound his back thinking he was choking on some food. Dennis then experienced a sharp pain in his chest and heart palpitations. Two of his male companions helped him to lie down on a couch in the foyer of the restaurant. In less than 30 minutes, all of his symptoms had passed and Dennis and Beth were able to return home. Although shaken by this attack, Dennis did not seek medical advice. He did, however, become even more reluctant to going out to

restaurants with his wife and her friends. Interestingly, he continued to eat business lunches with his own colleagues without apparent discomfort.

The second attack occurred six months later, while driving home in peak hour traffic. The symptoms were essentially the same; the sudden sensation of smothering, accompanied by an inexplicable, intense fear. Fortunately, Dennis was able to pull his car off the road and lie on the seat until the experience was over.

By this point, Dennis decided he needed medical help. He made an appointment with a specialist who gave him a complete physical examination. There was no evidence of any pathology. The doctor told Dennis that his nerves seemed to be the problem and prescribed Valium for a period of four months. Dennis indicated that this did help him to relax and, in combination with his other medication, seemed to improve his gastrointestinal problems. However, he did not like the side effects (such as drowsiness) or the feeling of being dependent on medication to control his anxiety. He saw the latter as a sign of weakness and eventually discontinued the Valium.

Beth asked Dennis for a divorce three years after they married (two years after his first panic attack). This was no surprise for Dennis as their relationship had deteriorated considerably. He had become even more reluctant to going out anywhere with her, insisting that he needed to stay home and rest his nerves. He was very apprehensive in crowded public places and had also become careful about where and when he drove his car. He tried always to avoid peak hour traffic and always stayed in the left lane so that he could easily pull over if he experienced a panic attack. Long bridges made him extremely uncomfortable because he could not pull over easily and he dreaded the possibility of being trapped on a bridge during one of his attacks. However, these fears did not prevent him from doing his work. Dennis continued to force himself to meet new people, and he drove long distances everyday.

After his divorce, Dennis moved into a new home, in which he is still currently living five years later. His chronic anxiety, occasional panic attacks, headaches, and gastrointestinal problems have persisted relatively unchanged throughout this time, although they have varied in severity. He has a number of close friends and manages to see them fairly frequently. He does, however, avoid situations that involve large crowds. He would not, for example, accompany his friends to a football game, but he does like to play golf, where he can be outdoors in the fresh air with very few people and lots of space around him. He met his current fiancée Elaine four years after his divorce. She is slightly older than Dennis and much less socially active than Beth had been. They enjoy spending quiet evening at home watching television or entertaining one or two other friends at home. Although they plan to marry, neither wants to rush into anything.

Assessment Procedures

After the first few sessions in which a family and personal history were obtained, an initial assessment of anxiety within the client was undertaken using the following instruments:

The Anxiety Disorder Interview Schedule-IV (ADIS-IV; Brown, Di Nardo, & Barlow, 1994) is a semi-structured interview that assesses the presence of anxiety and mood. The interview also has screening questions for somatization disorders, substance abuse, and psychosis. Clinician severity ratings are made on a 0 to 8 Likert-type scale, with higher ratings indicating more severe symptoms and impairment in life functioning. Evidence suggests good reliability of the ADIS (Brown, Di Nardo, Lehman, & Campbell, 2001).

A clinician's rating of 6 was given indicating anxiety that was markedly disturbing or disabling. Dennis reported severe ratings (between 5-7) in relation to symptomology specific to panic disorder, agoraphobia, and generalized anxiety disorder.

The Beck Anxiety Inventory (BAI, Beck, Epstein, Brown, & Steer, 1988)

The BAI is a 21-item measure of primarily physiological symptoms of anxiety (Beck & Steer, 1990). Respondents use a 4-point severity scale to note symptoms experienced during the past week. Scores range from 0 to 63. Internal consistency of the BAI is strong (Beck & Steer, 1990), and both convergent and divergent validity has been demonstrated (Beck, Brown, Steer, Eidelson, & Riskind, 1987; Creamer, Foran, & Bell, 1995; Fydrich, Dowdall, & Chambless, 1992). The BAI was given to Dennis to take home and complete and then return on the following week. Upon the completion of treatment after a period of six months this measure was administered again.

Based upon the results of these instruments, it was decided that by working on a reduction in Dennis's generalized anxiety first, greater success could be achieved in his gaining control of his panic attacks.

Conceptualization and Treatment

When Dennis entered treatment, he expressed a desire to learn how to control his anxiety, and in particular, his panic attacks. He expressed that he did not feel comfortable taking medication because he considered it to be an artificial 'crutch'. He had read about behavioural approaches to the treatment of anxiety and was looking for a psychologist with whom he could follow such an approach. Dennis' problem was seen as largely attributable to a deficiency in particular behavioural and cognitive skills. This conceptual approach was discussed and it was agreed that the therapist would work with Dennis to help identify problem areas and teach him more appropriate responses for his

current, maladaptive efforts to cope with his environment. The process of arriving at this agreement led to a significant change in Dennis's behaviour toward the therapist. He became less defensive and dropped his superficial displays of bravado.

After establishing a working relationship, the first major task was to determine the situations in which Dennis was most likely to become anxious. These feel into two general categories: situations in which he experienced panic attacks, and situations in which he became tense and anxious but did not experience a full attack. The most frequent anxiety-provoking situations were his visits to prospective clients' homes. It was interesting to note that Dennis never experienced a panic attack in the presence of a client. One possible explanation for this was that Dennis was at least somewhat in control of these situations, and he had developed well-rehearsed responses that could be used for almost any situation that might arise. However, he was still very uncomfortable during these presentations. His panic attacks had always occurred in crowded public places such as shopping centres, restaurants, and in heavy traffic. These situations shared two common features. First, they were usually places he tried to avoid, and second, they were situations that he could not control.

It was hypothesized that Dennis contributed to the onset of his attacks. Presumably without awareness, he would maintain excessive muscle tension in his neck, shoulders, arms, and legs for extended periods of time while breathing in a shallow, rapid manner, thus leading to the experience of dizziness and exhaustion. The emotional response of fear could therefore be seen as the inevitable product of a dramatic change in arousal that Dennis could not attribute to external stimuli. Given this hypothesis, it seemed that future panic attacks might be avoided by teaching Dennis to control, and be aware of the muscle tension in various parts of his body and by helping him realize that he could precipitate the physical sensations associated with a

panic attack through his own muscular responses. These goals could be achieved by a procedure known as progressive muscle relaxation, originally developed by Jacobson (1938), in which Dennis would be taught to relax specific muscle groups throughout his body.

Dennis' anxiety in work-related situations, on the other hand, did not seem to be the product of a deficiency in his overt responses; he knew what to say and was successful at this, as evident by his excellent work sales record. As such, it was hypothesized that Dennis' perceptions and expectations (the things he said to himself and other people) were at the root of this area of his problem. It became clear, for example, that Dennis believed that it would be a catastrophe if someone did not like him. These were most likely attitudes that had been instilled in Dennis by his father, who had continually emphasized his demand for perfection and whose affection seemed to hinge on its attainment. More adaptive self-statements would have to be substituted for these irrational demands before Dennis would feel more comfortable in social situations, particularly those that involved his work.

Progressive muscle relaxation training was introduced to Dennis as an active coping skill that he could use to control muscular tension. Just as he had learned to be tense and anxious, he could now learn to relax. Initially, Dennis was shown how to use this procedure in the therapist's office. He was then told he would be expected to practice progressive relaxation at home on a daily basis for several weeks. He was cautioned against expecting a sudden change in his anxiety level and told that, for most people, the development of relaxation skills takes considerable effort. He was also given instruction in using a subjective rating scale that he could use to keep track of his progress and was asked to keep a written record of his subjective level of anxiety both

before and after each practice session. Dennis was consistent in completing his homework assignment.

Dennis responded positively to the relaxation training from the very beginning. He noted that he felt awkward and self-conscious at first but had quickly overcome his apprehension. His average rating of anxiety was about six or seven before practice and two or four at the end of the session.

The next three sessions were mostly spent discussing his progress with the relaxation training. In order to provide additional practice and also to correct any small difficulties in his technique, relaxation was still practiced in each of these sessions.

After four weeks, Dennis was asked to try practicing relaxation without the taped instructions and without following the tension-relaxation procedure. Instead of alternatively tensing and releasing, he was instructed to simply concentrate on breathing slowly and 'letting go'. Dennis chose to discontinue recording his anxiety before and after his relaxation sessions at week 12, although he continued to practice relaxation throughout the remainder of his treatment.

At this point, the focus of discussion in sessions shifted to introduce the process of cognitive restructuring. Discussion involved assisting Dennis to become aware that our emotions or feelings are influenced by what people say to themselves. At this point the general principles of cognitive restructuring were explained through the use of examples while carefully avoiding specific reference to Dennis' own experience. Once Dennis agreed to the general assumptions behind cognitive restructuring, a number of common irrational beliefs that have been identified by Ellis (1962) were outlined. Dennis was then asked if he could think of examples when he had engaged in this type of thinking. Initially, this was difficult and these discussions continued over the next several sessions. Much of this time was spent taking specific experiences that had been

anxiety provoking for Dennis and analyzing the self-statements that might have accompanied his response.

Dennis gradually became proficient in noticing the irrational beliefs that led to his anxiety in situations although at first, he could only do this with the assistance of the therapist. In order to facilitate his own independent ability to employ rational self-statements as a coping response both before and during stressful experiences, Dennis was asked to begin a diary. Each night he was asked to take a few minutes to write down a situation in which he had become particularly anxious during the day. He was instructed to note the irrational statements that he must have been making to become anxious as well as complementary rational statements that would have been more appropriate. After keeping this record for four weeks, Dennis noted he was beginning to be able to feel less anxious in social settings and during sales visits.

The final step in treatment was concerned with Dennis' avoidance of situations that had previously been associated with panic attacks. He had not experienced an attack in the three months he had been receiving treatment, but had also refused to take part in any activities that had previously been associated with past attacks. A program of graded prolonged exposure was initiated. This was to be conducted *iv vivo* (i.e. in the natural environment), by having Dennis purposefully enter situations that had previously led to feelings of apprehension and dread and then remain there until he had successfully demonstrated to himself that he would not have a panic attack. Dennis was not able to achieve a state of complete relaxation quickly and without the aid of the formal relaxation procedure. It was emphasized to him that he had now acquired skills with which he could cope with whatever anxiety, if any, he might experience in these settings. A hierarchy of stressful situations was constructed in the next session to which Dennis would expose himself in sequence and for increasing amounts of time. These

began with more simple situations and continued on to those that had previously been most difficult for him.

Treatment sessions were concluded after six months. Dennis had made considerable progress during that time. He had successfully mastered all the situations in the prolonged exposure hierarchy and had not experienced a panic attack since the one that had led to him seeking treatment. His general anxiety level was also considerably reduced. He continued to experience occasional tension headaches, particularly after especially busy days, but these were less frequent (two to three a month) and less severe than they had been in the past. His insomnia had disappeared completely. Whenever he did have trouble sleeping, he would use his tape recording of the relaxation procedure. Unfortunately his gastrointestinal problems remained. Dennis still suffered from intermittent constipation and diarrhea and continued to use medication to relieve these discomforts on an ad hoc basis.

Treatment Results and Interpretation

Beck Anxiety Inventory (BAI, Beck, Epstein, Brown, & Steer, 1988).

The BAI total score is the sum of the ratings given by the examinee for the 21 symptoms. Each the level of anxiety experienced for each symptom is rated on a 4-point scale ranging from 0 = not all, to 3 = severely. A baseline score of 50 obtained at the commencement of treatment placed Dennis around the mid level of the severe anxiety range. Dennis indicated experiencing extreme levels of anxiety for 8 of the 21-items (e.g., fear of losing control; unable to relax) and moderate levels of anxiety for the remaining 13-items (e.g., feelings of choking; face flushed). At retesting upon the completion of treatment Dennis recorded a score of 9 placing him at the low level of the

mild anxiety range. This indicated a significant reduction in the level of anxiety experienced over the course of the treatment.

Progressive Muscle Relaxation Training

As noted earlier, Dennis chose to discontinue recording his anxiety level before and after his relaxation sessions at week 12. His daily records for the first 12 weeks, however, indicated he was able to achieve a comparable level of relaxation as shown in Figure 1.

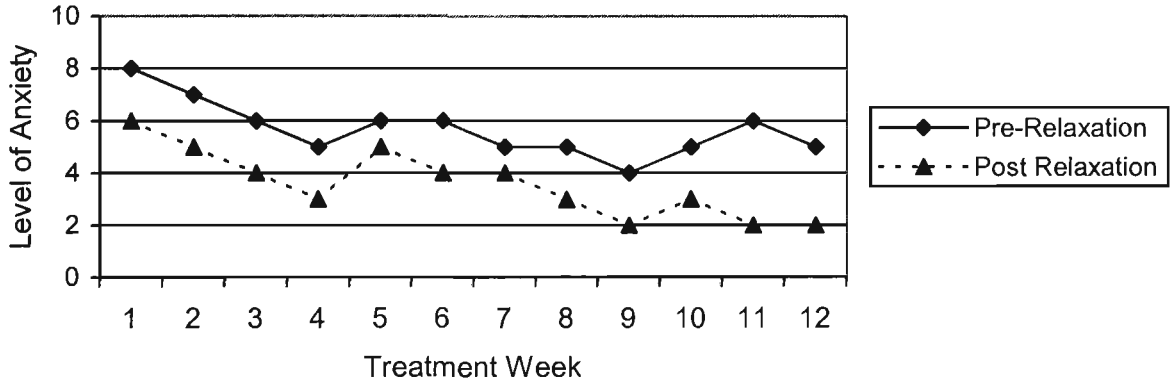

Figure 1 Average weekly anxiety ratings for first 12 weeks of treatment following daily application of a progressive muscle relaxation technique.

DSM-IV Diagnoses

Based on the treatment assessment and outcomes, the following diagnosis was made utilizing the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (APA, 1994). The DSM-IV uses a classification system. Dennis's profile is set out below according to the multi-axial nature of diagnosis indicated by the DSM-IV. The numbers indicate the reference point of each disorder within the DSM-IV.

Axis I:	300.21	Panic Disorder with Agoraphobia
	300.02	Generalized Anxiety Disorder (GAD)

Axis II: No diagnosis

Axis III: Irritable Bowel Syndrome

Axis IV: Family conflict, social isolation, stressful work schedule

Axis V: GAF Current = 55 (on admission), Best in Past Year = 80 (at discharge)

Axis I relates to clinical disorders, Axis II relates to personality disorders, Axis III relates to general medical conditions, Axis IV relates to psychosocial and environmental problems, and Axis V relates to a global assessment of functioning. In this way, the multi-axial system provides a convenient format for organising and communicating clinical information and assists in treatment planning and predicting outcomes. Dennis' diagnostic results indicated that he had a range of clinical issues that required treatment as well as several lifestyle problems that may have been impacting on his overall level of functioning.

Discussion

Disorders in which anxiety is the most prominent symptom are quite common. During any given year, 17% of people in the United States may suffer from at least one form of anxiety disorder, although only one out of four of these people receive treatment for the problem (Kessler et al., 1994). DSM-IV (APA, 1994) recognizes eight distinct disorders that are characterized by anxiety and avoidance behaviours. The DSM-IV description and organization of anxiety disorders pays special attention to the presence or absence of panic attacks. These extraordinarily frightening experiences, which seldom last more than a few minutes, are discrete periods of apprehension or fear, accompanied by sensations such as shortness of breath, palpitations, chest pains, choking or smothering sensations, dizziness, perspiring, and trembling or shaking.

Some people, like Dennis, experience only one or two attacks a year, whereas others may have them on a daily basis.

Dennis' treatment combined the use of relaxation with a cognitive approach to his problems (Rapee & Barlow, 1988). Dennis' perceptions of social events and the things he said to himself about these events played an important role in the maintenance of his anxiety. Dennis learnt to recognize the general kinds of self-statements that were associated with his anxiety and develop more appropriate statements to use to enhance his ability to cope with stressful situations. In addition to gaining 'insight' into his problem, Dennis was taught specific cognitive skills (i.e., adaptive self-statements) that had previously been absent from his repertoire of coping responses. Positive change was evident only after a prolonged period of practice employing rational self-statements, both in and out of treatment sessions. In addition, Dennis was assisted to learn specific behavioural responses (e.g., applied relaxation) and challenged to confront various stressful situations in the natural environment. This approach was founded on the realisation that while cognitive variables play an important role in the change process, the most effective treatment programs are performance based. This was clear in Dennis' case. His apprehension in crowded places was not significantly reduced until he had actually mastered a series of situations via the prolonged exposure procedure.

Controlled outcome studies indicate that cognitive-behavioural procedures are effective for the treatment of anxiety disorders (Borkovec & Costello, 1993; Chambless & Gillis, 1993). Overall, the results of this study support these findings and suggest that cognitive-behavioural procedures are an effective treatment method for individuals with panic disorder.

References

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). Washington, DC: Author.

Barlow, D. H. (1988). Anxiety and its disorders: The nature and treatment of anxiety and panic. New York: Guilford Press.

Barlow, D. H., & Craske, M.G. (1994). Mastery of your anxiety and panic II. San Antonio, TX: Harcourt Brace & Co.

Barlow, D. H., & Mavissakalian, M. (1981). Directions in the assessment and treatment of phobia: The next decade. In M. Mavissakalianm., & D. H. Barlow, (Eds.), Phobia: Psychological and pharmacological treatment. (pp. 1-34). New York: Guilford Press.

Beck, A. T., Brown, G., Steer, R. A., Eidelson, J. L. & Riskind, J. H. (1987). Differentiating anxiety and depression: A test of the cognitive content-specificity hypothesis. Journal of Abnormal Psychology, 96, 179-183.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. Journal of Consulting and Clinical Psychology, 56, 893-897.

Beck, A. T., & Steer, R. A. (1990). Manual for the Beck Anxiety Inventory. San Antonio, TX: Psychological Corporation.

Borkovec, T. D., & Costello, E. (1993). Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. Journal of Consulting and Clinical Psychology, 61, 611-619.

Brown, T. A., Di Nardo, P. A., & Barlow, D. H. (1994). Anxiety Disorders Interview Schedule for DSM-IV. Albany, NY: Graywind.

Brown, T. A., Di Nardo, P. A., Lehman, C. L., & Campbell, L. A. (2001). Reliability of DSM-IV Anxiety and Mood Disorders: Implications for the Classification of Emotional Disorders. Journal of Abnormal Psychology, 110 (1), 49-58.

Chambless, D. L., & Gillis, M. M. (1993). Cognitive therapy of anxiety disorders. Journal of Consulting and Clinical Psychology, 61, 248-260.

Chambless, D. L., & Goldstein, A. J. (1983). Agoraphobia: Multiple perspectives on theory and treatment. New York: Wiley.

Clark, D. M., Salkovskis, P., & Chalkley, A. (1985). Respiratory control as a treatment for panic attacks. Journal of Behaviour Therapy and Experimental Psychiatry, 16, 23-30.

Clark, D. M., Salkovskis, P., Gelder, M., Koehler, C., Martin, M., Anastasiades, P., Hackmann, A., Middleton, H., & Jeavons, A. (1988). Tests of a cognitive theory of panic. In I. Hand & H. Wittchen, (Eds.), Panic and phobias II. (pp.78-95), Berlin: Springer-Verlag.

Clark, D. M., Salkovskis, P., Hackmann, A., Middleton, H., Anastasiades, P., & Gelder, M. (1994). A comparison of cognitive therapy, applied relaxation, and imipramine in the treatment of panic disorder. British Journal of Clinical Psychology, 164, 759-769.

Creamer, M., Foran, J. & Bell, R. (1995). The Beck Anxiety Inventory in a non-clinical sample. Behavior Research and Therapy, 33, 477-485.

Ellis, A. (1962). Reason and emotion in psychotherapy. New York: Lyle Stuart.

Fydrich, T., Dowdall, D. & Chambless, D. C. (1992). Reliability and validity of the Beck Anxiety Inventory. Journal of Anxiety Disorders, 6, 55-61.

Goisman, R. M., Warshaw, M. G., Peterson, L. G., Rogers, M. P., Cuneo, P., Hunt, M. F., Tomlin-Albanese, J. M., Kazim, A., Gollan, J. K., Epstein-Kaye, T., Reich, J. H., & Keller, M. B. (1994). Panic, agoraphobia, and panic disorder with agoraphobia: Data from a multi-center anxiety disorders study. Journal of Nervous and Mental Disease, 182 (2), 72-79.

Jacobson, E. (1938). Progressive relaxation. Chicago: University of Chicago Press.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry, 51, 8-19.

Klein, D. F. (1964). Delineation of two drug responsive anxiety syndromes. Psychopharmacologia, 5, 397-408.

Klein, D. F. (1967). Importance of psychiatric diagnosis in prediction of clinical drug effects. Archives of General Psychiatry, 16, 118-126.

Markowtiz, J. S., Weissman, M. M., Ouellette, R., Lish, J. D., & Klerman, G. L. (1989). Quality of life in panic disorder. Archives of General Psychiatry, 46, 984-992.

Morrison, J. (1995). DSM-IV made easy: The clinician's guide to diagnosis. New York: Guilford Press.

Rapee, R. M.; & Barlow, D. H. (1988). Cognitive-behavioural treatment. Psychiatric Annals, 18 (8), 473-477

Sanderson, W. S., DiNardo, P. A., Rapee, R. M., & Barlow, D. H. (1990). Syndrome co-morbidity in patients diagnosed with a DSM-III-R anxiety disorder. Journal of Abnormal Psychology, 99, 308-312.

Telch, M. J., Lucas, J. A., & Nelson, P. (1989). Non-clinical panic in college students: An investigation of prevalence and symptomatology. Journal of Abnormal Psychology, 98, 300-306.

Placement Report 2

Clinical Case Study

Of

Co-Morbid Anxiety & Depression

Following Attempted Suicide

Acknowledgements:

To the Ballarat Health Services for allowing their data and resources to be used in the production of this research report.

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Preamble

The co-occurrence of mood and anxiety disorders is relatively common. Approximately 57% of depressed individuals also experience an anxiety disorder, and 56% of anxiety-disordered individuals also experience a depressive disorder (Kessler, et al., 1996). As compared with individuals with depression or anxiety alone, those with co-morbid mood and anxiety disorders experience increased clinical morbidity, greater functional impairment, higher symptom severity, and poorer prognosis (Hecht, von Zerssen, & Wittchen, 1990; Sherbourne & Wells, 1997). The poor clinical prognosis associated with individuals who are co-morbid with mood and anxiety disorders makes it understandable that some of the most prominent features of this condition are increased suicidal ideation, suicide attempts, and completed suicide (Lewinsohn, Rohde, & Seeley, 1995; Fawcett, 1997; Keller & Hanks, 1995). As such, there is a need for an effective and efficient treatment for individuals with co-morbid mood and anxiety disorders, especially those with suicidal ideation and/or behaviours. The following case study reviews the treatment of an individual with co-morbid depression and anxiety disorders using cognitive therapy.

Introduction

When an individual's presenting issue is suicidal ideation, but following an initial interview and subsequent assessment it becomes clear that the suicidal symptoms have emerged in the context of a major depressive episode combined with a generalized anxiety disorder, the challenge in treating the individual is in determining where to start. Because of their life-threatening nature, suicidal symptoms would be the most appropriate starting point, of course. However, because mood and anxiety symptoms can exacerbate suicidality, and clearly involve considerable distress and impairment, they too deserve attention.

