Rational Emotive Behavior Therapy-Informed

Treatment for Anxiety and Depression

FACILITATOR'S GUIDE

Allen B. Grove, Ph.D., Sarah M. Scott, Ph.D., Ashley R. MacPherson, M.A.
Central Virginia Veterans Affairs Health Care System • Richmond, Virginia, USA

VA | U.S. Department of Veterans Affairs

This page is intentionally left blank

Rational Emotive Behavior Therapy-Informed

Treatment for Anxiety and Depression

FACILITATOR'S GUIDE

Allen B. Grove, Ph.D., Sarah M. Scott, Ph.D., Ashley R. MacPherson, M.A.
Central Virginia Veterans Affairs Health Care System • Richmond, Virginia, USA

VA | U.S. Department of Veterans Affairs

ACKNOWLEDGEMENTS

We want to thank many people who contributed to this manual. First, Kelly McMullen did an amazing job of graphic design. She spent time learning about Rational Emotive Behavior Therapy (REBT) and about the authors just to have a sense of how to present our work in a way that fit both our patients and the treatment itself. This manual would not exist if it weren't for you, Kelly!

Second, we want to acknowledge Scott McDonald whose idea (and significant work as well!) it was to apply for a grant that led to the existence of this manual. Scott introduced the authors to Kelly and has continued to consult about the REBT project. Thank you, Scott, for everything!

Third, we want to thank the Veterans Integrated Services Network (VISN) 6 Mental Illness Research, Education and Clinical Center (MIRECC) whose funding sponsored the creation of this manual. We look forward to continued collaboration. Thank you for giving this research a chance!

Fourth, we want to mention Erin Kurtz and Caitlyn Laux Treadway who each looked at periodic drafts and graphic designs of the manual. Each has been significantly involved in the REBT project. Thank you, Erin and Caitlyn!

Fifth, several other people have been influential to the REBT project in general: Kim Aquino; James Bjork; Mary Bradshaw; Lisseth Calvio; Tom Campbell; Torran Claiborne; Lisa Clevinger; Brooke Green; Carline Holland; Sonya Matthews; Dena Pastor; Treven Pickett; Sarah Raymond; Christina Sheerin; and Rachel Wallace. Each has made important to vital contributions to the REBT project. Thank you all for everything!

Finally, we want to acknowledge past researchers and clinicians who helped pave the way for this treatment program. Thank you for the work you've already done! (Hopefully, we also cited you!) We also want to recognize anyone who has been involved in the treatment of Posttraumatic Stress Disorder (PTSD), anxiety, depression, anger, or guilt and has considered using this REBT-informed treatment. Thank you for giving this treatment a chance for your patients or clients!

CONTACT Allen B. Grove, Ph.D.:
allen.grove@va.gov
Central Virginia VA Health Care System
1201 Broad Rock Blvd
Richmond, VA 23249

Contents

Introduction

In this manual you will find a Rational Emotive Behavior Therapy (REBT)-informed approach to treating Posttraumatic Stress Disorder (PTSD) by focusing on co-occurring anxiety and depression. What you will not find is "shoulds." Consistent with REBT, this is *not* a prescriptive approach with rules clinicians "must" follow.

First, this treatment is patient-focused. We advise facilitators to go with patient flow and the interests of the group. For example, some groups include more patients with anxiety while others include more with depression. Still others may include a significant number of patients with each. The makeup of your group may impact your focus as a facilitator. Typically, a facilitator may determine whether this is an "anxiety," "depression," or "both" group in the topics group members bring forth as well as how often they speak in general.

Second, this treatment is clinician-focused. We seek to provide facilitators with the flexibility to be genuine and natural in order to adapt the treatment to each group's specific needs.

Just as patients have beliefs that interfere with their recovery, clinicians do as well. Consider if you have any of these beliefs *(Ellis, 1983)*:

> "I *have* to be successful with all my clients."
>
> "I *must* be an outstanding therapist."
>
> "*All* my clients must respect me."
>
> "Since I am doing my best as a therapist, my clients *should* be equally hardworking and *should always* push themselves to change."

Checking for these beliefs such as the ones outlined above will improve your effectiveness as a clinician as you model to patients the concept of **balanced** thinking.

Core Model of REBT

REBT is a cognitive- and behavior-based treatment based on the theory that reduction of *irrational beliefs* leads to reductions in negative emotions, such as depression, anxiety, anger, and guilt *(Ellis, 1957, 1962, 1992, 1993)*.

Irrational beliefs are rigid, extreme demands of others and ourselves which do not match reality. These beliefs tend to be rooted in "shoulds," "oughts," "musts," "catastrophizing," or "can't-stand-itis." It is these thoughts that cause distress, rather than a situation directly. Throughout these group sessions, many common irrational beliefs will be reviewed such as:

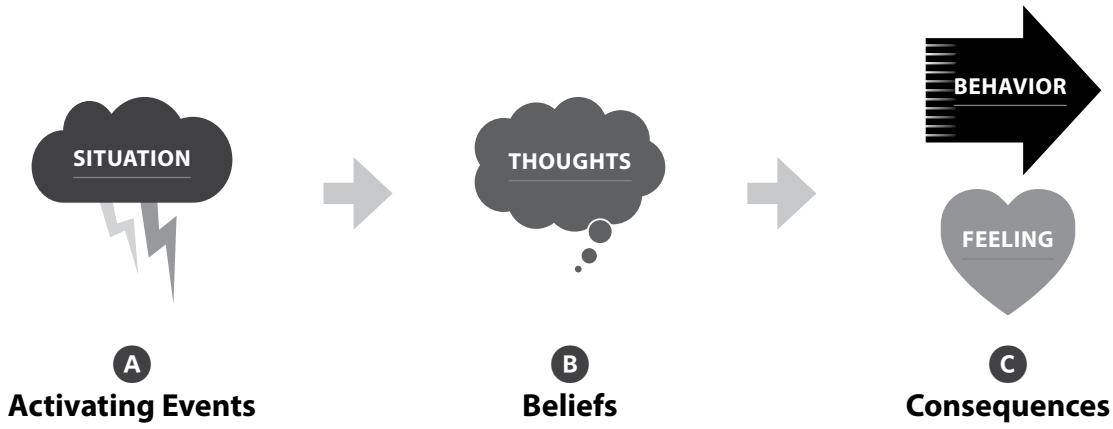
- Catastrophizing
- Demandingness
- Low Frustration Tolerance
- Depreciation

The A-B-C Model in REBT theorizes how patients' symptoms and distress are either increased or decreased.

A **Activating Event:** The situation that happens
(e.g., a patient storms out of the room in the middle of the class)

B **Beliefs:** Thoughts about the situation (e.g., "I am a terrible therapist!")

C **Consequences:** Behaviors or emotions that follow the belief
(e.g., "I stare down at the floor; I feel depressed")

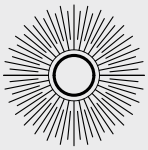


We do not have control over Activating Events, but we do have some control over managing our Beliefs. By identifying and challenging irrational beliefs, we have the potential to reduce distress.

The Spirit of REBT-Informed Treatment

We teach *unconditional self-acceptance (Ellis, 1972, 1976, 1983)* and see people as "holistic, goal-directed individuals who have *importance in the world just because they are human and alive;* it unconditionally accepts them with their limitations, and it particularly focuses upon their experiences and values, including their self-actualizing potentialities" *(Ellis, 1980, p. 327)*.

To encourage unconditional self-acceptance, it's recommended for providers to strive for *genuine positive regard* with patients *(Rogers, 1957)*. Providers can model warmth and acceptance toward patients so patients can learn to treat themselves (and others) similarly. For example, providers can strive for genuine positive regard when patients express emotions in session. Providers can simply note that a patient is having an emotion, without judgment, so that patients can also learn to identify emotions without judgment.



"There are three musts that hold us back: I must do well. You must treat me well. And the world must be easy."

—ALBERT ELLIS

Rational Emotive Behavior Therapy (REBT) for Posttraumatic Stress Disorder (PTSD)

ADDRESSES PTSD COMORBIDITIES

Although many treatments exist for PTSD, few address PTSD comorbidities like anxiety and depression. This REBT group focuses on conditions and emotions comorbid with PTSD (e.g., depression, anxiety, anger, guilt) to maximize patient treatment outcomes.

REDUCES BARRIERS TO TREATMENT

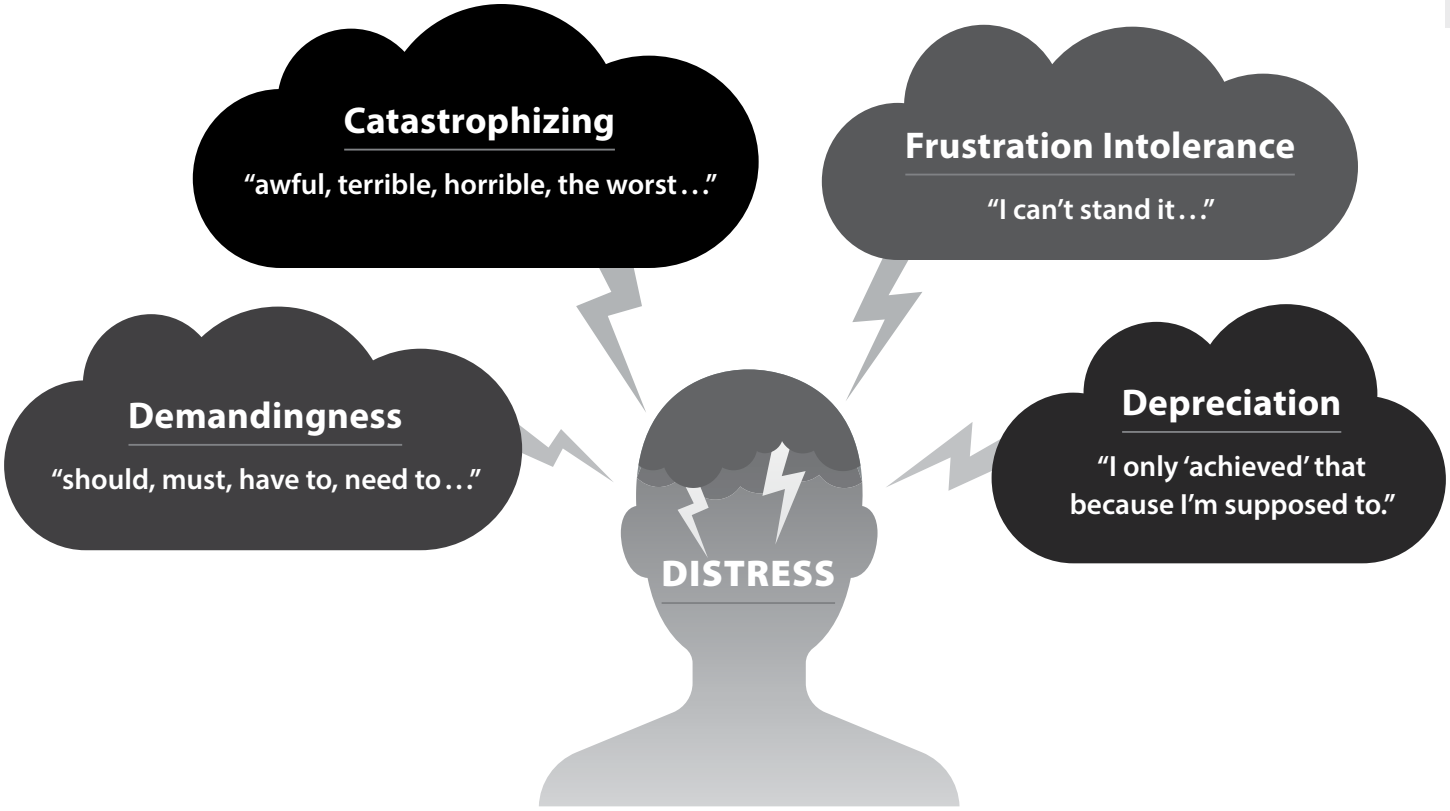
There are also many barriers to treatment for PTSD (avoidance of traumatic memories, time commitment, comorbidities). In fact, treatment dropout rates increase when PTSD is comorbid with depression *(Flory & Yehuda, 2015)*. To decrease the potential for treatment dropout, this REBT group is relatively short (5 sessions), does not require patients to discuss traumatic memories, and addresses depressive symptoms *(Grove et al., 2021)*.

FOCUSES ON IRRATIONAL BELIEFS

Based on recent research finding that specific irrational beliefs are associated with PTSD symptoms *(Hyland et al., 2014)*, this REBT group largely focuses on irrational beliefs such as:

1. **Demandingness:** "should, must, have to, need to," etc.
2. **Catastrophizing:** "awful, terrible, horrible, the worst," etc.
3. **Low Frustration Tolerance:** "I can't stand it," etc.
4. **Depreciation:** "overgeneralization of negatives, disqualification of positives," etc. *(David et al., 2008; Hyland et al., 2015)*.

IRRATIONAL BELIEFS CAN LEAD TO EMOTIONAL DISTRESS



This page is intentionally left blank

SESSION 1

Introduction to Anxiety and Depression

This page is intentionally left blank

SESSION 1

Introduction to Anxiety and Depression

SESSION GOALS

- Provide overview of group and group structure
- Increase patient's understanding of anxiety and depression symptoms
- Increase patient's understanding of differences between anxiety and depression
- Normalize the purpose of anxiety and depression
- Provide hope that the goal of the group is to learn skills to better manage anxiety and depression symptoms that interfere with everyday life

I. GENERAL DESCRIPTION OF GROUP (approximately 5 minutes)

Providers may give a general description of the group's structure and purpose. Additionally, providers may review the specific topics that will be covered in each session.

Welcome! You are here for Rational Emotive Behavior Therapy class, or REBT short. This class will meet once a week for five weeks. In this group we will focus on anxiety and depression, what they are, their causes, and what we can do about them. We will also talk a good bit about anger and guilt, which often go with anxiety and depression.

CLINICAL TIP:

Conveying genuine positive regard toward patients is key.

Let's review what we will cover in each of our five sessions. Today, our first session will discuss what anxiety and depression are. We hear these terms a lot, but they sometimes mean different things to different people.

In our second session, we will discuss causes of anxiety and depression. One cause we will spend significant time on is that of thoughts, the idea that the way we think affects the way we feel. We will learn that there may be certain thoughts that are likely to increase anxiety, depression, anger, and guilt. We want to know what these thoughts are; we also want to know if there is a way to look at things differently, to reduce anxiety, depression, anger, and guilt.

Our third and fourth sessions will explore specific thoughts which are likely to increase anxiety, depression, anger, and guilt along with healthier (and ideally more accurate) thoughts to reduce these emotions.

In the last session, we will discuss strategies you can use to reduce anxiety, depression, anger, and guilt.

II. ESTABLISH GROUP RULES (approximately 3 minutes)

Group rules will vary for individual practitioners and settings. Consider what group rules are necessary for your group to be effective, efficient, and comfortable. Sometimes presenting group rules can give patients the message that there is a right and a wrong way of being, which is not the spirit of REBT. Practitioners can consider explaining the reasoning behind the rules to patients, as well as presenting group rules as requests to ensure the well-being of the group (the word "please" makes a difference here!).

As you decide upon rules for the group, consider the following suggestions:

1. *Please show respect for one another and the instructor. Talking about anxiety, depression, anger, and guilt can cause those emotions to arise! This experience is normal, and you are accepted in this group exactly as you are. If these emotions happen for either you or another group member, please remember to be respectful of each other.*
2. *Please keep the information discussed in this group to yourself in order to maintain confidentiality (i.e., this group is like Las Vegas—whatever happens in group, stays in group).*
3. *Please keep cell phones on vibrate or silent. Having cell phones make noise during group can be distracting for some group members.*
4. *We will NOT be discussing traumatic events directly in this group because that can be triggering for some group members. If it sounds like you are moving in that direction, I will stop you; that is to ensure the comfort of the other group members.*

III. INTRODUCTIONS (approximately 5 minutes)

The provider can introduce themselves and ask group members to introduce themselves. If there are any "guests" (e.g., students observing), it is often beneficial that they sit at the table with the patients and group leader rather than "in the back." Sometimes when guests sit separately from patients, patients can have increases in hyperarousal due to being observed. By having guests sit with the group, patients may instead feel that each member of the group (including guests and instructors) are in the process together.

As we get started, it will be helpful for us all to introduce ourselves! I'll go first, my name is _____. **(Describe background or other relevant information about yourself.)** *Now I would like to get to know you all. How about we go around the room and introduce ourselves?*

IV. DISCUSSION OF ANXIETY SYMPTOMS: "WHAT IS ANXIETY?"
(approximately 10 minutes)

To get group members comfortable having discussions in the group, ask patients what they believe are anxiety symptoms. It can be helpful to write on a board what comes to mind for them. The provider may issue prompts to ensure both physical and emotional symptoms come up.

Hearing the responses from fellow group members can help validate and normalize these experiences as symptoms rather than traits, while also unifying the group.

It can be helpful to gauge the interest level of the group towards anxiety versus depression through the examples provided, number of responses, body language, etc. Note the "mood in the room;" for anxiety, patients are often pumped up and ready to go; for depression, patients are often less energized and quieter. Noticing the interests of the group can be helpful as a provider tailors this treatment to a particular group.

> *What is anxiety?*
>
> **Suggested prompts:** *What thoughts and feelings do you have when you are anxious? How might you act when you feel anxious? What do you feel in your body when you feel anxious?*

It can also be helpful for instructors to describe panic attacks when reviewing anxiety symptoms.

> *You may have experienced a panic or anxiety attack, which is especially scary the first time. It feels like you are having a heart attack! Like you are going to die! If you go to the ER you are often told it's "just anxiety," and get sent home. That can be deflating and leave you wondering: If I can't go to the ER for help, where can I go?*

Once patients have described and heard the most common anxiety symptoms, including physical and emotional symptoms, instructors may provide a summary of anxiety symptoms.

