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A Psychoeducational Approach to Improving College Student Mental Health

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A PSYCHOEDUCATIONAL APPROACH TO IMPROVING COLLEGE
STUDENT MENTAL HEALTH

PROFESSIONAL DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE SCHOOL OF PROFESSIONAL PSYCHOLOGY
WRIGHT STATE UNIVERSITY

BY

HARLAN KEITH HIGGINBOTHAM JR., M.A.

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

Dayton, Ohio

September, 2013

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June 27, 2012

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY HARLAN KEITH HIGGINBOTHAM, JR. ENTITLED A PSYCHOEDUCATIONAL APPROACH TO IMPROVING COLLEGE STUDENT MENTAL HEALTH BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Abstract

Mental health problems among the college population continue to increase in terms of frequency and severity. At the same time, the number of high school graduates who enroll in institutes of higher learning is also increasing making the college years an ideal opportunity to address existing and emerging mental and psychological challenges. Traditional counseling center services--while shown to be effective--are not appropriate for all students and are too resource intensive to meet the full need of the college population. Creative strategies are necessary to address the growing need for mental health services among college and university students that are resource efficient, can reach a broader range of students by overcoming barriers to treatment, can effectively address current mental health concerns, and that effectively prepare students for the mental and emotional challenges they will face in today’s world. Available research supports the application of several psychoeducational approaches to the treatment of common mental health concerns as well as in the development of resiliency for the protection against future challenges. This project provides a potential solution to the growing need for mental health services by combining proven psychoeducational approaches into a semester class under the umbrella of effective stress management. This class integrates physiological and psychological understandings of stress and stress management with evidence-based skills including relaxation techniques, problem-solving, mindfulness, cognitive restructuring, and assertiveness shown to be effective not only in the treatment of stress but also in the treatment of common mental illnesses such as anxiety and depression. Further, this course encompasses a set of skills consistent with the positive psychology literature on the development of resilience. An instructors
guide, course slides, course syllabus, and recommendations for readings, homework, and practices are provided and organized into separate modules to facilitate adaptation to various formats.
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A Psychoeducational Approach to Improving College Student Mental Health

The tragic shootings on April 16, 2007 at Virginia Polytechnic Institute and State University and February 14, 2008 at Northern Illinois University along with many attempted and completed suicides have caused concern regarding the mental health of college students and the mental health services of American institutions of higher learning (Hunt & Eisenberg, 2010; Kay, 2010; Voelker, 2003). While the percentage of American children who pursue postsecondary education continues to rise (NCES, 2010), advances in early diagnosis, evidenced-based psychotherapies, and psychiatric medications are enabling children with psychiatric disorders to attend and succeed in postsecondary education who before would not have had the attention span, motivation, or emotional capability to handle the academic and social challenges (Hunt & Eisenberg, 2010; Kay, 2010).

Recent studies also suggest that the number of college and university students who report symptoms of mental disorders continues to rise. One source of mental health trends among college students is the bi-annual National College Health Assessment (NCHA) administered from spring 2000 through spring 2008 and the revised NCHA II administered by the American College Health Association (ACHA). Higginbotham and Rando (2010) analyzed the results of the three surveys for the NCHA II and found the percentage of college students reporting impediments to academic performance due to stress to be 27.2%, sleep problems 19.5%, anxiety 18.5%, depression 11.4%, and relationship difficulties 10.7%. Students also reported experiencing within the past 12
months overwhelming anxiety (48.6%), seriously considering suicide (6.1%), self-injurious behavior (5.2%), and attempted suicide (1.2%). The lifetime rate of depression among the students was reported to be 17.7%.

Higginbotham and Rando (2010) also compared results of the NCHA over the 17 versions of the survey. They found that students who reported experiencing an anxiety disorder over the past year rose 0.9% a year from 6.7% in spring 2000 to 13.2% in spring 2008 and those experiencing depression rose 0.2% per year from 16.4% in spring 2000 to a high of 20.9% in fall 2005. The number of students indicating that depression and anxiety had some impact on their academic performance rose 0.9% per year (11.3% to 16.1% over the period of the assessment), while academic impacts due to sleep rose 0.7% per year (20.7% to 25.6% over the period of the assessment) and impacts due to stress rose 0.8% per year (28.7% to 33.9% over the period of the assessment). Clearly these results point to a growing concern of mental health issues among college students.

Two national surveys of counseling center directors, the national Survey of Counseling Center Directors (Gallagher, 2009) and the Association for University and College Counseling Center Directors Annual Survey (Barr, Rando, Krylowicz, & Winfield, 2010) also report growing mental health concerns among college students. Counseling center directors reported significant increases in the number of students entering college already on psychotropic medications (9% in 1994 to 25% in 2009; Gallagher, 2009) and over 90% of directors reported they are seeing more students with severe psychological problems (Barr et al., 2010, Gallagher, 2009). At the same time, directors reported difficulties in meeting the demand for services with nearly half
instituting session limits (Barr et al., 2010) and 31% reporting challenges in dealing with waitlist issues (Gallagher, 2009).

Additional data on college student mental health comes from the National Epidemiologic Study on Alcohol and Related Conditions (Blanco et al., 2008) which found that almost half of college students in the 2002-2003 school year met criteria for at least one DSM-IV condition within the previous year. Of this group, 20% met criteria for an alcohol use disorder, 11% met criteria for a mood disorder, and 12% met criteria for an anxiety disorder.

The Healthy Minds Study conducted by Eisenberg, Gollust, Golberstein, and Hefner (2007) found rates of depression over a two-week period and anxiety disorders over a four-week period to be 14% and 4% respectively for undergraduate students. Researchers also found that 2.1% reported suicidal ideation within the past four weeks and 0.7% reported having a specific plan for attempting suicide. In a two-year follow-up of this study, Zivin, Eisenberg, Gollust, and Golberstein (2009) found that 60% of those who screened positive for a disorder in 2005 also screened positive in 2007 while 24% who screened negative in 2005 screened positive in 2007 suggesting that mental health issues in college students are persistent and not merely transitory problems.

A collateral problem with respect to college student mental health is the low rate of mental health service utilization. Garlow et al. (2008) found that of college students with current suicidal ideation, 84% were not being treated while 85% of student with moderately severe or severe depression were not being treated. Eisenberg, Golberstein, and Gollust (2007) looked at rates of mental health service utilization by disorder and found 63% of students who screened positive for depression and anxiety sought
treatment, 36% who screened positive for major depression but not anxiety received treatment, and 52% who screened positive for anxiety but not depression sought treatment. In the two-year follow-up to the Healthy Minds Study, Zivin et al. (2009) found that of those students who screened positive for a mental disorder, 74% had not sought treatment. Blanco et al. (2008) found the rate of treatment-seeking to be 18% while Hunt and Eisenberg (2010) found it to be less than half of those who screened positive for a mental disorder. Despite the large demand for the services of college counseling centers, these studies suggest that those students seeking mental health services represent only a fraction of college students in need of such services.

Reasons provided for not seeking treatment included not perceiving a need for help, believing the problem would resolve on its own, not believing that help would be beneficial, and concerns about privacy (Eisenberg et al., 2007). Other researchers found the most common reasons given for not using mental health services were not having enough time, lack of knowledge, feeling embarrassed, and not believing services would help (Yorgason, Linville, & Zitzman, 2008). Stigma continues to be a significant concern in mental health service utilization especially a person’s personal stigma towards a person with a mental disorder in contrast to their perception of how others would view someone with a mental disorder (Eisenberg, Downs, golberstein, & Zivin, 2009). Factors found to be association with higher levels of personal stigma include being an international student, having higher levels of religiosity, and being heterosexual (Eisenberg et al., 2009). Factors of ethnicity (non-Caucasian), sex (male), and lower SES have also been shown to be associated with lower levels of mental health service utilization (Kessler, Costello, Merikangas, & Ustun, 2001; U.S. Department of Health
Overall rates of mental disorders and low rates of mental health service utilization are concerning especially in light of the significant consequences experienced by many students struggling with mental health issues. Students with mental disorders have been found to have lower GPAs (CSCMH, 2009), higher academic distress (CSCMH, 2009), and higher rates of early termination from college (Breslau, Lane, Sampson, & Kessler, 2008; Kessler, Foster, Saunders, & Stang, 1995). Adolescents and teens who have mental disorders are also more likely to be teenage parents which further puts them at risk for low educational attainment, poor employment outcomes, and marital instability (Bumpass and McLanahan, 1989; Maynard, 1996; McLanahan & Garfinkel, 1993) while also leading to risks for their babies including low birth weight, higher mortality rates, cognitive delays, school problems, behavioral disorders, and being teenage parents themselves (Bolton, 1980; Mecklenburg & Thompson, 1983). Additional problems for teens with mental disorders include decreased marriage stability (Kessler, Walters, & Forthofer, 1998), lower life satisfaction (Meyer, Rumpf, Hapke, & John, 2004), increased role disability (Merikangas et al., 2007), suicidal behavior (Drum, Brownson, Denmark, & Smith, 2009; Schwartz, 2006; Silverman, Meyer, Sloan, Raffel, & Pratt, 1997), and more persistent mental health disorders (Angst, 1996).

The need is clear for effective mental health treatments to address the growing concern of mental health issues among college students within the constraints of college and university budgets. Creative strategies are needed to reach a broader range of students whose goals and possibilities are being limited due to their mental health issues.
Students who are not treated in college are not only less likely to succeed academically but represent a missed opportunity to lessen the public health impact of mental health disorders.

What is missing from many university based mental health centers is a resource-effective approach to not only treating existing mental disorders but providing students with a strong foundation for maintaining positive mental health through the stress and challenges of college as well as post-college life demands. At the same time, approaches are needed that can overcome barriers to utilization of mental health services so that more students can benefit from learning positive mental health strategies. Current rationing of care remains an issue that needs innovative and creative solutions to overcome. It is high time that academic institutions recognize the importance of developing good mental and emotional health alongside the accumulation of knowledge and occupational skills.

Several studies have looked at non-traditional interventions that employ psychoeducation in workshop and self-administered formats such as bibliotherapy. These approaches are likely to be less stigmatizing as they do not require disclosures on the part of the client, can be provided outside of the counseling center, are resource effective, and can potentially be packaged and marketed to appeal to a broader range of students.

Several studies have looked at the efficacy of providing cognitive-behavioral therapy (CBT) based workshops for the treatment of depression. A one-day workshop provided in London which taught clients problem solving methods, assertiveness skills, ways of increasing social support, and activity scheduling demonstrated a large effect size in decreasing depression two years after the workshop, although there are concerns
with the dropout rate over the two-year period (Brown, Elliot, Boardman, Andiappan, Landau, & Howay, 2008). What’s more, these results were obtained regardless if the course was taught to a group or individuals were self-taught.

A popular CBT workshop that has been studied in many settings is the 12-week Coping with Depression course (Antonuccio, Breckenridge, & Teri, 1984) which teaches social skills, correcting distorted thoughts and beliefs, planning pleasant activities, and relaxation exercises. Studies with participants who met criteria for depression showed that only 25% still met criteria six months after the course with a low dropout rate of only 4.6%. Studies with subjects who screened positive for sub-clinical levels of depression found that those who completed the Coping with Depression course had fewer negative automatic thoughts, improved self-esteem and fewer depressive symptoms. Cuijpers (1998) conducted a meta-analysis of the 20 studies completed on the course and found a large effect size for lowering depressive symptoms.

Selgiman, Schulman, and Tryon (2007) also studied the efficacy of a CBT-based psychoeducational workshop for depression and anxiety. Their workshop consisted of 16 hours of instruction delivered over an eight-week period (two-hour session once per week) and also focused on CBT interventions for depression and anxiety. The workshop was shown to be effective for lowering depressive and anxiety symptoms in students with mild to moderate depression.

Another well-researched psychoeducational approach for treating depression is self-guided cognitive bibliotherapy. A meta-analysis conducted by Gregory, Canning, Lee, and Wise (2004) found 29 studies of cognitive bibliotherapy for depression and reported an overall effect size of 0.77 for lowering depressive symptoms. Many of these
studies used the book *Feeling Good* by Burns (1980) and found it to be appropriate for those adolescents and adults with reading levels of sixth grade or higher (Ackerson, Scogin, McKendree-Smith, & Lyman, 1998). Advantages of using bibliotherapy for depression are that it is highly accessible, avoids stigmatization, can be used by underserved groups, and is potentially empowering for recipients who gain self-efficacy by helping themselves (Gregory et al., 2004).

Although some of studies of CBT workshops measured anxiety symptoms and showed positive treatment of anxiety (Seligman et al., 2007), no studies were identified that focused on bibliotherapy or workshops specifically for anxiety. However, one psychoeducational approach that has been widely studied that has often included measures of anxiety is *mindfulness*. A recent meta-analysis (Hofmann, Sawyer, Witt, & Oh, 2010) looked at the results of 39 studies that measured the change in anxiety symptoms after a mindfulness-based workshop found treatment effects in the moderate to large range for both anxiety and depression.

Another psychoeducational approach that has been well studied with people diagnosed with borderline personality disorder is dialectical behavior therapy (DBT) developed by Marsha Linehan (1993). DBT teaches four primary skills aimed at improving a person’s ability to manage overwhelming emotions including distress tolerance, mindfulness, emotion regulation, and interpersonal effectiveness. One study was identified that used a modified DBT approach (emphasized mindfulness practice during each session) to treat clients with treatment-resistant depression delivered in 1.5 hour weekly sessions over a 16-week period. At the 6-month follow-up, 75% of the participants no longer met criteria for depression (full remission) resulting in an effect
size of 1.31. It is unclear from the study, however, which of the modules had the biggest impact on the change in depressive symptoms.

The purpose of this project is to look at student mental health needs and develop innovative, psychoeducationally-based strategies for delivering mental health services to a greater number of students with the aim of not only providing effective interventions but also developing positive mental health attitudes and skills. These strategies will aim to not only deliver services in a wide group format but also to reach students who would not otherwise come in contact with mental health services due to reasons such as stigma or cultural barriers, and provide these students with coping skills, self-help strategies, and information that may serve to ameliorate their psychological symptoms or reduce their barriers to help-seeking. Of course students with more severe disorders and conditions will still require the care and risk management approach of individual therapy and may not be appropriate for this venue.
Literature Review

According to the National Center for Education Statistics (2010), the percentage of high school completers (including those who obtained a GED) who enrolled in postsecondary education within 12 months increased from 45.1% in 1960 to 68.6% in 2008. Scientific advances in the diagnosis and treatment of mental disorders have undoubtedly permitted greater numbers of people with mental disorders to attend and be successful in a college setting (Kay, 2010) so this may in part explain the increase. Economic and job market changes are likely major contributors as well. Regardless of the cause, a large percentage of American teenagers are now entering college, many with previously diagnosed mental disorders. Researchers point out that mental disorders, for the most part, are disorders of young people and many tend to be lifelong (Kay, 2010; Mrazek, 2008). The peak onset of symptoms in the general population occurs between the ages of 15 and 19 years (Voelker, 2003) making it likely that many college students will experience their first symptoms of a mental disorder while attending college. Anecdotal evidence indicates that mental health issues are on the rise in American universities and colleges and a few studies have attempted to determine overall prevalence and trends in mental disorders among students.