The co-occurrence of mood and anxiety disorders is relatively common. Approximately 57% of depressed individuals also experience an anxiety disorder, and 56% of anxiety-disordered individuals also experience a depressive disorder (Kessler, et al., 1996). As compared with individuals with depression or anxiety alone, those with co-morbid mood and anxiety disorders experience increased clinical morbidity, greater functional impairment, higher symptom severity, and poorer prognosis (Hecht, et al., 1990; Sherbourne & Wells, 1997). The poor clinical prognosis associated with individuals who are co-morbid with mood and anxiety disorders makes it understandable that some of the most prominent features of this condition are increased suicidal ideation, suicide attempts, and completed suicide (Lewinsohn, et al., 1995; Fawcett, 1997; Keller & Hanks, 1995). As such, there is a need for an effective and efficient treatment for individuals with co-morbid mood and anxiety disorders, especially those with suicidal ideation and/or behaviours. However, few such treatments have been articulated and empirically supported.

Recent research suggests serotonin reuptake inhibitors (SSRIs) may be the preferred treatment for co-morbid mood and anxiety disorders, especially in suicidal

patients (Gorman, 1997; Keck and McElroy, 1997; Leonard, 1997; Nutt, 1997; Sheehan and Harnett-Sheehan, 1996). Treatment with fluvoamine (Luvox) has demonstrated lower levels of anxiety symptoms when compared with other SSRIs (Wagner, Zaborny, & Gray, 1994) and, in combined studies of over 34,000 individuals, has resulted in a very low suicide rate (Fox, 1990). Conversely, Fawcett (1997) presented selected case studies of suicidal individuals with co-morbid mood and anxiety disorders who, at initiation of pharmacotherapy (in the form of TCAs, SSRIs, or atypical antidepressants), showed no significant improvement or significant deterioration of symptoms and who died by suicide.

However, psychological treatment using cognitive behavioural therapy (CBT) has also provided promising results in individuals with mood and anxiety co-morbidity (Borkovec & Costello, 1993; Chambless & Gillis, 1993), especially in comparison to other forms of psychotherapy (e.g., analytic, nondirective, supportive).
Research on the psychological processes mediating suicidal behaviour has identified impaired problem-solving ability as an important underlying variable (Polloack & Williams, 1998; Schotte & Clum, 1987). A task force of the National Institute of Mental Health Center for Studies of Suicide Prevention developed a tripartite classification system in 1973 to describe suicidal behaviour, suicide ideation, suicide attempt, and completed suicide (Beck, et al., 1973)

Within these three processes, the variables of intent, lethality, and method can be assessed so the clinician can evaluate the degree to which the suicidal individual is at risk. Many factors play a role in suicidal ideation and behaviour. Hopelessness frequently has been reported to be the most critical psychological variable predictive of suicidal ideation and behaviour (O'Connor, Sheehy, & O'Connor, 1999, 2000; Petrie, Chamberlain, & Clarke, 1988). Degree of hopelessness, along with a negative self-

concept (a variable predictive of suicide independent of hopelessness), compose two of the three components of Beck's negative triad found operating in depressed individuals (Beck, Steer, Epstein, & Brown, 1990).

Cognitive distortions, cognitive rigidity, and dysfunctional assumptions have also been cited as leading to suicidal thinking. Ranier, et al., (1987) found that perfectionistic attitudes towards self and sensitivity to social criticism accounted for independent variance in suicide ideation. In a sample of psychiatric outpatients, four specific dysfunctional attitudes were found to be positively associated with suicide ideation: feeling vulnerable to becoming depressed, accepting other people's expectations, feeling that it is important to impress others, and being sensitive to the opinions of others (Beck, Steer, & Brown, 1993).

Hewitt, Flett, and Turnbull-Donovan (1992) explored three types of perfectionism associated with suicidal threats and impulses: expectation of self (self-orientated), expectations of others (other-orientated), and expectations that others hold for the person (socially prescribed perfectionism). Only socially prescribed perfectionism predicted a variance in suicide ideation scores that was not otherwise accounted for by depression and hopelessness.

Perceived and actual difficulties in solving problems are other characteristics found among those who consider suicide (Priester & Clum, 1993; Rudd, Rajab, & Daham, 1994). It is not clear whether problem-solving ability, beliefs about self-efficacy regarding problem solving ability, or a combination of both factors contribute to thoughts about suicide. Bonner and Rich (1988) argue that hopelessness causes low problem solving appraisal and poor problem solving attempts. Suicide may seem to be a solution for a person who is struggling with problems and cannot tolerate the anxiety of problem solving.

The following case study illustrates the concepts found in cognitive behavioural therapy research as significant factors in the treatment of a suicidal individual. While alleviating hopelessness in the suicidal individual is a primary intervention, this case highlights the importance of targeting dysfunctional attitudes and socially prescribed perfectionism to further assist in inoculating the individual against future suicidal episodes. The following case study illustrates the therapeutic treatment strategies used to increase cognitive flexibility, decrease sensitivity to perceived social expectations, and increase tolerance of anxiety in problem solving and interpersonal conflicts.

Reason for Referral

Sally (not her real name) was a 28-year-old female of Italian ethnicity. Sally's father initially contacted the Ballarat Health Service seeking support for Sally who had returned home from Melbourne following a suicide attempt two weeks earlier. Sally had been admitted to hospital at the time of this attempt and following her release had returned to her family in Ballarat. Her suicide attempt had involved her overdosing on a mixture of prescription tablets she had obtained for this purpose. She had been found when her ex-fiancé had become alarmed when she would not answer the door when he came to remove his belongings. He subsequently used his own key to enter their flat, where she was found unconscious. Sally attended weekly sessions for approximately four months.

Therapist's Observations

The first interview was not very productive. Sally sat quietly and spoke hesitantly about herself. In response to the psychologist's persistent but gentle queries, Sally explained that she had found it increasingly difficult to cope with the everyday

demands of her life. Nevertheless, she was reluctant to admit she had any serious problems, and she evaded questions pertaining to her suicide attempt two weeks ago. Sally seemed intent on convincing the psychologist that she was just experiencing a temporary problem that would resolve itself in due course. She continued to minimize her actions of the past week, saying that it had merely been an error in judgment at the time.

In subsequent sessions it became clear that the difficulties in coping with the day-to-day demands of living had been ongoing for several years but had escalated over the last six months, due to the added stress of her upcoming marriage. Sally was a tense and anxious person who worried about doing the right thing constantly. She frequently experienced severe headaches that sometimes lasted for several hours. These generally took the form of a steady diffuse pain across her forehead. The headaches were accompanied by an aching sensation in her neck and shoulders. Sally also complained that she lack energy and experienced frequent insomnia. Her job often required her to work long hours, and in recent months her workplace had been undergoing a downsizing in staff numbers and had involved her taking on additional responsibilities for which she felt she was not paid appropriately.

Sally was very self-conscious and lacked self-esteem. Although she was an attractive woman and successful in her work, as shown by the additional responsibilities given to her, Sally worried constantly about what others thought of her. She spoke of always feeling that people were judging her actions and seeing her as inadequate.

Family and Social History.

Sally was the youngest of three children born to parents of Italian ethnicity. Sally has two older brothers who are married and live with their families in the Ballarat

area. Her parents reside together in Ballarat also. Sally recalled a happy childhood, stating that birthdays, Easter and Christmas were good times for her and her family. She remembers fondly many holidays camping at Ocean Grove during the summer holidays with her own family and the families of her aunts and uncles. These camping holidays still occur, however Sally does not always take part in them. Sally recalled being very protected by her older brothers who would always 'check out' her friends and boyfriends to make sure they are 'ok'. She has seven nieces and nephews and often baby-sits for her brothers. Until their deaths, Sally's maternal grandparents also lived with her family and she recalls enjoying the experience of having such a large extended family with a constant stream of uncles, aunts and cousins also spending periods of time with her family.

Sally states she has a good relationship with her parents but expressed concerns that she often felt like she was letting them down, particularly because she was still unmarried at 28. This troubled Sally who felt her mother in particular was worried she would remain single and never have children. Her mother speaks often of her desire for Sally to settle down and have a family. Sally admitted to feeling pressure over this and felt this had contributed to her becoming engaged six months ago. Sally also recalled always feeling pressured to do her best as a child, with her parents constantly urging her to do better in her both her school and sporting endeavours. She minimized this by saying 'that they just want the best for me'. Sally admitted, however, this had made her worry constantly throughout her school years and that she was always anxious that she wasn't obtaining the best marks she could. She also stopped participating in sports because ' I was never very good at anything'; and that although she had enjoyed the social aspect of team sports, she felt she could not continue if she couldn't be successful. During her time at university she had experienced severe headaches for

which she had sought medical help. She was told these were due to stress and anxiety and was prescribed pain relief and advised to seek counseling for help with her anxiety. Sally did not follow up with this recommendation.

Developmentally, Sally recalls reaching all the usual milestones at the appropriate age. She had a healthy childhood except for contracting the childhood illnesses of measles, mumps and chicken pox. Her school days were generally happy although Sally recalled some instances of feeling hurt and rejected when some of her classmates called her a 'wog' and told her she wasn't really an Australian despite being born here. Sally said that for this reason she refused to speak Italian in front of anyone except her family members from around the age of 10, as she did not like to feel 'different' from the other children. She was able to make friends easily at school and still maintains close friendships with several people with whom she went through school.

Sally went on to study business management at University in Geelong after finishing high school. Upon completing her degree, she obtained employment with a large organization in Melbourne and after commuting for two years, moved to Melbourne four years ago. She lived alone for two years before moving in to live with her boyfriend when they became engaged. Sally stated that she had a wide circle of friends and socialized often (2-3 times weekly). Sally reported that while she enjoyed her job, she often felt inadequate in her role and 'worried all the time' that her work was not of a high enough standard and that she was inferior to the other workers in her section. She cited the fact that she had only had one promotion in her six years with the organization as proof of this. Sally indicated that she had begun to worry more and more over the past several months in relation to her job, her parents' expectations, and her approaching wedding which had been scheduled for the end of the current year.

Precipitating factors for her attempt at suicide included breaking off her engagement to her fiancé, a perception of being judged for choosing to end the engagement, job stress due to the restructuring and downsizing in her department, and growing fears of inadequacy and hopelessness. Sally had been experiencing difficulties sleeping, irritability, and restlessness for about eight weeks prior to her attempt and had been absent from work often during this period due to feelings of being overwhelmed and unable to cope. She had ended her engagement four weeks prior to her attempt stating that she had done so because she felt her fiancé deserved a better person than herself and that she was being selfish to think she could make him happy. She had returned to her family home for a visit two weeks prior to her attempt, for moral support after breaking off her engagement. Following this visit, Sally stated that she also felt an increased sense of failure due to her parent's disappointment about her decision to end her engagement. Following her attempt, Sally's parents were adamantly against her returning to Melbourne and her father had traveled to Melbourne to collect all her belongings and bring her home. Sally saw this as further proof of her inability to cope.

Assessment Procedures

After the first few sessions in which a family and personal history were obtained, an initial assessment of anxiety within the client was undertaken using the following instruments:

The Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders –IV (SCID-IV, First, Spritzer, Williams, & Gibbon 1997).

The SCID, is a semi-structured interview designed to identify Axis I and Axis II diagnoses based upon the DSM-IV criteria. This was administered in order to determine the nature of Sally's problems and identify appropriate DSM-IV diagnoses as

applicable. Sally met the criteria for major depressive disorder, recurrent, severe, and generalised anxiety disorder.

Beck Depression Inventory (BDI) (Beck, Steer, & Brown, 1996).

The BDI is a self-report measure based on DSM-IV (American Psychiatric Association, 1994) criteria and consists of 21 items. Severity of depression in the two weeks prior to, and including the day of, completion of the measure is rated on a scale of 0-3, depending on the severity of the symptoms experienced. It possesses high internal consistency (α = .89). The scale targets two important items; hopelessness and suicide ideation (items two and nine).

Beck Anxiety Scale (BAI, Beck, Epstein, Brown, & Steer, 1988)

The BAI is a self-report measure of primarily physiological symptoms of anxiety (Beck & Steer, 1990) and consists if 21-items. Respondents use a 4-point severity scale to note symptoms experienced during the past week. Scores range from 0 to 63. Internal consistency of the BAI is strong (Beck & Steer, 1990), and it possesses high reliability (α = .92) and good validity (Beck, et al., 1988; Creamer, Foran, & Bell, 1995; Fydrich, Dowdall, & Chambless, 1992).

Scale for Suicide Ideation (SSI) (Beck, Kovacs, & Weissman,1979).

The SSI is a 19-item, clinician-rated inventory that assesses the intensity of specific attitudes, plans, and behaviours concerning suicidal behaviour. Items are rated on three choices: 0 = moderate to strong, 1 = weak, 2 = none. It has three factors: Active suicidal desire, passive suicidal desire, and preparation. Total score is the sum of all 19 items and can range from 0 to 38. Upon the completion of treatment after a period of four months these measures were administered again.

At the time of commencement of treatment, Sally scores on the BDI, BAI, SSI were 18, 28, and 16 respectively, which were all in the moderate to severe range.

Conceptualisation and Treatment

When Sally entered treatment, she expressed a desire to find peace and happiness in her life, which she currently felt was hopeless and unhappy. She expressed that she did not feel comfortable taking medication because she did not want to be medicated for the rest of her life. Sally's problem was seen as largely attributable to a deficiency in particular behavioural and cognitive skills. This conceptual approach was discussed and it was agreed that the therapist would work with Sally to help her identify problem areas and teach her more appropriate responses for her current, maladaptive efforts to cope with her environment. The process of arriving at this agreement led to a significant change in Sally's behaviour toward the therapist. She became less defensive and more engaged and focused in sessions. Standard cognitive behavioural therapy was delivered with an initial emphasis on structuring activities, socializing the client to the cognitive behavioural model, and decreasing hopelessness. Sally was seen weekly for a period of 12 weeks. This was followed by two further sessions one month later.

Socializing to the Cognitive Behavioural Model: Keeping a mood log and differentiating between thoughts and feelings were the initial steps in socializing Sally to the cognitive model. This model proposes that perceptions about specific situations influence how people feel and behave. Sally was asked to keep a daily log describing upsetting situations, thoughts about the situation, and behavioural as well as affective responses to the thoughts about the situation. In Sally's log, she noted many situations when she became depressed after thinking she was not living up to her parent's expectations. She frequently recorded feeling overwhelmed after thinking of all the things she 'should' be doing. This exercise quickly provided data about Sally's perception about other's expectations of her and her need to be overly responsible. This

socially prescribed perfectionism and sensitivity factored into Sally's vulnerability to suicidal ideation.

Structuring Activities: Daily Activity Schedule: A person who is experiencing depression may spend a considerable amount of time doing nothing. This inactivity and/or lack of accomplishment can deepen depression. The use of a daily activity schedule enables depressed people to make and carry through simple plans, break large tasks down into smaller components, and assist them to recognise when they have accomplished something (Copeland, 2001). The initial focus was on structuring Sally's time according to an activity schedule. Sally assisted in the development of a daily activity schedule, similar to a weekly calendar that blocked out each hour of the day and allowed her to actively schedule time and increase her activity level. Each week Sally was instructed to increase specific activities with high pleasure ratings. Sally's list of daily activities included things such as exercising, calling friends, going for a walk, going to the shops, cleaning her bedroom, taking a bath, listening to music, and writing a thought record.

Progressive Muscle Relaxation Training: This was introduced to Sally as an active coping skill that she could use to control muscular tension resulting form her anxiety. Initially, Sally was shown how to use this procedure in the therapist's office. She was given an audiotape of this exercise and told she would be expected to practice progressive relaxation at home on a daily basis for several weeks. She was also given instruction in using a subjective rating scale that she could use to keep track of her progress and was asked to keep a written record of her subjective level of anxiety both before and after each practice session.

Sally responded positively to the relaxation training from the beginning. She noted that she had been able to overcome her initial self-consciousness and had quickly

come to enjoy her practice times. Sally's average rating of anxiety was about six before practice and two to three at the end of the session. Part of each of her next three sessions was spent discussing her progress with the relaxation training and correcting any small difficulties in technique.

After six weeks, Sally was asked to try practicing relaxation without the taped instructions and without following the tension-relaxation procedure. In addition, she was told that instead of alternatively tensing and releasing, she should now simply concentrate on breathing slowly and 'letting go'.

Automatic Thoughts: These are spontaneous cognitions that are rapid, fleeting, and often outside immediate cognitive awareness. While people are not generally aware of their automatic thoughts, they can identify readily how upset (sad, anxious, irritable) they feel (Beck, 1995). Cognitive therapy uses thought stopping (Copeland 2001) to slow down this information processing and enable people to analyze their automatic thoughts for accuracy. Often automatic thoughts are distorted and inaccurate, and therapy allows the individual to respond to the troubling and inaccurate thoughts. Many of Sally's automatic thoughts were prefaced with 'should' statements, which maintained her anxiety and exacerbated her feelings of pressure. In Sally's case, her thoughts were often inaccurate because there was little evidence to support them. For example, she found it difficult to identify information that supported her automatic thought that others were disappointed in her.

Self-Talk and Hopelessness: People who experience anxiety and depression are prone to engage in negative self-talk (Bourne, 2000). Prior to her current problems, Sally related that she had been a bright, energetic, articulate young woman who functioned successfully in a job that involved entailed problem-solving ability. When Sally was depressed however, she was unable to solve relatively simple problems, such

as calling a credit card company to report a change of address details. A recognition of this difficulty made her even more despondent and anxious. A cycle developed when the anxiety about her struggles in solving personal and work problems and her concern about disappointing her parents led to an increase in her hopelessness and generation of increasing 'should' statements in her mind. Collecting her 'should' statements and asking her how the 'should' statement was generated was one step.

This step was followed by asking herself if this rule applied to other people, allowing her to recognize her unreasonable expectations of herself and her perfectionism. Tracking her 'should' statements and the provision of psychoeducational material about the impact of depression on problem-solving ability was useful in decreasing her anxiety and alleviating her hopelessness.

Sally reported feeling frightened that her suicidal thoughts would return and that she might once again harm herself. During her treatment, she participated in the development of a list of warning signs that would indicate increased hopelessness and suicide risk. These included: decreasing time normally spent with her family, sleeping late in the morning, feeling overwhelmed, being self-critical, thinking of how she has disappointed everyone, and focusing on her 'failures'. Sally was able to identify that these events led to activation of her schemas of over-responsibility, vulnerability, and defensiveness.

Emotional Reasoning: Relates to feeling something and using that feeling as affirming evidence; for example, feeling overwhelmed and then believing it to be true without examining the facts (Bourne, 2000). Sally was easily tearful, which she interpreted as a fact that she could not cope. She believed that 'because I felt overwhelmed, I must be overwhelmed'. This led to an increase in hopelessness.

Therefore, in Sally, increased affect led to schema activation, which in turn led to emotional reasoning.

Coping Cards: Are written verbal responses made in preparation to address troubling thoughts or feelings. A coping card model includes: acknowledging and accepting the feeling, recognizing it as temporary, examining resources, initiating constructive action, and thinking of how to respond to a friend experiencing the same feelings (Davis, Eshelman, & McKay, 2000). For example, Sally's coping card for feeling overwhelmed read:

> *I know I am feeling overwhelmed but I have felt this way before and it passes. I do not have to respond to my feelings. I am working with my clinician to get better at fighting off my anxiety and depression and not giving into it. I refuse to be victimized by my anxiety and depression. I am going to look at my list of activities and begin working my way through the list until these feelings pass. If Cathy were telling me about feelings like these, I would reassure her that she has gotten through it before and she will again. I would tell her to remember all of the successful things she has successfully accomplished.*

Thought Record: This is a systematic approach to recording situations triggering automatic thoughts or distressing emotions. The thought record provides a method to analyze and rationally respond to automatic thoughts. Sally was encouraged to use this as a way of helping her to recognize when her automatic thoughts occurred and to develop rational alternatives for future encounters.

Treatment Results and Interpretation

Anxiety Disorders Interview Schedule(SCID-IV, First, et al., 1997).

Results of this Interview indicated that Sally met the criteria for major depressive disorder, recurrent severe, and generalized anxiety disorder.

Beck Depression Inventory (BDI) (Beck, et al., 1996).

The BAI score is the sum of the ratings given by the examinee for the 21 symptoms. Each the level of depression experienced for each symptom is rated on a 4-point scale ranging from 0 = not all, to 3 = severely. A baseline score of 18 obtained at the commencement of treatment placing Sally in the moderate level of depression range. At retesting upon the completion of treatment Sally, recorded a score of seven placing her within the mid level of the low depression range. This indicated a significant reduction in the level of anxiety experienced over the course of the treatment.

Beck Anxiety Inventory (BAI, Beck, et al., 1988).

The BAI total score is the sum of the ratings given by the examinee for the 21 symptoms. Each the level of anxiety experienced for each symptom is rated on a 4-point scale ranging from 0 = not all, to 3 = severely. A baseline score of 26 obtained at the commencement of treatment placed Sally around the low level of the severe anxiety range. At retesting upon the completion of treatment Sally, recorded a score of nine placing her at the low level of the mild anxiety range. This indicated a significant reduction in the level of anxiety experienced over the course of the treatment.

Scale for Suicidal Ideation (SSI, Beck, et al.,1979)

The SSI total score is the sum of the ratings given by the clinician for the 19-items, which assess the intensity of specific attitudes, plans, and behaviours concerning suicidal behaviour. Items are rated on a 3-point scale from 0 = moderate to strong, to 2 = none. A baseline score of 24 obtained at the commencement of treatment placed Sally

at the severe level of suicidal ideation. At retesting upon completion of treatment, Sally recorded a score of six, placing her low level of suicide ideation. This indicated a significant reduction in suicidal ideation over the course of the treatment.

Progressive Muscle Relaxation Training

Sally's daily records of her anxiety levels pre and post her relaxation exercise indicate that she was able to achieve a reasonable level of relaxation using this procedure, as shown in Figure 1.

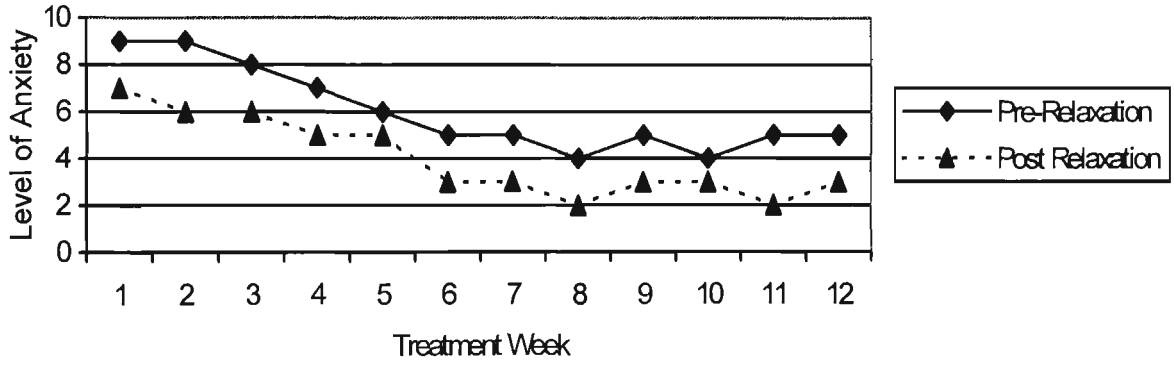

Figure 1 Average weekly anxiety ratings following daily application of a progressive muscle relaxation technique.