> *There are many symptoms of anxiety and sometimes you will feel multiple symptoms at once. Some anxiety symptoms are physical, like shaking or stomachaches; some are emotional like feeling worried; and some are behavioral like sleeping too much or using substances.*

COMMON SIGNS OF ANXIETY

- ❑ Anticipation
- ❑ Uncertainty
- ❑ Feeling overwhelmed
- ❑ Hyperventilating
- ❑ Irritability
- ❑ Loss of focus
- ❑ Conflict
- ❑ Shaking
- ❑ Sweating
- ❑ Fidgeting
- ❑ Stomachache
- ❑ Lump in throat
- ❑ Butterflies in stomach
- ❑ Eating too much or too little
- ❑ Sleeping too much or too little
- ❑ Coping with drugs or alcohol

✻ Patients can refer to page 14 of their workbook for a list of anxiety symptoms.

V. NORMALIZING ANXIETY (approximately 10 minutes)

As you educate patients about anxiety, review three key points: 1) Anxiety is usually related to "future-thinking" or anticipation of the future. 2) Anxiety is usually associated with a desire to have control. 3) Anxiety is usually associated with an increase in energy. Instructors may write down these features of anxiety on a board.

> ***Anxiety*** *is often about anticipation of the* ***future****. Just as you would not check yesterday's weather report, we are generally not worried about yesterday. We are usually concerned with the uncertainty we experience about the future (even if that uncertainty is based on past events). If we knew everything would be OK, our anxiety would likely decrease.*
>
> *Similarly,* ***we want to control everything and everyone****. When we can control (or at least think we can control) the future, our anxiety goes down. We want the world to be a chess board and we're in charge of all the pieces.*
>
> *Also,* ***energy*** *often goes* ***up*** *in response to anxiety. For example, have you ever been late for an important appointment and experienced anxiety? Maybe you started rushing around and felt really energized as you try to leave for your appointment. You might even be surprised at how quickly you can move when you're very anxious!*

Next, instructors may normalize that anxiety has a purpose. Providers may review that fight, flight, or freeze is a natural response to danger. Finally, instructors may describe that we are not trying to eliminate all anxiety because anxiety keeps us safe in dangerous situations. Our goal is to provide patients hope that they can learn how to cope with anxiety in situations that are not dangerous.

Let me ask you all, do you think anxiety is ever good? **Allow patients to discuss.**

There are times when ***feeling anxious is completely normal and healthy****.* ***Anxiety****—behaviorally,* ***fight, flight****, or* ***freeze****—is our* ***natural response to perceived danger*** *(e.g., events on deployment).* **(Patients sometimes benefit from a "bee" example if they question the existence or usefulness of the "freeze" response: When a bee comes near a person, some people run away (flight), some people swat at the bee (fight), and some people stay still until the bee flies away. Those who run away or fight the bee are sometimes more likely to get stung than those who freeze until the bee leaves.)** *If a bear were to come into the room right now, each one of us would fight, flee, or freeze. When you are in danger, those are often the healthiest responses. We want you to continue to have the fight, flight, and freeze responses. The goal of this group is not to eliminate anxiety; we still want you to look both ways when you cross the street. We just want to add a few more options, particularly in situations that are not actually dangerous.*

We often feel anxiety in situations that are NOT dangerous. For example, someone may feel anxious that they have a report deadline in one hour. In this group we will discuss helpful ways to cope in these everyday situations.

VI. DISCUSSION OF DEPRESSIVE SYMPTOMS: "WHAT IS DEPRESSION?" (approximately 10 minutes)

Instructors may have group members engage in a discussion of depression symptoms. It may be helpful to write symptoms on the board. Providers may issue prompts to ensure both physical and emotional symptoms come up. Physical symptoms of depression are often harder for patients to identify than physical symptoms of anxiety.

Hearing the responses from fellow group members can help validate and normalize these experiences as symptoms rather than traits, while also unifying the group.

Gauge the interest level of the group toward anxiety versus depression through the examples provided, number of responses, body language, etc. Note the "mood in the room;" for depression, people are often quiet and look away.

Let me ask you all, what is depression?

Suggested prompts: *What thoughts and feelings do you have when you are depressed? How might you act when you feel depressed? What do you feel in your body when you feel depressed?*

COMMON SIGNS OF DEPRESSION

- ❑ Sadness
- ❑ Loneliness
- ❑ Feeling worthless
- ❑ Apathy
- ❑ Indecisiveness
- ❑ Hopelessness
- ❑ Seclusion
- ❑ Sleeping too much or too little
- ❑ Appetite increases or decreases
- ❑ Negativity
- ❑ Suicidal thoughts
- ❑ Difficulty concentrating
- ❑ Weakness
- ❑ Emptiness
- ❑ Numbness
- ❑ Anger
- ❑ Coping with drugs/ alcohol
- ❑ Restlessness
- ❑ Fatigue
- ❑ Tearfulness
- ❑ Physical aches
- ❑ Guilt

✻ Patients can refer to page 14 of their workbook for a list of depression symptoms.

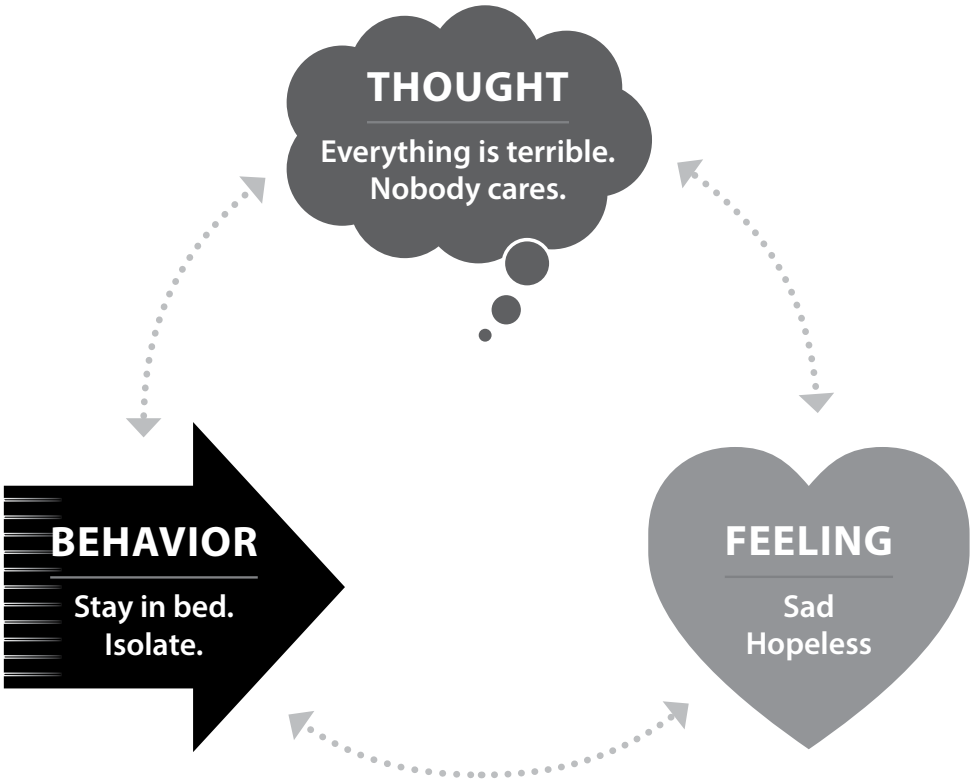
VII. COMPARING DEPRESSION TO ANXIETY (approximately 10 minutes)

As you educate patients about depression, review three key points: 1) Depression is usually related to thinking about the past. 2) Depression is usually associated with the sense that one has no control over anything. 3) Depression is usually associated with a decrease in energy. Providers may write down these features of depression on the board.

In contrast to anxiety, ***depression*** *is often more about the* ***past*** *(or sometimes the present)—the future is often a "cloud of haziness." You may think about negative events that happened in the past.*

Energy *levels go* ***down****. Things that used to be easy now seem hard. It's harder to get out of bed. It's harder to take care of yourself. You may even have difficulty going to work, doing activities, or even just showering.*

Lastly, when someone is depressed, ***they often perceive that they don't have control over anything or anyone,*** *including their own lives. It's as if others have a sledgehammer and they're the piñata being hit over and over again.*



VIII. NORMALIZING DEPRESSION (approximately 10 minutes)

Next, instructors may normalize that depression has a purpose. Providers may review that depression is a normal response when things repeatedly do not go your way. It can also be helpful to broach that depression is related to suicide. Because suicide can be especially difficult for patients to broach themselves, having the instructor broach the subject of suicide lets the patients know the provider is not afraid to talk about it. Finally, instructors may describe that we are not trying to eliminate all depression. Our goal is to provide patients hope that they can learn how to cope with depression in everyday situations.

*Are there times when **feeling depressed is completely normal and healthy?** Let's use an example. Let's say that I'm thirsty so I go to a drink machine. I put in a dollar to get a Coke. I get no coke. Now I'm likely angry, I may say a few choice words or shake the machine a bit.*

But I'm still thirsty! So I put another dollar into the drink machine. Again, no coke! Now I'm really mad! That machine owes me either 2 cokes or $2!

Who recommends that I put in a third dollar? **Allow patients to respond.**

It doesn't make sense for me to put more money in the machine anymore. It's not working and I'm just losing money! It is probably better for me to give up on getting a drink from this machine if I truly want to quench my thirst.

*The **lesson of depression** is to **give up** or **let go** of what we are doing. It is not working. If we want to solve the problem we are facing, we choose to let go of things that are not working.*

*The problem is that depression doesn't tell us what to do to get out of the situation. This can sometimes lead people to consider unhealthy "solutions" to their depression (e.g., substance use, continued isolation, or **suicide**).*

*We don't often think of "mental health issues" as killing people. Depression is one that can. We're not here to say that suicide is not an option (although we certainly hope you don't pick that one!), but the purpose of this group is to present many other options to depression (as well as anxiety, anger, or guilt) so that suicide will no longer be considered a possible option. This is a group based in life. You can't come to this group if you're dead. **If you're having any thoughts about suicide, please let me know.***

Depression *is our* ***natural response to perceived loss****. This could be loss of a person (i.e., a death), loss of a job, loss of a relationship, or loss of a health status. Basically, the loss of anything that we believe that we had (even if we didn't actually "have" it). This is often known as* ***grief****.*

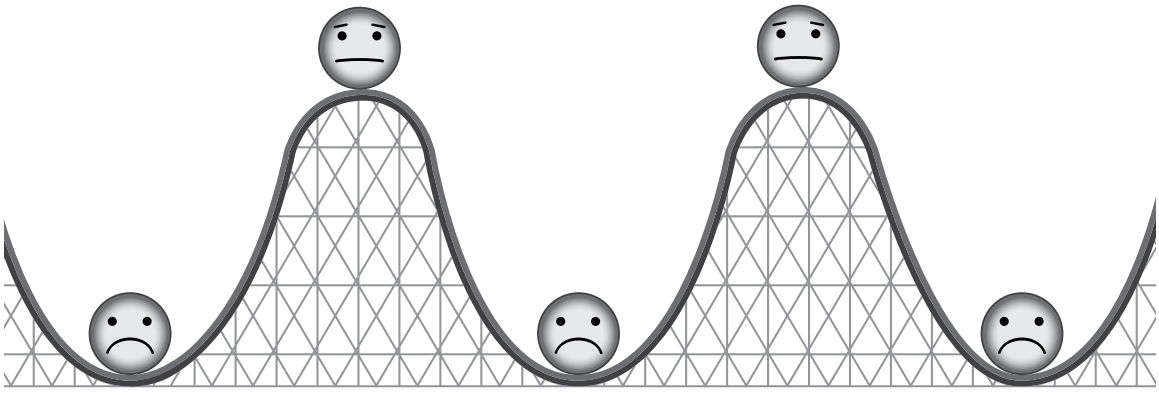
Depression (or grief) is ***healthy for a while.*** *How long is a while? That varies from culture to culture.*

In this group we will discuss helpful ways to cope in these situations. Any other questions, thoughts, comments about depression before we move on?

X. THE ANXIETY-DEPRESSION ROLLER COASTER

(approximately 10 minutes)

Instructors may review how patients can experience an anxiety-depression roller coaster, whereby the patient fluctuates between having anxiety and depression symptoms. It may be helpful to demonstrate the anxiety-depression roller coaster by drawing on a board. Our goal is to instill hope for patients that the skills learned in this group are effective for managing anxiety and depression, so that patients can "get off the anxiety depression roller coaster."



✻ Patients can refer to page 15 of their workbook for aan example of the anxiety depression roller coaster.

One of the reasons we're discussing anxiety and depression in the same group is that they often go together. Anxiety tends to come earlier—we have energy, then run out, crash, then depression may come. Anxiety may return, then depression, then anxiety, just like a roller coaster.

- *If you can picture a roller coaster, they often start at the bottom of a hill. This can be the beginning of anxiety: We worry about something, we don't want it to happen, we try to prevent it, our anxiety increases and then we get to the top of the coaster….*

- *Then, let's say whatever we were worried about happens. Ugh, after all that anxiety, the thing you were nervous about did happen just like you thought it might. You start getting depressed. You may stop doing some of the things you were doing (e.g., exercising, cleaning, seeing friends, paying rent). You head down the roller coaster. When we get to the bottom of the coaster…*

- *You stop caring. "Did I pay the rent this month? Who cares? I didn't pay it last month." What's weird is when you're down there, anxiety goes away. Depression actually becomes a vacation from anxiety! What's also strange at this point is that you start to feel better. Then…*

- *Anxiety comes back, but now you're anxious not just about what's coming, but how you're going to "fix" the things you didn't do while you were feeling depressed. "How do I keep my job when I haven't gone in 2 weeks? How do I stay in my home when I haven't paid the rent in 3 months?" And down we go again….*

The biggest reason we're discussing anxiety and depression together is that they often go together. We want to get off the anxiety-depression roller coaster. We don't want to decrease anxiety but increase depression or vice versa. We want both to go down. Many of the things we will learn over the next 5 weeks can reduce both anxiety and depression!

XI. HOMEWORK ASSIGNMENT #1 (approximately 3 minutes)

Homework # 1: Monitor how often you ask yourself "What if?"

It is helpful for instructors to explain the benefit of completing homework assignments. Patients who use the skills learned in group outside of group will probably have greater benefits than those who do not. In the spirit of REBT, patients are viewed as autonomous individuals who generally try to make "good" choices for themselves. Additionally, providers can't control what choices patients make. If patients sense that they will be "unacceptable" for not completing homework, they may be less likely to attend group than if they sense that they are unconditionally accepted.

Let's talk about homework assignments. We strongly encourage completing the homework assignment after each session—we are in this room only 1.5 hours but there are 168 hours per week. However, the only person who can control whether or not you choose to do homework is you!

Instructors can then review the first homework assignment. The first assignment encourages patients to monitor their use of "What if" statements. Instructors may review how "What if" statements can increase anxiety.

Planning is a wonderful thing! We plan for almost anything in life: Think about how much planning was involved in your being in group today (what time to wake up, what do I wear based on the weather, what will traffic be like). Planning reduces anxiety . . . to a point.

So, consider each duty station, base, post, camp, even deployment: What was the plan if a meteorite hit it? More than likely, there was no such plan. Yet, the military has Standing Operating Procedures for almost anything! What if there was such a hit? Why wouldn't there be a plan for something as destructive as a meteorite?

It's because the military is willing to accept the risk of being hit by a meteorite due to its low likelihood. Oftentimes, however, we are not able or willing to accept risks in our own lives: "What if I can't pick up my kids on time? What if I lose my job? What if I feel anxious or depressed forever?" Notice how I just said "What if" quite a lot.

Your first homework assignment is to note (count, write down, record, however you'd like to do it) how often you ask a "what if" question. While planning usually reduces anxiety, a "what if" question increases it.

XII. HOMEWORK ASSIGNMENT #2 (approximately 3 minutes)

Homework # 2: Monitor how often you ask yourself "Why?"

Instructors can then review the second homework assignment. The second assignment encourages patients to monitor their use of "Why" statements. Providers may review how "Why" statements can increase depression.

Imagine that I'm about 4 or 5 years old and I see a cookie. It looks really good. So I look and I see Momma over there, Daddy over there, no one's looking. So I eat it. Then I hear someone yell my name. What question am I about to hear? **Allow patients to respond.**

"Why did you do that?"

I'm smart enough to know not to give the "correct" answer to this question: That the cookie looked good and I thought I wouldn't get caught. So what do I actually say? **Allow patients to respond.**

"I don't know."

Fast forward 20, 30, 40 years. I'm trying to sleep and it's 0130 to 0330. I'm tired, frustrated, my concentration is off, and I ask myself these questions: "Why do I feel like this? Why did this happen to me? Why can't I get better?"

I learned decades ago that the "correct" answer to a "why" question is "I don't know." Yet, I expect when I feel depressed, tired, frustrated, and my concentration is off to be able to somehow answer these questions and "get myself" out of this? That's asking a lot! You may find that asking yourself these "why" questions when you're depressed actually makes you feel more depressed.

Your second homework assignment is to note (count, write down, record, however you'd like to do it) how often you ask a "Why" question. Asking yourself "Why" questions usually increases depression.

XIII. SUMMARY OF HOMEWORK AND CLOSING

(approximately 5 minutes)

It can be helpful to discuss the idea that the questions, "What if?" and "Why?" are usually part of anxiety and depression rather than problem solving. This excessive worrying is time-consuming, exhausting, and usually makes us feel worse. Many of us spend hours asking ourselves "what if" questions and considering the worst possible outcomes under the guise of "planning." We also often dwell on "why" we're in a certain situation rather than recognizing what we can do to begin to change it. This class is designed to help with these challenges.

✻ Patients can refer to pages 16–17 of their workbook for a description of both homework assignments and optional monitoring sheets.

Week # 1 Homework: Monitor how often you ask yourself "What if?" and "Why?"

Closing: Instructors may close the group session as they see appropriate. For example, instructors may:

1. Make time and space for group members' questions.
2. Remind group members to check in after session if they are having suicidal or homicidal ideation.
3. Validate each patient's efforts of coming to group.
4. Provide hope that each patient's efforts are a key step in reducing symptoms.