Prevalence of Mental Disorders among College Students

ACHA-NCHA surveys. Perhaps the most comprehensive sources of data on the prevalence and trends of mental illness among college students comes from the annual survey (National College Health Assessment, NCHA) of the American College Health
Association (ACHA). The ACHA conducted the original version of the survey twice a year from spring 2000 through spring 2008 and mental health trends indicated in these assessments are discussed by Higginbotham and Rando (2010). Beginning in the fall of 2008, the ACHA used an updated version of the survey (NCHA-II) that provides additional health information but also limits the ability to compare data between the two versions.

Although the NCHA II survey has not been conducted over a long enough period to provide reliable trend data, the results provide a recent view into the mental health status of college students. Using weighted averages of the five completed surveys, Higginbotham & Rando (2010) found that four percent of students reported having a “psychiatric condition” (though no definition of “psychiatric condition” was provided in the actual survey). In response to the question on impediments to academic performance, 18.2% endorsed anxiety, 11.4% endorsed depression, 10.7% endorsed relationship difficulties, 19.5% endorsed sleep problems, and 27.1% endorsed stress. Within the past 12 months, 48.3% reported experiencing overwhelming anxiety, 6.0% seriously considered attempting suicide, 1.2% reported attempted suicide, 5.2% reported self-injurious behavior (cutting, burning, or other), and 30.3% said they had been so depressed it was difficult to function. While these responses cannot be taken to equate to a DSM-IV diagnosis, they do provide some indication of functional impairment due to an emotional or other psychological issue. Lastly, 17.5% of students reported that they had received a diagnosis of depression at some point in their lives. Given the low rate of mental health service utilization (and therefore diagnosis), this number is likely to significantly underestimate the life-time rate of depression in students.
The original NCHA survey was administered twice per year from spring 2000 through spring 2008 and can be analyzed for trends over this period. A comparison of the mental health related items for each survey period is provided in Higginbotham and Rando (2010). In response to the question “Within the past school year, have you had any of the following” students were presented 30 physical and mental health options. Student response rates to “Anxiety Disorder” increased 0.9% per year from 6.7% in spring 2000 to 13.2% in spring 2008, while levels of depression increased 0.2% per year from 16.4% in spring 2000 to a high of 20.9% in fall 2005 (dropping to 17.0% in spring 2008). Students were also presented with a list of 26 items and asked to assess each with respect to “impediment to academic performance” with potential responses ranging from “this did not happen to me/inapplicable” to “received an incomplete or dropped the course.” Students who reported that “Depression/Anxiety Disorder/Seasonal Affective Disorder” had some impact on their academic performance increased 0.9% per year from 11.3% in spring 2000 to 16.1% in spring 2008. “Sleep” also increased as an impediment to academic performance rising 0.7% each year from 20.7% in spring 2000 to 25.6% in spring 2008 and “Stress” increased 0.8% per year from 28.7% to 33.9% across the same period.

While it is difficult to determine an overall rate of mental disorders from this data, it does suggest that the prevalence of mental disorders is both rising and alarming. A conservative estimate based just on those who sought treatment for mental disorders in 2008 and 2009 would put the estimate at 19%. However, we know that most students who have mental health issues do not seek treatment so the actual number is likely much higher than this. For anxiety disorders alone the rate may reach as high as 49% based on
responses to the question about experiencing overwhelming anxiety. Of course this alone would not be sufficient to diagnose an anxiety disorder but does indicate a significant concern. Further, while 18.5% reported impacts of anxiety on academics, 19.5% reported problems due to sleep, and 27.2% reported problems due to stress, both of which are characteristic of anxiety disorders (and depressive disorders as well). With respect to depression, 11.4% reported experiencing depression within the last 12 months, while 30.4% reported feeling so depressed it was difficult to function.

While the number of students who reported experiencing depression within the past school year increased only slightly, students reporting a life-time diagnosis of depression increased 0.8% a year from 10.3% to 14.9% across the period. However, students reporting a diagnosis of depression within the past school year dropped 0.9% per year which may suggest that while overall rates of depression may not be increasing substantially, children are being diagnosed and treated at a younger age.

Although the ACHA-NCHA surveys provide one of the best sources of data on the mental health status and trends of American college students there are several limitations as discussed by the authors (NCHA, 2009). Although participants were required to be randomly generated, the participating institutions were self-selected and non-member institutions were charged a fee for inclusion (98 of the 106 participating institutions in the spring 2008 reference group were members of ACHA). Thus the results cannot be generalized to all U.S. college students. This could also introduce a bias into the survey results such as campuses choosing to participate based on known or perceived problems with student health or risk behaviors. Institutions also had the option of administering the web-based survey or a paper survey and selecting participants either
by randomly generating individual students or specific classrooms. Thus colleges did not use a common method of selecting or administering the surveys which may have biased participation and responses (although comparisons of administration methods did not indicate any significant differences). The survey was also subject to response bias by individual participants who may have intentionally or unintentionally distorted their responses.

In addition to these limitations pointed out by the researchers, the survey is also limited in its ability to diagnose mental disorders and interpretations of the data should be made with caution. For example, feeling overwhelming anxiety is not a sufficient criterion for diagnosis of an anxiety disorder. According to DSM-IV-TR, such a diagnosis must also consider the duration, nature of, and functional impairment caused by the anxiety (APA, 2000). The same is true of the item “felt so depressed it was difficult to function.” While this item does get at functional impairment, it does not ascertain specific diagnosis criteria for a diagnosis of a depressive disorder. Lastly, increases in the number of students who reported being diagnosed or treated for a mental disorder may reflect increased help seeking, changes in stigma associated with mental health issues, changing diagnostic criteria, or increased awareness and diagnosis of mental disorders and not necessarily an overall increase in psychopathology within this group.

**National Survey of Counseling Center Directors.** Another significant source of information on the mental health of college students comes from the National Survey of Counseling Center Directors led by Robert P. Gallagher (2009) and sponsored by the American College Counseling Association (ACCA). The survey is conducted once per
year and in 2009, 302 counseling center directors provided responses to the survey. Items of interest from the 2009 survey include the following:

- 10.4% of enrolled students sought counseling in the past year. This rate is likely to underestimate the actual number since counseling centers are only one source of treatment and most students do not seek treatment for psychological issues.
- The number of clients being prescribed psychiatric medication has risen from 9% in 1994 to 17% in 2000 and to 25% in 2009.
- 93.4% of directors report that the recent trend toward a greater number of students with severe psychological problems continues to be true on their campuses.
- 91% agreed that there has been an increase in the number of students arriving on their campuses that are already on psychiatric medication.
- 28.5% have increased staff to address the increase of students with serious psychological problems.
- The number one administrative concern for counseling directors (75.5% endorsement) was due to an increase of students with severe psychological problems.
- 66.2% indicated an administrative burden due to the growing demand for services without an appropriate increase in resources.
- 31.1% responded that they experienced administrative concerns in developing strategies to keep the wait list down.
To effectively manage caseloads, 34% said they no longer hold regular appointments for clients, 19.5% said they assign new clients to counselors regardless of their caseload, and 13.6% said they are assigning more students to groups directly from intake.

The major themes from this survey are that counseling center directors are seeing an increased demand for services and an increasing number of clients experiencing severe psychiatric illnesses. The survey also provides evidence that many counseling center directors do not feel they have adequate staff to effectively serve the needs of their clientele and are resorting to various strategies of service rationing to manage large and more complex caseloads.

While this survey represents a broad picture of student mental health across American university counseling centers, it has a number of limitations. First, the survey is not random as counseling center directors must choose to participate. Thus it may be biased as for example by counseling centers that are more highly developed and associated with organizations such as the American College Counseling Association. Second, counseling center directors are likely to only have reliable information on the students who they see in their counseling center and so their responses only reflect clients who utilize counseling center services and not all students. Thus the increase in the number of students who have severe psychiatric diagnoses may reflect that more of those students are seeking counseling services and not that the overall number of students with severe psychiatric diagnoses is increasing. Third, there is an inherent bias in counseling center directors reporting on the number and severity of clients utilizing their services. While results are combined and reported, there is still an inherent motivation for the
numbers to reflect higher rates of students needing mental health services as well as issues of resource limitations to support increased budgets. However, the magnitude of agreement with respect to the upward trend in the number of students showing up already on psychotropic medications and having severe psychiatric disorders is hard to ignore.

**The Association for University and College Counseling Center Directors Annual Survey.** A similar survey of counseling center directors was reported by Barr et al. (2010) on behalf of The Association for University and College Counseling Center Directors (AUCCCD). The most recent survey was conducted between September 2008 and August 2009 using a secure web-based questionnaire. Seven hundred fifty two college and university counseling center directors were invited to participate, of which 385 (51%) completed the survey. Of the 385 directors who responded, 375 (97%) were from U.S. institutions and 4 (1%) were from Canadian institutions. Highlights from the survey include the following:

- The average percentage of students who seek services out of the student population is 10%.

- 73% of center directors reported an increase over the past year in the number of students seeking counseling services who are already on psychotropic medications.

- 94% of center directors reported an increase over the past year in the number of students with significant psychological problems.

- The most common presenting symptoms or diagnoses reported by directors for the previous year were depression (37%), anxiety (37%), relationship
issues (36%), suicidal thoughts or behaviors (15%), and substance abuse/dependence (11%).

- 21% of directors reported gaining professional clinical positions in the past year while 9% reported losing positions. This differs from the preceding two surveys when only 4% reported losing positions and 30% and 32% (2006-2007 and 2007-2008 respectively) reported gaining positions.

- 42% of centers reported a decrease in their operating budget.

- The average paid staff and intern to student ratio was 1,476:1.

- 48% reported having session limits of some kind.

These results are largely consistent with those presented by Gallagher (2009) and support the conclusion that many counseling centers are struggling to meet the mental health needs of the student body, are treating students with more serious psychiatric conditions, and continue to have to ration services for many students.

**National Epidemiologic Study on Alcohol and Related Conditions.** Blanco, et al. (2008) used data from the National Epidemiologic Study on Alcohol and Related Conditions (NESARC) to assess the 12-month prevalence of psychiatric disorders, sociodemographic correlates, and rates of treatment among individuals attending college and their non-college attending peers in the United States. The researchers pulled their sample from the 2001-2002 NESARC sample of 43,093 adjusted to match the 2000 Census on a variety of sociodemographic variables. The subsample was based on 19-25 year olds (a range that captures 87.1% of college students) providing a sample size of 2,188 who attended college in the past 12 months and a sample of 2,904 who did not attend college. Interviews were conducted using the National Institute on Alcohol Abuse
and Alcoholism (NIAAA) Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV (AUDADIS-IV).

The researchers found that the overall rate of psychiatric disorders did not differ between those attending college and those not attending college on most measures. The results of the study found that the most prevalent disorders for the college student sample were alcohol use disorders (20.37%), personality disorders (17.68%), mood disorders (10.62%), and anxiety disorders (11.94%). Overall, researchers found that almost one-half of college students met DSM-IV criteria for at least one psychiatric disorder in the previous year. With respect to treatment rates, the researchers found that 34.11% of those who met criteria for a mood disorder sought treatment, 15.93% who met criteria for an anxiety disorder sought treatment, and 5.36% who met criteria for a substance use disorder sought treatment. The overall rate of treatment for all disorders was found to be 18.45%.

This study represents one of the few studies that provided a representative sample of American college students and used structured interviews to assess mental disorders. However, there are several limitations and concerns about the data that should be considered. First is the rate of diagnosis of personality disorders in this age group which was reported to be 17.68% for the college-attending group and 21.55% for the non-college attending group. This number compares to a recent nationwide study on the prevalence of personality disorders that used structured interviews by clinical psychologists with a large representative sample (n>5000) and found the overall rate of personality disorders in an adult population to be 9% (Lenzenweger, 2008). Given that personality disorders must have their onset in adolescence or early adulthood and be
enduring patterns of behavior we would expect the rates in ages 19-25 to be similar to that of a general non-clinical population. It should be noted as well that the results of Blanco et al. do not include the diagnoses of Narcissistic or Borderline Personality Disorders. This discrepancy raises concern for the overall results. Although the study did use face-to-face interviews with professional interviewers (not clinicians, however) and a structured interview, there is no data to provide any accuracy or validity of the interview itself. The AUDADIS-IV was reviewed by Grant et al. (2008) and found to have good test-retest reliabilities (using Kappa coefficients) with respect to substance abuse disorders (0.63 to 0.74), major depression (0.59), and dysthymia (0.58) and fair reliability with respect to Panic (0.52), Social Phobia (0.44), Specific Phobia (0.40), and Generalized Anxiety Disorder (0.41). Test-retest reliabilities for personality disorders were fair to good for Avoidant (0.45), Obsessive-compulsive (0.52), paranoid (0.42), Histrionic (0.40), Dependent (0.66), Schizoid (0.53), and Antisocial (0.67). While the researcher’s efforts to establish test-retest reliability are commendable, they do not present any evidence with respect to validity, such as a comparison of results from the structured interview with those of a trained clinician or even other structured interviews. While the instrument may be repeatable and consistent (and for many disorders reliability is only marginal) no data is presented to demonstrate that it provides accurate diagnoses and the data on personality disorders highlights this concern.

**Healthy Minds Study.** Eisenberg et al. (2007) in their Healthy Minds Study conducted a web-based survey of undergraduate and graduate students at a large Midwestern public university in fall 2005 to determine rates of mental disorders among students. Using the Patient Health Questionnaire and adjusting for response bias,
researchers assessed for depression (over the past two weeks) and anxiety disorders (over the past four weeks). The questionnaire also included questions to measure the level of functional impairment (academic difficulties) due to mental health reasons over the past four weeks. The response rate for the survey was 56.6% (n = 2,843) with graduate students and women overrepresented and Black students slightly underrepresented. Researchers found that 13.8% of undergraduates and 11.3% of graduates screened positive for depression and 4.2% of undergraduates and 3.85% of graduate students screened positive for anxiety (Generalized Anxiety Disorder or Panic Disorder). The rates for students testing positive for either depression or anxiety were 15.6% and 13.0% for graduates and undergraduates, respectively. Interpretation of these results is complicated, however, since only 12.8% and 10.8% of those with either anxiety or depression reported functional impairments. These impairment rates call into question the rates of depression and anxiety disorders since functional impairment is a criteria for diagnosis, although they seem in line with estimates from other studies.