After 12 sessions, Sally terminated treatment on her own undertaking because she felt she had met her goal of decreasing her thoughts of hopelessness and felt sufficiently equipped to manage her depressive symptoms. She had been able to find a new job in Ballarat in her area of expertise and felt confident about her future. Within eight sessions Sally had moved out of her family home into independent accommodation in Ballarat, initiated social outings, and begun to look at her career options. Sally's goals were met, including increasing her tolerance for negative affect as opposed to interpreting it a sign she would not win the battle against depression, decreasing self-critical statements, and defining what she would do in specific situations as opposed to speculating about what she thought other's wanted from her. Trusting

her own abilities to solve daily problems at work enabled her to function more independently in her new job.

A month later Sally called requesting a 'booster' session. She was beginning to feel overwhelmed at work and was anxious about asking for a raise. This session involved a review of the cognitive techniques (i.e., completing thought records, structuring her time, responding to her schema activation) and a role-play on how to ask for a raise at work. Sally returned for an additional session where she reported that she had been successful in obtaining a raise and her feelings of being overwhelmed had subsided.

DSM-IV Diagnoses.

Based on the treatment assessment and outcomes, the following diagnosis was made utilizing the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). The DSM-IV uses a classification system. Sally's profile is set out below according to the multi-axial nature of diagnosis indicated by the DSM-IV. The numbers indicate the reference point of each disorder within the DSM-IV.

Axis I:	296.33	Major Depressive Disorder/Recurrent/Severe
	300.02	Generalized Anxiety Disorder (GAD)
Axis II:	No diagnosis	
Axis III:	No diagnosis	
Axis IV:	Broken relationship, stressful work schedule	
Axis V:	GAF Current = 45 (on admission), Best in Past Year = 80 (at discharge)	

Axis I relates to clinical disorders, Axis II relates to personality disorders, Axis III relates to general medical conditions, Axis IV relates to psychosocial and environmental problems, and Axis V relates to a global assessment of functioning. In this way, the multi-axial system provides a convenient format for organising and communicating clinical information and assists in treatment planning and predicting outcomes. Sally's' diagnostic results indicated that she had a range of clinical issues that required treatment as well as several lifestyle problems that may have been impacting on her overall level of functioning.

Discussion

The co-occurrence of mood and anxiety disorders is relatively common, with 57% of depressed individuals also experiencing an anxiety disorder, and 56% of anxiety-disordered individuals also experiencing a depressive disorder (Kessler, et al., 1996). This co-morbidity of mood and anxiety disorders can lead to increased clinical morbidity, greater functional impairment, higher symptom severity, and poorer prognosis (Hecht, et al., 1990; Sherbourne & Wells, 1997).

Cognitive behavioural therapy (CBT) has been shown to provide significant results in the treatment of individuals with mood and anxiety co-morbidity (Borkovec & Costello, 1993; Chambless & Gillis, 1993). Sally's treatment used a cognitive behavioural approach to her problems (Rapee & Barlow, 1988). Sally's perceptions of social events and the things she said to herself about these events played an important role in the maintenance of her anxiety. Sally learnt to recognize the general kinds of self-statements that were associated with her anxiety and develop more appropriate statements to use to enhance her ability to cope with stressful situations. In addition to gaining 'insight' into her problem, Sally was taught specific cognitive skills (i.e.,

adaptive self-statements, thought stopping) that had previously been absent in her coping responses. Positive change was evident only after a prolonged period of practice employing rational self-statements, both in and out of treatment sessions. In addition, Sally was assisted to learn specific behavioural responses in order to better manage her anxiety (e.g., relaxation training).

Further, a person who is experiencing depression may spend a considerable amount of time doing nothing. This inactivity and/or lack of accomplishment can deepen depression. The use of a daily activity schedule in Sally's treatment assisted in treating her depression through increasing her level of physical activity, helping her to carry through simple plans, break larger tasks down into smaller components, plan time to engage in pleasurable activities and increase awareness of her accomplishments.

This case illustrates one method of treatment for suicidal individuals with co-morbid mood and anxiety disorders. For Sally, as possibly for many others, the therapy must focus on the impact of their co-morbid disorders on the individual's current suicidal ideation and seek to address the issues of perfectionism, social sensitivity, and difficulties with problem solving, as well as their feelings of hopelessness. Cognitive behavioural therapy provides an appropriate framework for addressing these problems by assisting the individual in learning the skills necessary for structuring time; tracking thoughts, feelings, and behaviours; and developing strategies to manage and cope with destructive thoughts.

References

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders – DSM-IV (4th Ed.). Washington, DC: American Psychiatric Association.

Beck, J., S. (1995). Cognitive Therapy: Basics and Beyond. New York: Guildford Press.

Beck, A. T., Davis, J. H., Frederick, C. J., Perlin, S., Pokorny, A. D., Schulman, R. E., Seiden, R. H., & Wittlin, B. J. (1973). Classification and nomenclature. In H. C. P. Resnik & B. C. Hathorne (Eds.), pp. 7-12. Suicide prevention, Washington, DC: US Government Printing Office,.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. Journal of Consulting and Clinical Psychology, 56, 893-897.

Beck, A. T., Kovaks, M., & Weissman, A. (1979). Assessment of suicidal ideation: The scale for suicide ideation. Journal of Consulting and Clinical Psychology, 47, 343-352.

Beck, A. T., & Steer, R. A. (1990). Manual for the Beck Anxiety Inventory. San Antonio, TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. (1993). Dysfunctional attitudes and suicidal ideation in psychiatric outpatients. Suicide and Life Threatening Behaviour, 23, (1), 11-20.

Beck, A.T, Steer, R. A., & Brown, G. K. (1996). Manual for the Beck Depression Inventory-II. San Antonio, TX: Psychological Corporation.

Beck, A.T., Steer, R. A., Epstein, N., & Brown, G. (1990). The Beck self-concept test. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 2, 191-197.

Bonner, R. L., & Rich, A. (1988). Negative life stress, social problem-solving, self-appraisal, and hopelessness: Implications for suicide research. Cognitive Therapy and Research, 12, 549-556.

Borkovec, T. D., & Costello, E. (1993). Efficacy of applied relaxation and cognitive-behavioural therapy in the treatment of generalized anxiety disorder. Journal of Consulting and Clinical Psychology, 61, 611-619.

Bourne, E., J. (2000). The Anxiety and Phobia Workbook. Oakland, CA: New Harbinger Publications.

Chambless, D. L., & Gillis, M. M. (1993). Cognitive therapy of anxiety disorders. Journal of Consulting and Clinical Psychology, 61, 248-260.

Copeland, M., E. (2001). The Depression Workbook (2nd Ed.). Oakland, CA: New Harbinger.

Creamer, M., Foran, J. & Bell, R. (1995). The Beck Anxiety Inventory in a non-clinical sample. Behavior Research and Therapy, 33, 477-485.

Davis, M., Eshelman, E. R., & McKay, M. (2000). The Relaxation and Stress Reduction Workbook (5th Ed.). Oakland, CA: New Harbinger Publications.

Fawcett, J. (1997). The detection and consequences of anxiety in clinical depression. Journal of Clinical Psychiatry, 58, (Suppl. 8), 35-40.

First, M. B., Spritzer, R. L., Williams, J. B. W., & Gibbon, M. (1997). Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, (4th Ed.)(DSM-IV, SCID). Washington, DC: American Psychiatric Association.

Fox, T. (1990). Drug treatment of anxiety and depression. Practitioner, 223, 681-683.

Fydrich, T., Dowdall, D. & Chambless, D. C. (1992). Reliability and validity of the Beck Anxiety Inventory. Journal of Anxiety Disorders, 6, 55-61.

Gorman, J., M. (1997. The use of newer antidepressants for panic disorder. Journal of Clinical Psychiatry, 58, (Suppl. 14), 54–58.

Hecht, H., von Zerssen, D., & Wittchen, H. U. (1990). Anxiety and depression in a community sample: The influence of co-morbidity on social functioning. Journal of Affective Disorders, 18, 137-144.

Hewitt, P. L., Flett, G. L., & Turnbull-Donovan, T. (1992). Perfectionism and suicide potential. British Journal of Clinical Psychology, 31, 181-190.

Keller, M. B., & Hanks, D. L. (1995). Anxiety symptom relief in depression treatment outcomes. Journal of Clinical Psychiatry, 56, (6), 22-29.

Kessler, R. C., Nelson, C. B., McGonagle, K. A., Liu, J., Swartz, M., & Balzer, D. G. (1996). Co-morbidity of DSM-III-R major depressive disorder in the general population: Results from the U.S. National co-morbidity survey. British Journal of Psychiatry, 168, (Suppl. 30), 17-30.

Keck, P.,E., & McElroy, S., L. (1997). New uses for antidepressants: social phobia. Journal of Clinical Psychiatry, 58, (Suppl. 14), 32–36.

Leonard, K., L. (1997). New developments in the treatment of obsessive-compulsive disorder. Journal of Clinical Psychiatry, 58, (Suppl. 14), 39-45.

Lewinshon, P. M., Rohde, P., & Seeley, J. R. (1995). Adolescent psychopathology: III. The clinical consequences of co-morbidity. Journal of the American Academy of Child and Adolescent Psychiatry, 34, 510-519.

Nutt, D. (1997). Management of patients with depression associated with anxiety symptoms. Journal of Clinical Psychiatry, 58, (Suppl. 8), 11-16.

O'Connor, R. C., Sheehy, N. P., & O'Connor, D. B. (1999). A Thematic Suicide Note Analysis: some observations on depression and previous suicide attempt. Journal of Crisis Intervention and Suicide Prevention, 20, 106–114.

O'Connor, R. C., Sheehy, N. P., & O'Connor, D. B. (2000). Fifty cases of general hospital parasuicide. British Journal of Health Psychology, 5, 83–95.

Petrie, K., Chamberlain, K., & Clarke, D. (1988). Psychological predictors of future suicidal behaviour in hospitalized suicide attempters. British Journal of Clinical Psychology, 27, 247–258.

Pollock, L. R., & Williams, J. M. G. (1998). Problem solving and suicidal behaviour. Suicide and Life-Threatening Behaviour, 28, 375-387.

Preister, M. J., & Clum, G. A. (1993). The problem solving diathesis in depression, hopelessness and suicide ideation: A longitudinal analysis. Journal of Psychopathology and Behavioural Assessment, 15, 239-254.

Rainer, W. F., Steer, R. A., Laverence, T. I., Rissmiller, D. J., Piper, G. F., & Beck, A. T. (1987). Relationship of depression, hopelessness, and dysfunctional attitudes to suicide ideation in psychiatric patients. Psychological Reports, 67, 967-975.

Rudd, M. D., Rajab, M. H., & Daham, P. F. (1994). Problem-solving appraisal in suicide ideators and attempters. American Journal of Orthopsychiatry, 64, (1), 136-149.

Schotte, D., & Clum, G. (1987). Problem-solving skills in psychiatric patients. Journal of Consulting and Clinical Psychology, 55, 49-55.

Sheehan, D., V., & Harnett-Sheehan, K. (1996). The role of SSRIs in panic disorder. Journal of Clinical Psychiatry, 57, (Suppl. 10), 51–58.

Sherbourne, C. D., & Wells, K. B. (1997). Course of depression in patients with co-morbid anxiety disorders. Journal of Affective Disorders, 43, 245-250.

Wagner, W., Zaborny, B. A., & Gray, T. E. (1994). Fluvoxamine: A review of its safety profile in worldwide studies. International Clinical Pharmacology, 9, 223-227.

Placement Report 3

Cognitive-Behavioural Group Treatment for Generalized Anxiety Disorder

Acknowledgements:

To Barwon Health Community Health Centre, Newcomb for allowing their data and resources to be used in the production of this research report.

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Abstract

A 10-week CBT group treatment program for individuals with a diagnosis of Generalized Anxiety Disorder was conducted at Barwon Health, Geelong. A total of nine participants (1 male, 8 females) aged between 23 and 57 participated. Participant measures of depression, anxiety, and stress were obtained pre, during and post participation in the program using the Depression, Anxiety, Stress Scale. Results showed substantial decreases across all three variables over the course of the program. Further, participant feedback indicated that the group program had provided opportunities to reduce the sense of isolation many felt as a consequence of their anxiety. The participants also reported learning more about GAD and the effective management of anxiety in a supportive and enjoyable setting.

Introduction

Anxiety disorders are a common psychological problem among people presenting to primary care settings as well as psychiatric settings. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) definition of Generalized Anxiety Disorder (GAD) characterizes it in terms of excessive anxiety and persistent worry on most days of the week for a period of six months or more (American Psychiatric Association, 2000). GAD has a one-year prevalence rate of three percent, and a lifetime prevalence rate of around five percent (Sramek, Zarotsky, & Cutler, 2002). Among individuals seen by primary care clinicians, GAD has an eight percent prevalence rate, making GAD the most prevalent anxiety disorder in the primary care setting (Wittchen & Hoyer, 2001).

DSM-IV criteria require that at least three of the following symptoms be present for a diagnosis of GAD: restlessness, difficulty concentrating, easy fatigability, irritability, muscle tension and disturbed sleep. The diagnosis is excluded if the focus of anxiety or worry is confined to the features of another disorder. For example, if the anxiety is based on the fear of embarrassment in public, the diagnosis would be social phobia and not GAD (American Psychiatric Association, 2000). Yet despite these criteria, a diagnosis of GAD may be complicated by concomitant psychiatric or somatic illnesses, such as depression or other types of anxiety disorder (Rickells & Schweizer, 1990).

The clinical course of GAD is chronic and fluctuating in severity, often worsening during periods of stress. The usual age of onset is in the late teens or early twenties, however individuals report prior symptoms of anxiety during childhood as well (Sramek et.al., 2002). Blazer, Hughes, and George (1987) state that females account for two-thirds of those diagnosed with GAD, however, males who report four

or more significant life events have an eight times greater risk of GAD than those who report three or less. In contrast, females show no similar association with significant life events, but both males and females who experience at least one unexpected, negative and very important life event have a three-fold greater risk of developing GAD.

Cognitive-behaviour therapy (CBT) for anxiety disorders is well established as a promising and frequently effective treatment (Chambless & Gillis, 1993; Dobson, 1989; Hollon, Shelton, & Davis, 1993). CBT is a generic term referring to therapies that incorporate both behavioural interventions (direct attempts to reduced dysfunctional emotions and behaviour by altering behaviour) and cognitive interventions (attempts to reduce dysfunctional emotions and behaviour by altering individual appraisals and thinking patterns) (Brewin, 1996). Both types of intervention are based on the assumption that prior learning is currently having maladaptive consequences, and that the purpose of therapy is to reduce distress or unwanted behaviour by undoing this learning or by providing new, more adaptive learning experiences. CBT for the treatment of GAD has demonstrated substantial and clinically valuable improvements in individuals with GAD (Butler, Fennell, Robson, & Gelder, 1991).

The following report is a review of a CBT group treatment program for individuals with GAD, which was conducted at Barwon Health, Geelong. The CBT treatment used within this program was modeled on cognitive therapy as described by Beck (see Beck, 1976; Beck, Emery, & Greenberg, 1985; Beck, Rush, Shaw, & Emery, 1979) and behavioural therapy as described by Barlow (see Barlow, 1988, 2002; Barlow, et al., 1984).

Method

Overview

Individuals attending the five Barwon Health Primary Care Services in Community Centers across the city of Geelong who met the DSM-IV diagnostic criteria for GAD were invited to take part in the group. All participants were completed a series of questionnaires at the point they were identified as suitable for inclusion in the group, at week five of the group, and upon completion of the group.

Participants

Referrals for individuals to take part in the group where obtained from clinicians working within the Primary Care Services across the five Community Health Centres of Barwon Health, Geelong. Of the 24 individuals referred, 12 were not included in the study. The main reasons for exclusion were insufficient severity or duration of anxiety (5); or other psychiatric diagnoses (7). Two other individuals who were determined suitable for the group chose to withdraw their participation prior to commencement of the group.

A total of 10 participants (2 males, 8 females) took part in the program. All met the diagnostic criteria for GAD as defined by the DSM-IV. Admission criteria also required that participants were aged between 18 and 65 and had a history a GAD for a minimum of six months. Patients who experienced panic attacks were excluded if they had a primary diagnosis of panic disorder or if their generalized anxiety centered on fear of another panic attack. Diagnoses were made using the Anxiety Disorders Interview Schedule for DSM-IV: Lifetime Version (ADIS-IV-L; Di Nardo, Brown, & Barlow, 1994). The ADIS-IV-L is a semi-structured interview designed to establish reliable diagnosis of the DSM-IV anxiety, mood, somatoform, and substance abuse disorders and to screen for the presence of other conditions (e.g., psychotic disorders). The ADIS-IV-L includes the assessment of lifetime disorders, dimensional assessment (0-8

ratings) of key and associated features of most disorders, and a diagnostic timeline intended to foster accurate determination of the onset, remission, and temporal sequence of current and lifetime disorders.

Materials

The Depression Anxiety Stress Scale (DASS; Lovibond & Lovibond , 1995) was used to obtain a measure of each of the factors of depression, anxiety and stress for each participant prior to commencement of the program, midway through the program, and upon completion of the program. The DASS consists of 42 items, which are statements that describe negative emotional symptoms (e.g., 'I couldn't seem to experience any positive feeling at all', 'I was aware of dryness in my mouth'). Participants were asked to rate the extent to which they had experienced each symptom over the past week, on a 4-point severity/frequency scale, ranging from '0' Did not apply to me at all, to '3' Applied to me very much or most of the time. Items are divided into three factors, depression (14 items), anxiety (14 items, and stress (14 items). Scores on each factor range from 0 to 42. Higher scores indicate an increasingly more severe nature of symptoms, with lower scores (0-9 for depression, 0-7 for anxiety, 0-14 for stress) equivalent to normalcy. Scores are determined by summing the scores for the relevant number of items within each factor.

The DASS was designed to provide relatively pure measures of the three related negative affect states of depression, anxiety and stress. The Depression items assess dysphoria, hopelessness, devaluation of life, self-depreciation, lack of interest or involvement, anhedonia, and inertia. The Anxiety items assess autonomic arousal, skeletal musculature effects, situational anxiety, and subjective experience of anxious effect. The Stress items assess difficulty in relaxing, nervous arousal, being easily upset or agitated, irritability and impatience. Alpha coefficients for the 42-item DASS

subscales are as follows: Depression = 0.91, Anxiety = 0.84, and Stress = 0.90 (N – 2,914; Lovibond & Lovibond, 1995).

Generalized Anxiety Participant Manual

The program content was designed by a probationary psychologist and delivered by her and a social worker. Topic areas used within this program were modeled on cognitive therapy as described by Beck (Beck, 1976; Beck, et al., 1985; Beck, et al., 1979). The participant manual provided participants with an overview of the material to be presented each week and additional information and reading for home study. It also contained information about the various coping techniques and strategies taught in sessions for reference at home. See Appendix A. Participants were also provided with an audiotape that provided instruction for working through a session of progressive muscle relaxation and isometric exercises for home practice of these techniques. See Appendix A.

Overview of CBT Treatment Program

The program used was loosely divided into three parts; (1) an initial treatment interview, (2) the treatment program (sessions 1 to 8), and (3) review and relapse prevention (sessions 9 and 10).

The treatment orientation interview had several specific goals. Most importantly, it allowed the participants to become acquainted with the therapists, thereby providing a familiar face at the first group meeting. The participants were asked to complete a series of questionnaires in order to obtain base measures for comparison with outcome measures upon completion of the program. Participants were also introduced to the Subjective Units of Discomfort Scale (SUDS), which was used throughout the program to quantify their anxiety experience. The techniques of CBT

were also described and any questions were answered. Finally, reading materials were supplied for participants to read prior to the first group session.

The first session outlined the themes and topics that would be presented over the course of the program. The specific tasks of the first session were: (1) presentation of the anxiety model, (2) anxiety symptoms, (3) the role of hyperventilation, and an (4) introduction to breathing retraining. Participants were also provided with daily symptom record sheets for completion at home and given instruction on how to fill these in.

Session two introduced the anxiety symptom triad and provided training in the use of progressive muscle relaxation. The power of thoughts in relation to anxiety was examined prior to instruction on using thoughts stopping techniques. Session three built on this by providing training in the use of self-instruction to challenge unhelpful thinking and assist in the monitoring of negative self-talk and automatic thinking.

Session four explored the thinking patterns and cognitive distortions that are associated with anxiety and revisited the use of self-instruction to challenge these. Session five continued this theme with an examination of the effects of catastrophising, worry, perfectionism and unhelpful thoughts along with an introduction to isometric relaxation.

Session six examined avoidance behaviour and fear prior to provision of the rationale for exposure techniques. Participants were asked to construct a hierarchy of feared situations and to plan how they would complete the first step of their hierarchy using the techniques they have been given in previous sessions. Imaginal practice for rehearsal in completing step one of hierarchy was explained then undertaken within the group with participants instructed to continue this as homework. Imaginal practice continued to be a part of all the remaining sessions. Session seven continued this

process with those participants who reported success in completing a step in their hierarchy moving onto planning subsequent steps. Long-term and short-term goals were also discussed in relation to goal setting and planning, while session eight explored the role of lifestyle and anxiety.

Session nine examined recognising success and maintaining change along with coping with negative emotions and anxiety in terms of relapse prevention. Session ten sought to review the areas covered, along with the anxiety triad and the coping skills developed. Participants were encouraged to acknowledge their achievements. Finally, a review of the coping techniques and strategies learned were presented and informed a discussion regarding preparation for future high-risk situations and/or relapses.

Procedure

Individuals referred were first interviewed by the therapists who would conduct the program to determine their suitability for the group. All referrals were received through Barwon Health's internal mail through which clinicians working in the primary care areas of all Barwon Health Community Health Centers could refer any current clients they had who were experiencing anxiety to the group.

At the time of the interview, clients were assessed to ensure they meet the eligibility criteria for entry into the group. Those who were found to be unsuitable were offered individual treatment for their problems with other clinicians within the primary care team at Newcomb.

Participants took part in the CBT group program over a ten-week period. Sessions were held at the Barwon Health Community Centre located in Newcomb, Geelong. Sessions were held in the group training room located on this building each Wednesday afternoon. Each session ran for approximately two hours.

At the last session, participants were also asked to fill in feedback forms to provide them with an opportunity to provide their comments and evaluation of the program. See Appendix B.

Results

Description of Sample

Participants consisted of two males and eight females ranging in age from 23 to 56. Of the total sample, two participants had completed tertiary education, three TAFE trade courses, 3 had completed Yr 12 at secondary school, and two had left school at Year 10. Six participants were married, two were divorced, and two were single. One of the male participants failed to complete the full 10-week program, leaving after week three. This participant indicated that he was uncomfortable in a group setting and felt he could not longer participate. Arrangements were made for this individual to continue treatment individually within the Primary Health Care service.

Depression, Anxiety, Stress Scale (DASS)

All three factors of the DASS were observed to have decreased over the course of the 10-week program. The means of these three factors (depression, anxiety, stress) for the nine participants who completed the group are shown in Figure 1.