Suggested closing: *I commend you for making the choice to come here today. It may not have been an easy choice. Sometimes it feels easier to not work on anxiety and depression, but you took a step today to try and feel better and that takes courage.*

Introduction to Anxiety and Depression

COMMON SIGNS OF ANXIETY

- ❑ Anticipation
- ❑ Uncertainty
- ❑ Feeling overwhelmed
- ❑ Hyperventilating
- ❑ Irritability
- ❑ Loss of focus
- ❑ Conflict
- ❑ Shaking
- ❑ Sweating
- ❑ Fidgeting
- ❑ Stomachache
- ❑ Lump in throat
- ❑ Butterflies in stomach
- ❑ Eating too much or too little
- ❑ Sleeping too much or too little
- ❑ Coping with drugs or alcohol

COMMON SIGNS OF DEPRESSION

- ❑ Sadness
- ❑ Loneliness
- ❑ Feeling worthless
- ❑ Apathy
- ❑ Indecisiveness
- ❑ Hopelessness
- ❑ Seclusion
- ❑ Sleeping too much or too little
- ❑ Appetite increases or decreases
- ❑ Negativity
- ❑ Suicidal thoughts
- ❑ Difficulty concentrating
- ❑ Weakness
- ❑ Emptiness
- ❑ Numbness
- ❑ Anger
- ❑ Coping with drugs/ alcohol
- ❑ Restlessness
- ❑ Fatigue
- ❑ Tearfulness
- ❑ Physical aches
- ❑ Guilt

Anxiety-Depression Roller Coaster

You start to worry about something…

You do everything you can to prevent that negative outcome from happening…

Anxiety is starting to build.

"It would be so 'awful' if that happened, I wouldn't be able to handle it."

After all that worrying, the thing you were nervous about happened…

You start to feel depressed.

"The bad thing happened just like I knew it would, this 'always' happens to me!"

You feel more depressed…

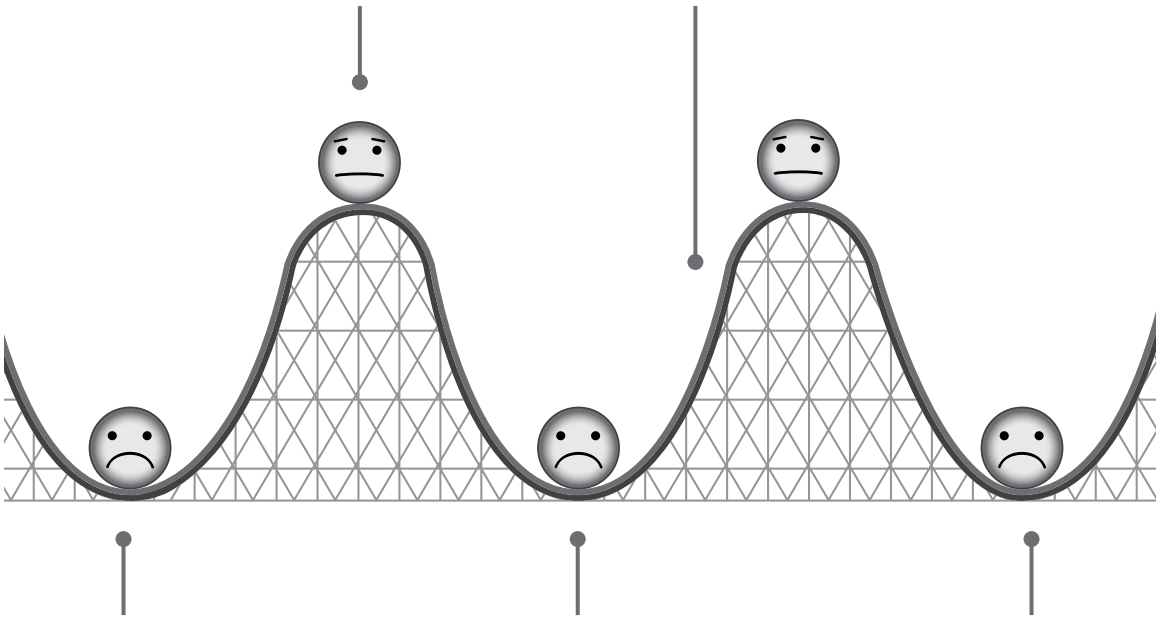
You might stop doing things you normally do (e.g., going to work, cleaning) or enjoy (e.g., seeing friends)…

You feel depressed but may feel relief that you don't feel anxious! It's odd but depression can be a **vacation** from anxiety.

But things start to get better. Then you worry about how you will "fix" all the things you haven't done while you were depressed…

Anxiety is starting to build again.

"I'm 'always' behind, I'll 'never' get back on track."



The Anxiety-Depression Roller Coaster continues…

Session 1 Homework

ASSIGNMENT #1:

Note (count, write down, record, however you'd like to do it) how often you ask a "what if" question. While planning usually reduces anxiety, a "what if" question increases it.

WHAT IF . . . ? QUESTIONS	
How often?	**Situation**
Example: 𝍸 ||	*Example:* Early mornings—What if I'm late to my meeting? What if I miss the bus?

ASSIGNMENT #2:

Note (count, write down, record, however you'd like to do it) how often you ask a "Why" question. Asking yourself "Why" questions usually increases depression.

WHY . . . ? QUESTIONS	
How often?	**Situation**
Example: 𝍸	*Example:* Waking up in the middle of the night— Why did that happen to me? Why can't I get better? Why do I feel like this?

SESSION 2

Control, Choices, and Consequences

This page is intentionally left blank

SESSION 2

Control, Choices, and Consequences

SESSION GOALS

- Increase patient's understanding of causes of anxiety and depression symptoms
- Increase patient's understanding of how thoughts, behaviors, and emotions are related using the thoughts, behaviors, emotions triangle
- Increase patient's understanding of the concept of control and its relationship with anxiety and depression
- Discuss choices and consequences, and how these are related to anxiety and depression

I. REVIEW HOMEWORK FROM LAST WEEK (approximately 5 minutes)

In the spirit of REBT, patients are given the autonomy and *choice* to complete homework. Although providers can encourage patients to do homework, providers do not have *control* over whether or not patients complete the homework. At the beginning of the session, providers can ask patients what the process of homework was like to complete.

Sometimes, new group members arrive for the 2nd session. If so, it may be helpful to go over rules and do introductions again.

Any questions about what we talked about last week?

Any examples of "what if" thoughts over the past week? What about "why" thoughts?

II. DISCUSSION OF CAUSES OF ANXIETY AND DEPRESSION
(approximately 10 minutes)

Instructors may facilitate a discussion of the causes of anxiety and depression. First, it can be helpful to hear how patients believe anxiety and depression are caused. We recommend writing whatever group members describe as causes on the board.

> *What are some causes of anxiety or depression?*

During this discussion, providers can also give a brief overview of how biology and genetics influence anxiety and depression.

> *Just like some physical conditions, like Type 1 Diabetes, are genetic, anxiety and depression can also be genetic. Maybe you have even noticed that other members of your biological family have anxiety and depressive symptoms just like you.*
>
> *Another way that anxiety and depressive symptoms are caused is due to biology. Let's explain this with a metaphor: Think of your brain like a city full of roads and highways. There are cars on these roads and highways that try to move around the city, and these cars keep the brain functioning well. Unfortunately, sometimes the cars do not make it to their destination, and the brain then doesn't function as well. These cars are called neurotransmitters, which are chemicals in our brain. We have neurotransmitters called serotonin and norepinephrine, and these neurotransmitters aid our mental health. When these neurotransmitters do not make it to their destination in the brain, anxiety and depressive symptoms increase. This is why anti-depressant medication can help mental health. These medications can help the neurotransmitters get where they need to go in the brain.*

After a robust list of anxiety and depression causes are identified by the group, the provider can note how most of the causes listed could be categorized as thoughts and perceptions. Having patients understand that thoughts and perceptions have the power to influence mental health will be key for the following sessions.

Let's look at this list, do we see any similarities among these causes? **Allow patients to respond.**

Most of these are actually thoughts and perceptions we have. For example, there may be a perception that you have no control over your life, or there may be a thought that bad things will continue to happen to you.

SAMPLE RESPONSES

THOUGHTS/ PERCEPTIONS

- no control
- stressful situations
- traumatic experiences
- the unknown
- putting too much on my plate
- the environment (people, places, and things)
- the unexpected
- expecting the worst
- people not really understanding, isolation
- genetics/chemical imbalance (serotonin, norepinephrine, etc.)

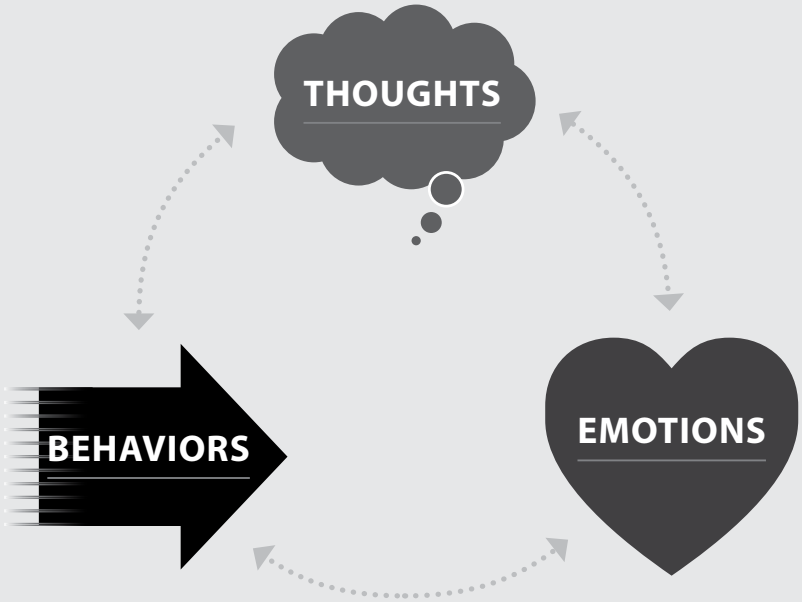
III. THOUGHTS, EMOTIONS, BEHAVIORS TRIANGLE
(approximately 10 minutes)

We recommend drawing the "thoughts, behaviors, emotions" triangle on the board as a visual description of this point.

This triangle represents the basis of the theory of REBT. It can be helpful to spend time on this. Some patients understand the relationships between thoughts, behaviors, and emotions quickly. Other patients either do not understand the relationship or actively challenge it.

As REBT is about becoming aware of, challenging, and changing thoughts to improve emotions (and behaviors), responding to such a challenge from patients is well within the bounds of treatment (and often very helpful!). Modeling comfort with challenge from patients will be useful once the direct challenge of patients' thoughts begins.

THOUGHTS, BEHAVIORS, AND EMOTIONS MUTUALLY IMPACT ONE ANOTHER



✻ Patients can refer to page 23 of their workbook for a description and visual of the thoughts, emotions, behaviors triangle.

CLINICAL TIP:

Model acceptance as a facilitator: try to not tell patients they "should" or "should not" agree with or understand this theory. Instead, try to encourage patients to have patience as these concepts are further reviewed throughout sessions.

Here is a triangle that will be a key part of our REBT group. This is the "thoughts, emotions, behavior" triangle. Notice these arrows? These arrows tell us that thoughts, emotions, and behaviors influence each other. We're first going to discuss emotions.

IV. WHAT ARE EMOTIONS? (approximately 10 minutes)

Ask participants to list all the feelings that come to mind. If patients do not identify a common emotion, it can be helpful for the provider to "act out" the emotion and have patients guess what that emotion is. For example, many patients do not identify disgust as an emotion. To "act out" disgust, a provider can scrunch up their face as if they smell something unpleasant, and have patients identify that the provider is demonstrating disgust.

There are different degrees of emotions, but there are not that many distinct types *(Ekman & Friesen, 1971)*. It is important to note that feelings are healthy, whether angry or happy. It's also ok to be aggressive, although there may be *consequences* (something folks rarely hear from providers!).

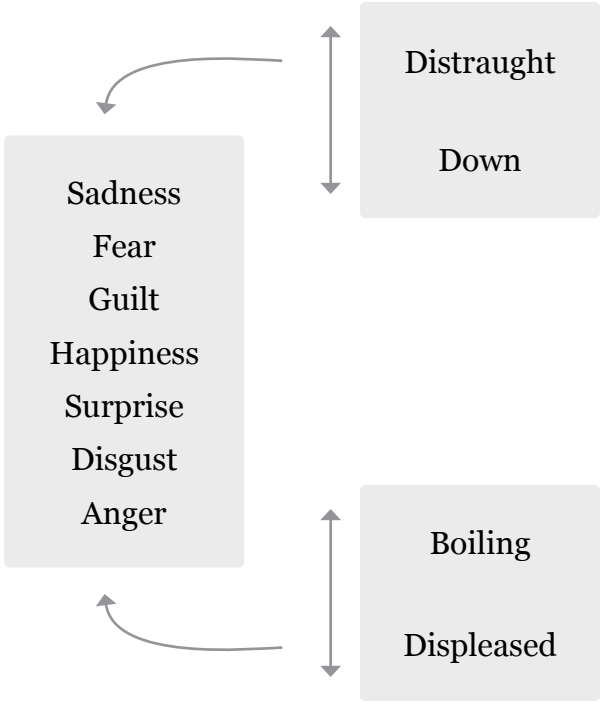
What are some different emotions you can have? **Allow patients to respond**.

There aren't that many emotions. There are different degrees of emotions like from "displeased" to "boiling" for anger, but there aren't that many separate emotions.

Provider may then list or circle the emotions that most humans experience (sadness, fear, guilt, happiness, disgust, anger).

These are the emotions most humans experience.

EXAMPLES OF EMOTIONS



So I have a 2-word solution to your PTSD, anxiety, depression, anger, or whatever is bothering you. After these 2 words, you won't need the rest of this group or more treatment at all.

Feel happy.

Who feels happy now? It doesn't work. This is exactly what we're told when we're feeling anxious or depressed (or angry or guilty). "Just snap out of it." We'd love to do that!

We can't change our emotions just because we want to. It is much easier to change our thoughts. That doesn't mean it's easy! But it's a lot easier than changing emotions!

Let's do an example to better understand this triangle.

Let's pretend that you're in a romantic relationship, and your partner comes home from work. The partner is very quiet and doesn't even say hello when they get home. You might start having thoughts like "What happened" or "They are being so rude to me, I had a long day and they can't even say hello?!" When you have those thoughts, you start to have an emotion. If you're thinking, "What did I do wrong?," how might you feel? **Allow patients to respond.**

You might feel anxious or sad! If your thought is "They are being so rude to me. I had a long day and they can't even say hello?!", how might you feel? **Allow patients to respond.**

You might feel angry! Our thoughts influence how we feel. Then, our thoughts can influence how we behave. If you're angry after your partner doesn't say hello, how might you behave? **Allow patients to respond.**

You might yell at them, which usually doesn't end well. What about if you feel sad after your partner doesn't say hello, how might you behave? **Allow patients to respond.**

You might isolate and not talk to your partner, which also doesn't really address the situation. This is just one example, but do you see how our thoughts, emotions, and behaviors are related? **Allow patients to ask questions.**

V. BEING IN CONTROL (approximately 10 minutes)

Discuss with patients how thoughts about control play a key role in mental health. It can be helpful to have a visual of the thoughts, emotions, behavior triangle available to refer to during this discussion. When discussing what we can and can't control, it can be helpful to list these on the board for patients to have a visual.

When we feel anxious, we want control of everything and everybody. It's like you want the world to be a chessboard, where you are in control of all the pieces. As soon as we have control—or think we have it—anxiety can go down.

When we are depressed, we often believe that we do not have control over anything. It seems like we're a piñata and everyone in the world has a sledgehammer.

As it turns out, what we can control does not change no matter how we're feeling. What can we control? **Allow patients to respond.**

Our actions, our thoughts, and, indirectly, our emotions can be managed. What can we NOT control? **Allow patients to respond.**

Discussion prompts:

Can parents have control over their kids?

Can we make our spouse happy, as we often profess in wedding vows?

We can't control others' actions, others' thoughts, others' feelings.

We often like to control others, especially people we care about. We like them to feel better and be safe. Can we MAKE them safe or feel better though? Imagine how good a therapist I'd be if I could wave a magic wand and make you felt better! But I don't have control over your feelings. We often get caught up in trying to control people's emotions. Then we feel bad if it doesn't work. We do have INFLUENCE on others. In fact, I'm trying to influence you as we speak! However, we ultimately do not have the power to control others' feelings.

VI. CHOICES AND CONSEQUENCES (approximately 10 minutes)

Providers can help patients understand that the belief that one does not have any choice in their life or in hard situations increases anxiety and depression symptoms. By helping patients see that we often do have choices, though those choices may be hard, patients can begin to challenge their perception that they do not have choices (and therefore control) in their lives.

Providers can validate why choices are sometimes very difficult. Some choices are hard to make because the consequences are not ideal. This is referred to as a "rock and a hard place" choice. It can be helpful to go over an example of a "rock and a hard place" situation so that patients can understand that although every choice has consequences, patients often do have choices.

What determines our behavior (and thoughts as well): Choices and Consequences. We make our decisions based on the consequences we expect. For example, at this moment you could be anywhere you choose; yet you are in this group with the expectation that it will be better than wherever else you could be. I certainly hope that turns out to be true!

Some choices are easy. For example, if I said I'd either give you a million dollars or I'd punch you in the stomach, which one would you pick? The million dollars, right? That's an example of an "excellent choice" vs. a "horrible choice."

The hardest choices are what one may call, "Rock vs. Hard Place." We often don't want to make choices in such a situation. However, it's important to keep in mind that not making a choice is also a choice itself. In addition, either the "rock" or the "hard place" is usually better (or worse) than the other one.

In these sorts of situations, we can often perceive that we are "trapped." This often increases anxiety, depression, anger, or guilt. The opposite of anxiety and depression are choices and options. The trick is recognizing that we have choices even in situations where it does not seem like we do.