Eisenberg et al. (2007) also reported correlates of suicidal behavior in this study. Suicidal thoughts, intentions, and attempts within the past four weeks were measured with the inclusion of three questions from the National Comorbidity Survey Replication (NCS-R; Kessler et al., 2004). Of the sample, 2.1% reported suicidal ideation within the past four weeks, 0.7% reported having a plan, and 0.1% (one person) reported an attempt. Of students reporting suicidal ideation, 67% screened positive for depression (Major Depression, Dysthymia, or Depression NOS) and 35% screened positive for either Panic Disorder or Generalized Anxiety Disorder. Thus there was a strong relationship between symptoms of depression and anxiety and suicidal ideation.
In a two-year follow-up study, Zivin et al. (2009) re-surveyed 763 students who had participated in the original Healthy Minds study to determine the persistence of mental health problems in a student population. Specifically, they wanted to know to what extent student mental health needs are transient in that they are related to, for example, developmental changes or temporary stressors associated with college life, as opposed to being persistent over time. Persistence rates varied by disorder, but overall, 60% who screened positive for a mental health issue (depression, anxiety, eating disorder, self-injury, and suicidal ideation) in 2005 also screened positive two years later though not necessarily for the same disorder. The percentage of students who screened positive for the same disorder or symptom two years later was as follows: depression 27%, anxiety 30%, eating disorder 59%, self-injury 40%, and suicidal thoughts 35%. Additionally, 24% who screened negative in 2005 screened positive in 2007. Unfortunately the authors did not discuss how many of those whose mental health issues had resolved between 2005 and 2007 had received treatment. While this would not demonstrate that the treatment was effective or provide cause and effect evidence it would lend support to the benefit of help-seeking behavior. These results suggest that mental health issues in college students are persistent problems and are not of a transitory nature.

**Integration of data on prevalence rates.** While it is difficult to reconcile the results of these studies, they suggest that close to half of college students report some problem associated with a mental health issue and that the prevalence rate for having a disorder ranges from 10-15% to a high of 40-50%. Additionally, the rate of students with severe mental disorders appears to have increased over the past decade. Other authors
reviewing many of the same studies draw their own conclusions. Mowbray et al. (2006) put the number of college students who appear to meet diagnostic criteria for mental disorders between 12 and 18%. Hunt and Eisenberg (2010) agree that mental disorders among college students appear to be increasing in number and severity. They point out that one potential factor is that more youth are accessing effective treatments during adolescence and that widespread evidence indicates increased use of mental health services among child and adolescent populations. They also acknowledge the multiple challenges to interpreting the evidence with respect to the prevalence of mental disorders including the confounding of changing stigma associated with mental illness and seeking mental health care, changing DSM diagnostic criteria, and improved screening for mental illness. Regardless of the exact number, these studies collectively support the conclusion that mental disorders and behavioral and psychological issues continue to be a significant problem in the college population.

**Help-Seeking Behaviors among College Students**

Given the alarming prevalence of mental disorders among college students and the evidence that suggests that not only the rate but also the severity of disorders may be increasing, it is important to understand the help-seeking behaviors of college students.

**American Foundation for Suicide Prevention Suicide Screening Project.** The American Foundation for Suicide Prevention (AFSP) Suicide Screening Project (Garlow et al., 2008) was conducted over a 3-year period at Emory University in Atlanta. The survey was conducted once a year for three years and used a web-based questionnaire to assess for depression (PHQ-9), suicidal ideation and self-harm, distressing emotional states, alcohol and drug use, functional impairment, current treatment, and demographics.
The survey was completed by 729 students (71.7% of whom were female) and the response rate was 8% indicating the results must be interpreted with caution due to likely sampling bias. Researchers found that 11.1% of respondents reported current (past four weeks) suicidal ideation and 16.5% reported a past suicide attempt or episode of deliberate self-harm. Of students with current suicidal ideation, 13.6% were taking medications, 12.35% were in psychotherapy, and 9.9% were in both modalities of treatment. Overall, 84% of the students with suicidal ideation and 85% of students with moderately severe or severe depression (PHQ-9 score ≥ 15) were not in treatment (medication or therapy/counseling; Garlow et al., 2008).

**Eisenberg, Golberstein, and Gollust (2007) student help-seeking study.**
Eisenberg, et al. (2007) conducted a study to quantify and understand help-seeking behaviors in college students. They surveyed a sample of 2,785 undergraduate and graduate students at a large Midwestern university and adjusted their results to account for the non-response bias. The survey used the Patient Health Questionnaire to screen for depression and anxiety disorders. Researchers also included questions on academic performance, perceived need for mental health services, utilization of health and mental health services, reasons for not pursuing services, and demographic variables. The results show that overall 15% of the sample had received either medical treatment or therapy/counseling (one or more sessions). Breaking this down by positive screenings for depression and anxiety, 63% who screened positive for depression and anxiety sought treatment, 36% who screen positive for major depression but not anxiety received treatment, and 52% who screened positive for anxiety but not depression sought treatment. What is interesting in terms of utilization is the ratio of those who sought help
to those who perceived they needed help. Assuming no student went for help who didn’t perceive a need for help, this ratio (number of students who sought help divided by the number of students who screened positive and believed they needed help), which was not included in the results of the study, shows the percentage of students who have barriers to mental health services over and above not believing that they need help. The highest rates of students who believed they needed treatment and actually sought treatment were for students with an anxiety disorder (71% for depression and anxiety and 83% for students with anxiety and no depression) suggesting that anxiety disorders are distressing and motivate students to seek help. The lowest ratios were for Major Depression and other depression which were 50% and 31% respectively. Thus, depressive illnesses among college students are associated with low help-seeking behavior even when there is a perceived need for help and may indicate that these disorders are associated with unique barriers to treatment.

A study by Wilson, Rickwood, and Deane (2007) investigated the potential effect of depression on help-seeking behaviors and provides some additional support to the idea that depressive disorders are associated with unique barriers to help seeking. They surveyed three groups of children and adolescents (7-10 years old, 8-12 years old, and first year college students with median age of 19 years old). In the group of college students, researchers found that higher levels of depression were associated with lower help-seeking behaviors. They theorized that this effect could be due to the social withdrawal symptom of depression, to negative beliefs about the benefit of help stemming from increased hopelessness, or decreased motivation. They also speculated based on the work of Wisdom, Clarke, and Green (2006) that at a time when adolescents
are struggling to define their identity, they might be adverse to the threat of defining their identity based on an inclusion of mental illness. This idea would be consistent with the concept of internalized oppression that is experienced by many people with disabilities, however it would not explain the higher rates of help seeking found in those with anxiety disorders reported by Eisenberg et al. (2007).

Wilson et al. (2007) recommended promotion, prevention and early intervention programs that incorporate education about help-seeking avoidance caused by depression to potentially inoculate students from the effects of depression on help-seeking behavior. They also concur with Wisdom et al. (2006) that to the extent that providers can help students feel normal, support their autonomy and role in decision making about their treatment, and meet their disclosures with empathy and compassion, they will go a long way towards a successful treatment and positive experience with a mental health professional.

Eisenberg et al. (2007) found that students who perceived a need for mental health services but did not pursue them, provided the following reasons: “stress is normal in college/graduate school” (51%), “Have not had any need” (45%), “The problem will get better by itself” (37%), “I don’t have time” (32%), “I don’t think anyone can understand my problems” (20%), “I question the quality of my options” (16%), “I am concerned about privacy” (16%), and “I worry that my actions will be on my academic record” (10%). These responses could suggest that stigma of mental health services is not a significant barrier to utilizing mental health services and that the real reasons can be characterized as misconceptions about mental disorders and beliefs (whether informed or misinformed) about the efficacy and consequences of treatment options, both of which
are addressable. However, the available responses to the question do not allow for the direct measurement of stigma so it cannot be ruled out as a factor. At the same time, the answers may give us indications of how to reduce stigma by addressing the reasons that have stigma associated with them. For example, perhaps providing additional information about the nature of mental disorders (prevalence and impact) would help students overcome their resistances to seeking services by providing additional motivation to resolve their issues. Although the study was well conducted, its limitation to a single university precludes the results from being generalized to other universities.

**Health Minds Study follow-up examining use of mental health services.**

Zivin, et al. (2009) in their 2007 follow-up to the Healthy Minds Study, re-surveyed 763 of the original study participants to determine their use of mental health services over time and the extent that perceived need for services influenced the longitudinal course of their disorders. Results showed that there was a high degree of persistence in lack of perceived need for help and in lack of services use, even among those students who screened positive at both points in time. Of those students who screened positive for a mental health issue at both points in time, 50% did not perceive a need at either point, and 74% had not obtained treatment at either point. Thus, even of the 50% that did perceive a need for treatment only about half (26%) reported receiving treatment.

Researchers in this study also looked at predictors of mental health issues from initial to follow-up using multivariable logistic regression models. They compared the incidence of depression, anxiety, eating disorders, self-injury, suicidal thoughts, therapy, medication use, and perceived need in 2005 (independent variables) to the rates of depression, anxiety, eating disorders, self-injury, and suicidal thoughts (dependent
The prediction values for having any disorder in 2007 (higher number indicates a stronger predictor of future mental illness) were eating disorders (4.48), suicidal thoughts (4.11), depression (1.81), medication use (1.79), anxiety (1.17), and therapy (0.71). Interestingly, medication use is a better predictor of mental disorder two years later than depression is and therapy had the overall lowest prediction value. Thus, this data suggests that if you have a mental disorder, the best way to reduce your odds of having a future mental disorder is to engage in therapy and that medication may not have as good of long-term efficacy. This data also supports the fact that mental disorders in college students are persistent and that having a disorder at one point in time greatly increases the probability of having a mental disorder two years later. This study is unique in its longitudinal design which provides additional evidence for causality though falls short of a true experiment that allows for control of confounding variables.

To better understand the role of stigma in help-seeking behaviors among college students, Eisenberg, Downs, Golberstein, and Zivin (2009) conducted an online survey of college students in fall of 2007. Thirteen schools participated (there was a fee) and participants were chosen at random from each of the schools netting over 5,000 responses (44% response rate). Researchers measured the level of perceived mental health stigma (the stigma participants believed “most people” would have towards people with mental disorders), personal stigma (or participant’s own beliefs about people with mental disorders), actual health seeking behaviors (medication or therapy/counseling for mental or emotional health), and screened participants for depressive and anxiety disorders with the PHQ. Results indicated that the demographics of the sample closely matched those of institutions granting master’s and doctoral degrees. Perceived stigma was found to be
significantly higher than personal stigma. In fact, it was very rare in the survey for respondents to have a higher level of personal stigma than perceived stigma. Personal stigma was also found to vary more by personal characteristic correlating the strongest with age (negative correlation), being an international student, having higher levels of religiosity, and being heterosexual. The most important finding of the study was that personal stigma, and not perceived stigma, was significantly associated with a lower likelihood of seeking help. While this relationship does not demonstrate a causal relationship it should motivate studies that look at lowering personal stigma to measure their effect on help-seeking behaviors. The authors point out, however, that there is still likely a relationship between perceived and personal stigma in that our personal values typically derive from our perception of normative values and that there is still likely to be value from social norms campaigns. The authors also recommend efforts to reduce personal stigma such as education and social contact although little is known about how these efforts would affect help-seeking behavior.

Rosenthal and Wilson (2008) conducted a study of 1,773 second-semester college students in two commuter colleges in Queens, New York City. In a self-administered questionnaire conducted in classrooms over the seven-year period from 1999 to 2005, researchers measured demographics (ethnicity, sex, and SES), use of “counseling services for emotional problems,” and psychological distress (using the Dysphoria Domain of the Trauma Symptom Inventory, α = .95). Only 10% of participants reported that they had received counseling over the prior six-month period and there was a small relationship between the level of distress and the use of counseling (r = .16). Of the students who reported experiencing significant levels of psychological distress, three
fourths indicated they had not received counseling in the past six months and the overall use of counseling was not impacted by the sex, ethnicity, or SES of the respondent. This study is limited by its inclusion of only one inner-city university, its use of a questionnaire for screening of distress, and its ambiguous definition and partial inclusion of mental health services. However, it provides an important piece of information countering the common perception that there is a disparity in mental health service utilization based on ethnicity, sex, and SES that have been shown to exist in adult populations (Kessler, Costello, Merikangas, & Ustun, 2001; U.S. Department of Health and Human Services, 2001).

Yorgason, Linville, and Zitzman (2008) surveyed 750 students at an eastern US land grant university to measure knowledge and attitudes about campus mental health services. Of those surveyed, 266 responded (35% response rate). The survey assessed mental health via the Outcome Questionnaire (OQ-45; internal consistency of .90 and concurrent validity of .80), knowledge and use of university mental health resources, and demographics. The results show that only 32% of respondents reported being adequately informed about university mental health services. Factors associated with higher levels of knowledge about mental health services included level of distress, on-campus living status, and years in college. Being female was only slightly (but significantly) related to knowledge about mental health services; ethnicity and international student status were not. The top reasons for not using mental health resources by students who indicated that they could have benefited from using services (in order of endorsement) were: “not enough time,” “lack of knowledge,” “embarrassed,” “did not think services would help,” “lack motivation,” “independent approach to solving problems,” “frightened or nervous,”
and “worried about anonymity.” The top concerns provided about using mental health services in the future (in order of endorsement) were: “not enough time,” “lack of knowledge,” “None; I would use the services,” “believe they would be unhelpful,” “financial costs,” and “do not want to talk to a stranger.” The fact that the top answer for both questions was “not enough time” suggests that students are not distressed enough to have functional impairments, do not have good insight into their functional impairments, do not have good insight into or valuation of the consequences of their impairments, or do not perceive their time would be well spent in seeking mental health services.

Education about the negative effects of mental issues, both immediate and longer term, might be of benefit in helping students properly assess the value of mental health and thus find the time to pursue positive mental health.

The second highest response, “lack of knowledge,” suggests that students still lacked sufficient knowledge of campus mental health resources and that additional outreach and information campaigns may be useful. This study was limited in the fact that it was restricted to a single university, had a fairly low response rate which could reflect a response bias, used a sample that did not match national demographics, and does not demonstrate causality.