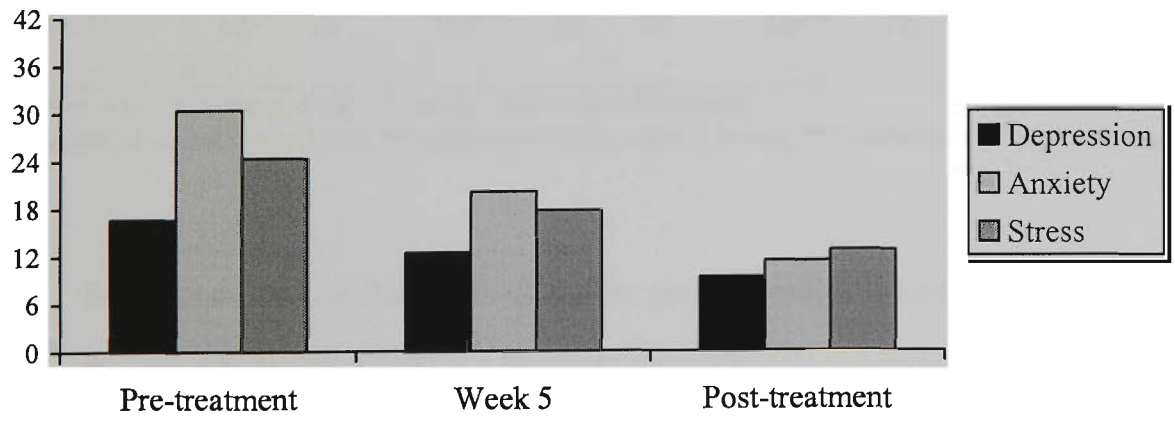


Figure 1. Mean DASS Profile Scores over 10-week Program.

Mean scores on all three factors of the DASS Scale were observed to have reduced a total of two severity levels, from a rating of severe to mild for depression, severe to normal for anxiety, and severe to normal for stress.

Individual progress throughout the 10-week program on the three factors of depression, anxiety, and stress indicated a downward trend for most participants. Scores for each participant on each factor of the DASS Scale are presented in Table 1.

Table 1. Participants' individual DASS scores over the 10-week program

	DASS Scale Factor								
	Depression			Anxiety			Stress		
Participant	Pre	Wk 5	Post	Pre	Wk 5	Post	Pre	Wk 5	Post
Person 1	19	11	8**	30	19	10**	21	17	12**
Person 2	18	12	7**	29	18	12**	17	15	10*
Person 3	10	9	9*	27	16	7***	12	9	11
Person 4	20	16	13*	31	21	14**	40	29	19**
Person 5	15	10	12*	28	16	9***	19	14	12**
Person 6	12	10	7*	26	19	11**	17	15	12*
Person 7	22	16	10**	34	23	12**	30	22	15**
Person 8	18	14	8**	36	28	14**	28	20	13***
Person 9	16	14	10*	33	21	13**	25	18	10**

Note: Pre = pre-treatment, 5 wk = 5 weeks, Post = post-treatment
* reduction of one severity level, ** reduction of two severity levels, *** reduction of three severity levels.

Severity ratings on the DASS Scale are given across five levels: Extremely severe, Severe, Moderate, Mild, and Normal. Most participants achieved a reduction of two severity levels across the three DASS factors, typically from a rating of extremely

severe or severe to a rating of mild or normal. For some participants severity ratings reduced by three levels (eg., from a severe rating of 27 for anxiety to a normal rating of seven)

Participant Review and Feedback

In general, the feedback provided by participants about the group was extremely positive, with all participants indicating that they felt they had benefited from the program and had found it interesting, educational and enjoyable. All participants also indicated that the program had strongly met their expectations. Participants reported that the program had introduced them to a variety of strategies for dealing with their anxiety, enabling them to reduce their stress and depression and over come sleeping difficulties. Participants noted that the session on relaxation was valuable, as this was an aspect that many felt they had not considered before in managing their anxiety. Participants also noted that they had valued the opportunity to hear others experience of GAD and that this had helped them to feel less isolated in their own experiences. The social support of the other participants in the group was a particularly positive aspect for many participants who related that they had been able to make new friendships; the first in may years for some participants.

Criticisms of the program related to feelings that aspects of the program were too rushed. Comments such as 'we needed twice as long as was available to sift through all the information given'. This aspect had been considered in developing the program and attempts were made through the provision of the participant manual in which all the material presented was reproduced for further review and reflection between sessions. Perhaps greater emphasis on home reading was required to ensure participants were aware this option was available for those who found themselves 'information overloaded' during the group sessions. However, as participants appeared

to respond to different components and aspects of the program, it is felt that the program should remain in its present form, but examination of the content and how it may be more clearly and concisely presented may be beneficial.

Discussion

The CBT group treatment program offered through Barwon Health, Geelong to individuals with Generalized Anxiety Disorder (GAD) appears to have produced positive outcomes. All participants who completed the 10-week program recorded substantial reductions in their ratings for depression, anxiety and stress on the Depression, Anxiety, Stress Scale (DASS, Lovibond & Lovibond, 1995). All participants also indicated that they felt the quality of their lives had improved and that the program had provided them with valuable education about GAD and its impact along with specific training in the techniques and strategies for effective management of their anxiety. The social aspects of being involved in a group program had also assisted to reduce the sense of isolation felt by some participants in relation to their anxiety, with many indicating that the group experience had enabled them to think more positively about the future through the enjoyment and company of the other group members.

As stated previously, the treatment goal of CBT for anxiety disorders such as GAD is to reduce the symptoms associated with it by uncoupling the pairing between stimulus events and the anxiety response. This is accomplished by helping individuals to reduce the anxiety associated with the stressful events, to override the anxiety response with a relaxation response and more logical thinking, and to teach alternative coping responses to replace avoidance and other nonproductive attempts at coping. In this way, the negative reinforcement cycle can be broken. CBT for anxiety disorders then integrates the cognitive model with the principles of learning theory to help explain

the chain of events that creates or maintains the anxiety response. This integrated model then forms the basis for treatment methods, such as those incorporated into this program, that seek to break the sequence of events that maintain the anxiety.

As such, CBT aims to provide individuals with the tools to combat anxiety not only in the present but also in the future, should anxiety symptoms re-occur. Using the CBT treatment outlined in this report, the individual is encouraged to recognize the sequence of maladaptive responses to anxiety-arousing responses they currently engage in and provides intervention strategies aimed at breaking the cycle of anxiety that maintains their condition. The goal of CBT program presented in this report was to break the negative reinforcement cycle so that the anxiety disorder loosens its grip on the individual's life. By reducing the individuals avoidance behaviours and assisting them to learn methods to control their anxiety it was proposed that this would increase the likelihood that the individual could resume normal functioning and have a life that is not limited by anxiety. For the participants of this group program, their outcomes in terms of the reductions achieved in their levels of depression, anxiety and stress, along with their feedback of the positive experiences and learning they acquired within the group suggest they have been able to regain some control of their anxiety and begin the development of new skills for the future management of their condition which will serve to provide them with a brighter future.

References

American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders (4th ed. Revised). Washington, DC: Author.

Barlow, D. H. (1988). Anxiety and its disorders. The nature and treatment of anxiety and panic. New York: Guilford Press.

Barlow, D. H., (2002). Anxiety and its disorders: The nature and treatment of anxiety and panic. New York: Guilford Press

Barlow, D. H., Cohen, A. S., & Waddell, M. T., Vermilyea, B. B., Klosko, J. S., Blanchard, E. B., & Di Nardo, P. A. (1984). Panic and generalized anxiety disorders: Nature and treatment. Behaviour Therapy, 15, 431-449.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. New York: International Universities Press.

Beck, A. T., Emery, G., & Greenberg, R (1985). Anxiety disorders and phobias: A cognitive perspective. New York: Basic Books.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford Press.

Blazer, D, Hughes, D., & George, L. K. (1987). Stressful life events and the onset of generalized anxiety syndrome. American Journal of Psychiatry, 144, 1178-1183.

Brewin, C. R. (1996). Theoretical foundations of cognitive-behavior therapy for anxiety and depression. Annual Review of Psychology, 47, 33-57.

Butler, G., Fennell, M., Robson, P., & Gelder, M. (1991). Comparison of behaviour therapy and cognitive behaviour therapy in the treatment of generalized anxiety disorder. Journal of Consulting and Clinical Psychology, 59, (1), 167-175.

Chambless, D. L., & Gillis, M. M. (1993). Cognitive therapy of anxiety disorders. Journal of Consulting and Clinical Psychology, 61, 248-260.

Di Nardo, P. A., Brown, T. A., & Barlow, D. H. (1994). Anxiety Disorders Interview Schedule for DSM-IV: Lifetime version (ADIS-IV-L). San Antonio, TX: Psychological Corporation.

Dobson, K. S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. Journal of Consulting and Clinical Psychology, 57, 414-419.

Hollon, S. D., Shelton, R. C., & Davis, D. D. (1993). Cognitive therapy for depression: conceptual issues and clinical efficacy. Journal of Consulting and Clinical Psychology, 61, 270-275.

Lovibond, S. H., & Lovibond, P. F. (1995). Manual for the depression, anxiety, stress scales. Sydney, Australia: Psychology Foundation.

Rickels, K., & Schweiser, E. (1990). The clinical course and long-term management of generalized anxiety disorder. Journal of Clinical Psychopharmacology, 10, 101-110.

Sramek, J. J., Zarotsky, V., & Cutler, N. R. (2002). Generalised anxiety disorder. Drugs, 62, (11), 1635-1648.

Wittchen, H. U., & Hoyer, J. (2001). Generalized anxiety disorder: Nature and course. Journal of Clinical Psychiatry, 62, (supp), (11), 15-21.

Appendix A

Participant Manual

Barwon Health

Primary Care Services

Anxiety Group Program

Session 1

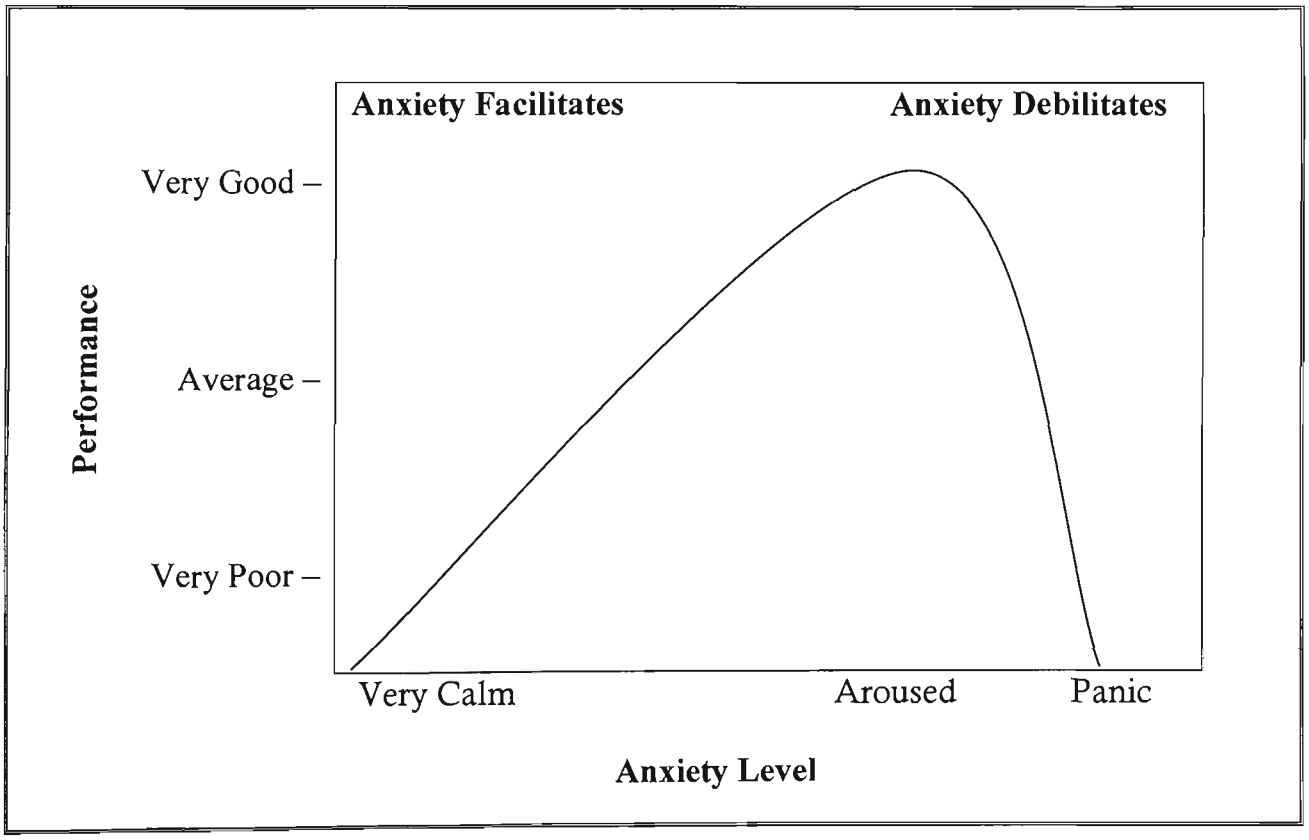
Session Plan

- **Introduction of group members & welcome.**
- **Confidentiality & group rules.**
- **Course plan: Themes & topics to be covered.**
- **Presentation of the anxiety model – What is anxiety?**
- **How do anxiety symptoms begin & perpetuate.**
- **Hyperventilation.**
- **Introduction to breathing retraining.**
- **SUDS – Subjective units of distress.**
- **Daily symptom record sheet.**

WHAT IS ANXIETY?

Anxiety is an emotion that is experienced by everybody. It is a **normal** and healthy reaction that can act as a productive, driving force. It arises in situations where some threat to safety or well-being is perceived. This response to threat is an adaptive characteristic of human beings. It is aimed at facilitating action to deal with the threatening situation. In fact, a healthy level of anxiety can facilitate optimal performance. For example when making a speech some anxiety will have the effect of heightening awareness and concentration, thus enabling that the task is done well. There are few tasks that could be done well in a state of complete relaxation.

When people become too anxious however their skills in a wide range of areas are likely to be impaired. For example, the ability to hold a conversation or argue a point, or general the ability to think clearly and act appropriately may be diminished. As the diagram below illustrates, optimum levels of performance are most likely to be achieved when we are in a state of mild anxiety or arousal. This enables us to remain alert, tense and in control, thus facilitating maximum efficiency.



The primary purpose of anxiety is protective. It prepares our mind and body to react appropriately when a threat is present. Anxiety is different from fear however. Fear is a response that occurs when a threat or danger is perceived to be immediately present. Anxiety is the state of preparation for a reaction to threat or danger. The presence of anxiety does however, put our body on alert. This makes the activation of a fear response more immediately accessible, should the situation warrant fear.

The anxiety and fear response is often spoken about in terms of three components. These are the cognitive component (thoughts and feelings), the physiological component (physical symptoms) and the behavioural component (actions). These three components are in constant interaction.

The **cognitive** component refers to our thoughts and feelings about the threatening situation and our ability to cope with it. When we feel highly anxious our thoughts become focused on the perceived threat. This may involve nervous wondering about what is about to happen in a specific situation, or non-specific thoughts that something bad is about to happen. Anxious thoughts are often referred to as worry. The range of things that people worry about is broad. Some examples of common themes of worry are concern about one's own health or the health of others, the well being of family or friends, work or school performance, finances, daily activities or social performance.

The **physiological** aspect of anxiety arises due to the arousal of the central nervous system. When danger is perceived to be present a series of reactions occur within the body. These changes are designed to enable us to act to avoid the danger perceived. This response is often spoken of as the "fight or flight" response. The brain becomes aware of the danger as a result of messages received from the sensory organs (eyes, ears etc.). In response, hormones are released and the involuntary nervous system activates to send messages to the various parts of the body.

Physical changes that occur within the body during the "fight or flight" response include:

- Heart beat speeds up and blood pressure rises
- Breathing rate increases, air passages open wider, hyperventilation occurs
- Sweating increases to help cool the body
- Blood is diverted to the muscles, they become tense, ready for action
- Mind becomes more alert and focused on threat or danger
- Digestion and saliva production slows
- Liver releases sugar to increase energy
- Immune response decreases to allow massive response to immediate threat.

These responses prepare the body to act in response to the threat. They also account for the physical symptoms we experience when anxious or frightened. These physiological changes are likely to result in the experience of one or a number of physical sensations or symptoms.

Physical sensations or symptoms we may experience as a result of physiological changes include:

- Feeling sick or nauseous
- Trembling or shaking
- Increased rate of breathing, shortness of breath
- Butterflies in the stomach
- Pounding or racing heart
- Cold or clammy hands
- Hot flashes or chills
- Muscle tension
- Restlessness
- Sweating
- Dry mouth
- Tingling sensations

These symptoms become problematic if they continue over a prolonged period of time and if they occur in situations where there is no real danger. Some results of feeling anxious over a prolonged period of time may include:

- Tiredness
- Being easily startled
- Irritability
- Difficulty concentrating
- Constipation or diarrhea
- Frequent urination
- Difficulty falling asleep or staying asleep
- Feeling keyed up or on edge
- Depression

When these symptoms are present the anxiety has begun to interfere with every day life.

The **behavioural** component refers to dealing with or avoidance of the threatening situation. It often involves carrying out frequent safety checks such as regularly phoning home to check on the safety of others or procrastination for fear of negative outcomes. It may also include completely avoiding potentially threatening situations or more subtle behaviours such as pacing, fidgeting and restlessness, all of which are responses to the physiological changes described above. Another common behavioural response to threat may be doing nothing or freezing and feeling unable to act appropriately to either deal with, or avoid the threat.

Why do symptoms of high tension and anxiety begin?

It is most likely that you have become anxious due to a combination of reasons. Debilitating anxiety may be triggered by high levels of stress related to life events that have been beyond your coping resources. This may involve one single event or an accumulation of stressors or worries. Of course no two people will react to any given situation in the same way. Some people may be prone to respond to situations with sensitivity, nervousness or worry by personality.

Personality refers to those personal qualities that are stable and resistant to change. Generally personality is thought of as an inherited predisposition or tendency. It can operate to enable or compromise our capacity to deal with the events of the world that are potentially anxiety provoking. It is influenced by out thoughts, feelings and actions and the meanings we take from life. It functions to filter what we take from our experiences and what we understand about them. The personality filter is in turn modified and shaped by our experience.

While personality, by definition is not easily changeable on any grand scale, we can learn to challenge the thoughts, feelings and actions that influence personality. In so doing, we can manage our experience of anxiety at appropriate levels. For example, a tendency in an individual's personality to unhelpful values such perfectionism, or a high need for control could seriously compromise that person's ability to manage anxiety levels. Attention to these unhelpful personal values and the ways in which these affect that person's thoughts, attitudes, beliefs and behaviour, could allow a significant change which promotes more effective coping.

Whatever the reasons behind your anxiety the aim of this program is to enable you to recognise and manage your anxiety by identifying, understanding and controlling the factors that cause it to perpetuate and escalate.

HYPERVENTILATION

Many of the unpleasant sensations experienced during anxiety and panic may be due to hyperventilation, which occurs in response to over breathing or increased breathing rate.

Breathing is central to life. When we breathe too much however it disturbs the balance between oxygen and carbon dioxide on our blood, oxygen levels increase and carbon dioxide levels decrease. The drop in carbon dioxide brings about a number of changes in the system. Firstly, blood vessels contract, limiting the supply of blood to the brain and around the body. Secondly, haemoglobin, the substance in the blood that carries oxygen around the body, increases its "stickiness" for oxygen. Consequently, not only does less oxygen rich blood reach certain areas of the body but also it is also less likely that the oxygen carried by the blood can be released to the tissues.

The over supply of oxygen in our system brings about a drop in carbon dioxide. This results in the constriction of the amount of oxygen able to be delivered to the brain and around the body.

It is important to remember that the reduction in the supply of oxygen around the body is very slight. It is not life threatening! It is however likely to be responsible for many of the unpleasant symptoms of anxiety and prolonged anxiety discussed earlier in this session.

It is also important to note that hyperventilation can be very subtle and difficult to detect. This is especially true if you have been slightly over breathing for a long period of time. There are several types of over-breathing.

Types Of Over-breathing.

1. **Chronic habitual over-breathing:** Slight increase in the depth or speed of breathing sustained over a long period of time. Results in person feeling constantly apprehensive, slightly dizzy and unable to think clearly.
2. **Panting or rapid breathing:** Tends to occur during periods of acute anxiety or fear. This causes a rapid reduction in carbon dioxide level and may lead to a panic attack.
3. **Sighing, yawning and gasping:** Tends to occur in response to negative emotions or thoughts and involves excessively deep breathing leading to mild hyperventilation. Contrary to popular belief, taking a few deep breaths when stressed is not going to help you to feel better.

The most significant muscles involved in breathing include the diaphragm muscles (between the chest and stomach area) and the chest muscles. Accessory muscles in the shoulders and neck become involved when the body is under stress. In relaxed conditions the majority of activity should occur via the diaphragm muscles. Also, under relaxed conditions we should breathe mostly through our nose rather than our mouth, which again, become involved when the body is under stress. In order to minimise over breathing, your breathing should be light and regular and balanced between your stomach and your chest.

PRACTICE EXERCISES

Slowing down your breathing rate: The six-second cycle.

1. Find a comfortable place – either sitting or lying down is fine.
2. Breathe in and out slowly following the six-second cycle. If you are breathing faster than the six-second cycle, gradually slow your breathing down.
3. You should be breathing at a rate of approximately 10 – 12 breaths per minute.
4. Try to complete 5 – 10, 1-minute cycles.
5. If you have noticed that you are experiencing symptoms of over breathing, continue until all signs have diminished.

Helpful Hints:

- Use your watch and practise estimating a period of six seconds – three seconds in, three seconds out. Observe the rhythm of the seconds hand and after a minute, close you eyes and count to yourself, open your eyes when you think six seconds has passed. It will take only a couple of minutes to develop this skill.
- If you have been over breathing for a long time you may need to set realistic goals. Aim to reduce your breathing rate over a number of days. E.g.: if you take more than 20 breaths per minute you may set a target of 17 on the first day, 14 on the second day and 10 – 12 on the third day.

Light and balanced breathing.

As mentioned above, your breathing should be light, regular and balanced between your stomach and your chest and should mostly involve your diaphragm muscles.

1. Lie down on your back in a comfortable position and relax your stomach, shoulders and neck muscles.
2. Place one hand on your chest, the other on your abdomen, with your thumb and pinky finger touching.
3. Relax your chest and stomach muscles and as the tension drops allow your breathing to slow.
4. Without pushing let as much air out of your lungs as possible.
5. Breathe as slowly and lightly as is comfortable and as you do, adjust your breathing so that your stomach rises more than your chest, with your chest rising only slightly.
6. Continue for a period of 5 – 10 minutes.

It is recommended that you practice these breathing techniques for at least a period of 5 – 10 minutes daily. Of course the more you practice the better.

Breathing Techniques for the Management of Panic Attacks

Slowing down your breathing rate – The Five Second Cycle:

As soon as you feel the signs of panic beginning:

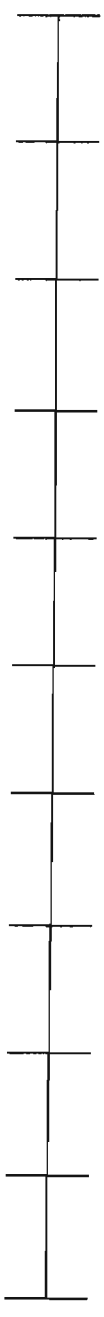
1. Stop what you are doing and sit down. Stay where you are if you can.
2. Hold your breath and count to 10 (don't take a breath)
3. When you get to 10 breaths out and say the word "relax" calmly to yourself.
4. Then breathe in and out slowly following the five-second cycle. If you are breathing faster than the five-second cycle, gradually slow your breathing down.
5. At the end of each minute (or after 10 breaths) hold your breath again for 10 seconds and then continue breathing in the 5-second cycle.
6. Continue until all signs of over breathing have gone.