For example, you may be faced with a "rock or hard place" choice of staying at a job that you hate or quitting and not having a job. Those choices are hard because of the consequences. You either continue enduring a job you hate, or you might have financial difficulties without a job. These are hard consequences which make this choice hard, leading you to think you are "trapped," but you actually do have a choice.

So how do we determine which choices to focus on? Our priorities! What's our highest priority? Without much thought, we may list the following priorities in some order: children, family, God or spirituality in general, work, friends, health, finances. I'm guessing many of your highest priorities might be on that list.

By understanding our priorities, we can better work through what choice we want to make, especially when we are in a "rock and a hard place" situation.

VII. HOMEWORK (approximately 5 minutes)

This week's homework facilitates a patient's understanding of their individual priorities. By understanding their priorities, patients can better work through difficult choices they may face.

This week for homework, you can reflect on what your individual priorities are. Try to be very specific—for example, if you rank your children as #1, what exactly does that look like? Do you value spending time with your children? Providing money for your children? There may be a conflict: More money may mean more time working and less time with children or vice versa. It could be providing for your children as your #1, and time with children as #2 (or vice versa).

This list is both specific to you (your children may have a different list that doesn't match up to your priorities) and this point in time. This is NOT permanent. It is likely different from what you would have said 10 to 30 years ago. For example at age 10, your priorities may have been playing outside, video games, and recess, but those are likely not your priorities now.

This is important because we can get very worked up about things not in our Top 3. Traffic is probably not in your Top 3, yet you may get very worked up when there is a lot of traffic. Maybe, "being on time" is your priority, but then you can control when you leave (and the importance of what and where you just left). Take some time on this assignment reflecting on what your true priorities are at this time.

FREQUENTLY ASKED QUESTIONS IN SESSION 2

How can my thinking be causing my depression instead of the bad things happening to me?

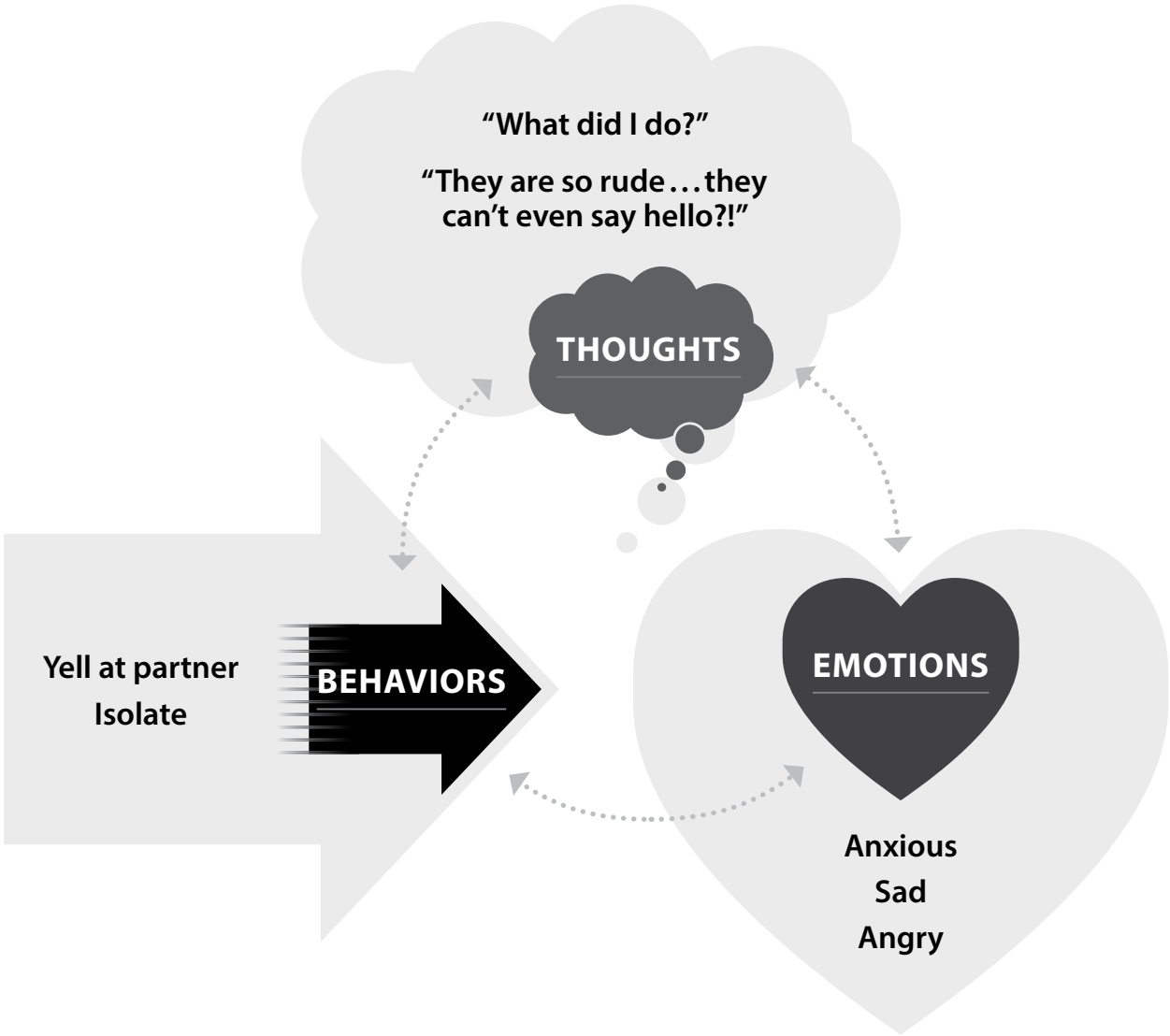
The way we think about events influences how we feel and act. The same event can make one person happy or angry, depending on their thoughts about it. Furthermore, research shows that quality of life or happiness is not determined by life-changing events *(e.g., Zidarov et al., 2009)*. Therefore, you can influence your mood by changing your thoughts and actions.

People tell me to "cheer up," but that just makes me feel angry and think I'm alone. Does this mean I just need to decide to think happy thoughts?

Changing your thoughts is NOT easy! It's not as simple as deciding to just "be happy." Over time, we will note which thoughts are likely to make us feel depressed or anxious. We are also not just looking for happy thoughts, but balanced thinking.

Thoughts-Emotions-Behaviors Triangle

EXAMPLE: Jamie is in a romantic relationship, and the partner comes home from work. The partner is very quiet and doesn't even say hello.



Session 2 Homework

Reflect on what your individual priorities are. Try to be very specific—for example, if you rank your children as #1, what exactly does that look like? Do you value spending time with your children? Providing money for your children? There may be a conflict: More money may mean more time working and less time with children or vice versa. It could be providing for your children as your #1, and time with children as #2 (or vice versa).

This list is both specific to you and this point in time. This is NOT permanent and is likely to change throughout your life.

MY PRIORITIES
1
2
3

SESSION 3

Common Thinking Errors, Irrational Beliefs, Part 1

This page is intentionally left blank

SESSION 3

Common Thinking Errors and Irrational Beliefs, Part 1

SESSION GOALS

- Provide overview of common unhealthy thinking patterns: mind reading, fortune telling, catastrophizing, and all-or-nothing thinking
- Increase patient's understanding of how these thought patterns increase anxiety and depression

I. REVIEW HOMEWORK (approximately 5 minutes)

Discuss with patients how the assignment of their top 3 priorities went.

Any questions about what we talked about last week?

How did it go trying to identify your top 3 priorities? Any examples of what priorities you identified?

II MIND READING (approximately 15 minutes)

Providers can help patients understand that there are common patterns of thinking that are likely to lead to anxiety, depression, anger, or guilt. Providers can review how "mind reading" is one of those patterns of thinking.

Up to now, we've discussed general thoughts that are likely to lead to anxiety, depression, anger, or guilt. Now we're going to begin identifying specific patterns of thoughts that lead to those emotions. What is mind reading? **Allow patients to respond.**

Mind reading is thinking we know what someone else is thinking!

Why do we mind read? **Allow patients to respond. (It may help to write this on the board.)**

Patients tend to give several reasons why we mind read, usually reflecting concerns about safety and predicting the future (which will be discussed right after this discussion of mind reading). This is of particular use when explaining (and normalizing) hyperarousal. Sometimes it is useful to describe an example of why we might mind read. For example, patients can imagine that they are in a grocery store during a hot summer day. Have patients imagine what they would think if they saw a man with his hands in his pockets wearing a large trench coat in the grocery store. The man is alone and walking around the grocery store without a cart or basket. Patients will likely understand that they mind read this man because they are concerned for their safety.

How do we mind read? **Allow patients to respond. (It may help to write this on the board.)**

Potential reasons describing how we do this include body language, facial expressions, and active listening. In addition, patients often mention our past experiences in general, of an individual specifically, or those with similar people or situations.

A couple of concerns with regards to mind reading. First, we think we are better at mind reading than we actually are. We'll talk more about that in a minute. Second, we think we are better at mind reading than other people are. We believe, "I can mind read you, but you can't mind read me!"

Here's an example of mind reading: A former group member, an E-6 in the military, was sitting across from an E-3 in the group. They did not know each other outside of the group, but he was using her as an example. He said, "Just by being in this group, I am saying that I struggle with anxiety and depression. How can I lead her when she knows that I struggle with anxiety and depression? She's going to think it's ridiculous for me to lead her when she knows I'm struggling!" After he was done, he took a sip of a cup of coffee he had brought to the group.

So the group leader then turned to her and asked, "What are you thinking?" For all the group leader knew, she was about to say, "I can't believe I'm in this group with this dirtbag." The group leader had no idea what she was about to say. This is what she said: "That coffee looks good and I wish I had some."

Who was she thinking about? **Allow participants to respond**.

Herself! She was thinking about herself. We are ***selfish*** *people. We're taught that this is bad, that somehow it is immoral to be selfish. But it's actually natural. We spend 24 hours a day, 7 days a week with ourselves; we're the only person we can say that about. We are also the only person who has any idea what we're thinking or feeling without observing or asking. It makes complete sense that we think about ourselves.*

And that is the mistake we make when we're mind reading. We're thinking about ourselves so we assume other people are, too. But who are they thinking actually thinking about—themselves.

Yes, sometimes we nail it when we mind read others. For instance, it's my hope that you're thinking about what I'm saying right now. I'm guessing some of you are. But others of you might be thinking about picking up your kids after group, or what you're going to do tonight, I don't know!

The lesson here is not to stop mind reading. That is not possible, nor is it healthy for the reasons we discussed earlier. The lesson is to be aware that we're doing it and to begin to question whether or not we're right. Does that make sense? Any questions about mind reading? **Allow patients to respond**.

III. **FORTUNE TELLING** (approximately 10 minutes)

Discuss another common pattern of thinking that influences anxiety, depression, anger, and guilt. Aid patients in understanding that we are not good at predicting the future, and that sometimes predicting the future ends up making our prediction come true.

Mind reading has a partner and it's one of the main reasons we do it: ***fortune telling.*** *What is fortune telling?* **Allow patients to respond.**

Fortune telling is exactly what it sounds like, predicting the future.

Like with mind reading, we think we're better at fortune telling than we are. For example, When meteorologists describe the weather, how do they do it? What do they say? 30% chance of rain? 50% chance of snow? Mostly sunny? Partly cloudy? They give a range; they hedge their bets. And they have doppler radar, satellites in the sky, tons of science to support their predictions! Yet, they still rarely give a definitive prediction of the weather.

And we think we ***know*** *what's going to happen, when we usually don't even have a lot of information? We are not very good at fortune telling!*

Fortune telling is concerning for another reason. We can inadvertently ensure the future we thought was going to happen. For example, imagine it is 0730, you just arrived at work, and your supervisor walks right past you without making eye contact. Since you are likely focused on yourself, your first thought might be, "I am in trouble, something is wrong with my report, did I even turn it in?" etc. In this situation, we may even get so worked up by expecting the worst that something bad ends up happening, thus confirming our original thought! Then, ironically, we can say, "I ***knew*** *that would happen!" And we don't realize our own role in the fact that it worked out that way. In this way, our fortune telling can impact our behaviors and increase our anxiety and depression.*

Another example: Have you ever said, "It's going to be one of ***those*** *kind of days." Generally, when we say it that way, we mean a bad day (although that is an example of me mind reading!). Again, what we don't realize is that by assuming that it will be a bad day, we can ensure that it becomes one. And weirdly after we say, "I* ***knew*** *it would be a bad day!" we actually feel better! It's like we're thinking, "Well, at least I was right about something!"*

Instead of experiencing pride about predicting our bad day, if we begin to challenge the accuracy of our fortune telling, we can begin to challenge some of the sources of our anxiety, depression, anger, or guilt. And then we can actually feel better!

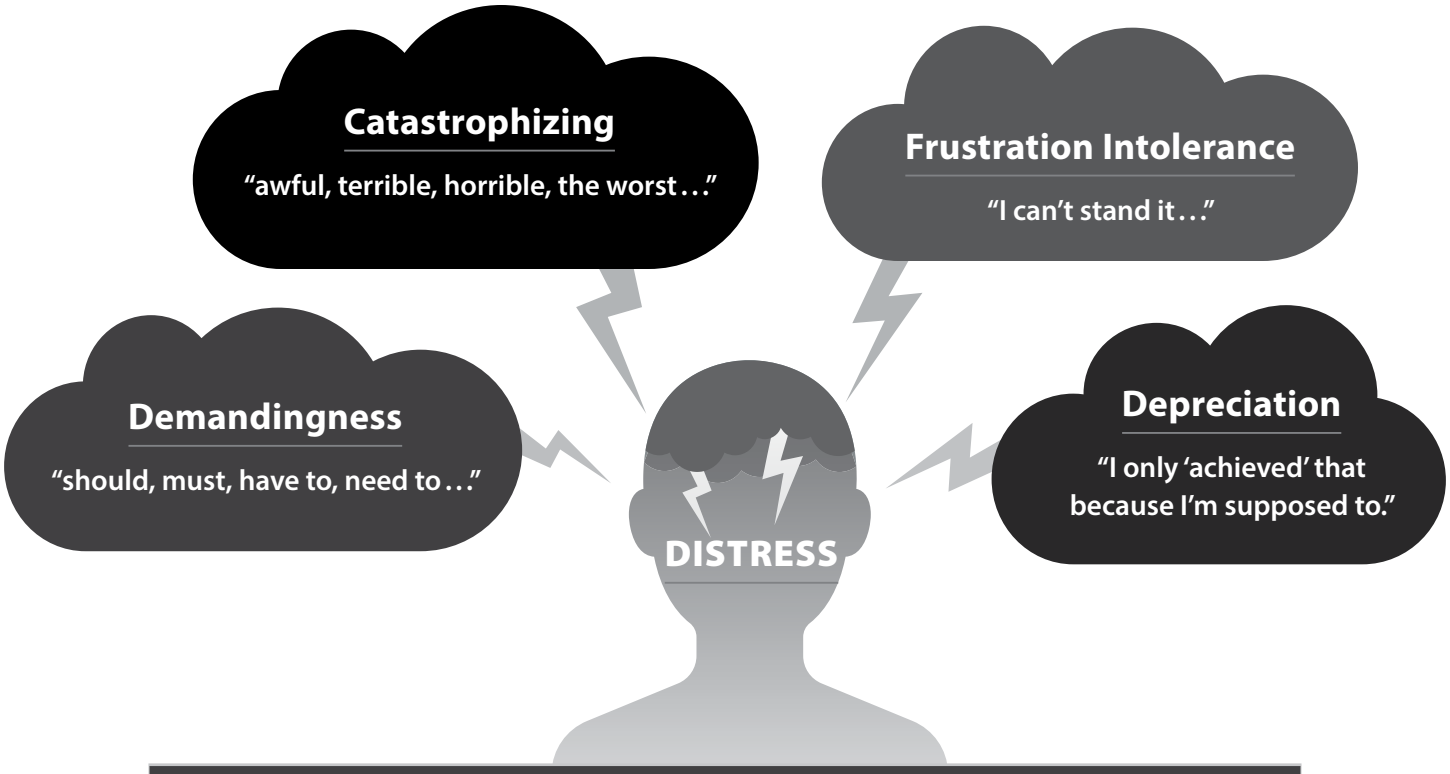
IV. WHAT ARE IRRATIONAL BELIEFS? (approximately 5 minutes)

Irrational beliefs indicate rigid, extreme demands of others and ourselves which do not match reality. These beliefs tend to be rooted in "shoulds," "oughts," "musts," "catastrophizing," or "can't-stand-itis." It is these thoughts that cause distress, rather than a situation directly.

It is not necessary to use the term, "irrational beliefs," to discuss the concept with patients although it is fine to do so.

The tables and figures on this and the next page describe potential consequences of irrational beliefs. These are particularly useful for therapists new to the basic concepts of REBT.

It is helpful to illustrate the difference between rigid and flexible language. Note how each evokes different feelings.



IRRATIONAL BELIEFS CAN LEAD TO EMOTIONAL DISTRESS

DEMANDINGNESS

I should/ought/must/have to/need to

They should have/ought to have/must have

Life shouldn't have/ought not to have/must not have

CATASTROPHIZING

This is the worst/awful/terrible/horrible!

I am…terrible.

FRUSTRATION INTOLERANCE

I can't stand this!