Some of the studies discussed previously also reported data on utilization rates. Gollust et al. (2008) in their Healthy Minds Study found that only 26% of those who reported self-injury over the previous four weeks received mental health therapy or medication in the previous year and Hunt and Eisenberg (2010) reported that fewer than half of students who screened positive for major depression or anxiety disorders received any mental health services in the previous year. Blanco et al. (2008) found that 34.11%
of those who met criteria for a mood disorder sought treatment, 15.93% who met criteria for an anxiety disorder sought treatment, 5.36% who met criteria for a substance use disorder sought treatment, and 18.45% who met the criteria for any disorder sought treatment.

Considering this data in aggregate we see a difference between treatment rates based on a number of factors including the method used for diagnosing mental disorders, the criteria used, the disorders included, the sample used, how treatment was defined in the study, and various other factors. Rates of help-seeking in these studies by those with mental health issues ranged from 15% to 50% with several studies (Gollust et al., 2008; Rosenthal & Wilson, 2008; Zivin et al., 2007) finding about 75% of students with a mental disorder do not seek treatment. Thus, 25% seems to be a good and consistent estimate for the number of students experiencing mental health issues that seek medical or psychological treatment.

**Impact of Mental Health Issues on Measures of Student Success**

Several studies have been conducted to look at the effect of childhood and adolescent mental disorders on academic achievement, divorce rates, adult income, and life satisfaction. While the results are not always clear, there is a significant amount of research suggesting that mental disorders have significant and serious consequences on various measures of health and success.

**Academic achievement.** Breslau et al. (2008) conducted a study using data from the National Comorbidity Survey Replication (NCS-R) which conducted interviews with 9,282 participants ages 18 and older from 2001 through 2003 to determine the impact of mental disorders on academic achievement. Interviews were conducted by trained
professional interviewers using the Composite International Diagnostic Interview (CIDI; Kessler et al., 2004) and questions developed to determine educational attainment, childhood adversities, and selected demographics (sex, race/ethnicity, and age). The researchers found that impulse control, substance use disorders, panic disorder, and bipolar disorder were associated with early termination from college. Anxiety and depressive disorders (except for panic and bipolar) were not found to be associated with higher rates of early termination from college.

However, this study has two major limitations. First, in an effort to eliminate confounding variables, researchers controlled for childhood adversities including childhood traumatic events, childhood neglect, parental mental illness, family disruption, and low parental educational attainment. While some of these variables, such as low parental educational attainment, make sense in that they would appear to be logically related to lower academic completion, others may have served to minimize the impact of mental disorders on completion of school. For example, early childhood trauma may impact educational attainment directly through mental health issues such as depression and anxiety such that the mental disorder becomes a mediating variable. By controlling for the variable of trauma it is likely that the researchers eliminated or reduced the effect of these mental disorders. A second major flaw of this study was that childhood mental disorders were indicated based on participant reports. Given the high rates of undiagnosed mental disorders this hardly seems like a reliable method for ascertaining childhood mental issues and would likely underestimate the number of participants with mental disorders in the sample. These limitations are significant and cause serious concern with the study conclusions.
Another source of data for studying the relationship between mental health and academic performance comes from the Center for the Study of Collegiate Mental Health Pilot Study (CSCMH, 2009). The CSCMH collaborated with college and university counseling centers across the country to collect data on counseling center clients. Using standardized Titanium software and aggregating data from 66 institutions, 28,000 responses were collected in fall 2008. Part of the standardized data set includes the Counseling Center Assessment of Psychological Symptoms (CCAPS), a 70-item psychometric measure of mental health that is completed by center clients upon intake and at periodic intervals during treatment. The instrument has seven subscales: Depression, Generalized Anxiety, Social Anxiety, Eating Concerns, Substance Use, Family of Origin Issues, Academic Distress, Hostility (frustration and anger), and Spirituality. Results of the pilot study support the relationship between mental health issues and lower academic success. Scores on the Academic Distress subscale of the CCAPS were related to all indices of mental health on the CCAPS but were most strongly related to the subscales of Depression and Generalized Anxiety. Further, higher levels of Academic Distress were shown to be related to lower self-reported GPA score, and higher reports of suicidality were related to lower reported GPA and greater Academic Distress. This study provides strong support that mental health issues, especially depression and anxiety are related to poor academic achievement.

Kessler et al. (1995) using data from the National Comorbidity Study (NCS) found that students who had a prior mental diagnosis had about a ten percent lower probability of college graduation with all measured types of disorders significant predictors of failure in college (odds ratios: anxiety = 1.4, mood = 2.9, substance use =
One of the biggest limitations of this study that the authors do not mention is the fact that those who reported being diagnosed with a mental disorder as a child were likely to have received treatment which may have lowered the rate of early termination prior to graduation and lessened the measured correlation between mental illness and early termination. This study also did not measure the impact to academic achievement of students who had mental disorders but were never diagnosed or treated, a group that is likely larger than the one that received treatment. Thus, the results of this study are likely to significantly underestimate the impact of mental disorders on academic achievement.

Other studies, however, do not support this connection. Brockelman (2009) argues that mental illnesses do not predict academic achievement and that self-determination is a better predictor of academic success. To test this theory (self-determination theory), Brockelman measured the self-determination (perceived autonomy, competence, and relatedness), GPA, and mental health status of 375 undergraduate students at a large Midwestern university. Curiously, the researcher found that mental illness status negatively correlated with self-determination and self-determination correlated with GPA but that mental illness did not correlate with GPA (A correlates with B, and B correlates with C, but A does not correlate with C). This result seems problematic as one would expect that a person’s sense of autonomy, competence, and relatedness would be significantly related to their mental health and would affect their academic success. In addition to this problematic result, limitations include the fact that the sample was limited to one university limiting the ability to generalize from the results and the use of self-reports for the presence of mental illness. Given the low rates
of help-seeking behavior among college students with mental illnesses, the use of self-reports to determine mental illness likely biased the results by not properly categorizing most of the students with mental disorders.

**Teenage parenthood.** Another impact of mental disorders in adolescents and teens is the issue of teenage parenthood. Teenage parents are at higher risk of low educational attainment, poor employment outcomes, and marital instability (Maynard, 1996; McLanahan & Garfinkel, 1993; Bumpass & McLanahan, 1989) while their children are at increased risk of low birth weight, increased mortality in the first year, delays in cognitive development, school problems, behavior disorders, and becoming teenage parents themselves (Bolton, 1980; Mecklenburg & Thompson, 1983). To better understand the impact of mental illnesses on teenage pregnancy, Kessler et al. (1997) conducted a study based on the National Comorbidity Survey (NCS) that was conducted between 1990 and 1992. For this study, individuals between the ages of 15 and 54 who screened positive in the first part of the survey for any lifetime diagnosis of mental disorder were asked questions about children, pregnancies, and sexual activity as children. Researchers found that all four classes of disorders included in the initial screening (anxiety, affective, addictive, and conduct) were positively related to subsequent female teenage childbearing and male parenthood, and that the number of comorbid disorders positively correlated with the increased likelihood of teenage parenthood. Although the study has a number of limitations (principally that the study relied upon self-reports of childhood disorders and the correlational design that does not demonstrate cause and effect) it provides some rationale to conduct a proscriptive study that could provide more convincing evidence of the relationship between mental
disorders of childhood and teenage pregnancies. Unfortunately, no studies of this kind were identified 14 years after publication.

**Marriage stability.** Kessler et al. (1998) also used the NCS data to study the impact of childhood and adolescent mental disorders on the probability of marriage stability. They found that all four classes of disorders were significantly related to an increase in divorce rate (odds ratios: mood = 1.7, anxiety = 1.6, substance use = 1.3, and conduct = 1.2). There was also a significant relationship between the number of comorbid disorders and divorce rate (odds ratios: one disorder = 1.3, two disorders = 1.5, and three or more disorders = 1.9). The limitations for this study are the same as those for other studies using the NCS data.

**Life satisfaction.** Meyer et al. (2004) conducted a study to determine if there is a relationship between mental disorders and life satisfaction. They randomly selected participants from a northern area of Germany and conducted surveys of 4,093 participants (70.2% response rate). Assessment measures included the fully structured standardized and computer-assisted Munich Composite International Diagnostic Interview (M-CIDI; Wittchen et al., 1995) to determine the presence of mental disorders in the past 12 months. Additionally, life satisfaction was measured with the five-item Satisfaction with Life Scale (reported Cronbach’s alpha ranging from 0.79 to 0.89). Significant differences of life satisfaction were found for all analyzed disorders except for hypomania and bipolar disorders with the lowest life satisfaction ratings associated with dysthymia, posttraumatic stress disorder, obsessive-compulsive disorder, social phobia and alcohol dependence, in that order. Effect sizes (using Cohen’s d) were large for all of these disorders. There are several limitations to this study including the correlational
design that precludes drawing causative conclusions, using interviewers who were not mental health professionals for diagnosing mental disorders, and using a sample that did not include institutionalized psychiatric patients and was culturally and geographically homogeneous. However, given these limitations and the study provides important evidence of the connection between mental illness and life satisfaction.

**Role disability.** Merikangas et al. (2007) conducted an analysis of data gathered through the National Comorbidity Study Replication (NCS-R) in order to estimate the effects of common mental and physical conditions on role disability in the U.S. population. Role disability was used instead of missed work to account for non-employment activities such as being a housewife or a student. Twelve-month occurrence of mental disorders was measured using the World Health Organization Composite International Diagnostic Interview (CIDI) and role disability was measured by asking participants to report the number of days of the past 30 days when they were totally unable to work or carry out other usual activities because of problems with physical health, emotions or nerves, or use of alcohol or drugs. Sociodemographic controls were used for age, sex, race/ethnicity, family income, marital status, employment status, and number and ages of children. Major Depressive Disorder was second to musculoskeletal conditions (primarily back and neck pain) as having the largest estimated effect on disability at both the individual level (takes into account impact of the condition on role performance) and population level (takes into account prevalence and comorbidity in the population). Mental disorders overall had individual-level effects as large as those of most chronic physical conditions and the number of disability days associated with all mental conditions at the population level was equal to more than half the number of days.
associated with all the physical conditions considered in the study. The authors note that the substantial impact of mental disorders can be attributed to their high prevalence, substantial comorbidity with physical conditions, comparatively early age of onset, and broad influence on functional impairment. This study shares the same limitations as the other studies using the NCS-R data.

**Suicidal behavior.** Perhaps the most serious consequence of untreated mental disorders in the college population is suicidal behavior. Suicide among college students is the second leading cause of death next to accidental injury (Suicide Prevention Resource Center, 2004) with estimated rates between 6.5 and 7.5 per 100,000 students (Drum et al., 2009; Schwartz, 2006; Silverman et al., 1997). As noted previously, Eisenberg, et al. (2007b) found that, 67% of students who reported suicidal ideation screened positive for depression (Major Depression, Dysthymia, or Depression NOS) and 35% screened positive for either Panic Disorder or Generalized Anxiety Disorder supporting the relationship between symptoms of depression and anxiety and suicidal ideation.

**Persistence of mental disorders.** Another question concerns the longer term impact of untreated mental disorders in terms of the persistence of the disorder and development of other mental disorders, especially for those disorders associated with lower rates of help-seeking. A study by Angst (1996) looked at the comorbidity of mood disorders over a ten-year period. The researcher conducted a longitudinal prospective study with a subset of a randomly selected Zurich cohort of 4,547 19-20 year old men and women. A subset of 591 participants was selected from this cohort, two-thirds of which scored above the 85th percentile on the SCL-90 and the other third randomly
selected form the remaining participants of the original cohort. The participants were then interviewed by psychiatric residents and clinical psychologists and administered the Structured Psychopathological Interview and Rating of the Social Consequences for Epidemiology (SPIKE; Angst et al., 1984) which was used to assess a number of somatic syndromes as well as mood disorders, anxiety disorders and substance misuse.

Interviews were conducted at four times across the study—in 1979 (n=591), 1981 (n=456), 1986 (n=457), and 1988 (n=424). A total of 356 (60%) participants were interviewed all four times and 89% were interviewed at least twice. Of participants who met criteria for Major Depressive Disorder (DSM-III; n=41), 80% still met criteria for a mood disorder 9 years later and only 20% no longer met criteria for a mental disorder. What’s more, of the 80% who still met criteria for a mood disorder, 15% met criteria for a substance use disorder and 7% met criteria for either Generalized Anxiety Disorder or Panic Disorder.

There are some issues with this study as the researchers did not define lower severity depressive disorders including minor depression (Angst, 1996) and brief recurrent depression (Angst et al., 1990) that are included in the mood disorder category. The ability to draw conclusions from this study is also limited by the fact that study did not measure the number of participants being treated or how they were being treated. Lastly, the study is limited by the sample for which no demographics are defined. Barring these limitations, the study does provide support for the persistence of many mental disorders.

**Summary of impacts of mental disorders in college students.** Taken together, these studies provide a broad base of evidence demonstrating the effects that mental
disorders have on various measures of success for college students both while they are in college and after they leave college. These students are less likely to finish school, have lower GPA’s, have higher rates of teenage parenthood, experience greater role disability, have more suicidal behavior, continue to suffer from their mental disorder for many years, and are likely to find less satisfaction with life in the future than those students who do not have mental health issues.

**Summary of Mental Health Issues in College Students**

The studies reviewed provide substantial evidence that mental health issues among college students are a serious concern. Prevalence rates for mental disorders are substantial (15% to 40%) and there is some evidence to suggest these rates are not only increasing but that more students are attending college who have serious mental health issues. These trends are placing a greater burden upon university counseling centers and administrative staff who are being forced to ration services to students at a time when additional services are called for. While signs indicate that rates of early diagnosis are rising, about three-fourths of students with diagnosable mental disorders still do not seek treatment for various reasons. Finally, evidence indicates that the impact to students with mental health issues who do not receive treatment include academic, occupational, social, emotional, and health consequences. At the same time, with 65% of high school completers now attending college, colleges and universities represent a golden opportunity to make a significant impact on overall mental health issues in this country, a problem that is a huge public burden. However, data reviewed suggests that university counseling centers are already dealing with capacity issues and may not have additional ability to treat more students and certainly not a 300% increase. Creative solutions are
needed to address this significant problem. Colleges and universities must be called upon to not only prepare students academically, intellectually and socially for their careers but to also prepare them emotionally and psychologically for the challenges they will face in their lives both during and after graduation.