Remember:

- Be patient. The discomfort you are feeling is very unpleasant but it will not last for long.
- Don't fight the panic and try not to tense up.
- If you must leave the situation in which the panic occurred, return there as soon as you possibly can.
- Try to continue with your day after a panic occurs. Do not cut the day's activities short and return home. This will only reinforce the cycle of avoidance and escalate fears of another attack.
- Nobody has ever been hurt from having a panic attack. These are temporary occurrences from which you will recover and which you can eventually learn to manage more effectively.
- It is important that you practice the breathing techniques set out in the homework for session one regularly.

Subjective Units of Discomfort
SUDS

Throughout this program we will be rating your anxiety or discomfort on a scale from 0 to 100. This will offer a measure of changes in your anxiety over time and provide a means by which to describe the level of discomfort you experience in relation to a range of different situations.



0	Totally relaxed, on the verge of sleep.
10	Alert and awake, concentrating well.
20	Tiny amount of tension or anxiety.
30	Mild anxiety does not interfere with performance.
40	
50	Moderate distress, feels uncomfortable, concentration a problem, but can continue.
60	
70	Quite unpleasant, interfering with performance.
80	Very uncomfortable can't concentrate, want to escape the situation.
90	Extremely uncomfortable, got to leave the situation.
100	Highest anxiety/distress that you have ever felt.

Daily Symptom Record

Keeping a daily record of your anxiety response and the situations that trigger your response is essential in developing an understanding of your own very particular experience.

Date/Time	Situation	Symptoms Experienced	SUDS/100
	1. Where were you? 2. What was the situation? 3. Who was there? 4. What were you thinking?	Food for thought: Heart rate, breathing, sweating, dry mouth, nausea, trembling stomach discomfort, body temperature, muscle tension?	

We will build on and develop the monitoring and recording process as the course continues.

Barwon Health

Primary Care Services

Anxiety Group Program

Session 2

Session Plan

- **Review practice tasks – Difficulties and achievements shared**
- **Review controlled breathing task**
- **Review the anxiety symptom triad**
- **Introduction to relaxation**
- **Progressive muscle relaxation**
- **The power of our thoughts**
- **Introduction to thought stopping**

HOME PRACTICE REVIEW

Food for Thought and Discussion

For those who completed the home practice exercises:
- What did you observe; were there any beneficial changes?
- What difficulties arose?
- Overall, what did you achieve?

For those who did not complete the exercises as often as they would have liked:
- What got in the way?
- What would need to happen to help you to succeed next week?

RATIONALE FOR RELAXATION TRAINING

We have talked about how feelings of anxiety need to be understood in terms of a combination of factors, including thoughts, behaviour, and our physical responses. For that reason, learning to relax physically is one way of interrupting the cycle of worry and apprehension. The fight-or-flight response involves the activation of muscle tension, which helps us to perform many tasks in a more alert way. Normally, these muscles become activated and deactivated according to a person's needs. When people have been under stress for long periods of time, they seldom allow their muscle tension levels to become deactivated, and the tension tends to remain with them for longer and longer periods. This tension may make people feel irritable, nervous, or apprehensive. Because this tension may exist for a long time, these people may not even realise that they are tense. When the body is in a continual state of tension, people are more likely to feel anxious, worry excessively, experience unpleasant and unhelpful thoughts or develop physical symptoms associated with tension. Also, constant tension makes people over-sensitive and may cause them to respond to smaller and smaller events as though they were threatening. By learning to relax, you can gain control over these feelings of anxiety.

Relaxation is the voluntary letting go of tension from your body. This tension can be a physical tension in your muscles or it can be a mental or psychological tension. When we physically relax the impulses in our muscles change the nature of the signals that they send to the brain. This change brings about a general feeling of calm, both physically and mentally.

To learn to relax you need to:
1. Learn to recognise tension;
2. Learn to relax your body in a general, total sense; and
3. Learn to "let go" in specific muscles.

Progressive muscle relaxation.
Progressive Muscle Relaxation (PMR) is a technique in which the muscles are relaxed in a progressive manner. It is usual to begin at the feet and end with the face and neck muscles. In this program a relaxation tape will be provided. Side A presents relaxation instructions which require the listener both to tense and then relax various muscles throughout the body in an orderly sequence.
Side B presents instructions for various isometric relaxation exercises that will be covered in a

later session. Some people prefer one of these forms of relaxation to the other, but in order to experience the true range of sensations associated with deep muscle relaxation, you should aim to eventually master both. Relaxation is a skill that is learned through regular practice.

Relaxation exercises should be done once a day to begin with, preferably before any activity that might prove difficult. Initially, do the exercises in a quiet room, free from interruption, so that you can focus on the relaxation process. Select a comfortable chair with good back and head support. Some people prefer to do the exercises lying down but do not use this position if you are likely to fall asleep.

As you master the relaxation exercises, try inducing deep relaxation in other postures and situations. It is not a good idea to practice deep muscle relaxation while performing activities, which require a high degree of alertness, such as driving a car. For these situations, it is better to use isometric relaxation exercises, which you will be taught later on.

When you have finished your relaxation session, get up slowly and try to preserve the state of relaxation for as long as possible. Set about your planned activities in a slow and calm manner. Do not worry if you do not reach deep levels of relaxation during your early sessions. Remember, relaxation is a skill and as such requires practice. The more frequently you practice relaxation, the deeper the relaxation will be, and the longer lasting will be the effect, resulting in a quick reduction in anxiety.

KEY POINTS TO REMEMBER ABOUT LEARNING TO RELAX.

- Relaxing is a skill - it requires frequent and regular practice.
- Do the exercises immediately whenever you notice yourself becoming tense.
- Develop the habit of reacting to tension by relaxing.
- You can practice tensing your hand and leg muscles without anyone noticing. This can help in situations where you are unable to go through your relaxation routine.
- When circumstances prevent you holding the tension for seven seconds, shorter periods will still help but you may have to repeat it a few more times.
- Do not tense your muscles to the point of discomfort or hold the tension for longer than seven seconds.
- These exercises can be adapted to help in problem settings, such as working at a desk or waiting in a queue. Use them whenever you need to relax.
- Using these exercises you should in a few weeks be able to reduce your tension, prevent yourself from becoming overly tense and increase your self-control and confidence.

Difficulties with relaxation

Some people report that they cannot relax and that relaxation training does not work for them. Since all human beings share a similar biological make-up, there is no physical reason why relaxation should work for some people and not others. The general reason why relaxation does not work for some people is usually due to some psychological factor or insufficient practice. If you are having difficulties, please discuss this with one of the group facilitators. Some examples of difficulties are presented below.

1. "I am too tense to relax". In this instance the person is using the very symptom that needs treating as an excuse for not relaxing. Relaxation may take a little longer to master for someone who is very tense, but there is no reason why someone should remain tense.

2. "I don't like the feelings of relaxation". About 1 in 10 people report that when they relax they come into contact with feelings that they don't like or feelings that frighten them. These feelings indicate that you are coming into contact with your body again and noticing sensations that may have been kept under check for many years. You do not have to worry about losing control during relaxation. You can always let a little tension back in until you get used to the sensations.

3. "I feel guilty wasting so much time". You need to see relaxation as an important part of your recovery. Many therapies take time. You do not have to be openly productive to be doing something useful.

4. "I can't find the place or time". The sense of time pressure may be one of the things that are keeping you tense, so changing your routine to make time for relaxation is all part of the program. Be adaptive. If you can't find 20 minutes, find 10 minutes somewhere in the day to relax. If you do not have a private room, go to a park. You do not have to be alone to relax. It is good practice to relax while others are engaged in other activities around you. You may need to consider if other factors are preventing you from relaxing if you keep making the excuse that there is no time.

5. "I'm not getting anything out of this". Unfortunately, many people expect too much too soon from relaxation training. You cannot expect to undo years of habitual tensing in a few relaxation sessions. Impatience with waiting is in fact a symptom of your anxiety. This reaction is therefore a sign that you actually need to continue with the relaxation training. It is extremely important that you give the training time to take effect. Set long-term goals, rather than monitoring your improvement day by day.

6. "I haven't got the self-control". You need to recognise that quick and easy cures for anxiety requiring little or no effort do not exist. If the problem were easily overcome it would not require effort and work. It is true that working through these difficulties will take some time and effort. The longest lasting treatment effects occur when the individual takes responsibility for his or her recovery. Responsibility means self-control, but self-control is difficult if you are not motivated. In this case you may need to consider what is hindering your motivation.

THOUGHTS AND ANXIETY

As discussed in the last session, anxiety is represented in thoughts, behaviours and physiological responses. We will now look at how our thoughts can interfere in our daily lives. Thoughts sometimes trigger and stimulate anxiety. The trouble may lay not so much in what you are thinking, but that the concern keeps popping back into your mind, over and over again. For some people, these worries or ruminations become so pervasive that they find it difficult to concentrate on anything else.

The thinking component of anxiety also involves the identification and interpretation of situations as threatening, sometimes without you even being aware of it. Most often these situations, which are perceived as dangerous, are actually events that are within the general realm of human coping. However, when an individual is experiencing high levels of anxiety, they tend to produce thoughts and beliefs which are generally unhelpful. Once these unhelpful thoughts are identified it is possible to use strategies to overcome and control your thoughts. You will be taught one of these strategies today. Remember, like relaxation, cognitive work also requires practice to be mastered and used effectively.

THOUGHT STOPPING

Thought stopping exercises are useful when you continue to be troubled by a distressing thought that keeps popping into your head. You need to deliberately practice stopping your intrusive thoughts in order to learn and master thought stopping. There are several ways to practice thought stopping. Some people use a technique that involves calling out the word "STOP!" After you call STOP, you then focus your attention onto something pleasant or practice your rational thinking. Later, when you are more practiced and other people are around you, you can shout STOP firmly to yourself, inside your head.

The technique we will be learning today involves the use of an elastic band. This involves wearing an elastic band around your wrist. When intrusive and unhelpful thoughts enter your mind say stop firmly in your head and snap the elastic band on your wrist. This will give you a sharp reminder to refocus your thoughts. Then, as with the technique above, refocus your attention to something pleasant or to the task you were attempting to concentrate on before the thoughts entered your mind.

It is important to differentiate between thought stopping and avoidance. Thought stopping is not an avoidance strategy. The problem with avoidance is that you put off dealing with the problem so it is never resolved. In thought stopping you have identified thoughts that serve no useful purpose. Rather, they are a source of anxiety for you. In thought stopping you make a conscious decision to take control of your life by rejecting the problematic thought.

PRACTICE TASKS THIS WEEK

- Controlled breathing
- Relaxation practice
- Thought stopping

Barwon Health

Primary Care Services

Anxiety Group Program

Session 3

Session Plan

- **Home practice task review: Breathing, relaxation and thought stopping**
- **Introduction to self-instruction training.**
- **Self-talk and automatic thinking – becoming aware.**
- **Understanding the impact of your thoughts – Group discussion.**
- **Beginning to take control of your thinking – balanced helpful thinking.**
- **Alternative self-statements - replacing unhelpful thinking.**
- **Monitoring self-talk and automatic thinking.**

HOME PRACTICE REVIEW
Relaxation, thought stopping and breathing retraining

Food for Thought and Discussion

For those who completed the home practice exercises:
- What did you observe; were there any beneficial changes?
- What difficulties arose?
- Overall, what did you achieve?

For those who did not complete the exercises as often as they would have liked:
- What got in the way?
- What would need to happen to help you to succeed next week?

INTRODUCTION TO SELF-INSTRUCTION TRAINING

As discussed in sessions one and two, anxiety can be described as our response to perceived threat. There are three components to the anxiety response, physiological, behavioural and cognitive symptoms. These three components are in constant interaction. Together they help to increase and perpetuate anxiety symptoms. In the last two sessions we have worked on developing skills and techniques that help to control physiological symptoms in the anxiety response. These are controlled breathing and progressive muscle relaxation. In this session we focus on understanding the impact of our thoughts and beliefs on anxiety. This technique is referred to as self-instruction training. By developing awareness of our thoughts and we can begin to increase our control over them and work towards more balanced thinking, thus enabling better management of anxiety levels.

The Cognitive Component of the Anxiety Symptom Triad.
As discussed in session one, human beings constantly scan the environment for threatening situations and evaluate the level of threat associated with that situation. Our evaluation of the level of threat depends not only on our beliefs about the situation but also on beliefs about our ability to cope with that situation. Because people constantly evaluate the presence of threat in the environment, a continuous stream of thoughts runs through our minds forming part of a running evaluative commentary. This continuous stream of thoughts is referred to as "self-talk".

Self-Talk: It may surprise you that people are constantly thinking and talking to themselves (in their mind) about what is happening to them in the environment and how they think that they will cope with it. You are probably not aware that self-talk is occurring. It tends to be a very automatic process that occurs in the background or outside conscious thinking. It may also surprise you that although you are not necessarily aware of self-talk, its impact on your emotional state and on the experience of anxiety can be extremely powerful.

It is very likely that when your anxiety levels rise suddenly that thoughts of which you are not consciously aware have been running through your mind and have played a part in the activation of an anxiety response. Whether or not you feel that you know what has activated this response, it is quite likely that close examination of those thoughts would reveal some surprises. It is

therefore extremely important that you develop an awareness of self-talk in order to begin developing an understanding of the impact of your thinking on your experience of anxiety. Once aware of your self-talk you can begin to challenge thinking that is not helpful.

Of course, not all self-talk is negative or unhelpful nor should all self-talk be positive. The aim is to achieve balanced thinking which is realistic and which does not interfere with every day functioning.

What shapes S elf-Talk: Every individual has a range of expectations, beliefs, attitudes and assumptions which they call upon in evaluating potential threat and their ability to cope. These shape our thinking and assist us in making predictions and judgments about any given situation. They arise and develop out of our own past experiences or our knowledge of the experiences of others.

Unfortunately, when the beliefs, attitudes and assumptions we call upon to evaluate situations are not realistic, relevant or helpful our evaluations are not always accurate representations of reality. Our thinking about a given situation can therefore become distorted and unhelpful.

EXERCISE 1: IDENTIFYING AUTOMATIC THOUGHTS

Recall a situation in the last week in which you felt anxious. Record below the thoughts and feelings you experienced in this situation. If you have difficulty identifying your thoughts, replay the situation in your mind like a video. Stop at different points in the scene and reflect on your thoughts. Analyse your thinking as much possible. There are some important rules in identifying automatic thoughts that are helpful when it comes to challenging those thoughts.

1. Be specific. Identification of the thought as "I felt terrible" is too global and may serve to increase your anxiety. Ask yourself for further analysis. What do you picture happening? What do you fear may happen as a result of your feeling terrible? Try to think about what you said to yourself at the time.
2. Do not attempt to dispute or challenge fact. Facts are not the same as thoughts. Eg: "I failed the exam" cannot be challenged and is probably not the thought that is upsetting you. There are likely to be distorted thoughts following this fact such as "I am stupid".

Situation:

Thoughts:

Feelings/Symptoms:

Common Cognitive Distortions

All or nothing thinking: You see things in black and white categories. Eg: "That person used bad language therefore they must be a bad person." "I made a mistake, the whole job is ruined".

Overgeneralisation: A single event can be perceived as a never-ending pattern. "I was anxious on the tram on my way to work today – I am hopeless, I can never catch the tram again, I am always anxious."

Mental Filter: When we become over-focused on a specific negative aspect of a situation and lose our ability to see the whole picture and all of the positives in it. Eg: The public speaker who feels that his speech was a complete failure because his voice trembled a from time to time.

Minimising the positive: Successful experiences are rejected, you find ways disqualify their value and believe that they do not count for some reason or another. Eg: Despite anxiety, you take the bus all the way to work but discount this saying: "It wasn't really an achievement because the bus was not crowded". You may also minimise your positive qualities.

Jumping to conclusions: You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.

- **Mind reading**: you assume you know what the other person is thinking
- **Fortune telling**: you predict disaster and anticipate things will turn out badly.

Catastrophising and Awfulising: You magnify or exaggerate the importance of such things as a mistake, someone else's achievement or a problem and tell yourself that it is much worse than it actually is. Eg: the person who thinks that a mistake made at work means being fired or publicly humiliated and never able to find another job.

Emotional reasoning: You assume that negative emotions reflect the way things really are. "I feel bad therefore people will think that I am performing badly".

Should statements: You try to motivate yourself with should and must statements. If you find yourself unable to do something, you then feel guilty and demoralised. "I should be able to…"

Personalisation: You see yourself as the target of some negative external event for which you are not primarily responsible and make statements such as, "It was my fault, I made them upset". In reality, you are responsible only for your own thoughts and feelings. You cannot make anyone think or feel anything.

Maladaptive thoughts: Are not necessarily distorted or based on information which is factually flawed or based on an assumption, instead such thoughts refer to those which may simply be emotionally draining when dwelled upon. For example: "This is impossible".

Remember: Any single thought may contain several cognitive distortions. When identifying these in your thinking, don't worry too much about whether you have selected the correct one.

We will return to some of these styles of thinking in greater detail as we move further through the course.

Challenging Automatic Thoughts

It is possible to minimise the effects of self-talk on anxiety by reflecting on, and challenging your thoughts. This activity is different to positive thinking. Part of the problem with positive thinking is that it does not last very long since it often is not easily believed in. This is particularly the case if your negative thoughts are very entrenched in your thinking. In fact, pretending that everything is perfect can be just as much strong a distortion of reality as the common negative errors of thinking above.

Remember that the goal is not to become so focused on your thoughts that this becomes distracting in itself. The goal is to gradually develop the ability to recognise when your thoughts are either overly negative or unrealistically positive. When your thinking is realistic and rational, you will also experience reasonable and appropriate emotions.

EXERCISE 2

1. Once you have identified the thoughts triggering your anxiety response, see if you can identify the errors of thinking that you have made in this situation. Remember, there may be more than one relevant cognitive distortion. Don't worry about getting exactly the right one, so long as you are able to recognise why the thought was unhelpful.

2. The next step is to dispute or challenge the thought(s). You can do this by asking yourself questions about that thought and examine the evidence. Some examples of useful questions to ask are:
    - What evidence do I have for this?
    - Is there another way of looking at this situation?
    - Is there an alternative explanation?
    - How would someone else see this (someone who does not feel over anxious)?
    - Are my judgments based on how I am feeling rather than what is actually happening?
    - Am I setting myself unrealistic goals?
    - Am I forgetting relevant facts or over-focusing on irrelevant or negative facts?
    - Is my thinking in black and white, all or nothing terms?
    - Am I overestimating how responsible I am for the way things work out?
    - Was it really all my fault?
    - Am I overestimating how likely that event is?
    - Do I know for certain that it will happen?
    - Is it really so important that it will affect my entire future?
    - How will things be in six months time?
    - Am I underestimating what I can do to deal with the problem?

3. Develop rational alternatives. If you are able to accept that your original thought was not completely true, try to come up with some alternatives. For example: in response to an automatic thought such as "I've blown my diet and I'll get fat", try, "it's disappointing that I have blown my diet. At worst I'll put on an extra Kilogram or so. I can still lose the weight I want to this week or next".

4. Some space is provided over the page to complete this task.

EXERCISE 2: CHALLENGING AUTOMATIC THOUGHTS

SITUATION

AUTOMATIC THOUGHT/S

COGNITIVE DISTORTION

DISPUTE

RATIONAL ALTERNATIVES

MONITORING

Keeping a diary of anxiety symptoms and thought processes.

Monitoring is very important in the treatment of anxiety. Because the symptoms and triggers of anxiety differ markedly between individuals, the monitoring process is essential in developing understanding and targeting treatment appropriately. It is, therefore, an important part of beginning to gain control of your anxiety symptoms.

To date, you have kept a very general record of your symptoms and situations in which these arose. In order to increase the benefits of this process, you will also be asked to begin recording your thoughts underlying your experiences of symptoms. From today, your monitoring should also include details of automatic thoughts and whenever possible a dispute of these thought/s and rational alternatives statements. A monitoring sheet designed for this purpose is on page 22 of this manual.

This more involved monitoring process is time consuming, but essential, if you are to really gain control over your symptoms. It is useful for several purposes. These include:

- Development of awareness of the thought processes which lead to and exacerbate the anxiety response.
- Identification of specific triggers and situations in which anxiety is more likely to occur.
- More effective communication of what was happening for you at the time.
- Minimisation of the extent to which you have to rely on memory.
- Help to focus on the roles that specific beliefs play in the maintenance of your anxiety.
- A way to practice challenging your unhelpful thoughts and beliefs.
- Evaluation of progress over several sessions.

Keeping an anxiety diary will be an important part of this program that we hope you will find beneficial. Remember, monitoring is an important early step in enabling you to address some of these problems.

PRACTICE TASKS FOR WEEK 3

- Repeat exercise 2 at home as often as you can when you notice your anxiety levels rising. You could also practice by returning to your monitoring sheets from week one and reflecting on, analysing and challenging your automatic thoughts.
- Monitoring of anxiety symptoms and thoughts.
- Controlled breathing.
- Relaxation practice.

Remember, the more you practice the more you will achieve in the program.

Situation	Automatic Thoughts	Cognitive Distortions Dispute	Rational Alternatives
Getting anxious about going to a social event this evening.	1. I won't be able to think of anything to say. 2. Everyone will think I am stupid.	Fortune Telling: How do I know I won't think of anything? I usually manage to say a few things. Fortune Telling, Catastrophising, Mind Reading: How do I know they will think that I am stupid. I won't know what they are thinking. Just because I am quieter than the others does not mean that I am stupid. Even if my worst fears were realised and they did think me stupid why is that so terrible?	I don't have to be the life of the party. I can think of a few topics of conversation before I go. I've got no reason at all to think that everyone will think that I am stupid. If a few people did think I was stupid, that would be disappointing, but certainly not the end of the world

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Session 4

Session Plan

- **Review practice tasks – Relaxation, thought stopping, breathing, monitoring and challenging self-talk.**
- **Group cohesion and issues of emotional frankness, vulnerability, processes of avoidance, and learning from other people's experiences.**
- **Develop understanding of thinking patterns and cognitive distortion.**
- **Revisit cognitive self-talk and challenging exercise.**
- **Small group exercise exploring examples of unhelpful thinking and challenging.**

HOME PRACTICE REVIEW

Food for Thought and Discussion

For those who completed the home practice exercises:
- What did you observe; were there any beneficial changes?
- What difficulties arose?
- Overall, what did you achieve?

For those who did not complete the exercises as often as they would have liked:
- What got in the way?
- What would need to happen to help you to succeed next week

GROUP DEVELOPMENT: Getting the most out of the group.

- Learning within a group is not just about learning independently or watching others learn. It involves taking that step further to think about how the experiences of others may apply to you.
- Need for emotional involvement in the process.
- There are many ways to avoid our emotional experiences without even realising that that is what we are doing. Intellectualising, counter avoidance (getting it over with), empathy for others without acknowledging your own similar experiences.
- Fear of emotional exposure, vulnerability.

SELF-INSTRUCTION TRAINING

In the last session we worked on increasing our awareness of our thinking processes and the impact of these on our behaviour and emotional reactions to situations. As you will have discovered, this is a complex and difficult area to master. It requires practise and perseverance. It is also important to begin the process with an event that is manageable and does not overwhelm your thinking. Once you begin to master the challenging process in relation to events that invoke moderate anxiety you will be able to increase the difficulty and address the situations that invoke higher anxiety. Initially this process may be time consuming, but like all new strategies the more you practice the easier they become. It is reasonable to expect that with practice you could complete this task in less than a minute or so. The focus of this session will be on further developing and consolidating challenging techniques.