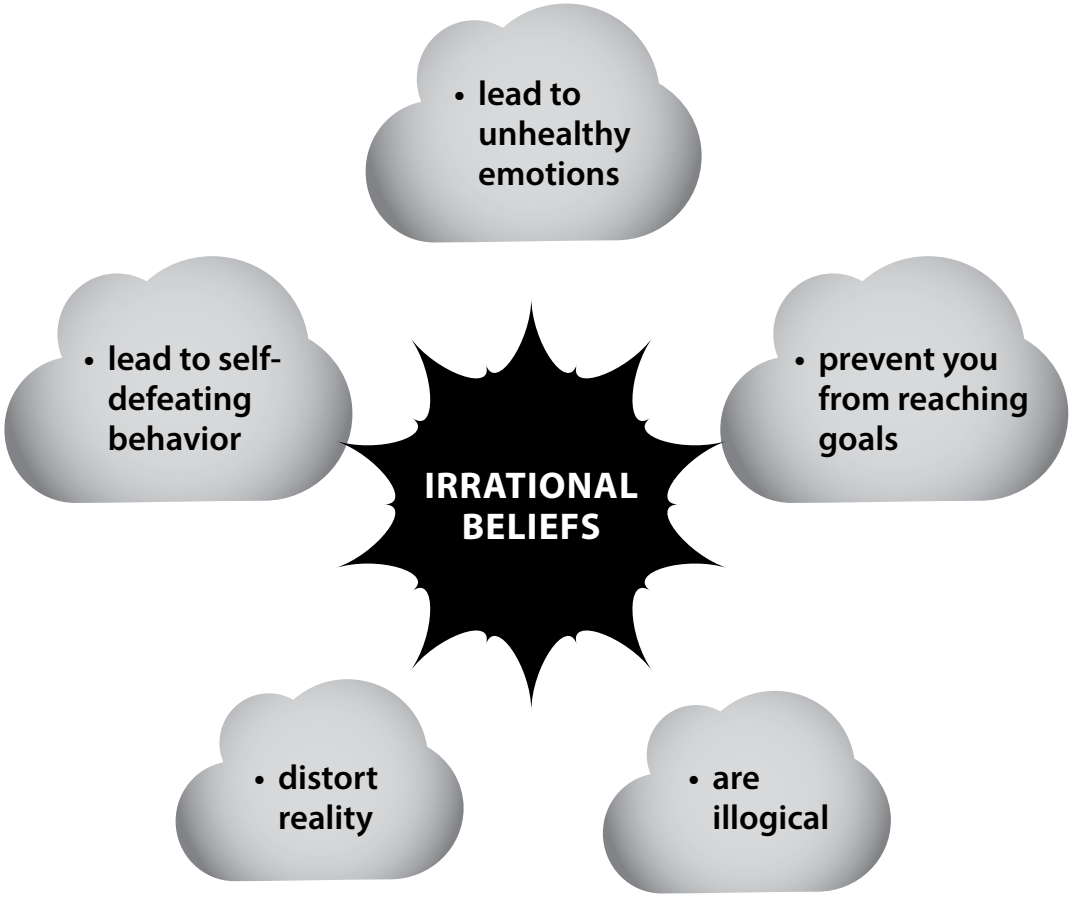
DEPRECIATION

Things will never get better!

I only "achieved" that because I'm supposed to.

✻ Patients can refer to page 28 of their workbook to see this visual..

ISSUES WITH IRRATIONAL BELIEFS



✻ Patients can refer to page 29 of their workbook to see this visual..

VI. CATASTROPHIZING AND FRUSTRATION INTOLERANCE
(approximately 15 minutes)

Providers can review the pattern of catastrophizing, particularly the words that hint someone is likely engaging in catastrophizing.

> *At times, this may come across as an "English class" because there are several words in the English language (and presumably in other languages as well) that are likely to lead to anxiety, depression, anger, or guilt. It may help to know what they are!*

We recommend writing the following words on the board:

Awful
Terrible
Horrible
Disaster
The worst
I can't stand it

> *What do these words have in common?*

Patients often quickly suggest that the words are "negative." It can sometimes take a bit of coaxing to prompt that the words are also "extreme."

It can help to give an example at this point. One example that works well at some hospitals is related to parking:

> *Parking at this hospital is _____. Are there any words on the board that could finish this sentence?*

Patients usually respond vehemently, "Yes!" and provide examples of catastrophizing language.

RIGID LANGUAGE

Just awful!

I can't stand it!

This is the worst!

This is a disaster!

REALISTIC AND FLEXIBLE LANGUAGE

Not Ideal

Tolerable

Not preferable

Manageable

Not the way I want

✻ Patients can refer to page 31 of their workbook to see examples of changing rigid language to more realistic and flexible language.

Next, it is often helpful to use an example of how catastrophizing language is used to describe traumatic events. Providers can consider using an example of a traumatic event that is not directly related to war (or anything else patients are likely to have encountered). For example, providers could describe the earthquake, tsunami, and subsequent radiation scare that struck Japan in March 2011. This example may be useful because it involves a traumatic event that is less likely to be experienced by group members. Providers can use other examples of using catastrophizing language to describe traumatic events.

We're going to come back to parking at this VA in a few minutes. As you may remember, one of the rules of this group is that we won't talk about the traumatic events that brought us into this room. However, I do want to discuss an incident one provider dealt with during their career.

In 2011, a military psychologist was stationed in Japan during the earthquake, tsunami, and radiation scare. I know you were not there, so I'm not asking this with the idea that you may have some historical knowledge about this. I just want you to think about it for a moment. Did anything or could anything good have come from this event?

Patients usually give several responses (e.g., improved warning or safety systems for earthquakes or nuclear technology, communities coming together, etc.).

I want to be clear here. I'm not saying, "Thank goodness there was an earthquake, tsunami, and radiation scare in Japan in March 2011 and I hope it starts happening every Tuesday." I'm saying that we just came up with X positive things that resulted from what I think each of us might classify as a "horrible disaster." We're also using the same language to describe an earthquake, tsunami, and radiation scare as we are parking at this hospital.

This last sentence usually provokes either an "Aha!" moment or an uncomfortable squirming among patients.

I don't think any of us would equate these two issues, so it may help to have other language to describe something like parking at this hospital.

So here are some options:

We recommend writing the following words on the board:

Tolerable

Not ideal

Not preferable

Manageable

Not the way I want

Yes, our parking preference is closest to the door we want to enter! Note that none of these is a compliment or very positive; we're not saying parking is great. But we can handle it, it's manageable. Now maybe parking isn't a big complaint for you, but this concept still applies. It's likely that we have used catastrophizing language at times to describe unpleasant situations, and we are working to start noticing when we use catastrophizing language so that we can instead use language that is more accurate and helpful.

Providers can review another example of language that often leads to frustration.

I want to say a bit about "I can't stand it." I may know a little bit about what you've been through, but I certainly don't know the extent of it. But I do know this: You did stand it; you are standing it now. Maybe not great, maybe not ideal, but you are standing it. We are stronger and more resilient than we often give ourselves credit for.

It's sometimes hard to keep that in mind. That can really affect us, the absolute, negative thinking. When we say things like "Parking at this hospital is the worst!" Or "I can't stand it anymore!", how do we usually feel? **Allow patients to respond.**

These extreme negative thoughts often lead to extreme negative emotions like anxiety, depression, anger, or guilt! In order to manage these feelings, we choose to change the language we use.

VII. ALL-OR-NOTHING/BLACK-AND-WHITE/DICHOTOMOUS THINKING (approximately 10 minutes)

Providers can review another pattern of thinking that increases anxiety, depression, anger, and guilt: all-or-nothing thinking. Therapists can also give examples of what relatively balanced thinking looks like. By practicing changing language from all-or-nothing thinking to more balanced thinking, patients may decrease their extreme perspectives of events or placing situations in black-and-white categories. Instead of categorizing people or situations in black-and-white terms, it is healthier and likely more accurate to consider the gray areas.

We recommend writing the following words on the board:

All
Nothing/No one
Everything/Everyone
Always
Never
Perfect
Failure
Best
Worst
Right
Wrong

What do these words have in common?

Patients may suggest a variety of responses (e.g., opposites, extremes, no gray area, etc.). *These are examples of what is known as all-or-nothing thinking, black-and-white thinking, or for those about to take the SAT, dichotomous thinking. It's either this or that.*

Let's talk about an example, "No one ever cares about me."

Maybe you've said that exact sentence to yourself. That is the sort of thought that is likely to lead to depression. But is it true? No one cares about me? It's likely not true. Some people probably care about me. They may not show me in the way I prefer, but it doesn't mean they don't care about me.

"They always treat her that way."

This sounds bad, even if we may be mind reading that the "always" treatment is bad. But is it true? Do they always treat her that way? 100% of the time? Probably not. Some of the time, they probably treat her differently.

"If it's not perfect, it's a failure."

Now that is a military sentence! Yes, there are times when perfection is important. But this is saying, if I get 100 on a test, I pass. If I get a 99, I fail. Most situations are not like that. For example, how many laws did you break during your most recent car trip? Speeding? Was that light really yellow? Was that a full and complete stop at the stop sign? Did you signal during every lane change or turn?

Driving is a pretty serious situation and can be dangerous. But did you drive ***perfectly*** *on that last car trip? Even in a "pretty serious" or possibly "dangerous" situation, things may not be perfect. You arrived safely (hopefully without a ticket!) and ideally so did the drivers around you.*

Why are "right" and "wrong" on the list? What do they have to do with this?

Many of us were taught these words in math class; for example, if I were to say, "2+2=0," you would say, "That is wrong." If I were to say, "2+2=4," you would say, "That is right." In math, the number 4 exists to be 2+2 or 1+3 or 9–5. There is a right answer.

Outside of math, when we use the words, right and wrong, we are likely talking about morals and values.

"It is wrong the way he treats her."

What are we saying here? We are likely saying that the way he treats her violates our morals and values.

I want to say something about this. I'm not here to change your morals and values. They are your own. But I do want to say this: Rigid or strict morals or values may increase your chances of anxiety, depression, anger, or guilt.

This is because we often do not meet our own rigid standards of morality. Moreover, we do not control other people's actions (as we discussed last week). Therefore, being fixated on the "rightness" or "wrongness" of other people's actions is an excellent way to stay angry. We tend to feel frustrated because we cannot change the way other people behave.

Maintaining balance in our thinking can help. Remember, one negative action represents one negative action (for them and for us!), not the entirety of one's life.

Here are some healthier (and I'd suggest, more accurate) words:

We recommend writing the following words on the board:

Most

Many

Often

Usually

Some (times/one)

Occasionally

Rarely

We may not go from negative to positive, but to less sadness, anxiety, anger, or guilt with a reduction in mental health symptoms. Our goal isn't even to think positively (although that can help!), but just a little more neutrally with the same facts about a situation.

Providers and patients may practice switching the word choice from all-or-nothing thinking to more balanced thinking in class.

COMMON THINKING ERRORS / IRRATIONAL BELIEFS	DEFINITION	EXAMPLE
Mind reading	Thinking we know what someone else is thinking, often to assess threat level and our safety.	*I just know they are thinking about all the foolish things I did.*
Fortune telling	Predicting the future, usually assuming things will turn out badly.	*They will hate me forever!*
Jumping to conclusions	Making negative predictions based on initial information.	*This mistake means that everything is now ruined!*
Catastrophizing	Exaggerating the negative consequences of an event.	*This is horrible!*
All-or-nothing thinking	Viewing events in extremes, placing situations in black-and-white categories	*If I make a mistake, I'm a total failure and I am completely unlovable.*
Perfectionism	Assuming that because something is not flawless, it is a failure.	*I should have done perfectly on that task, not just very well! This means I am incompetent.*
Disqualifying the positive	Filtering out positive experiences which contradict your negative self-image.	*I don't deserve compliments on things I'm supposed to do.*

(Burns, 1980)

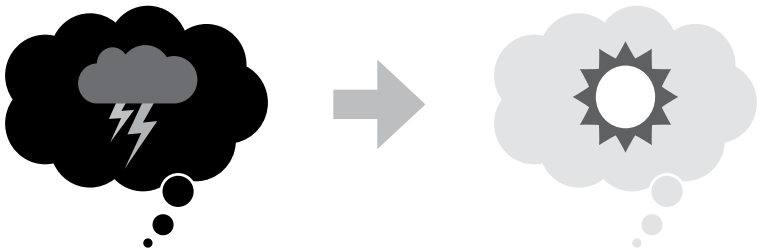
✻ Patients can refer to page 30 of their workbook to see this table.

VIII.HOMEWORK (approximately 5 minutes)

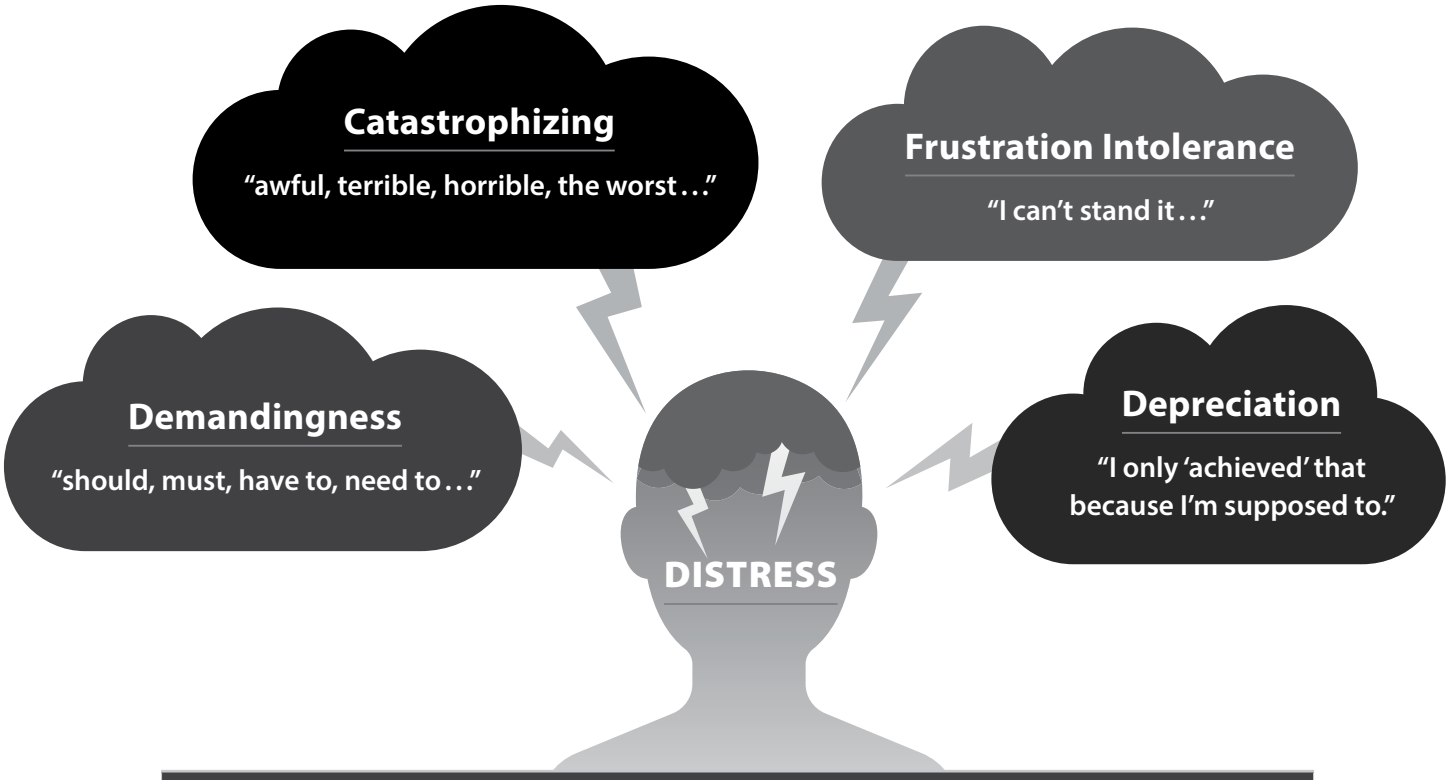
To decrease a patient's use of catastrophizing language or all-or-nothing thinking, it is helpful for patients to first begin identifying when they are engaging in these thought patterns.

Your homework is to notice how often these extreme words (or thoughts) enter your mind in the next week. Begin replacing them with healthier and more accurate words (or thoughts).

For example, if you find yourself saying, "This is absolutely terrible!" Try replacing this with: "This is not ideal" or "This will be challenging."



Common Thinking Errors/ Irrational Beliefs



IRRATIONAL BELIEFS CAN LEAD TO EMOTIONAL DISTRESS

DEMANDINGNESS

I should/ought/must/have to/need to

They should have/ought to have/must have

Life shouldn't have/ought not to have/must not have

CATASTROPHIZING

This is the worst/awful/terrible/horrible!

I am…terrible.

FRUSTRATION INTOLERANCE

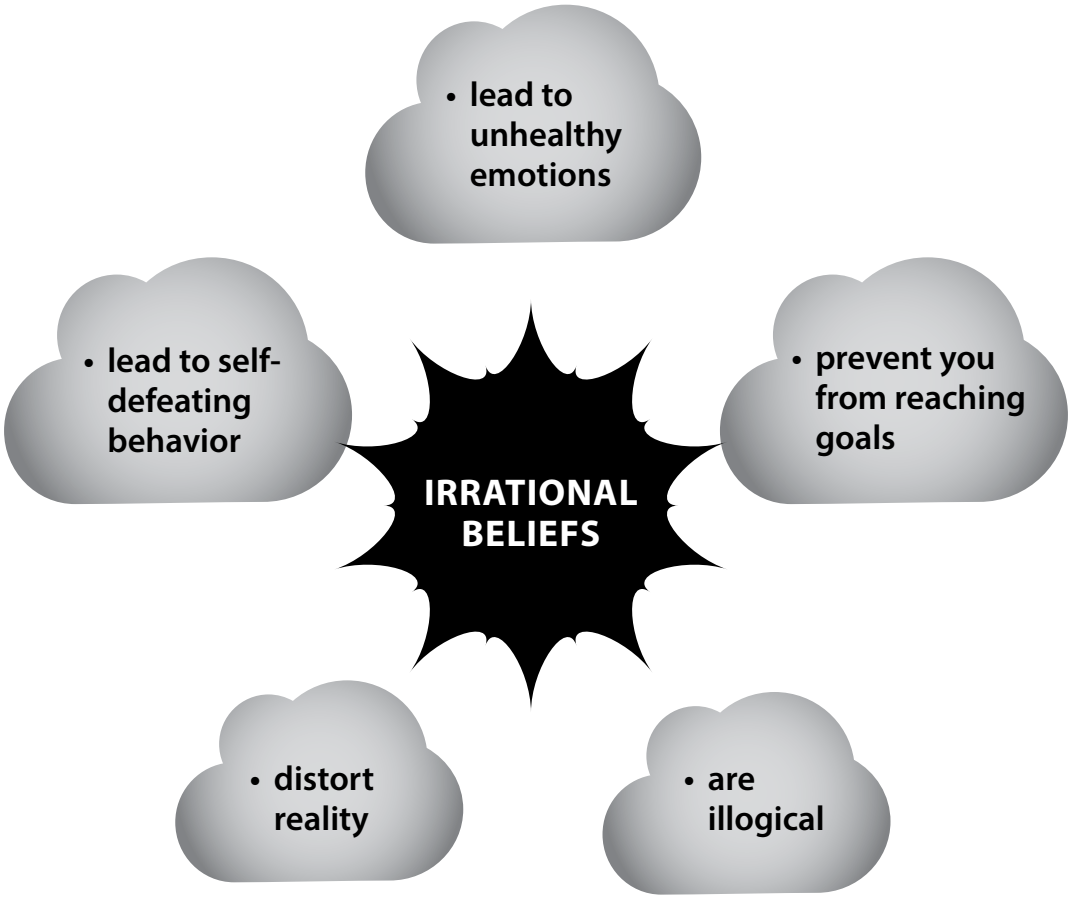
I can't stand this!