**Interventions**

While evidence suggests that counseling can be beneficial for the treatment of mental health issues (Kitzrow, 2003; Wilson, Mason, & Ewing, 1994), many counseling centers cannot keep up with the demand for counseling services (Barr et al., 2010; Gallagher, 2009) and many students have barriers to using traditional mental health resources. Creative solutions are required to meet the increased need for mental health services and to reach students who would otherwise not pursue treatment.

It makes sense to target the most common disorders faced by college students and to teach skills that are useful for the treatment or prevention of multiple disorders. Teaching skills that are effective in the treatment of multiple disorders would certainly be preferred since this approach does not require intensive psychotherapy and the investment of significant therapist time as do process, relationship, and insight oriented therapies. This review will focus on treatment strategies that have been shown to be effective for the treatment of disorders, lend themselves to a psychoeducational approach, and require minimal therapist involvement. These approaches, to remain resource effective, must not require intensive therapist-client interaction such as those that rely on the therapeutic relationship, insight or interpretation. These approaches are likely to be more focused on building skills that have been shown to be effective in treating and preventing mental disorders. This approach may also have the benefit of avoiding the
stigma of traditional therapeutic approaches and be more appropriate for students who are not comfortable with traditional therapy and prefer a more self-guided or educational approach to dealing with their psychological issues. Of course such an approach will not be applicable to all students and many students will still need the more intensive and personal experience of the therapeutic relationship and professional guidance to overcome their psychological issues. This is especially the case with high risk clients but also with more severe forms of disorders and personality disorders. Given the rise in more severe forms of psychopathology (Barr et al., 2010; Gallagher, 2009) this strategy could help alleviate the backlog of clients and need to ration services by treating the less severe cases with psychoeducational or self-guided approaches, freeing up professional staff to focus on students with more severe issues.

CBT workshop. Preexisting and researched workshops are an appropriate place to start in investigating methods of treating less severe though common forms of mental disorders. Workshops can be efficiently taught, can be customized for any target group, and may be packaged in such a way as to draw non-traditional clients who do not want to be in therapy but may be attracted to learning skills they can employ on their own.

Brown et al. (2008) investigated the benefits of a one-day CBT-based psychoeducational workshop. Their study was a two-year follow-up of the original study conducted by Brown, Elliot, Boardman, Ferns, and Morrison (2004). The original study recruited members from the general public in London in a non-clinical setting. The workshops were run by two clinical psychologists and two assistant psychologists and ran from 9:30 am to 4:30 pm. To overcome the stigma of mental health treatment, the workshop was based on Fennel’s (1999) “Overcoming Self-Esteem” teaching CBT
techniques of identifying and challenging beliefs. The workshop also taught behavioral methods including problem solving, assertiveness, increasing social support, and activity scheduling. Initial and follow-up measures included the Beck Depression Inventory (BDI), the Spielberger State-Trait Anxiety Inventory-Train Anxiety (STAI-T), the General Health Questionnaire (GHQ-12), and the Rosenberg Self-esteem Scale (RSES). The original group was comprised of 102 participants, 60 in the treatment group and 42 in the wait-list control group who attended the workshop three months later. At the two-year follow-up, 56 participants completed assessments (54.9%) and depressed participants (initial BDI ≥ 14) obtained significant improvements on all measures with an effect size of 1.11 on the BDI. In contrast, the non-depressed group (BDI < 14) did not obtain significant improvements.

Several aspects of this study limit the significance of the results. First, the study did not maintain a control group across the two-year follow-up period and so time cannot be ruled out as an element of change though the researchers found that 64% of participants reported that they were still using the skills at follow-up. Second, 83% of the participants were female indicating a selection bias with unclear impacts on the ability to generalize from the results. Third, data suggested that many of those who dropped out of the study did not have significant improvements in their depressive symptoms at the three-month post-workshop follow-up indicating that the results may overestimate the effectiveness of the workshop. The researchers note in their discussion of limitations that 35.7% of those reporting results at the two-year follow-up sought further mental health treatments. Though not framed in this light this may actually be a positive outcome in that perhaps the workshop motivated some of the participants to seek mental
health services when they might not have without the workshop. Overall this workshop demonstrates a potentially effective method of marketing and presenting a mental health treatment strategy in a manner that may circumvent some stigma reactions. However, the fact that 83% of the participants were women indicates that stigma may still have been a significant problem with men.

**Cognitive bibliotherapy.** Another viable approach is that of bibliotherapy. Bibliotherapy is often used as an adjunct to treatment, especially by cognitive-behavioral therapists. If students can be motivated to engage in bibliotherapy and it can be shown to be effective, this would be an ideal strategy in that it would require very little time of the professional staff and would be available for anyone with the appropriate reading level and motivation.

Several studies have looked at the benefit of cognitive bibliotherapy on symptoms of depression. Ackerson et al. (1998) recruited 30 participants in grades seventh through 12th who scored a ten or higher on the Child Depression Inventory (CDI; Kovacs, 1981) and ten or higher on the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960). Participants were randomly assigned to a treatment or a delayed treatment (one month) group. Treatment consisted of reading *Feeling Good* (Burns, 1980) within a four-week period (of which 22 participants completed) and measures included a test of comprehension on the book, the CDI, HSRD, Automatic Thoughts Questionnaire (ATQ; Hollon & Kendall, 1980), and the Dysfunctional Attitude Scale (DAS; Weissman, 1979). Data was collected for the immediate treatment group at pretreatment, immediately following treatment, and one month post-treatment. Data was collected on the delayed treatment group before the waiting period, one month after the waiting period and before
the beginning of treatment, and immediately following treatment. At the one-month follow-up (at which times both groups had received the treatment) significant decreases were seen on both the CDI and HRSD and these improvements were correlated with measures of treatment completion (pages read and exercises completed) and comprehension. Mean depression scores were reduced more than 50% and 16 of 22 participants (73%) met criteria for clinically significant change (scored in the non-clinical range on the HSRD or CDI, i.e., < 10). Although limited by a small sample size, this study provides evidence that cognitive bibliotherapy using *Feeling Good* can be an effective intervention for adolescents suffering from depressive symptoms provided they have obtained sufficient reading abilities (sixth grade).

Jamison and Scogin (1995) conducted a study of 171 subjects who scored ten or higher on the HRSD or the BDI and met DSM-III-R for mild or moderate depression (using responses on HSRD matched against DSM-III-R criteria). Subjects were randomly assigned to a treatment or delayed-treatment group and treatment consisted of self-administration of the book *Feeling Good* (Burns, 1980). Several measures (HRSD, the BDI, the ATQ, the DAS, and the SCL-90) were completed pre-treatment, post-treatment, and three months post-treatment (initial treatment group only). The amount of book completion and book comprehension were assessed post-treatment. Results indicated that 70% of participants no longer met criteria for depression immediately after treatment and increased to 75% at the three-month follow-up. Lastly, researchers found that reductions in automatic thoughts and dysfunctional attitudes were correlated with reductions in depressive symptoms providing some evidence (though not cause and
effect) that there is a relationship between the decrease in distorted thinking and reduction of depressive symptoms.

Gregory, Canning, Lee, and Wise (2004) conducted a meta-analysis on bibliotherapy for depression and found a total of 29 studies that met their criteria for quality of intervention and study design. Researchers found an overall effect size of 0.99 which is considered a large effect size. When limited to only the 17 studies that included a control group the effective size dropped to 0.77 which still compares favorably with the effect size for individual therapy which was estimated by Gloaguen, Cottrauz, Cucherat, and Blackburn (1998) to be 0.83. Researchers also compared the group-administered format to the self-administered format and found the differences to be non-significant. The authors provide several supporting reasons for using cognitive bibliotherapy: it is highly accessible, avoids stigmatization, can be used by underserved groups, and is potentially empowering for recipients. They further suggest that it is an effective treatment for mild and moderate depression, but may not be appropriate in cases of complicated comorbidity, when reading level is not adequate, or when cultural values or expectations preclude a belief in the appropriateness of bibliotherapy. Lastly, the authors provide several recommendations for the use of bibliotherapy including proper diagnosis and screening by a qualified professional, appropriately negotiating and orienting a person to bibliotherapy, selecting material that is well researched and proven effective, and monitoring of progress by the referring professional.

Not all studies of bibliotherapy have demonstrated positive results. Haeffel (2010) conducted a study of 72 at-risk college freshmen who provided one of three interventions-- traditional cognitive workbook, non-traditional cognitive workbook (did
not teach participants to identify and dispute cognitive distortions), and academic skills (time management, goal-setting, memory aids, etc.). Students were considered “at-risk” based on their scores on the Cognitive Style Questionnaire (the cutoff range was not defined in the study). The researcher found the greatest improvement in symptoms from the group that was taught academic skills and the non-traditional cognitive approach and the least improvement from the group provided the traditional cognitive workbook. The researcher concluded that self-taught cognitive skills such as modifying distorted thoughts may be ineffective and potentially harmful for college students. However, the biggest limitation of this study is that it does not define or describe the workbook that was used. Clearly studies which have used Feeling Good have reported very positive results so the quality of the workbook remains a significant question and potential limitation of this study. At the same time, this study points to the problematic consequences of attempting to teach cognitive skills in a less than robust or effective manner.

**Coping with Depression course.** Several studies have been conducted on Lewinsohn, Antonuccio, Breckenridge, and Teri’s (1984) “Coping with Depression” (CWD) course which is a 12-week course based on a social learning theory of depression. This course has a fairly robust amount of research support, is based on proven cognitive-behavioral treatments of depression, has been shown effective across a range of populations, can be delivered in a cost-effective manner, and has the potential of reaching students who may otherwise not seek help for their depression. A sampling of studies are reviewed here including one meta-analysis that combines the effects of the studies available at the time. According to Brown and Lewinsohn (1984a) the CWD course has
12 units, two focused on presenting the rationale of the treatment and self-change methods, eight focused on teaching specific skills (two units per for each social skills, distorted thinking, pleasant activities, and relaxation), and two units for integration and maintenance. The course employs the text, *Control Your Depression* (Lewinsohn, Munoz, Youngren, & Zeiss, 1978) and a participant workbook (Brown & Lewinsohn, 1984b).

The first of these studies was conducted by Brown and Lewinsohn (1984a) to determine the efficacy of the course on a sample of clinically depressed adults. They recruited a sample of 80 participants (75 of which completed all study activities) with 70% female, 83% having attended some college, and 44% meeting criteria for Major Depressive Disorder (the other 56% met criteria for a less severe form of depression). Participants were divided into four groups--15 were assigned to individual tutoring (50-minute individual sessions reviewing assignments and readings), 15 to the phone contact group (15-minute weekly phone calls to review material and encourage participants), 32 to the class (12 2-hour class sessions with seven to nine people per class); and 15 to the wait-list condition. Assessment instruments included the Schedule for Affective Disorders and Schizophrenia (SADS) conducted by specially trained graduate and advanced undergraduate level students and the BDI. Data was collected at four points in time: pre-treatment, post-treatment, 1 month post-treatment, and 6-months post-treatment. Researchers concluded that the effect of the treatment was significant and differences between the three treatment groups (group, individual and phone) were not significant. For all three treatment groups combined only 25% of the participants still
met criteria for depression after 6 months. Additionally, the dropout rate was only 4.6% across all treatments and session attendance was 88.2%.

This study was limited by the fact that sample sizes were relatively small, depression was defined to include lower forms not currently recognized in the DSM-IV, 30% of participants were concurrently receiving individual therapy (though the difference in number of participants receiving individual therapy was non-significant across groups), and the sample was self-selected and potentially biased (70% were female). However, this study does provide some evidence for the effectiveness of the course in treating depression. What’s more, the course was effective in all three conditions—group, individual, and with phone support.

Allart-Van Dam, Hosman, Hoogduin, and Schaap (2003) also conducted a study on the efficacy of the CWD course in the reduction of depressive symptoms in a subclinical population. Participants were between the ages of 18 and 65 who scored 10 or above on the BDI but were not currently experiencing a major depressive episode. A total of 110 subjects (presumably Dutch) met criteria for the study and were randomly assigned to the treatment or non-treatment group. Researchers found significant effects of the course in lowering depressive symptoms (effect size of 0.88 with respect to the BDI), reducing the frequency of depressive thoughts, increasing the amount of pleasant activities and social interactions, as well as enhancing self-esteem and frequency of social supports. However, only automatic thoughts (ATQ) and self-esteem (Self-Esteem subscale of the Dutch Personality Questionnaire) were found to be significant mediators of post-intervention depression levels. The dropout rate for this study was 25%. One major limitation of this study was that participants self-selected by responding to
advertisements in newspapers and on television which may have biased the study. However, this condition held for both groups indicating the course is at least effective for many of those who have the motivation and resources to attend.

Cuijpers (1998) conducted a meta-analysis on the studies of the CWD course available at the time. Twenty studies of varying quality (use of control group, randomization, included data on dropouts, collection of follow-up data, description of intervention, sample sizes, and appropriate statistical analysis) were included. The researcher found a mean effect size for those studies which compared results of the treatment group to a control group (i.e., wait list, bibliotherapy, or other form of CWD) to be 0.65 which is considered to be a large effect size. Pre-post effect sizes were much larger with a mean of 1.18 to 1.23 depending on which studies were included. This study aggregates the evidence provided by 20 separate studies and shows the potential effectiveness of the course for a broad range of populations with various levels of depressive symptoms.

Group prevention of depression and anxiety. Researchers at the University of Pennsylvania have been studying the effects of a cognitive-behavioral psychoeducational approach to preventing depression and anxiety in a college-aged population. Seligman, Schulman, and Tryon (2007) conducted an 8-week, 16-hour workshop (two-hour session once per week) with 240 participants over a two-year period. Participants were selected based on pre-enrollment BDI scores in the range of nine to 24 (mild to moderate depression) with the rationale that they were at increased risk for a future depressive episode. Student who met the criteria and were willing to participate in the study (described as a study to evaluate a workshop teaching stress management skills) were
randomly selected to the workshop group or a no treatment group. Students were administered the SCID to measure the occurrence of Major Depressive Disorder and Generalized Anxiety Disorder. The SCID was administered at the beginning of the study, at the end of the workshop, and during follow-up periods but only if a person exceeded thresholds on depression and anxiety screeners. The BDI and BAI were both administered pre, post, and at follow-up periods to measure depressive and anxiety symptoms. The workshop included the following topics: cognitive theory of change, identifying automatic negative thoughts and beliefs, questioning and disputing negative thoughts, behavioral activation strategies (graded task breakdown, time management, anti-procrastination techniques, creative problem solving, and assertiveness training), interpersonal skills (active listening, taking each other’s perspectives, controlling emotions, and passive vs. assertive vs. aggressive behaviors), and relaxation training.