The task then is to:
1. Recall an anxiety-provoking situation of moderate intensity.
2. Identify the unhelpful thoughts that work to increase your anxiety.
3. Challenge the unhelpful thought(s).
4. Develop rational alternatives.

Much of this work will be completed as a group or in smaller groups where members will be working collaboratively. The aim will be to gain further understanding about unhelpful thoughts and can be a valuable opportunity to learn from assisting others.

EXAMPLES OF THINKING PATTERNS

Unrealistic Thinking: I didn't get the job, which proves I'm a failure.
I'll never get a job or have things go right for me.
Realistic Thinking: I am disappointed that I didn't get that job, but I can cope.
Wishful thinking: Who cares! I didn't want that job anyway.

Unrealistic Thinking: What if I can't cope with this? It will be absolutely disastrous!
Realistic thinking: I'm going to give this a try. I'll give it my best shot and see how it goes.
Wishful thinking: It'll be easy.

Sometimes people have unhelpful thoughts that plague them daily. These are often generalisations that have no grounding in truth but develop from long-standing and ongoing negative thinking. Some examples of these are listed below.

Unhelpful Thoughts	**More Helpful thoughts**
I can't stand it.	I can put up with what I don't like.
I'm hopeless.	What I did was not too good.
I am to be blamed.	I am at partly responsible but am not to be blamed.
Things always go wrong.	Sometimes - if not frequently - things will go wrong and I can survive.
I need him/her to do that.	I want/desire/prefer him or her to do that but I don't have to have what I want.
Things never work out.	More often than I would like things don't work out.
This should be easier.	I wish this was easier, but often things that are good for me are not easy.
I should have done better.	I would have preferred to do better but I Did what I could at the time.
I am a failure.	Sometimes I fail.

PRACTICE TASKS

- Practice the challenging technique as often as you can by selecting situations from your monitoring sheets or exploring situations you are faced with. Remember, however, that you need initially to focus on situations of moderate anxiety.
- Monitoring of anxiety symptoms and thoughts.
- Controlled breathing.
- Relaxation practice.

Remember, the more you practice the more you will achieve in the program.

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Session 5

Session Plan

- **Review practice tasks – Relaxation, thought stopping, breathing, monitoring and challenging self-talk.**
- **Catastrophising, worry and unhelpful thoughts.**
- **Perfectionism.**
- **Introduction to isometric relaxation.**

HOME PRACTICE REVIEW

Food for Thought and Discussion

For those who completed the home practice exercises:

- What did you observe; were there any beneficial changes?
- What difficulties arose?
- Overall, what did you achieve?

For those who did not complete the exercises as often as they would have liked:

- What got in the way?
- What would need to happen to help you to succeed next week

CATASTROPHISING, WORRY AND UNHELPFUL THOUGHTS

Our thoughts often go unnoticed and we don't appreciate the important role they play in the way we feel and behave. The key to whether your thinking is causing you more anxiety than is warranted is how helpful it is. Often we catastrophise, that is, we see things as worse than they are, or worse than they need to be. This results in excessive and unnecessary anxiety. Individuals who have experienced anxiety over many years develop habitual and unbalanced ways of thinking about situations that upset them. These people often expect the worst. This can result in bringing on the worst. The way people react to events is intrinsically related to the expectations and assumptions they make about the situation. People with high anxiety tend to worry a lot more than other people. This worry usually centres on everyday events, which become blown out of proportion. These worries are usually unrealistic and preoccupy the individual for long periods of the day.

Sometimes people experience anticipatory worry. This is based on an extreme view of what might happen instead of a more realistic approach to what is likely to happen. It may feel like you are worrying about things you might be able to anticipate to avoid future catastrophes. In reality, the worry does not lead to productive or constructive action. Instead, problems remain unsolved, fears are not confronted, and the unrealistic, irrational beliefs about events or situations remain unchallenged.

Thus, a high number of individuals with anxiety problems are often responsible for creating and maintaining their own distressing reactions. They are generally totally unaware that they are doing this, but it evolves from many years of developing patterns of thinking about situations that are unrealistic and distressing.

Realistic thoughts are:	**Unrealistic thoughts are:**
REASONABLE	CATASTROPHIC
SELF-ENHANCING	SELF-DEFEATING
LOGICAL	ILLOGICAL
ACCURATE	INACCURATE
FLEXIBLE	RIGID

EXERCISE 1: Developing a Catastrophising Scale.

This exercise will have been completed in the group session. If the exercise seemed useful, you may want to develop your own scale using situations relevant in your life. This scale may help you to keep things in perspective when you are confronted with an anxiety-provoking scenario.

1. Select an example of a situation that you worry about often.
2. On a scale of one to ten, rate how bad this event would be where one is not at all catastrophic and ten is the worst thing that could possibly happen.
3. Compare this with other events that may occur.
4. Evaluate you perspective and question your rating.
5. De-catastrophise by making a more helpful evaluation of the significance of the event.

PERFECTIONISM

Good better best,
Never let it rest,
Until my good is better,
And my better best.

Perfectionism is ultimately a self-defeating pattern of thinking; it is just one style of thinking that is unhelpful and unrealistic. It may contribute to increase anxiety and inevitably lead to the experience of failure. It arises through internally generated standards that are unlikely to be to be expectations placed on you by others.

What are some of the ideas that underlie perfectionism?

CONTROL:	"I must always be in control"
COMPETENCE:	" I must be good at everything"
ACCEPTANCE:	" I must be loved by everyone"

Ways of disguising perfectionism.

1. Self-comparison: Other people are more perfectionistic than I am.
2. Self-comparison: I have to try harder than others to achieve the same results they do.
3. I set high standards but I'm not a perfectionist.
4. I'm only perfectionistic about some things.
5. Other people may have high standards and I won't be able to tolerate disappointing them.
6. I'm not always perfectionistic, it's just this task that has to be done right. Tomorrow I'll change.

Costs of perfectionism.

- Increased anxiety and all of the associated symptoms.
- Never being satisfied.
- Never enjoying your achievements.
- Setting you up for failure by setting unreachable goals.
- Negative impact on self-esteem over time.
- Loss of the broader perspective, tunnel vision.

ISOMETRIC RELAXATION EXERCISES

Isometric relaxation exercises can be done in everyday situations. Most of the exercises do not involve any obvious change in posture or movement so they can be done in public places without attracting attention. When you are first learning these exercises you will need to do them regularly to counteract tension and maintain a relaxed state. As you improve you will find that you are doing them without even thinking about it. They will become a habit that you do automatically to reduce tension.

In the following exercise you are asked to hold your breath for seven seconds. If you cannot hold your breath for this long do not worry. The most important thing is to concentrate on putting the tension in slowly over approximately seven seconds and releasing the tension slowly over approximately seven seconds. The most common mistake made with isometric exercises is putting the tension in too quickly or putting in too much tension. These exercises are designed to be slow and gentle.

Exercise 1 - When sitting or lying in private:

- Take a small breath and hold it for up to seven seconds.
- At the same time straighten arms and legs out in front of you and stiffen all other muscles in the body.
- After seven seconds breathe out and slowly say the word "relax" to yourself.
- Let all the tension go from your muscles.
- Close your eyes.
- For the next minute each time you breathe out say the word "relax" to yourself and let all the tension flow out of your muscles.
- Repeat if necessary until you feel relaxed.

Exercise 2 - When sitting in a public place

- Take a small breath and hold it for up to seven seconds.
- At the same time slowly tense leg muscles by crossing your feet at the ankles and press down with the upper leg while trying to lift the lower leg.

OR

- Pull the legs sideways in opposite directions while keeping them locked together at the ankles.

OR

- Combine these two movements.
- After seven seconds breathe out and slowly say the word "relax" to yourself and let all the tension flow out of your muscles.
- If circumstances permit, continue with various muscle groups.

You can design your own tailored isometric exercises by deciding which of your muscles tense up most readily. You can then choose a method to voluntarily tense and relax these muscles.

PRACTICE TASKS

- Practice the challenging technique as often as you can by selecting situations from your monitoring sheets or exploring situations you are faced with. Remember though that you need initially to focus on situations of moderate anxiety.
- Monitoring of anxiety symptoms and thoughts.
- Controlled breathing.
- Relaxation practice – if you can, try to practice both the isometric exercises and progressive muscle relaxation.

Remember, the more you practice, the more you will achieve in the program.

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Session 6

Session Plan

- **Review practice tasks – Relaxation, thought stopping, breathing, monitoring and challenging self-talk.**
- **Avoidance behaviours.**
- **Rationale for exposure techniques.**
- **Developing a hierarchy of feared situations.**
- **Planning to complete step one of hierarchy.**
- **Imaginal practice for completion of step one of hierarchy.**

HOME PRACTICE REVIEW

Food for Thought and Discussion

For those who completed the home practice exercises:

- What did you observe; were there any beneficial changes?
- What difficulties arose?
- Overall, what did you achieve?

For those who did not complete the exercises as often as they would have liked:

- What got in the way?
- What would need to happen to help you to succeed next week

AVOIDANCE

Experiencing anxiety is unpleasant and individuals often learn to anticipate the events that are likely to trigger their anxiety. Unfortunately, many people with generalised anxiety eventually avoid these situations altogether. Of course it is sensible to avoid situations that may be dangerous. The problem is that individuals with anxiety often avoid situations that are not dangerous just because they increase their anxiety. We may avoid situations that we know will cause us anxiety because the symptoms are so uncomfortable that we would rather not face up to them. Unfortunately, each time we avoid a situation, its power to cause an anxiety response in us increases.

The problem with avoidance is that it only brings temporary relief. In practice, the things we avoid become harder and harder to do, and gradually we avoid more and more things.

Our lifestyle may be seriously curtailed by a tendency to avoid stressful situations or escaping them wherever possible. This might include:

- Not going out.
- Not going to work.
- Not meeting people.
- Not using public transport.
- Not being able to do the shopping.
- Not being able to stand up for one.

By avoiding situations we reduce the quality of our life. It has been shown that if you stay in a stressful situation long enough your anxiety levels will eventually reduce. If you always leave a stressful situation quickly you will never find out that your anxiety will gradually die away of its own accord.

EXPOSURE

Exposure means facing something that is being avoided because of anxiety.

To be effective any exposure exercises need to be graduated, repeated, and prolonged. The first exposure task should be something you are confident you can do although it must be difficult enough to provoke some anxiety in you. The task should also be functional in that it causes anxiety and you are able to work at overcoming this. Ideally, you should begin with a task where anxiety is rated at around 40 on the SUDS. (Remember 0 = no anxiety - when you are asleep, 10-30 = modest anxiety). This task should be repeated regularly until it provokes little or no anxiety. Then you can move on to a task that is slightly more difficult than this. A graded hierarchy is an ordered list of anxiety provoking situations that can guide exposure tasks. It should begin with tasks that are mildly difficult and move on to tasks of increasing difficulty in terms of provoking higher levels of anxiety. Before constructing a hierarchy you need to think about what types of situations make you feel anxious. These will be different for everyone. Exposure can be practised using imagery before attempting the real thing. This can be a valuable preparation exercise. Imaginal exposure tasks are best practised following your relaxation exercises when your anxiety should be at its lowest. Simply imagine yourself performing the activity in a calm and collected manner. If you feel yourself getting overly anxious or panicky, stop the session, relax, and start the imaginal exposure again. Continue practising in this way until your anxiety while imagining the situation is low or non-existent. We will be practising your first task through imagery in today's session. When you are practising your exposure tasks, you need to make use of all the strategies we have been practising. For example, breathing exercises, relaxation and isometric exercises, and positive self-talk, are all strategies designed to help you to cope in situations in which you feel anxious so make sure you are well practised in these.

Constructing a hierarchy of anxiety-provoking situations is not as easy as it sounds and can take some time. Don't expect to get all of it done in this session. Care should be taken not to place unrealistic expectations on yourself too soon. This is often a mistake that is made. An example of a hierarchy in which anxiety is centred around social situations is offered below.

IMAGINAL EXPOSURE TECHNIQUES

Imaginal exposure has been found to be a useful technique for reducing your level of anxiety to a point where they are able to face the real life, feared situation. Because it may be very difficult to expose yourself to the situations in the hierarchy, this technique may be helpful as preparation.

The technique would involve rehearsing in your mind what would happen when in that situation. Once you have developed your hierarchy and defined your goals and the steps for achieving these, the technique involves closing your eyes and imagining those steps in detail in your mind.

It's all right to feel some anxiety. In fact, it is a necessary part of the process. The goal is to allow yourself to experience the anxiety and sit with it until it subsides. Remember that the nature of anxiety is such that in the absence of avoidance, it will subside. You may question this, but you have probably experienced this before when you have been faced with a situation you thought you could not cope with.

If you experience panic during the imaginal process, it is important not to give up. Don't stop, tell yourself that it will pass and keep going. It is important that you do not abandon the task at a point of panic as this will serve to reinforce the avoidance behaviour.

You may go through the imaginal process several times until you feel that you have mastered the task to a point where you feel able to move on to the next step in the process. This would probably be at a point where you would rate the anxiety experienced in this situation as mild (30 on the SUDS scale).

EXAMPLE: HIERARCHY OF FEARED SOCIAL SITUATIONS

Item	Situation	SUDS
1.	Walking outside the front of my home while my neighbour is outside.	10
2.	Waving to a neighbour.	20
3.	Introducing myself to my neighbour.	30
4.	Walking down to the local shopping centre alone.	40
5.	Entering a shop in my local shopping centre and making an inquiry.	50
6.	Visiting a major shopping centre.	60
7.	Approaching someone to ask for information.	70
8.	Approaching a crowd to ask directions.	80
9.	Having a meal in a busy restaurant.	90
10.	Being the centre of attention at my birthday party	100

EXERCISE: DEVELOP YOUR OWN HIERARCHY OF FEARED SITUATIONS

Item	Situation	SUDS
1.		10
2.		20
3.		30
4.		40
5.		50
6.		60
7.		70
8.		80
9.		90
10.		100

FACING FEARED SITUATIONS

The next step is to begin to plan how to successfully face and cope with the first couple of these situations to enable you to overcome the anxiety associated with them.

In the following situation, you will develop goals for achieving this. There are some important guidelines that will make achieving the goal more manageable and more likely.

First you need to identify your goal. The goal needs to be achievable and you need to be able to recognise when a change has occurred (ie: Be clear about how you will identify success). It will help if the identified goal is very specific. The next step is to identify what needs to happen in order to achieve the goal. Break the goal down, listing each step. Each part of the plan may be very small but still an important part of achieving the goal.

Once you have the steps outlined clearly, weigh up the advantages and disadvantages of attempting each step so that you are clear about the benefits. This will help to keep you focused and minimise avoidance.

Finally, put your plan into action. Once you have moved through the process, don't forget to recognise this and celebrate your achievement.

Identify a goal and describe it in detail (who, what, where, when, why, how):

Steps:

Advantages	**Disadvantages**

Identify goal and describe it in detail (who, what, where, when, why, how):

Steps:

Advantages	**Disadvantages**

Identify goal and describe it in detail (who, what, where, when, why, how):

Steps:

Advantages	**Disadvantages**

PRACTICE TASKS

- Continue breathing and relaxation exercises, monitoring and challenging self-talk.
- Continue developing your graded hierarchy.
- Expose yourself to the two steps in the hierarchy. If you master these, feel free to move on to further steps. You may wish first to begin with just the imaginal exposure

Remember, the more you practice the more you will achieve in the program.

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Session 7

Session Plan

- **Review practice tasks – Relaxation, progress with steps on the hierarchy, monitoring and challenging self-talk.**
- **Review avoidance behaviour and rationale for exposure techniques.**
- **Long and short-term goals.**
- **Goal setting and planning.**
- **Continue to develop hierarchy of feared situations.**
- **Planning to complete further steps of hierarchy.**
- **Imaginal practice.**

HOME PRACTICE REVIEW

Food for Thought and Discussion

For those who completed the home practice exercises:

- What did you observe; were there any beneficial changes?
- What difficulties arose?
- Overall, what did you achieve?

For those who did not complete the exercises as often as they would have liked:

- What got in the way?
- What would need to happen to help you to succeed next week

Exposure work is a crucially important skill in overcoming anxiety. This session therefore aims to further develop your skills in planning and implementing exposure tasks.

LONG AND SHORT TERM GOALS.

When we learn a new skill it is important that we target only moderately anxiety provoking scenarios, just as we did when beginning to challenge self-talk. It is also important to distinguish between your long and short-term goals. Short-term goals, by definition, are more manageable within a short period of time. Long-term goals, however, are more difficult to achieve quickly and require long term planning and work. Because anxiety may be very long standing and therefore difficult to overcome quickly, it may be necessary to initially set short-term goals. This will enable you to experience success and gradually work towards overcoming your anxiety in the longer term.

You may develop many hierarchies before reaching your long-term goal. These hierarchies should help to bring your long-term goal a little closer.

Examples of short-term goals for overcoming social anxiety:

1. Purchasing something in a department store and then returning it 5 minutes later.
2. Asking a stranger the time when you are obviously wearing a watch.

Both of these tasks may assist in achieving an ultimate goal of giving a talk at a friend's wedding.

Examples of short-term goals for overcoming phobias (e.g.: fear of dogs):

1. Going to see the movie 101 Dalmatians at the cinema.
2. Standing outside the pet shop and looking in from a distance.

Both of these tasks may assist in achieving an ultimate goal of being able to go to the local park.

Examples of short-term goals for overcoming perfectionism:

1. Leaving the dishes in the sink when going to work.
2. Purposely leaving a spelling error in a homework assignment.

Both of these tasks may assist in achieving an ultimate aim of being able to be away from the home or the office without being constantly stressed about what you may return to.

GOAL SETTING FOR COMPLETING STEPS IN YOUR HIERARCHY.

Example: Step one in hierarchy ultimately aimed at attending a short course in computer studies.

Identify goal and describe it in detail (who, what, where, when, why, how): Making telephone inquiries about beginner's computer studies courses available at universities and TAFE colleges in your local area. Aiming to make at least one call during lunch break from Monday to Friday of next week.	
Steps:	
1. Further clarify which course I am going to make inquiries about by identifying what my needs are, when I can attend and for how long. 2. Identify which tertiary institutions are in my locality. 3. Prepare a list of local institutions and their telephone details and prioritise these. 4. Prepare a list of appropriate questions.	
Advantages:	**Disadvantages:**
1. Working towards something that I want.	1. Feeling some anxiety about making the calls.
2. Feeling good about facing my fears.	1. Fear of failure.
3. Finding out that I am capable of achieving my goals.	1. Fear of asking a "stupid' question.
4. Overcoming the anxiety I am feeling.	1. Not having time to read the newspaper at lunchtime.
5. Finding out more about the courses available and my options.	1. Fear of embarrassing myself

PRACTICE TASKS

- Continue breathing and relaxation exercises, monitoring and challenging self-talk.
- Continue developing your graded hierarchy.
- Expose yourself to a further two steps in the hierarchy. If you master these, feel free to move on to further steps. You may wish first to begin with just the imaginal exposure

Remember, the more you practice the more you will achieve in the program.

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Session 8

Session Plan

- **Review practice tasks – Progress with steps on the hierarchy and challenging self-talk.**
- **Lifestyle**
- **Revisit self-instruction training.**
- **Planning to complete further steps of hierarchy.**
- **Imaginal practice.**

HOME PRACTICE REVIEW

Food for Thought and Discussion

For those who completed the home practice exercises:
- What did you observe; were there any beneficial changes?
- What difficulties arose?
- Overall, what did you achieve?

For those who did not complete the exercises as often as they would have liked:
- What got in the way?
- What would need to happen to help you to succeed next week

LIFESTYLE CHANGES AS STRESS-MANAGEMENT AND ANXIETY-REDUCING STRATEGIES

Throughout our lives we are constantly adjusting to demands placed upon us by challenging circumstances. Our body is designed to meet the challenge of constantly having to cope with these demands, and 'stress' describes the physical and mental changes involved in this coping. However, the term 'stress' is often used to describe the mental and physical changes, which take, place when the demands placed upon us strain, or even exceed, our normal powers of adaptation. High levels of stress are associated with a wide range of physical and psychological symptoms. These include sleep disturbances, poor concentration, irritability, depression, fatigue, tension, headaches, skin disorders, somatic problems, such as aches and pain, and a whole range of unpleasant effects. Unfortunately, many of the ways we deal with stress are often make matters worse (e.g., alcohol, cigarettes, tranquilizers). In this session we will look at lifestyle changes that we can make to reduce the stress reaction.

EXERCISE

The fitter you are, the better able your body is to cope with stressors without succumbing to the negative effects of long-term stress and anxiety. Exercise has been proven to be one of the most powerful and effective methods for reducing anxiety. Exercise is a natural outlet for your body when it is in the fight-or-flight-mode of arousal. Regular exercise has a direct impact on several physiological factors that underlie anxiety. It leads to:

- Reduced skeletal muscle tension, which is largely responsible for your feelings of being 'tense' or 'uptight'.
- More rapid metabolism of excess chemical substances in the bloodstream, the presence of which tends to keep you in a state of high arousal.

Regular exercise can help you to work off any accumulated tension. Along with relaxation it is

an excellent stress and anxiety reducing strategy. The benefits of exercise which directly relate to anxiety include:

- Increased energy
- Reduced muscle tension
- More relaxed and sound sleep
- Improved mood and mental concentration
- Increased subjective feelings of well-being
- Improved concentration and memory
- Reduced feelings of low mood
- Increased self-esteem
- A greater sense of control over anxiety

Exercise needs to be of sufficient regularity, intensity, and duration to have a significant impact on anxiety. Engaging in infrequent spurts of exercise is stressful to your body and generally does more harm than good. The following points may be helpful guidelines:

- Ideally exercise should be aerobic
- Optimal frequency is 4-5 times per week
- Optimal duration is 20-30 minutes or more per session

Getting started

Begin very gradually with 10 minutes every other day to start and add 5 minutes every successive week until reaching 30 minutes. Set yourself a one-month trial period and make a commitment with possibly a reward at the end. Hopefully, after this there should be enough benefit evident to make it self-motivating. Be realistic. It may take 3 to 4 months to achieve a high level of fitness. Keep a record of your exercise routine.

Please note: Before you begin any new exercise regime you should check your fitness level. Measure your resting pulse. If your pulse is 80 beats per minute or above it is an indication that you need to build up your fitness level. If you are not already exercising regularly and are over 30 years of age, you should consult your doctor for a medical examination prior to commencing any strenuous aerobic type exercise.

NUTRITION

Vitamin Supplements for Anxiety and Stress

Vitamins B and C: During times of stress your body rapidly depletes stores of vitamin B and C. B vitamins are necessary to help maintain the proper functioning of the nervous system. Deficiencies can lead to anxiety, irritability, restlessness, fatigue, and even emotional instability. Vitamin C is well known for enhancing the immune system and promoting health. However it also helps to support the adrenal glands, whose proper functioning is necessary to your ability to cope with stress.

Calcium: Calcium can act as a tranquilizer, having a calming effect on the nervous system.

Calcium is involved in the process of transmitting nerve signals in the brain. Depletion of calcium can result in nerve cell over-activity, which may be one of the underlying physiological bases of anxiety. It is important to have an intake of 1000mg of calcium per day from calcium rich foods such as dairy products, eggs and leafy vegetables, or by taking calcium supplements (If taking a supplement it is important to also take magnesium as the two work in tandem).