DEPRECIATION

Things will never get better!

I only "achieved" that because I'm supposed to.

Irrational Beliefs



COMMON THINKING ERRORS / IRRATIONAL BELIEFS	DEFINITION	EXAMPLE
Mind reading	Thinking we know what someone else is thinking, often to assess threat level and our safety.	*I just know they are thinking about all the foolish things I did.*
Fortune telling	Predicting the future, usually assuming things will turn out badly.	*They will hate me forever!*
Jumping to conclusions	Making negative predictions based on initial information.	*This mistake means that everything is now ruined!*
Catastrophizing	Exaggerating the negative consequences of an event.	*This is horrible!*
All-or-nothing thinking	Viewing events in extremes, placing situations in black-and-white categories	*If I make a mistake, I'm a total failure and I am completely unlovable.*
Perfectionism	Assuming that because something is not flawless, it is a failure.	*I should have done perfectly on that task, not just very well! This means I am incompetent.*
Disqualifying the positive	Filtering out positive experiences which contradict your negative self-image.	*I don't deserve compliments on things I'm supposed to do.*

(Burns, 1980)

RIGID LANGUAGE

Just awful!

I can't stand it!

This is the worst!

This is a disaster!

All

Nothing/No one

Everything/Everyone

Always

Never

Perfect/Failure

Best/Worst

Right/Wrong

Should

Must

Ought

Need to

Have to

Got to

Forced to

Supposed to

Ordered to

REALISTIC AND FLEXIBLE LANGUAGE

Not Ideal

Tolerable

Not preferable

Manageable

Most

Many

Often

Usually

Sometimes/Someone

Occasionally

Rarely

Choose to

Prefer to

Want to

Session 3 Homework

Notice how often extreme words (or thoughts) enter your mind in the next week. Begin replacing them with healthier & more accurate words (or thoughts).

For example, let's say you find yourself saying, "This is absolutely terrible!" Try replacing this with: "This is not ideal" or "This may be challenging."

CHANGING THOUGHTS TO BE ACCURATE AND HEALTHIER	
Number of extreme words:	
Words/phrases I say a lot:	**Replacement Words/phrases:**
Example: I'm a loser!	I made a mistake.

This page is intentionally left blank

SESSION 4

Common Thinking Errors, Irrational Beliefs, Part 2

This page is intentionally left blank

SESSION 4

Common Thinking Errors and Irrational Beliefs, Part 2

SESSION GOALS

- Review common unhealthy thinking patterns: demandingness, "should" statements, and disqualifying the positives
- Have patients practice identifying unhealthy thinking patterns and changing thoughts to be more balanced

I. REVIEW HOMEWORK (approximately 5 minutes)

Discuss with patients how noticing and changing thoughts such as fortune telling, catastrophizing, or all-or-nothing thinking went over the past week.

> *How did it go trying to notice your fortune-telling, catastrophizing, and all-or-nothing thinking this past week?*

II. DEMANDINGNESS (approximately 10 minutes)

Providers can review another pattern of thinking: demandingness.

> *For those who are into parts of speech, you may have noticed that we've discussed adjectives and nouns. We're going to talk about verbs today. What do these words have in common?*

We recommend writing the following words on the board:

Should
Must
Ought
Need to
Have to
Got to
Forced to
Supposed to
Ordered to

These words are "demands." That is, there is no choice! These words are frequently associated with anxiety, depression, anger, and guilt. Thus, you may think of the opposite of anxiety and depression as choices and options.

I want to talk a bit about one of the examples here, "need to." Is there anything that we "need to" do? **Allow patients to answer. It may help to write answers on the board. Patients tend to come up with answers like: eat, drink water, sleep, urinate/defecate, clothing/shelter/warmth.**

We don't even "need" a bathroom, job, or money if we can get the things above without them (though we tend to prefer having them)! There are not a lot of things we need to live! Yet, we use these terms constantly. Most of the things we "need" reflect our values and choices. Our anxiety and depression may increase when we have a long list of "musts" and "needs" instead of considering priorities and values.

What about following lawful orders? Or paying bills? We may think about this as having no choice (e.g., because we swore an oath), but we still have options (albeit with consequences). The civilian world is actually not that different from the military world in this sense except that the consequences are more certain in the military world than the civilian world. But most of life still comes down to:

Choices → *Consequences*

III. CHANGING "UNHEALTHY" SENTENCES (approximately 15 minutes)

Providers can aid patients in identifying and changing unhealthy thinking patterns by using examples.

Now that we have added verbs, we can create an entire "unhealthy" sentence. **It may help to write this (or a sentence similar to something patients in the group have said) on the board:**

I always have to do everything for my family or it's awful and I can't stand it.

How do we feel after thinking something like this? Anxious? Depressed? Angry? Guilty? **Allow patients to respond.**

Are there any "unhealthy" words in this sentence?

Always
Have to
Everything
Awful
I can't stand it

How could we change some of these words to be more accurate and balanced? **Allow patients to respond. It is helpful to write how each salient word can be changed to be more balanced.**

Always → ***Often***

Have to → ***Choose to***

Everything → ***Many things***

Awful → ***Not ideal***

I can't stand it → ***It's ok***

So our new sentence might be: ***I often choose to do many things for my family, which may not be ideal, but it's ok.***

How do we feel after thinking the second sentence? Calmer? Not as anxious, depressed, angry, or guilty? **Allow patients to respond.**

Which sentence is more accurate? The 2nd one is actually more accurate. You can see we didn't change the words to just be positive because that isn't accurate. We're not trying to see the world as roses and rainbows; we are trying to have a more accurate and balanced view of the world. By changing the words we use, in our minds or out loud, we not only feel better but also express ourselves more accurately.

IV. "SHOULD" STATEMENTS (approximately 10 minutes)

"Should" statements are often very common, and are associated with anxiety, depression, guilt, and anger (particularly the latter two emotions). Providers can review common ways that "should statements" occur, and how "should" statements influence emotions. Usually, when we use the word "should" in relation to others, there is anger. When we use the word "should" in relation to ourselves, there is guilt.

I want to spend a bit more time on one of the words on the list earlier, "should." This is a very powerful word. It's so powerful that some religions are based in it. For example, the Ten Commandments say things like "Thou shalt not…." That's another use of the word, "should."

How do we feel after thinking something like this? **Allow patients to respond. It may help to write this on the board:**

You/He/She/They…should/shouldn't/should have/shouldn't have…

For example, "He shouldn't have cut me off in traffic!" Often people feel ***angry****.*

But sometimes we use the word "should" in relation to ourselves. **It may help to write this on the board:**

I . . . should/shouldn't/should have/shouldn't have . . .

For example, "I shouldn't have treated her like that." Often people feel ***guilty****.*

Guilt is a powerful emotion; we really don't like it and will often do whatever we can not to feel it. It's so powerful that it's actually a verb: She "guilted" me into doing that. Who might try to "guilt" us into doing something?

Patients generally respond with answers such as family (sometimes naming specific family members), friends, colleagues, etc.

So the people most likely to try to "guilt" us into doing something are people we ***care*** *about. They do this because they are in* ***pain****, whether it be physical, emotional, financial, or whatever. And we hate it! We don't like seeing those we care about in pain. We want to help!*

It can also be helpful for the provider to aid patients in further understanding and managing their guilt. Guilt often involves a conflict between choices and consequences, which patients have learned about in previous sessions. Providers may review an example of how identifying choices and consequences can be a helpful way of managing guilt.

In another group just like this one, a group member who was still in the military said that he was giving 50% of his paycheck to his mother. That is, every time he got paid, 50% of it went to her. She wasn't doing well financially, and he was trying to help her. Yet, she would call him and say, "50% of your paycheck isn't enough. I need more." (There's that word, "need," again.)

He said to the group leader, "I can't give her any more. I'm already giving her 50% of my paycheck!" The leader said, "Yes, you can." He said, "What?!" He didn't expect that response from the group leader. He asked, "What else can I do?" The leader said, "You can give her 100% of your paycheck." He then said, "What???!!!" He really didn't expect that response. He asked, "How am I going to pay for food? Rent? Gas?" The leader said, "What do you care? Your mother is taken care of."

What was the group leader trying to tell him?

Even in difficult situations like this one, we usually have a choice. Remember when we talked about choices and consequences? It's ok to make the choice to ***set limits on those we care about****. But this is what he wanted her to say afterwards: "That's fine, Son. You're a wonderful son. I so appreciate your giving me the money you can. Thank you for being a great person!" But what will he actually hear?*

"I can't believe you'd do that to me! Your own mother?! I brought you into this world! I can take you out! What kind of a person wouldn't take care of his mother when she's in need?"

What is she aiming for? She is aiming right toward ***guilt****. She's trying to get more money. It has worked for her in the past! It's not her responsibility not to try to get more money (and "guilt" us into giving it).* ***It's our responsibility to manage our own guilt and be ok with the consequences of saying no****.*

I'm not saying that's easy. But I am saying that if we don't do it, no one will. As difficult as it may be, it really is ok to set limits on those we care about! However, we often set limits and think that others "should" be ok with those limits, when instead they disapprove and are frustrated. Albert Ellis (the person who created a lot of what we're talking about in this group) called this: "shoulding all over ourselves."

We can run into another issue when it comes to the word, "should," which is when we offer help "out of the goodness of our heart" to someone. What wonderful, giving people we are! Yet, what happens when we then ask that person for help and they don't give it? We feel ***angry****. That is because we believe we are* ***owed*** *for our help, even though we said it had been "free."*

I'm not telling you to stop helping people. I hope you help as many people as you'd like to! It's important to remember your priorities. Is it a priority for you to help even if there is a possibility that the help won't be returned? Maybe it is your priority. However, if it's not truly a priority to help that person, and you have the expectation that the help will be returned, anger may follow if help is not returned.

It is up to us to manage that anger or guilt as we make sure our needs are met, too, just as we would put our oxygen masks on first on a plane before assisting others. We set priorities to enable us to help ourselves and others. As much as we do not want others to be in pain, we cannot control that. We also cannot control others' reactions.

V. DEPRECIATION/DISQUALIFYING THE POSITIVE

(approximately 10 minutes)

Another common pattern of thinking is disqualifying the positive (an example of depreciation). Providers can aid patients in understanding what depreciating thinking is and how depreciating thinking influences emotions.

What is "disqualifying the positive?" It's exactly what it sounds like: ignoring or downplaying the positive things that are going on in our lives. This is an excellent strategy for remaining depressed! People with depression are experts at this! In fact, it becomes second nature as we do not even know we are doing it. We are so hyper-focused on one thing that went badly in the morning that we do not see the bigger picture of the many things that went well over the course of the whole day. For example, let's say I'm feeling depressed and I do these things over the course of a day: get out of bed, shower, eat breakfast, drive to work, do work, and drive home. If you ask me what I accomplished today, what will I say? **Allow patients to respond.**

Yes, "NOTHING! I didn't accomplish anything!" Even if you highlight the tasks that I completed, what will I say then?

"That's what I'm ***supposed to*** *do." Notice how "supposed to" was on our earlier list?*

When we are feeling depressed, it's hard to do things like showering or getting to work! These are accomplishments, things we overcame. Think what you went through earlier today. Just to be here you may have managed some sort of complication in your life. None of that is easy to do

and yet you did that. Just as we wouldn't say to someone with a broken leg to start running, it's ok to consider the impact of our depression or anxiety on our daily lives. Anything we are trying to do when depressed or anxious can be positive and an accomplishment.

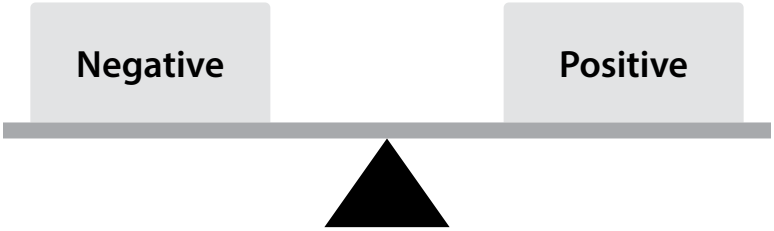
You may have thought you are "supposed to" be here in group, but actually you are here because you believe that spending the time in this group was worth more than whatever else you could be doing during that time. (I hope that turns out to be true!)

One way to begin to reduce depression is to notice the positive things going on around us. When we're depressed, "positive" things are often described as things like 1) winning the lottery, 2) meeting the person of my dreams, 3) living happily ever after. Even in our depressed state, we recognize that this is fantasy, so this is once again assurance that we will remain depressed!

Change happens gradually—we go from depressed to a little less depressed, not severely depressed to happy (as we may wish was the case). We're looking for balance in our thinking; it may not be an equal balance, but the closer to balance in our thinking, the less extreme our anxiety, depression, anger, or guilt will be. Soon we may be happier and better able to manage anxiety and depression in our daily lives.

Your first homework assignment for this week is to notice 3 positive things that happen each day. Write them down, put them in your phone, think about them in your head, however you'd like to do this.

BALANCING THINKING



A couple things about this. First, as I just said, when we're feeling depressed, we often define "positive" things as unachievable. What we're talking about are: getting out of bed, showering, eating breakfast (or something like this). We likely did 3 positive things before we even left our home!

So, we're not talking about noticing extraordinary things (though if they occur, please put them on your list!). We're talking about noticing what's going on in our everyday lives that is positive.

Now I want you to notice the homework assignment that I'm not giving you. As this is a class focused on balance, what might be the "balance" of 3 positive things? Yes, 3 negative things.

Why am I not giving you this assignment? Yes, because you're already doing it! We are experts at noticing the negative things going on in our lives. I'm guessing you could already name 3 negative things that happened today! Any questions about homework?

VI. DISCUSSION OF THE "NEWS" (approximately 5 minutes, can be done at any point during Sessions 3, 4, or occasionally 5 in response to a patient comment about the "news")

Often during the group, someone expresses concerns about the "news." It can be helpful to discuss the "news," but it can be done at any point during this or Session 3. The expressed frustration has often come up during Session 4 in past groups, which is why it's discussed here in the manual, but it really can be discussed at any time during Sessions 3 or 4 (or rarely Session 5).

Let's explore the "news." Notice the first 3 letters of this word: new. The "news" is interested in things that are "new." They don't call it, "olds." For instance, you rarely hear this story on the news: 9,872 planes landed safely, on time, and at their correct destinations yesterday (even though it is likely true). What do we hear? Plane crash in India! 200 people missing! Why do we hear that? A plane crash is weird; it is unusual. A plane landing safely, on time, and at its correct destination is "normal." It's boring. Who wants to watch that story? So you may consider the idea that the news is 30–60 minutes of "weird stuff."

Why discuss that in a group on anxiety and depression? The news is designed to focus on emotions because that increases viewers. Anxiety, in particular, is often a focus in the news business. "Next story: Are your children in danger?" We might want to watch that story! But no matter what is covered on the news, most places in the world are relatively safe most of the time. Some places in the world are sometimes dangerous. Notice how the words I used were less extreme and more accurate? When watching the news, it is easy to fall into the patterns of thinking we've discussed in our group. However, you have the power to balance your thinking when you choose to watch (or not watch) the news. Balancing your thinking is how you manage your emotions, anxiety, and depression.