The researchers reported the results at the six-month follow-up. The attrition rate at this point was only 5.4% (participants were paid for each follow-up period in which they provided data). They found that students had significantly fewer depressive and anxiety symptoms than the control group but had no significant difference in the number of depressive or anxiety episodes (meeting criteria for MDD or GAD). Participants also had significantly better scores on a measure of well-being (Satisfaction with Life Scale) and explanatory style (Attributional Style Questionnaire). The researchers provided two possible explanations for the fact that they did not find lower levels of MDD or GAD. First, they compared their results with a previous study (Seligman, Schulman, DeRubeis, & Hollon, 1999) in which they found differences in MDD and GAD but only after the 6 month point indicating that more time may be required to see the impact on incident rates.
for MDD and GAD. Second, the previous study conducted diagnostic interviews on all participants at the post and follow-up intervals while in the current study only those participants who reported a BDI or BAI score of 12 or more were given the diagnostic interview. Because not all students were interviewed it is possible that students who met criteria for MDD or GAD were not identified, although this would not explain why rates of MDD and GAD were higher than expected. An additional concern of this study is whether results that were found to be statistically significant are truly clinically significant. The mean BDI score pre-workshop was 9.8 and was reduced to 8.1 at the six-month follow-up. Given the large sample size it is not surprising that this result is statistically significant (p<.0001) but one has to question whether a two-point BDI decrease is really clinically significant. The researchers plan a three-year follow-up which should provide better indicators of the success of this workshop.

**Mindfulness for anxiety.** Another skill that potentially meets the criteria of this study is that of mindfulness. Mindfulness refers to an intentional process that leads to a mental state characterized as a nonjudgmental awareness of present moment experience including perception of bodily sensations, thoughts, and feelings while encouraging openness, curiosity, and acceptance (Hofmann, et al., 2010, Bishop et al., 2004, Kabat-Zinn, 1990). Many studies over the past decade have looked at the efficacy of mindfulness-based approaches for treating depression and anxiety-related disorders. Summarizing these studies is a recent meta-analytic study by Hofmann et al. (2010) that examined the efficacy of mindfulness-based therapy (MBT). The researchers found 39 studies that met the following criteria: 1) included a mindfulness-based intervention, 2) included a clinical sample (i.e., diagnosable condition), 3) included adults 18-65 years of
age, 4) did not couple the mindfulness program with another treatment such as is the case with Acceptance and Commitment Therapy or Dialectical Behavior Therapy, 5) included measures both pre- and post-intervention, and 6) provided sufficient data to perform an effect size analysis. Most (87%) of the studies used either Mindfulness-Based Stress Reduction (MBSR) or Mindfulness-Based Cognitive Therapy (MBCT) as the intervention strategy. Researchers employed several strategies to eliminate potential bias in their analysis including the use of a random effect model and quantification of study quality (i.e., assigning points based on factors such as comparison group, single-blind, double-blind, etc.). Results indicate that pre-post effect sizes were in the moderate range for reducing anxiety symptoms (Hedges’s g = 0.63) and depressive symptoms (Hedges’s g = 0.59). In patients with anxiety disorders and depression, effect sizes were in the large range (g = 0.97 for anxiety and g = 0.95 for depression). The researchers point out that these results may under represent the effect size due to the fact that some of the studies were conducted on subjects with chronic and treatment-resistant depression and several of the studies included subjects with chronic medical conditions who were undergoing intensive medical treatment and were likely to be experiencing significant side-effects that could have increased scores on depression and anxiety scales.

All of the studies included in this meta analysis were delivered in person and no studies have been located that looked at the efficacy of self-taught mindfulness skills for treatment and prevention of anxiety and depression. However, several non-religious self-help resources are available to guide individuals in developing a mindfulness practice including *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (Kabat-Zinn, 1990), *The Mindful Way through Depression*
(Williams, Teasdale, Segal, & Kabat-Zinn, 2007), and *A Mindfulness-Based Stress Reduction Workbook* (Stahl & Goldstein, 2010). Given the broad efficacy and skill-based approach that mindfulness provides as well as the fact that it is currently delivered in a psychoeducational approach makes it a viable skill for the purposes of this project.

**Dialectical behavior therapy.** Another psychoeducational strategy for the treatment of mental disorders is dialectical behavior therapy (DBT) developed by Linehan (1993). DBT teaches four primary skills aimed at improving a person’s ability to manage overwhelming emotions including *distress tolerance, mindfulness, emotion regulation,* and *interpersonal effectiveness.* While a significant amount of research has been conducted on the efficacy of DBT in treating persons with borderline personality disorder and those with suicidal and parasuicidal behaviors, the application of DBT skills to the treatment of mild to moderate depression and anxiety is still in its infancy.

One identified study was conducted by Harley, Sprich, Safrey, Jacobo, and Fava (2008) looked at the use of modified DBT skills with clients presenting with treatment-resistant depression. Researchers found that a 16-week DBT skills group (1.5 hour session one time per week) along with antidepressant medication was effective in treating depression (leading to full remission) in 75% of the subjects compared to 31% on medication alone. Effect sizes were large with a reported Cohen d of 1.31 for the BDI at the 6-month follow-up. The researchers point out that DBT shares common strategies with treatments already discussed such as CBT and mindfulness but adds the important dimension of interpersonal effectiveness that specifically targets deficits in psychosocial functioning.
In a separate article, Feldman, Harley, Kerrigan, Jacobo, and Fava (2009) conducted an analysis on the data provided by Harley et al. (2008) and found evidence to support the conclusion that improvements in depressive symptoms were the result of patients learning skills that facilitate processing emotions in a way that helps to reduce rather than exacerbate depressive symptoms. They referenced several studies that indicate that depressive rumination or the tendency to respond to depressed mood by passively and repetitively focusing on one’s emotional state and its causes, meaning, and consequences is linked to an increase in depressive symptoms. The researchers conclude that DBT helps individuals develop skills that facilitate a healthy, productive, engagement in emotional processing that helps alleviate depressive symptoms.

While the evidence is insufficient to include a full treatment of DBT skills at this time, some of the pieces seem of sufficient value to be included in an intervention strategy aimed at preventing and treating mild and moderate anxiety and depression in a college student population. One specific skill that has been included in several of the CBT approaches is that of assertiveness. According to McKay, Wood, and Brantley (2007), assertiveness is the core skill in the interpersonal effectiveness model and this skill was also included in many of the CBT workshops previously discussed. Sources for teaching assertiveness training include *The Dialectical behavior Therapy Skills Workbook* (McKay et al., 2007) and the popular *Your Perfect Right* (Alberti & Emmons, 2008).

**Stress Management.** Stress is also a significant mental health concern among college students and is related to issues of depression and anxiety. Data from the Spring 2008 ACHA-NCHA survey (ACHA, 2008) shows that 33.9% of students reported
impacts to their academics as a result of stress which made it the highest factor of those measured. Other factors included sleep problems, anxiety, depression, sickness, alcohol use, relationship difficulty, and computer games. Cohen, Janicki-Deverts, and Miller (2007) argued that there is substantial evidence that stress leads to disease most notably to clinical depression, cardiovascular disease, HIV/AIDS, and cancer and encouraged the development of interventions that reduce the behavioral and biological consequences of psychological stress which they define as the perception that environmental events are taxing or exceeding one’s ability to cope with them. Thus, not only does stress appear to impact students’ ability to perform successfully in college but there is also strong evidence that it may cause or exacerbate physical and mental illnesses.

Not only is stress an important condition to address with college students but the management of stress and can be directly linked to interventions for anxiety and depression making it an appropriate umbrella topic for teaching skills that address mental health concerns. Dozois, Seeds, and Collins (2009) argue for a transdiagnostic approach for the prevention of anxiety and depression arguing that these disorders frequently co-occur and share a number of vulnerability and risk factors. They proposed a preventative strategy that attempts to modify four different risk factors: 1) negative cognitive content and processes, 2) parental psychopathology and parenting, 3) stress and coping, and 4) behavioral inhibition and avoidance. With respect to negative cognitive content and processes, the authors recommend cognitive restructuring as well as mindfulness-based stress reduction strategies. Although addressing parental psychopathology is less easily dealt with in a college-aged population, the authors point out that if this factor could be assessed, it could be used to identify or recommend students for interventions. Stress and
one’s ability to cope with stress are also common risk factors for depression and anxiety. The authors recommend teaching problem solving skills such as the “I CAN DO” approach used by Dubow, Schmidt, McBride, and Edwards (1993) which stands for Identify the problem, generate Choices available to deal with the problem, pay Attention to the information and consequences, Narrow down the choices, Do what needs to be done, and Observe the outcome. Dozois et al. (2009) also recommend the teaching of relaxing skills such as progressive muscle relaxation, guided imagery, and diaphragmatic breathing to help individuals learn to deal with stress. Finally, the authors recommend strategies to deal with behavioral inhibition and avoidance which is characterized by avoidance, shyness, and fear of unfamiliar objects or people. They recommend strategies including exposure, behavioral activation, social skills training, emotional awareness training (helping people identify and stop using idiosyncratic emotional avoidance strategies and learn to stay more in the moment and engaged with their emotions), and self-monitoring (daily mood and thought diaries).

Stress management courses are certainly not new to college campuses. Deckro et al. (2002) studied the impact of a six-week program (90-minute group session once per week) on the perceived stress ratings of 128 college students. They recruited students for a study program they titled “Maximize Your Potential” and offered a $25 stipend. Students were randomly assigned to the experimental group (n = 63) or the control group (n = 65). Interventions included didactics, group discussion, and experiential mind/body skills. Topics included relaxation techniques, mindfulness, cognitive restructuring, goal setting, and the physiology of stress. The researchers found that those students who participated in the group had reductions in psychological distress, anxiety, and the
perception of stress compared to students in the control group. This study demonstrates an effective strategy for teaching students stress management interventions that was also effective in decreasing anxiety.

Stress management appears to be an appropriate umbrella for a psychoeducational intervention for anxiety and depression as it appears to be non-stigmatizing topic for college students going back to a survey conducted by La Civita in 1982 that found that college students were more interested in learning how to manage stress than in any other health topic. Given the NCHA data (NCHA, 2009) this result is unlikely to have changed. However, such an approach would be different from existing stress management education in that current efforts primarily focus on health and relaxation which are primarily aimed at helping people cope with the stress in their lives as opposed to dealing with the underlying causes and associated mood and anxiety issues. Thus, a new approach that marries current stress management practices with mindfulness and cognitive strategies is greatly needed to go beyond basic stress management and provide skills that will be useful to treating current mental health problems as well as helping inoculate students from future problems with anxiety and depression.

**Resiliency.** An important area to touch upon in addressing the mental health needs of the college population is that of resiliency. Though resiliency has been studied primarily in the context of withstanding, bouncing back, and even growing from the experience of trauma and adversity (Bonanno, 2004; Tedeschi & McNally, 2011) it can also be considered in a more general sense of being able to withstand difficult situations and experiences. Research has identified several aspects of resiliency that are amenable to change and thus could confer protection to people before they face adversity (Reivich
& Shatté, 2002; Seligman, 1990; Seligman, 2011). The Penn Resiliency Program is one model of a resiliency program developed for a college population that addresses prevention of depression and anxiety disorders. This program includes several elements of resiliency including optimism, problem solving, self-efficacy, self-regulation, emotional awareness, flexibility, and relationship (Reivich, Seligman, and McBride, 2011). Students gain skills in this area by learning CBT techniques such as identifying and modifying cognitive errors, challenging core beliefs and attitudes, learning relaxation skills, and learning problem solving strategies.

**Problem-Solving Therapy.** According to D’Zurilla and Nezu (2010) Problem-Solving Therapy (PST) is a clinical intervention that focuses on the development of constructive, effective problem-solving attitudes and skills to reduce the emotional stress that leads to physical and mental illnesses. PST is based on a Social Problem-Solving Model of stress which theorizes that a person’s ability to effectively resolve problems as they naturally occur in the social environment mediates the relationship between life problems and well-being. The theory further postulates that social problem-solving is a learned and self-directed skill and as such can be modified and improved as a strategy to reduce and prevent the emotional stress that leads to physical and mental difficulties. The theory is well supported by research that demonstrates that effective problem-solving ability mediates the relationship between negative life events and successful adaption and coping and also that improvement in problem-solving skills is an effective treatment for a broad range of physical and mental illnesses (D’Zurilla & Nezu, 2010)

D’Zurilla and Nezu (2010) deconstruct problem-solving ability into *problem orientation* and *problem-solving ability*. Problem orientation encompasses a person’s
attitudes and beliefs that serve as motivation factors. Two problem-solving orientations are identified—positive and negative. A positive problem-solving orientation involves seeing problems as challenges, believing that problems can be solved, believing in personal abilities to solve problems, acceptance that many problems take time and effort to solve, and a commitment to solving problems. A negative problem-solving orientation is indicated by a view that problems are threats to a person’s emotional, physical, or psychological well-being; doubt about one’s ability to solve problems; and poor emotional regulation and frustration tolerance that impede a person’s ability to approach problems and effectively cope with the challenges that problems present.

There are also three problem-solving styles—rational, impulsive/careless, and avoidant (D’Zurilla & Nezu, 2010). A rational style is a deliberate, systematic application of the problem-solving processes. The rational problem solver collects the necessary information to understand the problem, sets reasonable goals, identifies obstacles, generates a variety of potential solutions, carefully evaluates those solutions against the intended goal, selects the best solutions, implements the solutions, and verifies that the solution has been effective. The problem-solving style is seen as a self-control or meta-process for the problem-solving process and does not include the specific skills necessary to implement the solution. Thus, clinical implementation may focus on the general process of problem-solving or the specific skills required to implement a specific solution. The second style is the impulsive/careless style which is characterized by poorly thought through and unsystematic attempts at solving problems. Lastly, the avoidant style is typified by procrastination (hoping the problem will go away) and dependence (hoping someone else will solve the problem).
D’Zurilla and Nezu (2010) identify a number of studies that demonstrate the effectiveness of PST in a clinical setting for a wide range of physical and mental issues including stress, depression, and anxiety and suggest that it has received “strong” support as an empirically supported treatment. PST has also been taught as part of other psychoeducational workshops (as previously discussed) and has been formulated into a self-help manual (Nezu, Nezu, & D’Zurilla 2007). However, no studies were identified that assessed the effectiveness of PST alone in a self-guided or workshop format.