The calcium in milk is the product that makes hot milk helpful for sleep problems.

Caffeine: Caffeine has been identified as the dietary factor that aggravates anxiety the most. Caffeine has a directly stimulating effect on several systems in your body. One of its side effects is to keep you feeling alert and awake. It also produces the very same physiological arousal response that is triggered when you are subjected to stress. Too much coffee will keep you chronically tense, and aroused, leaving you more vulnerable to generalised anxiety. Caffeine is also found many types of tea, cola drinks, cocoa, and over-the-counter drugs. If you are prone to anxiety, it is recommended that your total caffeine intake is no more than 100mg per day.

Caffeine Content of Coffee, Tea, Cocoa and Cola Beverages

	(Milligrams per cup)		(Milligrams per can)
Coffee, instant	66 mg	Coca-Cola	65 mg
Coffee, percolated	110 mg	Dr. Pepper	61 mg
Coffee, drip	146 mg	Pepsi	43 mg
Teabag – 5 minute brew	46 mg		
Teabag – 1 minute brew	40 mg		
Loose tea – 5-minute brew	40 mg		
Cocoa	13 mg		
Decaffeinated Coffee	4 mg		

Having tea or coffee is a habit that many people have which generally develops over time. Like other behaviours that are addictive, it is often very difficult for people to break these habits. For people who are anxious, these habits are more detrimental than they are for people who do not have anxiety problems.

Did you know that apart from caffeine, coffee contains over 200 other chemicals?

Nicotine: Nicotine is as strong a stimulant as coffee. Smoking contributes to stress in a number of ways. It contributes to poor health, thus increasing our vulnerability to stress and anxiety. The healthier we are, the better able we are to cope with the demands of our day-to-day lives. Furthermore, many of the chemicals introduced into our bodies via cigarette smoke will act as stimulants. Some of the effects of nicotine include:

- Causes the heart to beat faster and harder
- Constricts all of the blood vessels
- Causes a rise in blood pressure
- Increases physiological arousal

Smoking has also been identified as leading to an increased risk of coronary heart disease, stroke and cancer. After quitting smokers often report feeling healthier, sleeping better, and being less

prone to anxiety states and panic. Over time the body will repair itself. If you are a smoker, becoming a non-smoker should be an important component of your stress and anxiety management program.

Stimulant drugs: Some over the counter drugs, such as cough mixtures, may also contain caffeine. As well as these some prescription drugs, such as cold and flu tablets, may contain stimulants that are likely to impact on your anxiety. If you have a history of anxiety it is worthwhile asking the pharmacist about stimulants present in over the counter medication.

MEDICATION

Medication can be a useful in the treatment of anxiety disorders and in some cases it may be necessary. However, medication should be seen as a short-term solution to anxiety. Ideally, non-medical strategies that provide you with skills to better cope and control your anxiety are a better alternative to a dependence on prescription drugs.

TIME MANAGEMENT

If you have a busy lifestyle daily pressures can serve to increase stress and anxiety. Much of this stress may be associated with poor time management. Poor time management is often caused by the following habits:

- Perfectionism
- Procrastination - Leaving things until the last minute.
- Poor ordering of priorities.
- Poor planning - being impulsive and rushing into activities without taking the time to plan them.
- Lack of balance between work and leisure.

The following strategies may help you to manage your time better.

- Use problem solving as a method for overcoming difficulties.
- Write down your goals and set down a plan for achieving them.
- Break down difficult goals into smaller, more manageable and less threatening steps.
- Make a list of all the things that you would like to and need to achieve on a daily basis.
- Prioritize the items on the list.
- Schedule activities. Schedule time blocks for activities but be prepared to be flexible. Also be sure to plan some rest time and some leisure activities. Be realistic about your time limitations and don't try to schedule too much into your day.
- Off-load the non-essential tasks in your social or work life.
- Control your environment. Minimise distractions; promote an environment conducive to the task you have to complete.

Some people are so concerned with time that they skip meals or even postpone toilet breaks.

SLEEP

Lack of sleep is a stressor that may exacerbate anxiety symptoms. Lack of sleep generally leads

to you feeling tired and irritable with those around you. The following are some useful suggestions for improving the quality and quantity of your sleep.

- Only lie down when you are ready to go to sleep (A 'natural sleepiness cycle' occurs about every 60 minutes).
- Don't use your bed for anything except sleeping (i.e. don't go to bed to read, eat, watch TV, talk on the telephone etc.).
- If you have not fallen asleep in about 20 minutes, get up and go to another room. Repeat this as often as necessary until you fall asleep within about 20 minutes of going to bed.
- Try and develop a sleep routine. Go to bed at the same time every night and do the same things before going to bed (e.g. put out the cat, lock up, clean your teeth, etc.). Plan to get up at a regular time. Set your alarm and get up at the same time every morning regardless of how long you've been asleep.
- Do not nap during the day.
- Don't do any thinking or worrying in bed. It may be helpful to set aside some time for thinking during the day or a couple of hours before bedtime. In bed, try to put worries aside until the morning.
- Avoid stimulants (e.g., tea, coffee, cigarettes) and spicy and heavy meals late at night.
- Do some form of relaxation during the day and before bedtime (meditation, breathing exercises, have a shower or bath, imagine pleasant scenes, listen to music)?
- Develop a regular daytime exercise program. This will improve both the quality and quantity of your sleep.
- Examine your bedroom. Check out that it is quiet and dark enough, or if your bed is sagging and uncomfortable check whether you need a new mattress.
- Never use alcohol to get you to sleep. Alcohol will help you to get to sleep more quickly, but will disrupt sleep later in the night.

PRACTICE TASKS

- Continue breathing and relaxation exercises, monitoring and challenging self-talk.
- Expose yourself to a further two steps in the hierarchy. If you master these, feel free to move on to further steps. You may wish first to begin with just the imaginal exposure
- Notice unhelpful lifestyle and consider what changes could be made.

Remember, the more you practice the more you will achieve in the program.

Barwon Health

Primary Care Services

Anxiety Group Program

Session 9

Session Plan

- **Review practice tasks – Progress with steps on the hierarchy and challenging self-talk.**
- **Recognising success.**
- **Maintaining change.**
- **Relapse prevention.**
- **Coping with and accepting negative emotions and anxiety.**
- **Planning to complete further steps of hierarchy.**

HOME PRACTICE REVIEW

Food for Thought and Discussion

For those who have completed the home practice exercises:

- What did you observe; were there any beneficial changes?
- What successes did you have?
- What difficulties arose?
- Overall, what did you achieve?
- What did it mean to you to achieve this goal?

RECOGNISING SUCCESS

Success should be defined as a change in the right direction, no matter how small. Change is gradual and sometimes, may be almost imperceptible. If in evaluating your progress you are finding it difficult to identify change, it is important to consider whether your expectations are realistic and manageable at this time. Success also needs to be viewed within the context of your current situation. If you are currently experiencing a major life change, or you are under stress, then your expectations for change need to be adjusted accordingly. If expectations for change are unrealistic, this can lead to frustration and feelings of failure. In fact, sudden and extreme changes may be more difficult to maintain than small steps towards change.

Unhelpful Thinking About Success

"I am a little bit better but I am still really bad."

"I did really well on the weekend but as soon as I got to work again I felt tense."

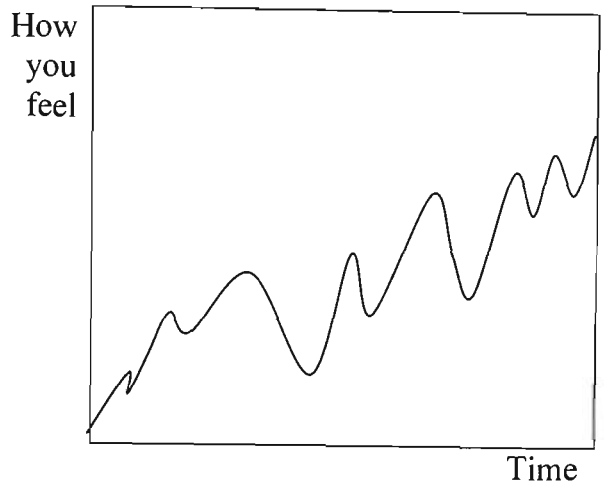
More Helpful Thinking About Success

"Things are still difficult but I have made important progress."

"Some situations are still difficult but at other times I am much better."

It will be easier to focus on the process of improvement if you are able to concentrate your attention on your achievements, and what you still hope to achieve, rather than on the difficulties that remain.

THE ROAD TO IMPROVEMENT



Some important points to remember about improvement:

1. The general rule for improvement is; two steps forward, one step back.

2. You will find that following a setback; it takes much less time to get back to a given level than it did initially.

3. It is likely to feel a little uncomfortable when you begin to make changes. Remember that your experience of anxiety is almost habitual and it will take time to adjust to new ways of doing things.

Source: David Morawetz

MAINTAINING CHANGE

The management of excessive anxiety is like any skill that you learn. Once learnt, it is likely to become more powerful over time and therefore more resistant to the triggers that cause relapse.

Guidelines to promote ongoing success

1. Recognise your anxiety or worry as a cue to begin implementing your coping strategies, such as evaluation of your thoughts, relaxation and breathing exercises.
2. Watch out for subtle situations, behaviours and events that exacerbate your anxiety or worry, such as hearing about other people's accomplishments and comparing them to your own or watching distressing news stories. Use these situations as cues to focus energy on coping, rather than allowing them to overwhelm you before you act.
3. Review the material in your anxiety management manual regularly. Use this to refocus, particularly if you feel that you are slipping.
4. Expect to have lapses occasionally.

RELAPSE

Because of the nature of anxiety and the tendency to catastrophise, people may interpret lapses in their coping as a total relapse. It is important that lapses are not exaggerated to a point where they are seen to mean total failure. The nature of everyday life means that we all have some ups and downs. These times should be cues to refocus.

Unhelpful thoughts about relapse

"I'm hopeless. I've failed again. I'll have to start all over again."

"Just when I think I'm getting ahead I realise that I'm right back where I started."

More helpful thoughts about relapse

"I'm disappointed that it didn't go well, but I'm not going to give up. I'll cope with it better next time."

"So I've had a setback. It's not the end of the world. I know I have all the skills to feel better again."

COPING STATEMENTS FOR FACING AND ACCEPTING BAD FEELINGS

Anxiety can often be a manifestation of bottled up negative feelings such as anger, grief, resentment or frustration. For some people it is very difficult to accept and feel OK about experiencing negative emotions. Negative emotions however are a part of life. It is impossible to avoid them completely. The following is a coping statement aimed at assisting with the process of accepting difficult negative emotions.

I expect to have some bad feelings in this situation
I am not going to deny that I have these feelings
At the same time, I am not going to dwell on them and magnify them.
I will not die from these bad feelings. I can cope with them.
If possible, I will do something constructive to improve the situation now.
If this is not possible, I will do something that is pleasant or constructive to distract myself.
I am a worthwhile person. I am OK.

Source: Dr Bob Montgomery.

ANTICIPATING LAPSES

It may be helpful to identify high-risk times and situations that may lead to a lapse in order to prepare for this possibility.

1.

2.

3.

4.

5.

6.

7.

PRACTICE TASKS

- Continue breathing and relaxation exercises, monitoring and challenging self-talk.
- Expose yourself to a further two steps in the hierarchy. If you master these, feel free to move on to further steps.
- Identify and plan for high-risk times and situations.

Remember, the more you practice the more you will achieve in the program.

Barwon Health

Primary Care Services

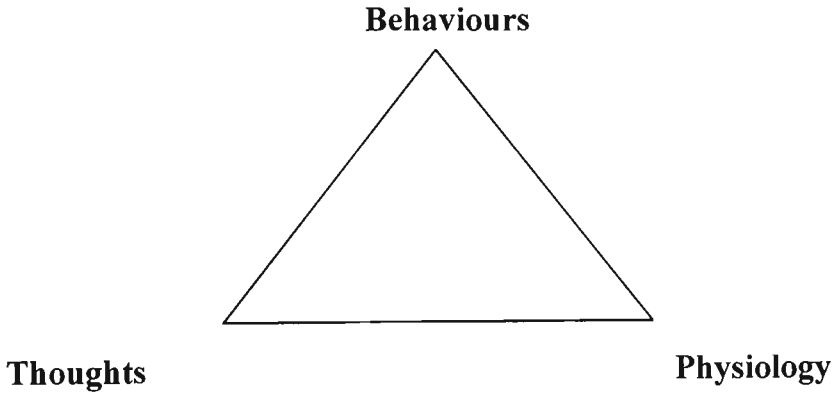
Anxiety Group Program

Session 10

Session Plan

- **Progressive muscle relaxation.**
- **Return to the anxiety symptom triad**
- **Your menu of coping skills.**
- **Highlighting achievements.**
- **Review and prepare for high-risk situations.**
- **Responding to lapses in coping.**
- **Congratulations!**

In early sessions of this program we noted the three different components of anxiety: physiological (symptoms), cognitive (thoughts) and behavioural. The aim of the group program was to provide a range of strategies to deal with anxiety at each of these levels.



Not all of the strategies presented will suit your style of coping. Part of our aim was to present a range of strategies from which you may choose those that are most helpful for you. One way to look at what you have gained is to view the learning process as gaining a menu of skills that you will be able to draw upon.

Skills to help manage the physiological symptoms of anxiety:

- Progressive muscle relaxation
- Isometric exercises
- 6 second, balanced breathing

Skills addressing negative and unhelpful thoughts associated with anxiety:

- Thought stopping
- Identifying cognitive distortions
- Identification and monitoring of unhelpful self-talk.
- Challenging unhelpful self-talk
- Developing more helpful self-talk

Skills targeted at behavioural manifestations of anxiety:

- Minimising avoidance behaviours due to anxiety
- Graded exposure

Remember, this program is only a beginning. The process of learning to manage anxiety is ongoing.

HIGHLIGHTING ACHIEVEMENTS

Group task: Brainstorm our achievements over the last 10 weeks.

1.

2.

3.

4.

5.

6.

RESPONDING TO LAPSES IN COPING

Because of the nature of anxiety there will always be times when the achievements and coping strategies that you have developed may be difficult to maintain. Although lapses in coping are part of the process of improvement and provide opportunities for new learning, it may be difficult to view them in this light all of the time. It is easy at the point of a lapse to fall into unhelpful thinking patterns. Lapses could be viewed as failures from which recovery cannot be achieved, or as evidence that your experience of anxiety is biologically determined and therefore out of your control. A coping lapse can therefore be conceptualised as a fork in the road and a point at which a choice about your future direction and coping activity is made.

The point at which you recognise that you have had a lapse in coping is an important time at which to take stock. The idea that your anxiety is out of your control is a common thought that may sneak up on you and attack your motivation. At this point in time many people give up on their coping strategies. The challenge is to consider what the thinking behind a lapse may be and to challenge these unhelpful thoughts.

Expect and plan for lapses.

If you haven't already filled in and planned coping strategies for high-risk situations, it is recommended that you devote some time to this.

CONGRATULATIONS!

It is important to congratulate yourself on your efforts throughout the group program. For some of you, even your attendance should be considered an achievement. The social interaction required for attending an anxiety management group can be anxiety provoking in itself, and the process of talking about experiences of anxiety can be very difficult. It takes a lot of energy and effort to attend a group such as this. Getting through the group process and attending can be conceptualised as a gigantic exposure task which all of you have coped with extremely well. WELL DONE!

KEEP PRACTISING!

Confidence comes from competence, competence from practice.

Appendix B

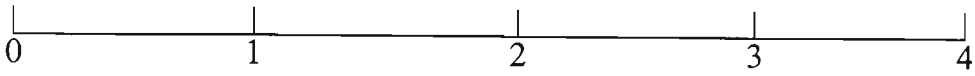
Participant Evaluation Form

ANXIETY GROUP EVALUATION

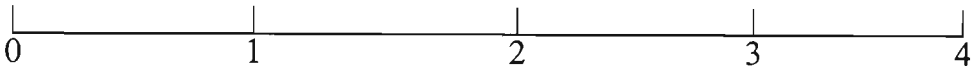
Please answer the following questions about the group

'0' is the lowest rating you can give
'4 is the highest rating you can give

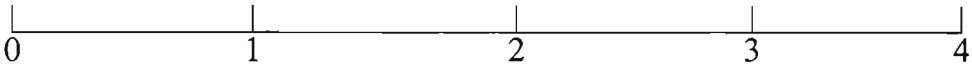
1. How effective has the group been in introducing you to new strategies for dealing with anxiety?



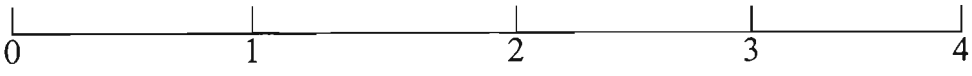
2. To what degree has the group helped you to think positively about managing your anxiety?



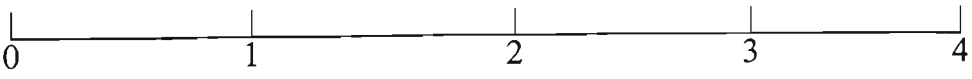
3. How much did you learn about how to reduce your anxiety?



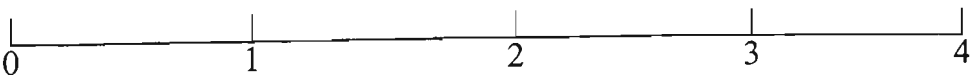
4.How much did the relaxation strategies help you to relax?



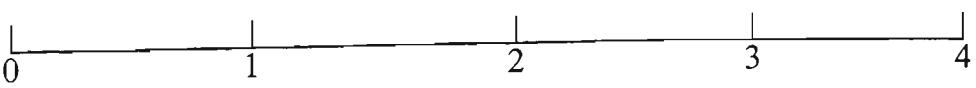
5.How well did the group help you to understand how to reduce your anxiety?



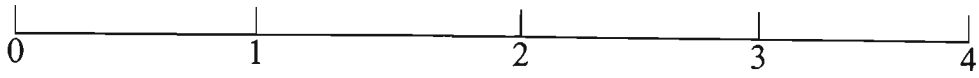
6. How much did the group help you to improve your confidence in managing your anxiety?



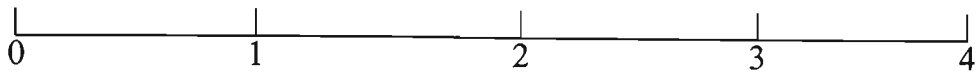
7. How well did the group help you to overcome your anxiety?



8. How interesting did you find the group?



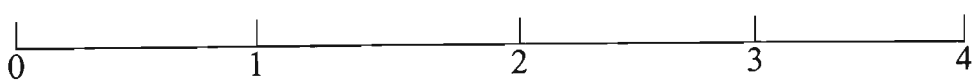
9. How enjoyable was the group?



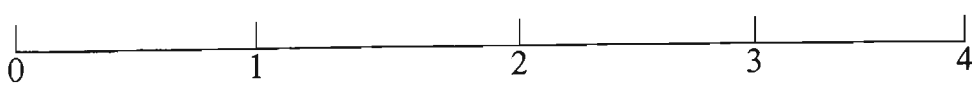
10. What was the best thing about the group?

11. What didn't you like about the group?

12. How much do you feel you have benefited from the program?



13. How well did the group meet your expectations?



14. Was there anything you feel that was missing from the group?

THANK-YOU FOR YOUR PARTICIPATION

Professional and Ethical Issues Report

TABLE OF CONTENTS

Preamble

Prior to commencing the Doctor of Psychology (Clinical) program, my professional and personal interest was in the areas of trauma and violence, and the impact upon mental health for the individual who is exposed to these. This interest arose from having been involved in these areas in my working and personal life and through the many books and research articles that I have read. In addition, I have always been interested in the area of mental health, particularly in the diagnosis, assessment and treatment of individuals with mental health issues. My clinical placements took place within a Regional Hospital setting, two Community Health Services, and a newly opened Regional Community Psychology Service. These placements not only contributed extensively to my knowledge base and skills as a psychologist, but also reinforced my interest and belief in practicing in those areas. My experiences throughout my clinical placements have provided me with numerous opportunities to develop my skills and knowledge in working with individuals who have experienced not only the abovementioned issues, but also a broad ranging and diverse plethora of other mental health conditions. The four clinical placements undertaken in this program also provided me with an experience of working as a psychologist across a number of different settings, and allowed me to develop a greater understanding of the diverse nature of the work that can be undertaken by psychologists.

The theme that has linked my three placement reports was anxiety and depression, and this became an extremely relevant link between all of the placements. I chose to link anxiety and depression together in my reports to highlight the co-morbid nature of these mental health conditions and the impact that having one or the other or both can have on the individual. As such, anxiety and depression, and their

long-reaching consequences, often played a major role in what lead individuals to seek treatment within the agencies I was placed at. When working with individuals with anxiety and depression, I also saw that these conditions were frequently, but not always, linked an experience of trauma. This reinforced my understanding of how the impact of trauma can lead to the development of various mental health concerns, including anxiety and depression. In addition being trained to a conduct group treatment program for children and parents who have been exposed to ongoing violence and trauma facilitated my understanding and ability to work more effectively with traumatised individuals. Many professional and ethical issues became relevant to me through the course of my placements and in my supervision and it is these issues, interspersed with research and reference to the Codes of Practice (Australian Psychological Society, APS, 2002) and the Psychologist's Registration Board of Victoria (1977), that form the basis of this report.

Introduction

Clinical psychology is focused on the prevention, diagnosis and treatment of mental health problems, within both the individual and the family, and seeks to assist individuals to recognize, acknowledge and utilize their own unique resources to overcome difficulties (Martin & Birnbrauer, 1996). My own experience of the practice of psychology varied during the course of my placements, due in part to the variety of settings I worked in. Within my placements, I gained experience in the roles of clinical psychologist, counselling psychologist, child psychologist, group therapist, and educator, and to some extent social worker. As noted previously, many professional and ethical issues were raised during my placements. As such, the time spent studying the unit 'professional practice' at university prior to commencing my placement program was valuable in providing me with a framework with which to identify and resolve such issues when they arose. The following discussion will focus on the main issues that presented themselves to me and will be discussed in reference to the Australian Psychological Society Code of Ethics (APS, 2002) and the Psychologists' Registration Board of Victoria (1997), with whom registration as a probationary psychologist was required prior to commencing my placement program. This report will be delivered under two main headings, professional issues and ethical issues. Prior to this, there will be a discussion regarding the other placement issues such as working within the framework of the Scientist-Practitioner Model, specialist qualifications, and self-care.

The Scientist-Practitioner Model

The scientist-practitioner model was adopted by the American Psychological Association (APA) in 1947 and has become the predominant model of training for

psychologists for the past 5 decades (Drabick & Goldfried, 2000). This model indicates that psychologists should consume and apply the results of research into the psychological assessment and treatment of individuals, evaluate their own interventions using empirical methodology, and report the findings of their own research to the wider scientific community (Berstein & Kerr, 1993). Further to this, the work of the researcher should be informed by practice with hypotheses and designs that are generated by the experience of practice (Barlow, Hayes, & Nelson, 1984). In this way, the model attempts to provide psychology with the ability to meet the assumptions of science as stated above. This model has been the primary focus of the Doctor of Psychology (Clinical) program at the University of Ballarat.

Within Australia, most institutions currently training clinicians use the scientist practitioner model to guide their course structure (Baker & Benjamin, 2000; Cherry, Messenger, & Jacoby, 2000). The result is that strong emphasis is placed on research based subjects, particularly those designed to develop an ability to understand experimental designs and to evaluate programs effectively. The practical placements, which are also a large part of the course structure, serve to provide training and expertise in the practitioner aspect the course and address the issue of clinical preparation for the emerging student/clinician.