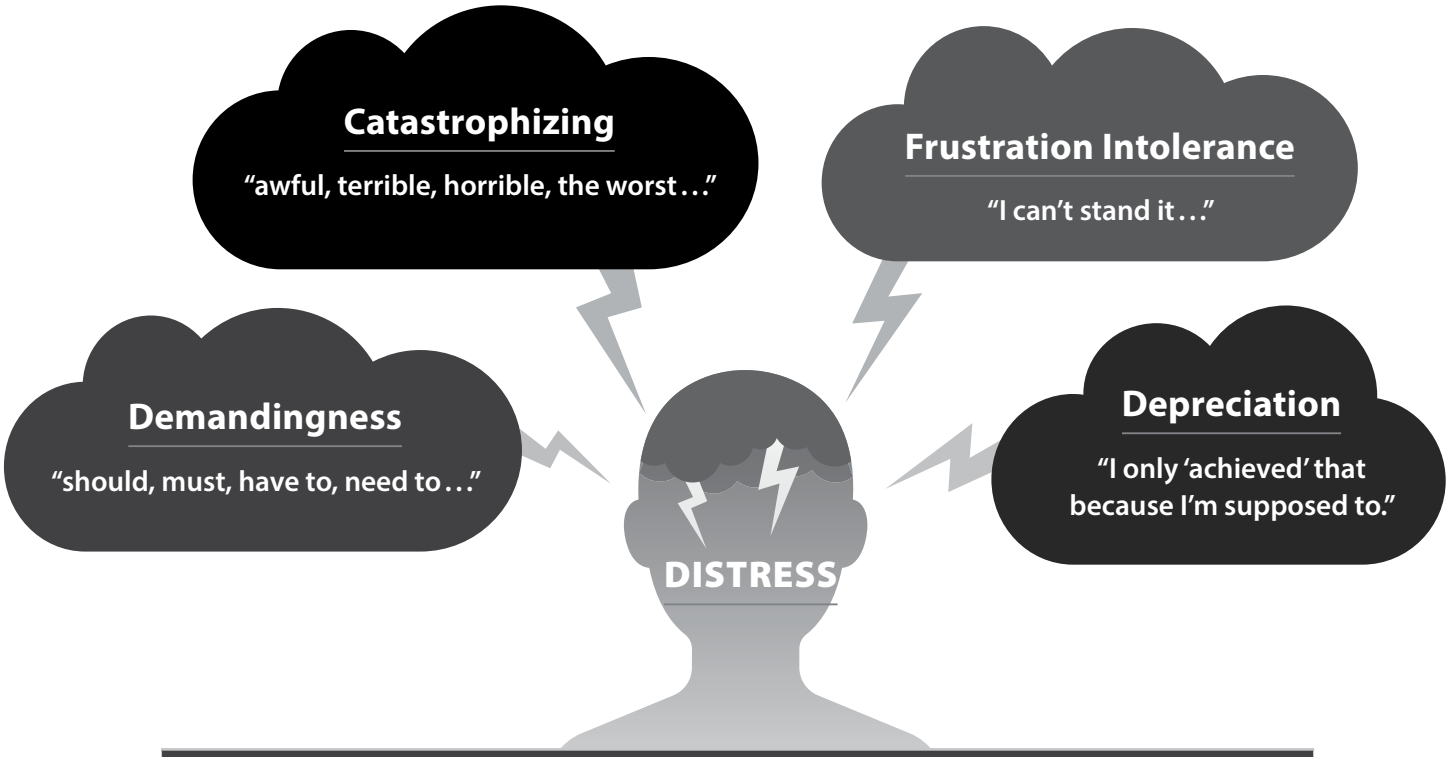
VII. HOMEWORK (approximately 5 minutes)

Providers can review the homework, which is to notice "should" statements and to identify 3 positive things each day.

This week, your homework is to:

1. *Notice how often you say "should" statements to yourself. This could be either about others or yourself.*
2. *Notice 3 positive things that happened today.*

Common Thinking Errors/ Irrational Beliefs



IRRATIONAL BELIEFS CAN LEAD TO EMOTIONAL DISTRESS

DEMANDINGNESS

I should/ought/must/have to/need to

They should have/ought to have/must have

Life shouldn't have/ought not to have/must not have

CATASTROPHIZING

This is the worst/awful/terrible/horrible!

I am…terrible.

FRUSTRATION INTOLERANCE

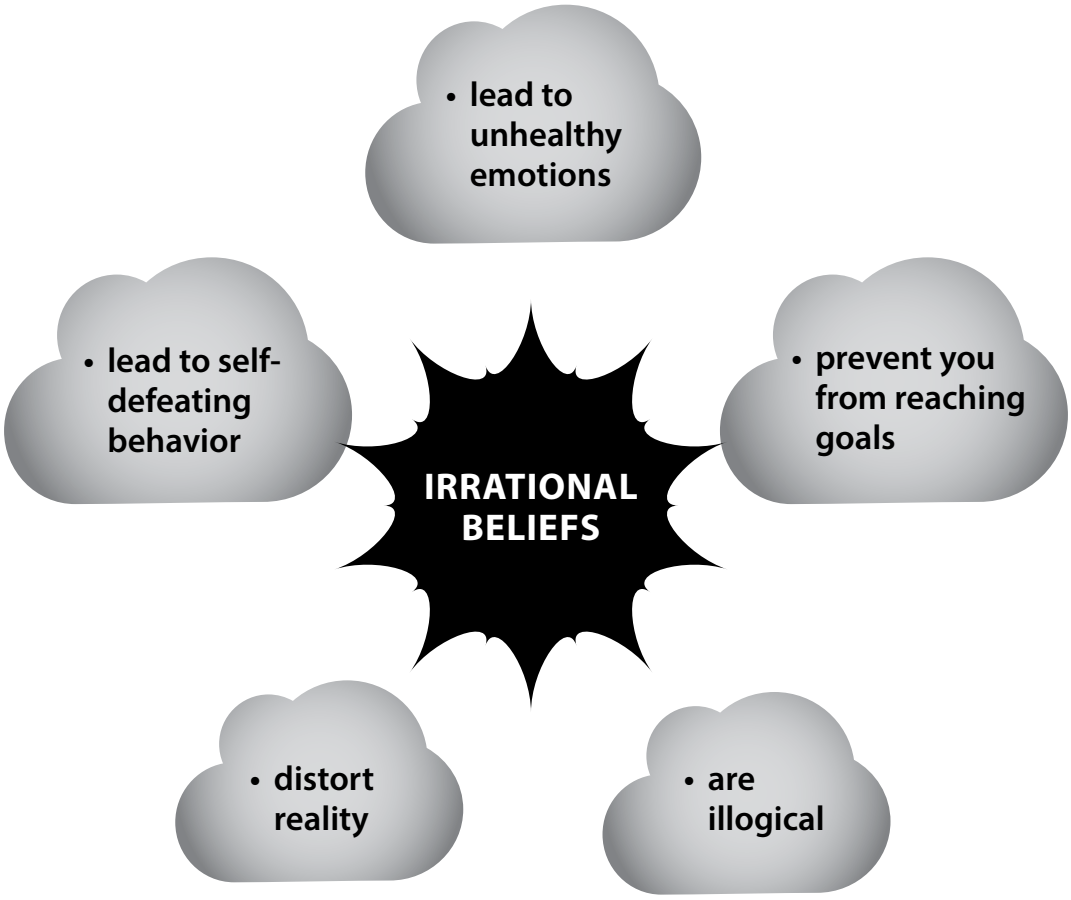
I can't stand this!

DEPRECIATION

Things will never get better!

I only "achieved" that because I'm supposed to.

Irrational Beliefs



COMMON THINKING ERRORS / IRRATIONAL BELIEFS	DEFINITION	EXAMPLE
Mind reading	Thinking we know what someone else is thinking, often to assess threat level and our safety.	*I just know they are thinking about all the foolish things I did.*
Fortune telling	Predicting the future, usually assuming things will turn out badly.	*They will hate me forever!*
Jumping to conclusions	Making negative predictions based on initial information.	*This mistake means that everything is now ruined!*
Catastrophizing	Exaggerating the negative consequences of an event.	*This is horrible!*
All-or-nothing thinking	Viewing events in extremes, placing situations in black-and-white categories	*If I make a mistake, I'm a total failure and I am completely unlovable.*
Perfectionism	Assuming that because something is not flawless, it is a failure.	*I should have done perfectly on that task, not just very well! This means I am incompetent.*
Disqualifying the positive	Filtering out positive experiences which contradict your negative self-image.	*I don't deserve compliments on things I'm supposed to do.*

(Burns, 1980)

 **RIGID LANGUAGE**	 **REALISTIC AND FLEXIBLE LANGUAGE**
Just awful!	Not Ideal
I can't stand it!	Tolerable
This is the worst!	Not preferable
This is a disaster!	Manageable
All	Most
Nothing/No one	Many
Everything/Everyone	Often
Always	Usually
Never	Sometimes/Someone
Perfect/Failure	Occasionally
Best/Worst	Rarely
Right/Wrong	
Should	Choose to
Must	Prefer to
Ought	Want to
Need to	
Have to	
Got to	
Forced to	
Supposed to	
Ordered to	

Session 4 Homework

ASSIGNMENT #1:

Notice how often you say "should" statements to yourself. This could be either about others or yourself.

SHOULD STATEMENTS	
How often?	**Situation**
Example: 𝍸	*Example:* My boss gave me feedback at work. I told myself, "I should have already been doing that. I can never do anything right!"

ASSIGNMENT #2: Notice 3 positive things that happened each day.

NOTE THREE POSITIVE THINGS EACH DAY	
Day 1	1 2 3
Day 2	1 2 3
Day 3	1 2 3
Day 4	1 2 3
Day 5	1 2 3
Day 6	1 2 3
Day 7	1 2 3

SESSION 5

Problem Solving and Relapse Prevention

This page is intentionally left blank

SESSION 5

Problem Solving and Relapse Prevention

SESSION GOALS

- Review common unhealthy thinking patterns: labeling/stereotypes, overgeneralization, and selective negative focus
- Review problem-solving steps
- Have patients practice working through problem-solving steps
- Discuss feelings and thoughts about the end of group
- Aid patients in planning how they want to continue working on their recovery

I. REVIEW HOMEWORK (approximately 5 minutes)

Discuss with patients how noticing their "shoulds/musts/oughts/etc.," and 3 positive things that happened each day went over the past week.

How did it go with trying to notice when you used words like "should?"

How did it go trying to notice 3 positive things that happened each day?

II. LABELING AND STEREOTYPES (approximately 15 minutes)

Providers can review another type of unhealthy thinking pattern—***labeling/stereotyping.*** It is helpful to provide examples of stereotyping as we are often unaware of when we engage in labeling. Providers can consider using the example of "blonde" stereotypes as this is usually less emotionally intense than many other labels. This example can also drive home the point that we are not often aware of the ways we stereotype. Providers can also review how we label ourselves and others, while noting the impact of this stereotyping on our emotions.

Generally, by this point in the group, most members have spoken (some quite often!). The more cohesive the group, the more members express themselves (and likely decrease their anxiety, depression, anger, or guilt). However, there are sometimes group members who have not said much at this point. This exercise can be an opportunity for members who have rarely talked to do so. Thus, we have generally called on the group member who has spoken least over the previous 4 sessions.

Asking a group member who is fairly quiet…

> *Describe the person you like least in the world. Tell us about this person. What qualities does the person have?*

Patients often give examples of selfish, conceited, bossy, etc., and periodically strong criticisms as well. We recommend writing these qualities on the board.

The group leader then turns to another patient (often another patient who has rarely spoken during the group).

> *What do you think of this person [described above]?*

Patients generally give examples of shallow, overconfident, someone I don't want to meet, etc. We recommend writing these statements on the board as well.

> *We'll come back to this person in a few minutes. But I have a question for you.*
>
> *What are blondes like?*

This question usually prompts looks of confusion or amusement from group members. Some immediately begin to answer, others are quite hesitant, and a few ask clarifying questions. But after a while, members often give some of the following stereotypes of blondes: dumb, ditzy, pretty, have more fun, etc. We recommend writing these qualities on the board.

I'm going to add a quality of blondes that I'm guessing you were thinking but did not mention or notice.

Female

I didn't actually say a gender. I just said a hair color. In our society, most of the time we refer to people by their hair color, we are talking about females. But genetically speaking, theoretically 50% of blondes are male. Yet, these "qualities" or stereotypes are rarely applied to them. Just females.

We stereotype people in a variety of ways: gender; race; ethnicity; religion; veteran status; age; national origin; weight; health status; hair color; lots of ways. There's a reason we do this. There are over 7 billion people in the world. Our brains cannot keep up with 7 billion different people, so we group them (often in some of the categories we just mentioned).

I'm not here to tell you to stop stereotyping. As we discussed, our brains cannot keep up with 7 billion people. I'm suggesting that the more we are ***aware*** *that we are doing it, the more we can begin to challenge our assumptions. We just established that we already have assumptions about the next blonde female who walks into this room (and that it didn't even occur to us that we did). We also likely have other assumptions that have not occurred to us.*

Stereotyping is often used when we assess our environment for threats—categorizing others as either friend or foe. Rather than thinking about this as a good or bad thing, consider instead when it is ***useful*** *and when it may not be. To work on balancing your thinking, you can notice when you are stereotyping, and ask yourself if those stereotypes are accurate and useful.*

Why are we talking about stereotyping in a group on anxiety and depression? We don't just do this to other people. We also do this to ourselves.

We may say to ourselves, "I am a loser."

Imagine if that's how I see myself. It would be very easy for me, after I've made a mistake, to say, "See, I knew it! I 'always' screw up!" And I don't catch that I'm noticing the "loser" things I do because I see myself as a loser.

We're looking for ***balance*** *in our thinking.*

The group leader then turns to the person who originally described someone they did not like very much.

> *I'd like you name three positive qualities of this person.*

This assignment is usually much more difficult than the previous one. It may help for the group leader to be patient as the member attempts to do this.

The group leader then turns back to the 2nd patient involved in this exercise.

> *I want to introduce you to someone* **(the group leader reads both the positive and negative traits).** *What do you think of this person now?*

Patient thoughts often vary from "the same" to "not as bad as before."

Providers may give another example of balancing thinking. This example is designed to be extreme, with the intent of showing that even what seems like the "worst" is not "all" bad. It can be helpful to describe a difficult example so that patients can understand that balancing their thoughts is possible even in extremely difficult situations.

> *A previous group member who was still in the military was asked to describe someone she did not like very much. She ended up describing someone who had sexually abused her as a child. It's fair to say that the "bad" list was quite long. When we got to the point of naming 3 positive qualities about the person, she was able to name 2.*
>
> *We often think of "balance" as an "equal balance." We're not saying that this person's 2 positive qualities matched the negative ones. That's certainly not the case in this example.*

Going back to the person you described, I specifically asked for someone you did not like very much. I'd expect the person's negative qualities to be greater than their positive qualities. It's not our goal for you to start liking them after doing this exercise, just to notice that even for people we really don't like, there are negative and positive qualities.

We're practicing with difficult examples to show that even in some of the most intense situations, it is possible to balance our thinking. When we're talking about "balance" in our thinking, when we're noticing others' and our own positive qualities, anxiety goes down; depression goes down; anger goes down; guilt goes down.

III. OVERGENERALIZATION (approximately 5 minutes)

Providers can review another unhealthy pattern of thinking—overgeneralization.

What does overgeneralization mean? **Allow patients to respond.**

Yes, this means making something more than it is or a mountain out of a molehill. We might take a small piece of information and make a big conclusion from it. For example, we might hear of one specific type of plane having engine trouble while watching the news, and we make the big conclusion that "all" planes aren't safe! We often do this, for example, about parking at the VA as "terrible" even though we still find a space somehow.

We can overgeneralize about ourselves and about our situation. We just overgeneralized about blondes a few minutes ago. These stereotypes and overgeneralizations are sometimes accurate for a certain person or situation, but they are not accurate at "all" times. For example, some planes do have engine troubles, that is accurate. However, it's not accurate that "all" planes aren't safe. The more we're aware of our thoughts, the more we can begin to challenge and change them, and ultimately manage our emotions better.

IV. SELECTIVE NEGATIVE FOCUS (approximately 5 minutes)

Providers can review another unhealthy pattern of thinking—selective negative focus.

> *What does this mean, selective negative focus? Yes, focusing on the negative. As we discussed last week, this is something individuals with depression are experts at, so much that we don't notice it. (But after last week's homework assignment, hopefully we do now at least a little!)*
>
> *For example, you may tell yourself that you're a "loser." When you win, you tell yourself, "Oh, I just got lucky" or "Oh, that's not a big deal anyway." If you lose, you tell yourself, "I knew it, just another example of me being a loser!" Bringing* ***balance*** *to our thinking reduces such perceptions and decreases anxiety, depression, anger, and guilt.*
>
> *We've actually completed the "thoughts" portion of the group. (It only took us 3 ½ weeks to do it!) Any questions about anything we've discussed up to this point?*

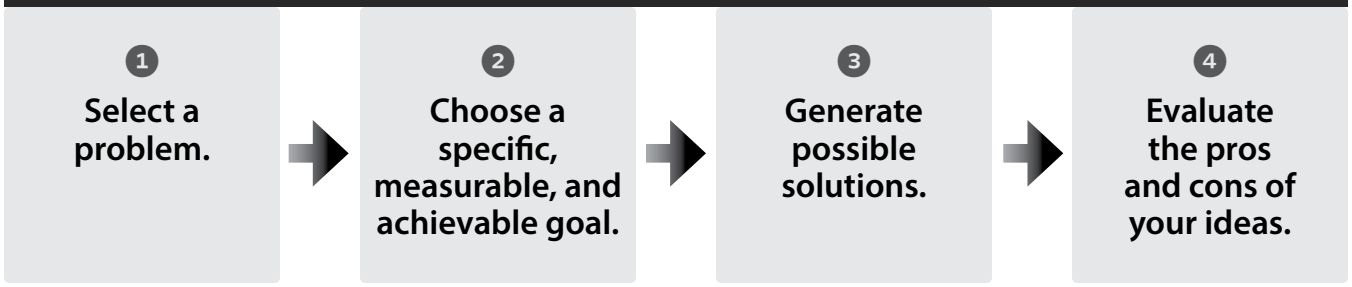
V. PROBLEM-SOLVING (APPROXIMATELY 15 MINUTES)

Providers can review the steps to problem-solving: identifying the problem, identifying a specific and measurable goal, identifying possible solutions, evaluating the pros/cons of each possible solution, and choosing a solution.

Providers can note that patients usually already engage in problem solving. The goal is to have patients slow down their problem-solving process so that they can understand their choices. Thinking about problems may increase anxiety and depression, so having strong problem-solving skills can be helpful in managing symptoms in the face of problems.

It is recommended to have a group member identify a recent or current problem they are having, so group members can actively go through a real example of problem-solving.

PROBLEM SOLVING



(Burns, 1980)

✻ Patients can refer to page 45 of their workbook to see this chart.

Let's talk about problem solving. This is not a new concept. You likely solved several problems just to be here today. We solve lots of problems each day. But how do we do it? What are the steps involved?

While there are several steps involved, we're going to find that we often skip some. For instance, we see a problem, we implement a solution. This quick action is often very helpful during a deployment but may not be as helpful in other situations. It also greatly increases the chances that we're using the "emotional" part of our brain to solve the problem rather than the "rational" part.