**Summary**

Mental health problems among the college population appear to be on the rise in terms of frequency and severity. Traditional counseling center services--while shown to be effective--are not appropriate for all students and are too resource intensive to meet the full need of the college population. Creative strategies are necessary to address the growing need for mental health services among college and university students that are a) effective, b) applicable to a broad range of students, c) address significant barriers to treatment such that a wider range of students are willing to utilize the services, d) focused on common mental health issues, e) facilitate resource-efficient intervention strategies, and f) provide a degree of resiliency against future adversity. Available research supports the application of several psychoeducational approaches for treating the most common disorders among college and university students—depression and anxiety. These approaches are skill-based and include learning to recognize and work though cognitive distortions and dysfunctional beliefs; learning behavioral strategies for activity scheduling and problem solving; mindfulness strategies for dealing with anxiety,
rumination, and overwhelming emotions; and assertiveness skills aimed at improving interpersonal effectiveness.

The purpose of this study is to develop a treatment strategy that meets the needs of a larger population of college students who experience mental health issues and could benefit from learning positive mental health skills and self-guided mental health interventions. This project will combine supported psychoeducational approaches into a semester-long class targeting the most common mental health disorders and symptoms—depression and anxiety—under the umbrella of stress management. If offered for academic credit, such an offering might overcome concerns about not having enough time—one of the most significant barriers to seeking help. This class will be geared towards reaching students who have symptoms of minimum to moderate severity who would prefer the independence of a self-guided, psychoeducational approach to solving their problems.

This approach would be much more resource effective than individual therapy and is likely to be more acceptable to clients who are resistant to or inappropriate for process-oriented group therapy. It also goes beyond current stress management classes in that it incorporates proven methods for teaching cognitive strategies that have been shown to be effective in the treatment of anxiety and depression. The proposed content for this course also goes beyond current efforts of developing resiliency by including core mindfulness skills which address resiliency elements of self-awareness, emotional regulation, and distress tolerance.
Method

Class Overview and Rationale

Evidence-supported skills that have been shown to be effective in the treatment and prevention of depression and anxiety will be incorporated into a semester class for stress management. Stress management has been selected since stress is a readily identifiable problem among college students and people freely talk about “being stressed” indicating that it does not carry the same stigma as do depression and anxiety. Additionally, the positive mental health skills that have been shown to be effective in the treatment and prevention of depression and anxiety can be taught under the umbrella of effective stress management.

The evidence-based skills will include learning to recognize and work through cognitive distortions and dysfunctional beliefs; learning behavioral strategies for relaxation, activity scheduling, problem solving, and assertiveness training; and mindfulness strategies for dealing with behavioral inhibition, avoidance, anxiety, worry, rumination, and learning emotional acceptance. Based on the research, these skills have the broadest applicability to stress, depression, and anxiety and are amenable to a psychoeducational approach supplemented by self-guided strategies. All are supported by quality self-help guides that can be used to supplement class materials. This approach combines the benefits of a formally taught class with the broad accessibility and independent approach of bibliotherapy. Thus, to focus this workshop on stress
management, the proposed title for the workshop is “Enhancing College Success through Effective Stress Management.”

The class will be targeted as a two credit hour class, meeting for two hours a week for 15 weeks. However, because it will be built using separate modules, the course could be modified to fit other time requirements.

Class Material Sources

Psychoeducational intervention methods will be developed based on materials shown to be effective in treating and preventing mental health issues. Materials will include self-help books, existing workshop materials, and appropriate intervention literature from the following sources:

- Existing workshops
  - Coping with Depression Course (Lewinsohn et al., 1978; Brown & Lewinsohn, 1984b)

- CBT skills
  - *Feeling Good* (Burns, 1980)

- Mindfulness
  - *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (Kabat-Zinn, 1990)
  - *The Mindful Way through Depression* (Williams, Teasdale, Segal, & Kabat-Zinn, 2007)
  - *A Mindfulness-Based Stress Reduction Workbook* (Stahl & Goldstein, 2010).
• Assertiveness

  o *Your Perfect Right* (Alberti & Emmons, 2008)

**Materials**

The results of this project will include a course syllabus with course goals, objectives, and outline; slides; and instructor notes with teaching points, discussion questions, and recommended readings. The course will require a classroom or group room and the use of a computer projection system.
Results – Course Products

The results of this project are the materials necessary to conduct a full semester course titled, *Enhancing College Success through Effective Stress Management*. Course materials include a Course Guide (Appendix A), a Course Syllabus (Appendix B) and PowerPoint slides (Appendix C). The course is broken down into a series of course modules that cover the physiology and nature of stress, mindfulness, cognitive therapy (called “cognitive strategies”), and assertiveness training. The Course Guide provides an explanation of the course; the goals and objectives; thoughts about how to conduct the course, assign grades and encourage student participation; a detailed schedule for conducting the class over a 16-week term meeting one time per week for two hours; and recommendations for tailoring the course to a shorter schedule. While the modules of the course are intended to be used together, they have been developed in such a way that they can be used separately as well to enhance flexibility. The slides for the course provide the content for the lectures along with exercises and practices.

The course begins with a discussion about the physiological and psychological aspects of stress and the stress response. It then introduces the concepts of stress management and separates strategies based on those that help a person to tolerate stress from those that target the reduction or resolution of problems leading to stress and emphasizes that the course is primarily focused on the latter. However, common relaxation exercises are initially taught to provide immediate coping skills to deal with stress. Problem resolution strategies are introduced through a discussion of problem-
solving and revolve around the social problem-solving model of stress which says that a person’s ability to solve the problems that naturally occur in their life mediates between those problems and a person’s well-being. Steps of effective problem solving are discussed as are common obstacles to effective problem-solving which sets the stage for the rest of the course. Mindfulness strategies are introduced as methods for developing self-control and emotional regulation and developing greater insight into the nature of one’s problems and coping styles. Cognitive strategies address a person’s attitudes and beliefs that often preclude effective problem solving and specifically address procrastination. Assertiveness training helps provide a critical skill in dealing with the majority of problems that occur in the social environment.
Discussion

The developed course meets the objectives of this project by providing a sequence focused on evidence-based strategies for treating anxiety and depressive mood disorders. These strategies have been shown to be effective when provided in psychoeducational formats and capable of attracting and maintaining people through the duration of the course. This course is applicable to a broad range of students and other individuals with current mental health problems or who have risk factors for mental health issues. This course is resource effective allowing one trained instructor to treat ten to 20 students in one class period across a semester. Lastly, this class not only teaches skills but familiarizes students with proven self-help resources that could continue to be utilized by the students indefinitely to help them deal with stress, anxiety, depression, and other difficult emotions and situations. While the skills provided in this course have been selected primary for their demonstrated effectiveness at ameliorating symptoms of stress, depression, and anxiety, their use is also consistent with the literature on resiliency and so it is expected that course will provide future as well as current benefit.

This course also has several other potential benefits that have yet to be demonstrated. First, the primary purpose of this course is to provide students who are currently dealing with mild to moderate anxiety and emotional issues the knowledge and skills to allow them to resolve their own issues. Second, this course will potentially be attractive to students who would not, for various reasons, utilize traditional mental health services. Third, it is hoped that this course will help build resiliency in students by
teaching them skills to deal with stress and develop behavior patterns that confer resiliency to the challenges and disappointments in life. These challenges and disappointments are inevitable for every student and knowing how to handle stress, deal with anxiety and avoidance, confront difficult situations, overcome procrastination, correct negative thinking and beliefs, tolerate painful emotions, develop intimate relationships based on equality, and to speak up for oneself are skills that have been shown to help most people through difficult times. Fourth, for those students for whom this program is not sufficiently successful, it is hoped that the interactions with mental health ideas and theories will reduce the stigma associated with seeking help from a professional. Lastly, it is hoped that through this course more students will complete their education, find careers, build solid relationships, and develop a strong sense of self-esteem and self-efficacy that will allow them to achieve their current and future goals.

There are several limitations and concerns regarding this course. While this course was based upon research supported theories and intervention strategies, development and presentation of a course like this has several variables that could influence its success such as the quality of the materials and their fidelity to theory, the expertise of the instructor, the personal elements that the students bring to the class, and the interaction of all of these variables. As such, this course is really only a foundation that will require modifications based on lessons learned and additional research.

Much work will be required to make this class a reliable and repeatable process that can then be replicated in other locations. Several questions must be answered through data collection and analysis such as whether or not symptoms of depression and anxiety are really decreasing and whether or not the training is sufficient to improve
moderating variables such as mindfulness, cognitive skills, and assertiveness. Longer term studies would also be beneficial to determine the lasting impact of the skills and whether or not students continue to use and practice the skills. Comparisons should also be made to more traditional stress management strategies such as time management and relaxation skills. Thus, the next step for this course is to conduct a trial run and determine if the potential benefits are achievable and what changes need to be made to reap such benefits. This could be done by running several sessions of the course and conducting pre- and post-course measures of functioning such as the OQ-45 (Lambert et al., 1996) or the CCAPS (Locke et al., 2010). If possible it would be good to randomly assign students to the course or a wait list for the next course and compare results. This would account for the potentially confounding variable of time. It would also be important to measure the outcomes of the course over time as for example at three- and 12-month intervals. This would indicate whether or not the effects of the course are indeed lasting and provide increased resiliency as intended.

Research would also be helpful in assessing the value of the various modules of the course. To achieve this objective, measures of functioning could be provided after each module though it would be important to rotate the order of the modules to ensure this does not bias the results. Outcome questionnaires could also be used to assess the perceived benefit of the different modules and such data could be used to make improvements. Focus group discussion conducted by someone other than the instructor could also be a means of providing a course feedback and relative merits of the various elements and process of the course.
Mental health providers within the college environment must continue to think out of the box for unique and creative ways to meet the growing mental health needs of the college population. Growing rates of stress and anxiety among college students and a greater number of students having more severe mental illnesses are trends that are not likely to reverse. What’s more, since traditional counseling services appear to reach only about a fourth of these students, colleges and universities remain vulnerable to student drop outs, academic and behavior problems, and suicidal/homicidal behaviors.

It is high time that institutions of higher learning incorporate sound mental and emotional health as one of the cornerstones of a quality education. Given the difficult, fast paced nature of today’s society where change is the only constant and economic security is less of a certainty than for prior generations, positive mental health and emotional resiliency are necessities of survival and success. College and universities might do well to look at the transformation the U.S. Army is making to their basic training by adding a mental health component. No longer is it sufficient to make soldiers “tough,” committed, and disciplined; the Army now aims for Comprehensive Soldier Fitness (Casey, 2011) that includes solid mental and emotional health. Though this change has been driven by the realities of the battlefield and the alarming rates of PTSD and soldier suicides, the difficulties in the civilian world are no less real or important. As a world becomes more complex, our challenges grow, and change continues to accelerate, reliable and cost effective methods of teaching positive mental health skills will be critical to maintaining the American dream.
Appendix A - Course Guide

About This Course

The purpose of this course is to help individuals who are dealing with stress, anxiety, and depression in their lives to learn through an educational format effective strategies for coping with and resolving these concerns. These strategies also help to develop resiliency by promoting better interpersonal relationships, resolving stress before it becomes a significant problem in a person’s life, and learning powerful strategies for developing positive mental health attitudes and practices.

While there are many stress management courses that are available in many different formats including self-help books, web sites, seminars, and from a therapist or counselor, this course offers a different approach. Strategies for managing stress can be broadly classified into two domains—those that help us manage the stress we experience (e.g., relaxation techniques) and those that help us resolve the underlying problems that lead to stress. While this course provides some strategies for relaxing and taking a break from stress, this is not the primary content of the course. The primary purpose of this course is to help people learn strategies to resolve the stress in their lives so they don’t have as much stress to deal with in the first place. The second major difference is that this course, while focused on stress, also provides skills that can be helpful in the treatment of many different emotional and psychological issues to promote good mental and emotional health. Third, while many books on stress management mention meditation and changing the way one thinks, they do not provide research-proven
strategies for truly helping people develop the proficiency to benefit from these skills. This course incorporates a number of different strategies for promoting proficiency including highly recommended readings, lecture and classroom discussions, multiple scenarios and examples completed in class, guided practice sessions, and home practice assignments. As the course integrates popular and proven self-help guides, these resources will be familiar and available to students after the course is over. Lastly, this course integrates three proven but different strategies (behavioral techniques, mindfulness, and cognitive restructuring) in such a way that they are supportive and synergistic. For example, a very powerful skill for managing stress is assertiveness training. In this course, assertiveness training builds upon a person’s ability to be mindful of their interpersonal reactions and incorporates cognitive tools for identifying and challenging one’s beliefs about being assertive.

**Course Goal**

Students who complete this course will learn the rationale for and be able to apply effective stress management strategies to all areas of their lives. At the same time the course is geared towards helping students increase their emotional, mental, physical, and spiritual health by being happier, less anxious and stressed, and more capable of being able to get their own needs met. Further, these strategies will help inoculate students from the effects of future stressors and enable them to cope effectively with stress in their lives or know when they need to seek help.

**Course Objectives**

- Nature of stress
  - Understand the physiology of the stress response
• Understand the psychological causes of stress
• Know the difference and relationship between stress and anxiety
• Know the detrimental consequences of prolonged stress response
• Understand the role of common stress management strategies
• Understand the problem with common but counterproductive strategies

- Behavioral Strategies
  • Learn, understand the rationale for, and be able to apply common relaxation techniques
  • Know the importance and fundamentals of assertive communications and learn to be assertive in personal situations

- Mindfulness
  • Understand what mindfulness is and the rationale for using it to deal with stress, anxiety, and other distressing states
  • Be able to practice and implement different mindfulness strategies to become more present-moment oriented
  • Be able to use mindfulness strategies to deal with stressors, anxiety, excessive worry, ruminating thoughts, and distressing emotions

- Cognitive Strategies
  • Understand connection between thoughts, emotions, and behaviors
  • Be proficient in monitoring automatic thoughts, recognizing cognitive distortions, and challenging dysfunctional beliefs
Preparation for Instructors

While this guide provides an overview of the areas covered in the course it is not a substitute for resources that provide a more thorough understanding of each topic area. Instructors should have foundational knowledge and experience with cognitive-behavioral interventions. Further, it is highly recommended that instructors be familiar with the self-help resources that provide much of the material for the course.

With respect to mindfulness, it is highly recommended that instructors have not only a good conceptual understanding of what mindfulness is, how it is practiced, and how it can be applied but also have their own practice that they have been involved in for several months if not years. Mindfulness is taught not just with words but also by the presence and attitude of the teacher, so unless the instructor has cultivated a good foundation of being mindful it will be difficult to transfer this skill to students.