However, there is a view that suggests that many students feel under-prepared for undertaking the 'practice' of psychology, and that this under-preparation is due in part to the shortcomings of the scientist-practitioner model (Albee, 2000; Bernstein & Kerr, 1993). This view proposes that the majority of scientist-practitioner programs are heavily weighted towards developing research competence and productivity to the detriment of the developing competency in clinical skills (Berstein & Kerr, 1993). In defense of this view, however, it has been argued that the emphasis on research skills

enables the practitioner to better meet the goals of the model, these being to train clinicians to approach clinical practice objectively and evaluate success empirically (Barlow et. al., 1984). Mittelstaedt and Tasca (1988) state that it is not a lack of clinical skills per se that contributes the feelings of under-preparation, but that it is an inherent contradiction between the content of research classes and their clinical counterparts. That is, that training programs seek to instill an attitude of skepticism about the assessment enterprise in students, while clinical training emphasizes competence and skill building (Mittelstaedt & Tasca, 1988). Despite a commitment to the scientist-practitioner model, critics maintain that while graduates continue to express concerns regarding the adequacy of preparation for clinical practice, further discussions regarding the content of psychology programs will continue.

Within the Doctor of Psychology program at the University of Ballarat, the program was heavily weighted towards research, which constituted 67 percent of the course. My own experience, and that related to me by many of my fellow students, was that we did indeed feel under-prepared when we entered into our first clinical placement. This is not a criticism of the course, but perhaps supports the view presented above which suggests that a strong focus on the research component of the model, may indeed impact in the areas of clinical training and knowledge. Students have provided feedback regarding a need for an increased focus in the areas involving the diagnosis, assessment, and treatment of problems a clinician is likely to encounter in the working lives, in addition to the presentation of scientific models and the problems that sit neatly within them. This outcome from this feedback has been positive with the university undertaking to have more clinicians currently 'working in the field' incorporated into the clinical units in the program, providing opportunities

to learn from the knowledge and expertise of these clinicians in the 'real world' application of psychology.

Specialist Qualifications

Specialist qualifications for psychologists no longer exist in the state of Victoria, however, within the APS, one is still able to indicate membership of a particular college. For me, this is most appropriately the College of Clinical Psychologists, with a level of competence being demonstrated by a psychologist prior to being granted full membership (APS, 1977). Such competencies are expected to be gained through university training and subsequent supervised practical experience (APS, 1977). As such, I was mindful of these requirements during my placements so that I may at some point obtain membership of this college. Similarly, the university requirements in relation to placements were also in line with these requirements ensuring that I undertook placements within the areas of adult and child clinical practice.

The supervisors I had over the course of my placements were all members of this college and had extensive experience in working in psychology. These wonderful practitioners provided me with opportunities to work within a variety of methods, including CBT, gestalt, psychodynamic, narrative, interpersonal, behavioural, and clinical perspectives. In addition to this, I was also involved in the aspects of administration, assessment, interpretation and reporting of different psychological tools. I was also provided with opportunities to participate in staff development programs where I presented case studies, reviewed treatment methods and facilitated theoretical discussions. In one instance, following my training in the delivery of workshops of children exposed to violence and trauma, I was asked to provide training to the other members of staff in this program.

The clients I worked with were also extremely varied in their issues and backgrounds and I gained experience in a range of issues ranging from drug and alcohol, attachment, developmental, mental, cognitive, behavioural, personality, trauma, and health to name a few. I feel the knowledge I have gained from these experiences will provide a framework with which to further expand my knowledge and development, which will in time, and with some additional supervision in my future work, see me fulfill the competency requirements and achieve full membership of the College of Clinical Psychologists. What I have gained from the experience of undertaking a clinical doctoral degree is that it provides you with a broad range of knowledge and skills that can be applied across a whole range of settings.

Self Care

This is an aspect of being a psychologist that has become increasingly important for me over the course of my placements. Psychological practice, while extremely rewarding and interesting work, can also be very demanding both physically and emotionally. Although research has studied the sources of clinician stress and burnout, only minimal steps have been taken to address how clinicians themselves understand and ameliorate their distress in a constructive manner (Guy & Norcross, 1998). As such, it is vitally important for clinicians to be aware of their own psychological health, and to take time to care for their own needs in order to reduce the risk of burnout.

Guy and Norcross (1998) state that clinicians should learn to recognize the hazards of the 'impossible profession'. It is widely held that clinical practice exacts a negative toll on the clinician. One of the difficult aspects of clinical work that I experienced during my placements was the stress associated with moving from one

location to another over relatively short spans of time. I had a sense of entering a new agency, getting settled, getting to know people and feel comfortable and then it was time to say goodbye and start again somewhere new. The early periods of each placement where stressful times as I recommenced the process of orientating myself to a new environment and becoming familiar with the policies and procedures specific to each agency. To combat this, I utilized my fellow students, whereby we would meet together to talk about our fears, stresses, and concerns as we moved to new locations. I also took to speaking to students who had previously been at a placement I was to commence and sought out their views and experiences of their time with that agency.

Another strategy I found valuable for my own self-care was learning to refocus on the rewards of practicing (Norcross & Guy, 1999). This strategy suggests that it is important to put yourself in contact with clients you can actually help and obtain satisfaction from doing so. This can often be difficult to identify when working in the areas of mental health and trauma due to the despair and hopelessness that often exists in these client groups. In such instances, the prospect of positive outcomes in terms of recovery may not be realistic and challenge the view that you should always be able to help other change their lives. It may be more appropriate to recognize that we cannot remedy every patient's problems and respect that we will have not only success but failures in our practice, and seek to spend time reflecting on both equally, rather than just with those for whom we feel we have failed. One way I learnt to reduce an overwhelming sense of failing was to balance the clients I worked with at any one time by ensuring I had some higher functioning clients whose contact was primarily for support and brief treatment. My involvement in attending conferences

and in tutoring classes at university also served to balance my 'successes' against my 'failures'.

One of the most important self-care strategies I have developed during my doctoral program is learning the importance of accessing regular supervision. My supervision sessions were invaluable for providing me with a space in my busy days to talk through the joys and disappointments of the work I was doing with my clients. In these sessions, I was not only able to review and discuss my clients and their ongoing treatment, but also the impact of the work on myself and my own reactions to the clients and the stories they related to me in sessions. Without this opportunity, there were many occasions where I would have taken clients issues home with me. By being able to speak about my own experiences in sessions, I also learned more about the impact of psychological work on myself and discuss and explore ways in which to care for myself to minimize the effects of this from a person with years of experience in these issues. Supervision is something that I will continue to attend throughout my working life. Its dual purpose of providing an opportunity to review my work with a colleague and a space to reflect and care for myself cannot be replaced.

Professional Issues

A number of professional issues were relevant to my clinical placements. These including working with young people, dual relationships, gifts from clients, ending relationships with clients, professional competency and relationships with other professionals (Section H, APS, 2002).

Relationships with Clients

Working with Minors. The APS Code of Ethics (Section B5, APS, 2002) states that when working with young people, or other individuals who are unable to give informed consent, the psychologist must seek to protect the client's best interests and regard their responsibilities as being directed to the parents, guardian, or next of kin. My own experience of this issue occurred in my last placement where I was working as a child psychologist.

When working as a child psychologist, I was instructed it was the policy of the agency that minor children under the age of 18 could not provide their own consent to receiving treatment and that I must obtain written consent from the parent/s, guardian or next of kin prior to commencing any treatment with a child. This seemed a clear-cut instruction when very young children were involved, however, when the child was an adolescent, it seemed that, while not legally 'of age', to deny them some involvement in giving consent to receive treatment, seemed dismissive of them as an individual in their own right and could potentially have a negative impact on the development of a healthy therapeutic relationship with the adolescent. After discussion with my placement supervisor about my concerns, this matter was brought up for discussion at a staff meeting and the issues of how to obtain the parent/s, guardian or next of kins' consent and provide an opportunity for the adolescent to also be involved in this consent were explored. The outcomes of this discussion were as follows; that following referral to the agency and the initial period of information gathering and family history taking (which usually occurred over two to three sessions), and prior to commencing treatment, a family meeting would be held to discuss the problems identified, outline the proposed treatment, and seek to obtain consent from both parent/s, guardian, or next of kin and the adolescent concerned.

This process allowed the adolescent to be an active participant in the discussion of the treatment proposed, which has proven to be very successful. The adolescents who have taken part in these meetings have shown greater motivation and commitment to their treatment. This has been identified through regular attendance at appointments and through satisfaction surveys that are completed by the parent/s, guardian, or next of kin and the adolescent upon the completion of treatment. This experience has shown me that while it is necessary to strictly adhere to both the APS Code of Ethics and the particular policies of the agency in which you may work, it is also possible to do so in a way that still enables you to treat the young person under your care with dignity and respect.

Dual Relationships.

Psychologists should avoid dual relationships that could impair their judgment or increase the risk of exploitation of a client (Section B7, APS, 2002). Further, the Psychologists' Registration Board Code of Behaviour for Psychologists states that psychologists must avoid improper and potentially harmful dual relationships (Section 3.2, 1997).

During my third placement, I found myself working with a young lesbian woman who had experienced a number of significant deaths over the six months prior to seeking treatment for depression and suicidal ideation. This young woman very quickly inquired as to my own sexual orientation as she indicated that she thought I also was a lesbian. I confirmed this for her and this information played no further role in the interactions I had with her in subsequent sessions. However, while out socializing with my partner at venues such as restaurants and theatres on a number of occasions, this young woman was also present and she would immediately walk over

and speak to me. I would keep these conversations brief and generic despite her invitations to join her and her partner for a meal, drinks, etc. On the last occasion, New Years Eve to be precise, this young woman again approached me at midnight and requested a kiss for the New Year. I declined and wished her a Happy New Year before moving to the other side of the venue with my partner. She continued to seek me out asking repeatedly for a kiss, to the point where I left the venue and returned home. Following this incident, I discussed this and the other incidents with her in our next session. At this time I outlined the difficulties having a social relationship would have on my ongoing professional relationship with her as her therapist. I suggested that while the therapeutic relationship can be an intimate one, it was inappropriate for me to engage in a friendship type of relationship with her when she was a client of mine. While disappointed, she agreed that she had wanted to be 'friends' with me as she felt we had many things in common but respected that by doing so, it would blur the boundaries around my role as her therapist, thereby making it inappropriate to continue working with her. We discussed how we could appropriately acknowledge each other if we met in public again and agreed to respect the professional boundary that was needed while she was a client receiving treatment. Subsequent to this conversation, I did encounter this young woman again while socializing and she was able to abide by our agreement. I continued to work with this young woman for the next four months at which time she completed her treatment. Since that time I have had no further contact from her.

Gifts from Clients

In relation to receiving gifts from clients, the APS Code of Conduct states that psychologists are not to receive private fees or gratuities for professional work outside

of their agency's arrangement (Section B15, APS, 2002). I experienced the personal dilemma of accepting gifts from clients on a number of occasions during my clinical placements. In each instance, a client would present me with a small wrapped gift and/or flowers. This would typically occur at the time of termination with a client, although occasionally occurred during treatment. I found this a difficult issue initially and acknowledge that I accepted that first gift of flowers, as I was concerned that refusal could be seen as rejection and I spent considerable time discussing this issue in supervision. Subsequently, I was able to thank my clients for the thoughts they had in wanting to give me a gift but refuse them by saying that their payment to the agency was sufficient and that ethically, I was uncomfortable accepting gifts from clients, particularly in light of the differences in the power structure of the therapeutic relationship and how this might be perceived. All clients took this well and indicated that they understood why I had declined their gift. For those clients still undergoing treatment, this issue did not appear to affect the therapeutic relationship.

Terminating Relationships

According to the APS Code of Conduct, psychologist's should demonstrate due regard for the therapeutic relationship when terminating relationships with clients and determine that all reasonable steps have been taken to ensure the client's ongoing welfare (Section B18, APS, 2002).

One of the major limitations of clinical placements is that of time. Each placement was for a period of approximately 50 days, which often meant needing to terminate with clients who were in the midst of their treatment. This is never an ideal situation. As such, termination with clients was a very real aspect of the work carried out within each placement. This issue was one that I found particularly difficult

initially, and I found myself struggling with feelings that I was abandoning my clients and spent time in supervision exploring my feelings around this issue. In talking through this issue with my supervisor, I was mindful of the boundary issues around ensuring that clients are not there to meet my needs and that treatment relationships are not reciprocal, but can at the same time be intense and heart wrenching. I found that by informing my clients at the time of the first session that my time with them would be limited and providing them with my departure date and then routinely reminding them of this date in subsequent sessions, this lessened the distress and/or difficulties for both the client and myself at the time of termination. I also sought to ensure that my clients were successfully referred onto other services or a new therapist prior to termination with me.

With minors, however, time is often an abstract term for them. As such, I would employ alternatives methods for them to gain an understanding of the limited nature of our contact, using things such as a train and carriages where each carriage represented a session and one carriage was removed at each session to signify the 'counting down' of our time together. Termination with one adolescent girl whom I had been seeing for psychotherapy for six months was particularly difficult due to her history of abandonment by parents and 76 foster homes and various other health professionals along the way. Initially she told me she was not concerned about my leaving but in a later session, she was able to verbalise how angry she was that people keep leaving her and how hard she finds it to trust adults. She asked who would take my place when I was gone, which was a sign that she was processing the sense of abandonment she was experiencing. As such, this may have provided an opportunity for her to be able to express her feelings around this issue, which she has not had before. While this was a potentially positive aspect of the termination, I still struggled

with a sense of guilt about being yet another person who had abandoned her. In our last four sessions, the therapist replacing me attended to facilitate a smoother transition to a new worker.

Having such intense but relatively short placements means that students are often confronted with the issue of termination and after years of clinical practice it is useful to reflect on the number of clients you do have to say goodbye to and what the accumulated impact of this may be (Guy & Norcross, 1998).

Professional Competency

The Psychologists Registration Board of Victoria states that psychologists' services should be restricted to their areas of expertise (Section 1.1 Psychologists Registration Board of Victoria, 1997). As such, psychologists are expected to bring a reasonable level of skill and learning to areas of professional practice and must not misrepresent their level of competence, training, or experience, nor offer or undertake work beyond their level of professional competence (Francis & Cameron, 1991).

This is a particularly relevant issue for a student. When I first commenced my clinical placements, I felt I lacked competence in most areas and initially relied on my judgment, common sense, and open communication with my placement supervisors to ensure that I acted appropriately at all times to the best of my ability. To further assist my developing skills and knowledge, I undertook additional reading around the particular mental health conditions I was treating, attended staff development sessions within my placement agencies, training seminars, and workshops to increase my sense of competence.

This issue was particularly difficult within one of my placements where a strong psychodynamic framework was being used within this agency.

Psychodynamic theory and application had not been a part of my university training and I therefore felt very incompetent in commencing this placement. To assist developing my skills and knowledge of a psychodynamic method of working, I met with my placement supervisor several months prior to commencement of my placement to discuss working within a psychodynamic framework and obtain specific reading material around this. As my placement approached, I was still apprehensive about my ability to be competent in using this method. I was also concerned about the ethical implications of using a method I was largely untrained in. By negotiation with my supervisor, it was agreed that two of my clients would be treated within a wholly psychodynamic framework under close supervision, whilst other therapeutic methods, in which I had greater levels of competence, could be used with my other clients (i.e., CBT, interpersonal therapy, dialectical therapy).

Another area in which I initially struggled to feel competent was working with children and families. For this reason I had left this experience for the last of my placements, when I felt more competent to handle this type of work. I had had only limited experience with children within my fourth year psychology placement when I worked as a child psychologist in an educational setting for a period of eight weeks. This placement had mostly involved testing and report writing. Initially, I found working with children daunting, but I took the initiative to seek out my supervisor and other professionals for advice and guidance to try and combat my feeling of inadequacy. Despite my often-said claim that I did not want to work with children, I have found that I am able to successfully engage and work with children and families.

Relationships with Professionals

According to the APS Code of Conduct, psychologists should refrain from any criticism, which may make another professional incompetent (Section H5, APS, 2002). This issue was only evident within one of my clinical placements. This placement was within a large community health centre, which housed a variety of allied health professionals including, psychologists, physiotherapists, health nurses, dentists, podiatrists, social workers, and mental health workers. At the time of my placement, this centre was in the midst of a long-standing dispute with its management and administration. My involvement within this agency was working within the Primary Care Team, comprised of both psychologists and social workers. During my time there I encountered one incident that professionally I objected to and felt that boundaries were being crossed in relation to the ethical treatment of clients. This is not a criticism of the workers per se, but of their training and lack of knowledge of the appropriate use of psychological tests. The incident that occurred involved one of the social work counselors asking me to administer a WAIS-IV Intelligence test to one of their clients. When I asked why they were requesting this, I was told that this client thought he was very intelligent and the counselor did not believe this and therefore wanted them tested to 'burst their bubble'. They indicated that they did not like this client and wanted to end his constant inferences that he was intelligent. I explained the purpose of testing people with the WAIS-IV and suggested that testing them for this reason was not an appropriate use of the test and questioned was there any other reason they should be tested. The counselor said no, they merely wanted to put him in his place. I indicated I was not willing to administer a test under these conditions. I then discussed this matter with my supervisor who supported my decision. Following this incident a discussion about the

appropriate use of psychological tests was undertaken at the next staff development meeting for the entire Primary Care Team.

In contrast to this experience, working across both the Primary Care and Mental Health areas at Barwon Health was an extremely informative and useful experience. Within this context, a number of my clients were also currently under case management within the Mental Health Team. As such, I regularly attended case management meetings with the Mental Health Team workers and psychiatrists to review and discuss on the ongoing treatment of these clients. Further during my placement within the Queen Elizabeth Centre, I regularly attended to inpatients of the hospital and attended meetings and case planning meeting with nursing staff, general practitioners, physiotherapists, and occupational therapists. Working alongside these highly qualified professionals whom I respected and engaged well with has balanced my one negative experience and has shown me that I am able to be a part of a team in which many disciplines can work positively together.

Ethical Issues

A psychologist is expected to practice psychology in a professional manner, and to act ethically at all times in their execution of such practice. For a psychologist, membership with the APS means that they are expected to adhere to the standards of conduct provided in the Code of Ethics (APS, 2002). However, membership to this organisation is not compulsory. The guidelines contained within the APS Code of Ethics, while not exhaustive, present a model of what is currently seen to be the minimum standards in terms of professional practice and ethical behaviour for the discipline of psychology.

My discussion of the ethical issues I encountered within my clinical placements will mostly relate to the General Principles of the Code, and more specifically to I(b) having regard to the highest standards of the profession and III(c) refraining from any act that would bring the profession into public disrepute. If I had handled the following situations differently, these sections may easily have been breached. The main ethical concerns I had on placement relate to physical contact with clients.

Physical Contact with Clients

The issues of physical contact with clients had not been a problem in my placements until my last placement where I found myself working with children. I had felt competent in managing to limit the amount of physical contact with adult clients in my other placements and had typically restricted contact to a handshake when meeting a client for the first time and a hug (if the client requested this) at the time of termination with a client. I had discussed this issue with each of my placement supervisors who had all agreed that a quick hug at this time was perfectly fine, as long as it was not happening after each session, and could be seen as an acknowledgement of a client's appreciation of your assistance in helping them sort out their problems and their desire to give something back to you for that support.

In my final placement where I was working with children, however, I found the issues of physical contact more difficult. This was a setting in which the children were the clients and their needs were paramount to the staff. I often had young children coming in and it was a challenge to engage many of them. Many of these young children aged between five and fifteen had very emotional and traumatic histories with parents who did not want them or who had treated them badly. These

children would look so alone and lost at times that it was often difficult to remain unaffected by their need to be nurtured and there were occasions when I felt like taking some of them home with me.

The children would range from being fearful and withdrawn in sessions to extremely affectionate and would seek to hold your hand or touch you in someway in every session. I felt that to pull away from any form of touching would suggest another adult rejection to these children, so I would allow some touching in sessions but restricted this to hand holding when collecting a child from reception and/or when returning them to reception at the end of a session. I had observed that the other psychologists also did this. Working with young children often involved play therapy with them and this usually meant sitting on the floor with them, playing board games, drawing or engaging in role-play. As such, the very nature of this work suggests that some contact will occur.

At times, it was also difficult to see these young children expressing deep pain and crying, and at these times I very much felt a need to reach out and hug them. From discussions with my supervisor, I knew this should not be done, but instead I learnt to verbalise how I was feeling or how the child must have been feeling with comments such as 'I bet you would love to have a hug right now' or similar. At these times, being aware of my own emotions, yet still aiming to behave in a professional and ethical manner was a valuable learning from this placement and is one that I am sure will occur many times over in my future working life.

Summary

In conclusion, the experiences and knowledge I have received over the course of my four clinical placements has been an invaluable training ground for my future

work in the area of clinical psychology. When I think back to the beginning of my doctoral program, I am pleased to relate that my expectations have been met, and at times exceeded. As my program reaches its end point, I feel I am leaving with a greater sense of competency and confidence in the work I will under take as a psychologist. I am sure that this will continue to grow in the years ahead as I make my way in the discipline of psychology. This report has focused on those aspects of the professional and ethical issues associated with psychological practice that I experienced directly within my placements. These experiences have served to increase my desire to continue to strive to always practice my profession to the highest standards of the profession, to always be ethical in my delivery of services, and to act with responsibility, competency and propriety.

References

Albee, G. W. (2000). The Boulder model's fatal flaw. American Psychologist, 55, 247-248.

Australian Psychological Society (1997). The APS college competencies: Specification areas of specialist knowledge and skills. Parkville, Australia: Author.

Australian Psychological Society (2002). The APS code of ethics. Parkville, Australia: Author.

Baker, D. B., & Benjamin, L. T. Jr. (2000). The affirmation of the scientist-practitioner: A look back at Boulder. American Psychologist, 55, 241-247.

Barlow, D. H., Hayes, S. C., & Nelson, R. R. (1984). The scientist-practitioner: Research and accountability in clinical and educational settings. New York: Pergamon Press.

Berstein, B, L., & Kerr, B. (1993). Counselling psychology and the scientist-practitioner model: Implementation and implications. The Counseling Psychologist, 21, 136-151.

Cherry, D. K., Messenger, L. C., & Jacoby, A. M. (2000). An examination of training model outcomes in clinical psychology programs. Professional Psychology: Research and Practice, 31, 562-568.

Francis, R. D. & Cameron, C. (1991). Handbook of professional psychology. Bowen Hills, Australia: Australian Academic Press.

Guy, J. D. & Norcross, J. C. (1998). Therapist self-care checklist. Psychological desk reference. New York: Oxford University Press.

Martin, P. R., & Birnbrauer, J. S. (1996). Introduction to clinical psychology. In P. R. Martin, & J. S. Birnbrauer (Eds.), Clinical psychology: Profession and practice in Australia. pp.3-20. South Melbourne, Australia: Macmillan.

Mittelstaedt, W., & Tasca, G. (1988). Contradictions in clinical psychology training: A trainee's perspective of the Boulder model. Professional Psychology: Research and Practice, 19, 353-355.

Norcross, J. C., & Guy, J. D. (1999). Leaving it at the office: Understanding and alleviating the distress of conducting psychotherapy. New York: Guilford Press.

Psychologists Registration Board of Victoria (1997, September). Code of behaviour. Psychologists Registration Board of Victoria Bulletin, 6, 1-3.