So what's the first step in problem solving? **It may help to write the steps and examples on the board.**

1. ***Select a problem.*** *The first step in problem solving is to have a problem. Does anyone have a problem you'd like some help from the group to solve?*

2. ***Choose a specific, measurable, and achievable goal.*** *It's amazing how often we skip this step when problem solving. We often just go from having a problem to implementing a solution without keeping in mind what our goal is. Or we'll come up with a goal that is not achievable. For example, if our problem is that we don't have enough money, our goal is to become a millionaire. Hey, if you can do that, more power to you! But that's a bit of a challenge for most of us. What about increasing monthly income by 10%? That's likely more achievable!*

   Other examples of achievable goals:

Being liked by everyone (an unhealthy word!)	→	*Increasing your number of friends from 1 to 3.*
Never (another unhealthy word!) feeling angry again.	→	*Reducing angry outbursts from 5 times a week to 2 times a week.*

3. ***Generate possible solutions.*** *This is another step we often skip. What we're saying here is anything you can think of that gets us from Step 1 to Step 2 above will go on this list. So if you think, "Punch me in the face," will help us get from Step 1 to Step 2, it will go on the list. We're not evaluating options (we will, but not yet). Think outside the box and do not rule anything out. List anything that comes to mind.* **Allow patients to identify possible solutions. Provider may list possible solutions on the board.**

4. ***Evaluate the pros and cons of your ideas.*** *Now is our chance to evaluate our options. Each option likely has at least one positive and one negative quality or reason that we might or might not want to choose this option. We'll go through each option one-by-one.* **Allow patients to identify pros and cons of the possible solutions. Providers may list the pros and cons of each possible solution on the board.**

5 ***Choose one (or more than one choice).*** *Now that we can see the positives and negatives of each option, which do you want to try?* **Allow patients to respond which solution they might choose in this situation.**

I want you to notice a few things. First, by allowing our brains to consider any option that came to mind, we weren't limited by biases or previous experiences. We gave a chance to any thought that came into our heads.

Second, by suggesting thoughts that we might have rejected as ridiculous (e.g., punching me in the face; at least hopefully ridiculous!), we were able to come up with useful options that hadn't initially occurred to us.

Third, is anyone bored? The interesting thing about going through this process is that it takes some time. As we discussed earlier, we often go through problem solving very quickly using the emotional part of our brains. What we just did is ***slow the process down*** *such that we used the rational part of our brains. Ironically, that can seem boring. But for decision making in many situations, that can be good!*

Any questions about anything we've discussed? **Allow patients to respond.**

VI. THOUGHTS ABOUT THE END OF THE GROUP
(approximately 5 minutes)

It can be helpful to have group members discuss their thoughts and feelings about the group as well as the end of group. Sometimes, members have bonded significantly and are a bit sad about the end of the group (of course, increasing sadness is not a goal of the group!). It can be helpful to normalize this.

Providers may aid patients in making a plan for the next steps in their recovery. Providers may have patients reflect on what they learned in group that they want to continue using. It is also important to discuss treatment options following this treatment *(e.g., Cognitive Processing Therapy [CPT]; Resick et al., 2017)*.

What has the group been like for you?

How do you feel about this being our last group?

What did we talk about in group that stood out to you?

Is there anything that you tried in group that you want to continue using?

Thank you for being part of the group!

PROBLEM SOLVING WORKSHEET *example*		
Define the Problem:	Too many bills	
Achievable Goal:	Increase spending money by $100 per month	
Generate Solutions:	**PROS**	**CONS**
1. Get a second job	Extra cash, might make new friends	Reduced family time
2. Borrow money until securing a promotion	Family would help	Feelings of guilt for borrowing money
3. Cut unnecessary spending	Extra cash without needing to borrow money	Eating out less at restaurants
4. Use debt consolidation service	May reduce bills	May not help reduce bills
Choose a Solution:	Get a second job	
Subtasks:	1. Search online for part-time work 2. Update resume 3. Submit resumes for 10 jobs 4. Interview given the opportunity	

PROBLEM SOLVING WORKSHEET		
Define the Problem:		
Achievable Goal:		
Generate Solutions:	**PROS**	**CONS**
1		
2		
3		
4		
5		
Choose a Solution:		
Subtasks:		

Sample Group Notes

Rational Emotive Behavior Therapy-Informed
Treatment for Anxiety and Depression

SESSION 1

Date:

Time:

Number of Participants:

Group Leader:

Topic: Introduction to Anxiety & Depression

Dx:

PROGRESS NOTE:

The patient attended the 1st session of group therapy for anxiety and depression. The patient was an active participant in the group. Group topics included introductions to anxi ety and depression, their causes, and potential treatments. Group members were assigned homework to notice "what if" and "why" thoughts.

MENTAL STATUS EXAM:

This patient was oriented in all spheres. No abnormalities noted in speech, behavior, or thought processes. Patient was attentive. Pt did not report suicidal or homicidal ideation, intent, plan, or actions.

RECOMMENDATIONS/PLAN:

1. The patient will continue group psychological treatment with _____. Next group session is _____.
2. Patient did not endorse suicidal and homicidal ideation, intent, plan, or actions. The patient is considered a low risk for self-harm behavior at this time. The patient's immediate environment is not of concern from a safety standpoint. The most appropriate setting for ongoing therapy is outpatient mental health. Pt is released on pt's own accord.
3. The patient agrees that if thoughts of self-harm, suicidal ideation, or harm to others occur the patient will immediately report to the nearest medical facility or to the ED.

Rational Emotive Behavior Therapy-Informed
Treatment for Anxiety and Depression

SESSION 2

Date:

Time:

Number of Participants:

Group Leader:

Topic: Control, Choices, & Consequences

Dx:

PROGRESS NOTE:

The patient attended the 2nd session of group therapy for anxiety and depression. The patient was an active participant in the group. Group topics included an introduction to the links between thoughts, behaviors, and emotions. Other topics included the concepts of choices & consequences, control (e.g., what one can and cannot control) and acceptance. The idea of challenging thoughts was also described. Group members were assigned homework to rank their top three priorities.

MENTAL STATUS EXAM:

This patient was oriented in all spheres. No abnormalities noted in speech, behavior, or thought processes. Patient was attentive. Pt did not report suicidal or homicidal ideation, intent, plan, or actions.

RECOMMENDATIONS/PLAN:

1. The patient will continue group psychological treatment with _____. Next group session is _____.
2. Patient did not endorse suicidal and homicidal ideation, intent, plan, or actions. The patient is considered a low risk for self-harm behavior at this time. The patient's immediate environment is not of concern from a safety standpoint. The most appropriate setting for ongoing therapy is outpatient mental health. Pt is released on pt's own accord.
3. The patient agrees that if thoughts of self-harm, suicidal ideation, or harm to others occur the patient will immediately report to the nearest medical facility or to the ED.

Rational Emotive Behavior Therapy-Informed
Treatment for Anxiety and Depression

SESSION 3

Date:

Time:

Number of Participants:

Group Leader:

Topic: Common Thinking Errors, Irrational Beliefs, Part 1

Dx:

PROGRESS NOTE:

The patient attended the 3rd session of group therapy for anxiety and depression. The patient was an active participant in the group. Group topics included common thinking errors/irrational beliefs such as mind reading, fortune telling, catastrophizing, and all-or-nothing thinking. The idea of challenging thoughts was also described. Group members were assigned homework to notice how often extreme words or thoughts enter their mind and to begin replacing them with healthier and more accurate words or thoughts.

MENTAL STATUS EXAM:

This patient was oriented in all spheres. No abnormalities noted in speech, behavior, or thought processes. Patient was attentive. Pt did not report suicidal or homicidal ideation, intent, plan, or actions.

RECOMMENDATIONS/PLAN:

1. The patient will continue group psychological treatment with _____. Next group session is _____.
2. Patient did not endorse suicidal and homicidal ideation, intent, plan, or actions. The patient is considered a low risk for self-harm behavior at this time. The patient's immediate environment is not of concern from a safety standpoint. The most appropriate setting for ongoing therapy is outpatient mental health. Pt is released on pt's own accord.
3. The patient agrees that if thoughts of self-harm, suicidal ideation, or harm to others occur the patient will immediately report to the nearest medical facility or to the ED.

Rational Emotive Behavior Therapy-Informed
Treatment for Anxiety and Depression

SESSION 4

Date:

Time:

Number of Participants:

Group Leader:

Topic: Common Thinking Errors, Irrational Beliefs, Part 2

Dx:

PROGRESS NOTE:

The patient attended the 4th session of group therapy for anxiety and depression. The patient was an active participant in the group. Group topics included common thinking errors/irrational beliefs such as should statements, owning others' problems, and disqualifying the positive. Pts also engaged in challenging their thoughts. Group members were assigned homework to notice how often they say "should" statements to themselves as well as three positive things that happen over the course of the week.

MENTAL STATUS EXAM:

This patient was oriented in all spheres. No abnormalities noted in speech, behavior, or thought processes. Patient was attentive. Pt did not report suicidal or homicidal ideation, intent, plan, or actions.

RECOMMENDATIONS/PLAN:

1. The patient will continue group psychological treatment with _____. Next (and last) group session is _____.
2. Patient did not endorse suicidal and homicidal ideation, intent, plan, or actions. The patient is considered a low risk for self-harm behavior at this time. The patient's immediate environment is not of concern from a safety standpoint. The most appropriate setting for ongoing therapy is outpatient mental health. Pt is released on pt's own accord.
3. The patient agrees that if thoughts of self-harm, suicidal ideation, or harm to others occur the patient will immediately report to the nearest medical facility or to the ED.

Rational Emotive Behavior Therapy-Informed
Treatment for Anxiety and Depression

SESSION 5

Date:

Time:

Number of Participants:

Group Leader:

Topic: Problem Solving & Relapse Prevention

Dx:

PROGRESS NOTE:

The patient attended the 5th and final session of group therapy for anxiety and depression. The patient was an active participant in the group. Group topics included labeling; overgeneralization; selective negative focus; problem solving techniques; a review of challenging thoughts; relapse prevention; and thoughts and feelings related to the end of the group. Members engaged in a discussion of future treatment options.

MENTAL STATUS EXAM:

This patient was oriented in all spheres. No abnormalities noted in speech, behavior, or thought processes. Patient was attentive. Pt did not report suicidal or homicidal ideation, intent, plan, or actions.

RECOMMENDATIONS/PLAN:

1. Patient did not endorse suicidal and homicidal ideation, intent, plan, or actions. The patient is considered a low risk for self-harm behavior at this time. The patient's immediate environment is not of concern from a safety standpoint. The most appropriate setting for ongoing therapy is outpatient mental health. Pt is released on pt's own accord.
2. The patient agrees that if thoughts of self-harm, suicidal ideation, or harm to others occur the patient will immediately report to the nearest medical facility or to the ED.

Suggested Measures for Treatment Outcomes

- *Patient Health Questionnaire-9* (PHQ-9; Kroenke et al., 2001)
- *Generalized Anxiety Disorder 7-item* (GAD-7; Spitzer et al., 2006)
- *Irrational Belief Scale* (IBS; Malouff & Schutte, 1986)
- *Posttraumatic Stress Disorder (PTSD) Checklist for DSM-5* (PCL-5; Weathers et al., 2013)

Last name:	Last 4 digits of SSN:
Date:	

PHQ-9

Please read each item carefully and give your best response.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10 **If you checked off any problems, how DIFFICULT have these problems made it for you to do your work, take care of things at home, or get along with other people?**	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

GAD-7

Please read each item carefully and give your best response.

Over the past 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious, or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

FOR PROVIDER

Group name:	Session #:
Clinician name:	

Last name:	Last 4 digits of SSN:
Date:	

IBS

Instructions: Indicate for each of the statements below the degree to which you agree or disagree with the statement, using the following scale.

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 To be a worthwhile person I must be thoroughly competent in everything I do.	1	2	3	4	5
2 My negative emotions are the result of external pressures.	1	2	3	4	5
3 To be happy, I must maintain the approval of all persons I consider significant.	1	2	3	4	5
4 Most people who have been unfair to me are generally bad individuals.	1	2	3	4	5
5 Some of my ways of acting are so ingrained that I could never change them.	1	2	3	4	5
6 When it looks as if something might go wrong, it is reasonable to be quite concerned.	1	2	3	4	5
7 Life should be easier than it is.	1	2	3	4	5
8 It is awful when something I want to happen does not occur.	1	2	3	4	5
9 It makes more sense to wait than to try to improve a bad life situation.	1	2	3	4	5
10 I hate it when I cannot eliminate an uncertainty.	1	2	3	4	5
11 Many events from my past so strongly influence me that it is impossible to change.	1	2	3	4	5
12 Individuals who take unfair advantage of me should be punished.	1	2	3	4	5
13 If there is a risk that something bad will happen, it makes sense to be upset.	1	2	3	4	5
14 It is terrible when things do not go the way I would like.	1	2	3	4	5
15 I must keep achieving in order to be satisfied with myself.	1	2	3	4	5
16 Things should turn out better than they usually do.	1	2	3	4	5
17 I cannot help how I feel when everything is going wrong.	1	2	3	4	5
18 To be happy I must be loved by the persons who are important to me.	1	2	3	4	5
19 It is better to ignore personal problems than to try to solve them.	1	2	3	4	5
20 I dislike having any uncertainty about my future.	1	2	3	4	5

FOR PROVIDER

Group name:	Session #:
Clinician name:	

Last name:	Last 4 digits of SSN:
Date:	

PCL-5
(MONTHLY)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem *in the past month*.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1 Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2 Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3 Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4 Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5 Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6 Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7 Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8 Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9 Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10 Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11 Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12 Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13 Feeling distant or cut off from other people?	0	1	2	3	4
14 Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15 Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16 Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17 Being "superalert" or watchful or on guard?	0	1	2	3	4
18 Feeling jumpy or easily startled?	0	1	2	3	4
19 Having difficulty concentrating?	0	1	2	3	4
20 Trouble falling or staying asleep?	0	1	2	3	4

FOR PROVIDER

Group name:	Session #:
Clinician name:	

References

Burns, D. D. (1980). *Feeling good: The new mood therapy*. New York: Avon Books.

David, D., Szentagotai, A., Lupu, V., & Cosman, D. (2008). Rational emotive behavior therapy, cognitive therapy, and medication in the treatment of major depressive disorder: A randomized clinical trial, posttreatment outcomes, and six-month follow-up. *Journal of Clinical Psychology,* 64, 728–746. doi: 10.1002/jclp.20487

Ekman, P., & Friesen, W. V. (1971). Constants across cultures in the face and emotion. *Journal of Personality and Social Psychology*. 17 (2): 124–129.

Ellis, A. (1957). Rational psychotherapy and individual psychology. *The Journal of Individual Psychology,* 13(1), 38–44.

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

Ellis, A. (1972). Rational-emotive psychotherapy: A comprehensive approach to therapy. In (G.D. Goldman & M.S. Milman (Eds.), *Innovations in psychotherapy* (147–163). Thomas.

Ellis, A. (1976). The rational-emotive view. *Journal of Contemporary Psychotherapy,* 8, 20–28 (1976). doi: 10.1007/BF01813187

Ellis, A. (1980). An overview of the clinical theory of rational emotive therapy. In R. Grieger & J. Boyd (Eds.), *Rational-Emotive Therapy: A Skills-Based Approach* (pp. 1–31). Van Nostrand and Reinhold.

Ellis, A. (1983). Rational-emotive therapy (RET) approaches to overcoming resistance: II How RET disputes clients' irrational, resistance-creating beliefs. *British Journal of Cognitive Psychotherapy,* 1(2), 1–16.

Ellis, A. (1992). Group rational-emotive and cognitive-behavioral therapy. *International Journal of Group Psychotherapy,* 42, 63–80.

Ellis, A. (1993). Changing rational-emotive therapy (RET) to rational emotive behavior therapy (REBT). *Behavior Therapist,* 16, 257–258.

Flory, J. D., & Yehuda, R. (2015). Comorbidity between post-traumatic stress disorder and major depressive disorder: alternative explanations and treatment considerations. *Dialogues in Clinical Neuroscience,* 17(2), 141–150.

Grove, A. B., Kurtz, E. D., Wallace, R. E., Sheerin, C. M., & Scott, S. M. (2021). Effectiveness of a rational emotive behavior therapy (REBT)-informed group for post-9/11 Veterans with posttraumatic stress disorder (PTSD). *Military Psychology,* 33(4), 217–227. doi: 10.1080/08995605.2021.1897496

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2014). The organisation of irrational beliefs in posttraumatic stress symptomology: Testing the predictions of REBT theory using structural equation modelling. *Journal of Clinical Psychology,* 70, 48–59. doi: 10.1002/jclp.22009.

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2015). Irrational beliefs in posttraumatic stress responses: A rational emotive behaviour therapy approach. *Journal of Loss and Trauma: International Perspectives on Stress & Coping*. doi: 10.1080/15325024.2013.839772.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9:validity of a brief depression severity measure. *Journal of General Internal Medicine,* 16(9), 606–613.

Malouff, J. M. & Schutte, N. S. (1986). Development and validation of a measure of irrational belief. *Journal of Consulting and Clinical Psychology,* 54, 860–862.

Resick, P. A., Wachen J. S., Dondanville, K. A., Pruiksma, K. E., Yarvis, J. S., Peterson, A. L., Mintz, J., & STRONG STAR Consortium (2017). Effect of group vs. individual Cognitive Processing Therapy in activity-duty military seeking treatment for Posttraumatic Stress Disorder: A randomized clinical trial. *JAMA Psychiatry,* 74, 28–36. doi: 10.1001/jamapsychiatry.2016.2729

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology,* 21, 95–103.

Spitzer, R.L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine,* 166(10): 1092–7.

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.

Zidarov, D., Swaine, B., & Gauthier-Gagnon, C. (2009). Life habits and prosthetic profile of persons with lower-limb amputation during rehabilitation and at 3-month follow-up. *Archives of Physical Medicine and Rehabilitation,* 90(11), 1953–1959.

This page is intentionally left blank

This page is intentionally left blank