Modification and Tailoring of Course

This course has been designed as a two-semester hour class meeting weekly over a 16-week semester for two hours a week. Any deviations from this schedule will require tailoring of the material. While all of the modules are deemed important to effective stress management, all of the methods included in the course have been shown to provide benefit when provided alone. However, because mindfulness and cognitive skills are both challenging to learn and incorporate into one's life, it is not recommended that the course simply be compressed in order to retain all of the strategies. It would likely be more useful to know one skill well than to have only a basic knowledge of all of the skills. It is also recommended that the first module that defines stress be included in any
version of the course to help set the stage and provided the necessary background information to make the other modules most useful.

**Thoughts about Grading**

In order to assign credit for this course when delivered within a college or university curriculum, some form of grading must occur. Suggestions are provided below for graded material that could be used for this purpose.

**Attendance** – would encourage students to show up for class.

**Weekly practice logs** – would encourage students to complete assigned practices which are important for students to gain benefit from the course. At the same time, having students complete the practices for credit might make them feel like work and detract from the inherent benefits of the practices. A trade-off might be to require these for the first eight lessons and then make the practice optional after that.

**Thought worksheets and other assigned practices** – encourages students to complete these exercises so they get some practice in identifying automatic thoughts, recognizing distorted thinking, and learning strategies to change their thoughts and beliefs. It also would allow for feedback from the instructor to help correct misconceptions and other problems in using the strategies.

**Capstone paper** – this could be designed in any number of ways as a method of facilitating the application of skills gained with a student’s own self-exploration of how they create and handle stress in their own lives. Topics covered could include a self-examination of causes of stress and stressors, normal coping strategies, new perceptions or understandings of his/her personal stress and response to that stress, application of learned methods and strategies for dealing with stress, goals for reducing stress, and plans
to continue their growth and ability to handle stress and other difficult emotions. This paper could be worked on throughout the course and would somewhat follow the sequence of topics presented in the course.

**Ideas for Student Participation**

Additional exercises and activities may be developed to help foster student participation in the discussions. While the lecture material is primarily focused on the material to be presented, instructors should use these as a guide and encourage open discussion about the material as much as time allows for. Some of these discussion points are built into the slides but others discussion topics are encouraged.

It would also be helpful if students felt open and safe enough to share to their own personal experiences with stress and stress management. This would provide real-time examples with which to demonstrate the strategies and skills being taught, would allow students to learn from each other both what stressors they experience and how they handle them, and a certain amount of disclosure can help students develop friendships and feel a sense of commitment and membership of the class. This kind of disclosure borders on a group therapy paradigm so practical and ethical considerations should be taken into account. First, it would have to be made clear up front that the classroom and the discussions therein would not constitute a therapeutic relationship and that feedback provided would be in the purpose of helping the student learn the skills and not for the purposes of delivering mental health services. Second, confidentiality would need to be discussed and students would need to know that while there would be no intention of sharing information provided in the classroom to others outside of the classroom, no formal confidentiality or privileged communication would exist. A signed
acknowledgement discussing these conditions would be to the benefit of the instructor and the students.

Another strategy that might be helpful to facilitate discussion, depending on the size of the class, would be to break up into small groups at times and work through different scenarios, practicing the application of the various strategies. Additional scenarios would need to be created but most practicing therapists have a well-earned supply of practical examples.

**Maintaining Role Boundaries**

One of the challenges for a mental health professional in providing this course will be the maintenance of role boundaries. While it will likely be tempting to take on the role of therapist with some students, it will be important to maintain one’s role as an instructor. This should be made clear up front in the course with a clear indication that no professional, privileged relationship between a licensed professional and a client exists as a result of this course. This situation could become murky as students share their experiences and reactions and as the instructor reads assignments and may call for a reminder of the instructor’s professional role. For example, what would be an instructor’s legal/ethical responsibility to a student who discussed thoughts of suicide in a journal? This is a challenging question but is not necessarily unique to this course (though perhaps could be more common) and instructors would be encouraged to reference institutional policies and guidance for instructors. Ideally this student would be referred or escorted to an appropriate provider who could then assume responsibility for the student’s care. This situation highlights the difficulties involved in maintaining one’s role as an instructor and not a mental health provider.
Another difficulty that may arise with role boundaries would be having a student who is also a therapy client (assuming the instructor has a role as a treatment provider for the institution). While these two roles are not necessarily in conflict, the situation could pose challenges to the therapeutic relationship given that grading is involved. It is recommended that this situation be avoided but if it is unavoidable then it should be fully discussed up front to minimize.

**Dealing with Disruptive or Severely Activated Students**

Another ethical dilemma that may present itself is with students with mental health issues that are too severe or disruptive to the class. While it would be ideal to exclude such students as we often do for some therapy groups, if this course is offered to the general student body it would likely go against institutional policies and federal law (Americans with Disabilities Act; ADA) to prohibit students from taking the course on this basis. At the same time, students with severe mental health issues such as substance dependence issues, suicidal thoughts, or students in crisis may overwhelm the class or become activated during the class, dangerous to themselves or others, and disruptive to the learning of other students. While this is unlikely, it should be a consideration and appropriate policies should be reviewed for removing students from class and referring students to mental health services. Throughout these actions, it will be important to focus on the overt behaviors of the student and not on presumed diagnoses or underlying conditions since such an action could constitute an ADA violation.

While it is possible that some students will be activated by this class, focusing solely on managing risk may obscure the benefits for many students who are dealing with severe mental health issues and those who are concurrently in some form of therapy. This
course could provide a beneficial adjunct by teaching skills for coping with stress and also skills proven to be useful in the treatment of a variety of mental health issues. Further, it may help eliminate barriers to treatment such as stigma and help prepare students who need additional support to reach out for the help they need.

**Teaching Points**

The following teaching points are intended to provide a quick synopsis of each knowledge area and are not intended to be a replacement for formal training and experience or to replace personal familiarity with the resources being used.

**Understanding the nature of stress.**

*Definition of stress and stressor.* The terms stress and stressor are used to connote many different things from emotional states to physiological processes and so a more precise definition of these terms is necessary. A *stressor* is typically anything in our environment that requires some kind of unusual demand or response and can range from mild to severe (traumatic) such as a threat, a failure, or even a success (Garrett, 2011). It is something that requires us to respond such as our boss telling us to do something or a spouse complaining about our behavior. It could also be a drop in the stock market that threatens the security of our future and so is seen as a threat. *Stress,* then, is the physiological and emotional response to a stressor. It is our body’s reaction that prepares us to respond. Stress is a biological response that all animals share and provides a means of survival. In the animal kingdom, the stress response prepares an animal to respond to a threat by either fighting, fleeing, or freezing. Stress is also used sometimes to refer to the emotional feeling of being stressed. In this sense it refers to feeling taxed or overwhelmed and gets to the psychological element of the stress reaction.
Stress is an adaptive response and so infers survival benefits. In humans, stress can also be beneficial. The Yerkes-Dodson curve (Yerkes & Dodson, 1908) is an example that depicts the beneficial nature of stress and how some stress is necessary to achieve optimum performance. There are many examples of this from school assignments where some people perform better to a quickly approaching due date to sporting situations where athletes “rise to the occasion” and perform better than they ever have before. However, stress can also have negative effects on an individual especially when it is prolonged and the body does not have the opportunity to recover from being in a stress-response mode.

**Background physiology.** The peripheral nervous system (outside of the brain) is divided into the somatic nervous system which controls motor movements and receives sensory information and the autonomic nervous system which controls the functioning of organs through control of smooth muscle. The autonomic system maintains heart rate, blood pressure, breathing, and controls digestion. The autonomic nervous system is divided into two branches—the sympathetic and the parasympathetic. The sympathetic branch is responsible for activating the body to deal with demands (i.e., stressors) while the parasympathetic branch helps the body to recover and renew itself by slowing activity and activating digestion. Most organs can be controlled by both branches of the autonomic nervous system and both branches operate to some extent all of the time. It is incorrect to think that only one branch controls organs at any one time (Garrett, 2011). In fact, both branches are active to some extent all of the time though their relative activity varies greatly and is dependent on the state of the person.
The endocrine system is also important in understanding the biology of stress. The endocrine system is a series of glands that produce hormones which help regulate biological processes. The endocrine system is composed of various glands including the pituitary, the adrenal, the thyroid, and various organs which have a secondary function of producing and releasing hormones such as the kidneys and the liver. Hormones play a role in regulating various biological processes such as digestion, energy production and availability, and growth. The main element of the endocrine system in the stress response is the hypothalamus-pituitary-adrenal axis.

The last system involved in the stress response is the immune system which protects the organism from invaders such as bacteria and viruses. The immune system is composed of different types of cells that identify and attack organisms that the body does not recognize and considers to be foreign invaders.

**Biological mechanisms of stress – an adaptive response.** When the brain perceives a stressor it signals the body to activate the stress response. The sympathetic nervous system signals the body to increased heart rate, blood flow, and respiration rate to increase muscular response. The endocrine system, specifically the hypothalamus-pituitary-adrenal axis triggers the release of the hormones epinephrine (adrenaline), norepinephrine, and cortisol. Epinephrine and norepinephrine increase output from the heart and help provide glucose from the muscles for additional energy. Cortisol increases energy levels by converting proteins to glucose, increasing fat availability, and increasing metabolism to provide a sustainable source of energy (Garrett, 2010). Brief stress also activates the immune system to help protect the body from bacteria and viruses that might enter the body through a wound.
Common symptoms experienced during the stress reaction include rapid heartbeat, rapid breathing, sweating, nausea or upset stomach, numbness or tingling, dizziness or light-headedness, tight or painful chest, bright vision, choking sensation, heavy legs, and hot or cold flashes (Otto & Pollack, 2009). All of these sensations are reactions to the body's stress response but can be misinterpreted by people leading to symptoms of panic and fears of going crazy or dying. Panic symptoms will be discussed in a later section.

**Stress and anxiety.** Stress and anxiety are very closely linked. While stress predominantly refers to the physiological response to an unusual demand (a stressor), anxiety is an emotional response that signals the body of a future or impending danger. Anxiety is closely related to fear, though according to Beck and Emery (1985), fear is the intellectual appraisal of a situation as being dangerous or threatening while anxiety is the emotional response to that appraisal. When a person experiences anxiety, she experiences the distressing symptoms of emotional distress as well as the physiological symptoms of stress which can also be perceived as being unpleasant. The purpose of anxiety appears to be to protect a person from a situation or event that is perceived to involve some threat or danger for which the person is not yet capable of managing (Beck & Emory, 1985). Thus, stress and anxiety are the emotional and physiological responses to perceived fears and demands. But a distinction should be made between fearful situations and demanding situations. Take for example, a person who is accosted by a man with a gun who demands all of his money. This situation would naturally evoke the emotion of anxiety and the physiological reaction of stress. However, take a golfer who is in the heat of battle walking down the fairway with a one-shot lead. While he may or
may not experience anxiety (i.e., an emotional reaction to the fearful thought of “blowing it”) he most likely will be experiencing some degree of stress and while the anxiety response would impede his chances of winning, the stress response will provide the necessary energy and focus to face the challenge.

**Psychological causes of stress.** Stress, like anxiety and fear, also has psychological causes and mediators. This is apparent when two people have very different reactions to the same situation such as riding a roller coaster. While one person is excited and laughs throughout the ride another will avoid even being close to the ride and would experience sheer terror if they found the nerve to ride it. This example points out the importance of *appraisal* in the formation of fear. Beck and Emory (1985) elaborate on the appraisal process as originally described by Lazarus (1966). Lazarus broke this process into three segments—primary appraisal, secondary appraisal, and reappraisal. In the primary appraisal, a person is alerted to the potential of a situation being dangerous. The secondary appraisal assesses a person’s ability to respond, evaluating their own ability and potential allies. The reappraisal is then a more specific assessment of the potentially threatening situation. Beck and Emory (1985) stated that these processes likely occur at the same time and are highly automatic processes dependent upon past learning and other individual characteristics. The result of this appraisal process is that the estimate of danger is based on the perceived likelihood and severity of injury. It is also based on a person’s belief in their ability to respond effectively to the situation. Thus, fear, anxiety and stress, result as much, if not more, from a person’s appraisal of a situation as the situation itself.
Consequences of prolonged stress response. While the stress response can be advantageous, prolonged stress can inflict damage to a person’s body and lead to problems with emotional and mental functioning. Prolonged stress can lead to memory problems, increased or decreased appetite, decreased sexual desire and performance, depletion of energy, and mood disruptions (Garrett, 2011). Prolonged stress also leads to a weakening of the immune system making the body more vulnerable to disease and sickness (Garrett, 2011). Chronic Stress is particularly damaging to the cardiovascular system leading to high blood pressure which can damage the heart and cause strokes (Garrett, 2011). Traumatic stress can lead to changes in brain physiology such as reduced hippocampal volume and decreased cortical tissue (Garrett, 2011). While it is difficult to prove that stress itself leads to disease, there is strong evidence to suggest this connection for several conditions including depression, cardiovascular disease, some cancers, and progression through the phases of HIV/AIDS (Cohen, Janicki-Deverts, & Miller, 2010). Development of diabetes and weight gain have also been linked to prolonged exposure to stress hormones, especially when experienced early in life (McGrady, 2007). Stress events in childhood have been linked to increases in both depression and anxiety disorders (Mazure, 1998; Monroe, Harkness, Simons & Thase, 2001; O’Connor, Rasmussen & Hawton, 2010; Turner & Lloyd, 2004; van Praag, 2004).

Traditional stress management strategies. Stress management has been promoted and practiced for several years and various strategies have been developed to both decrease the amount of stress experienced as well as increasing the body’s ability to tolerate stress. These common methods typically revolve around finding a way to relax the body so that it can switch from a predominantly sympathetic mode to a more active
parasympathetic system which fosters recovery and reconstitution. Such methods include progressive muscle relaxation, deep breathing, Yoga, exercise, sex, and laughter. Any activity that helps one to relax can be beneficial in terms of stress reduction. Other strategies increase the body’s ability to handle stress such as exercise (especially cardiovascular exercise), nutrition, and sleep. Lastly, other strategies deal with our perception and experience of stress itself. Cognitive techniques help us to examine our appraisal of situations while behavioral practices help people resolve the situations in their lives that are contributing to their experience of stress such as teaching methods of problem solving and improving interpersonal functioning. Mindfulness and meditation practices are more and more being researched as powerful ways of teaching people non-stressful reactions to their environment. Additionally, these methods can help increase a person’s awareness of stress so that stress-reducing strategies can be employed.

The training in this course will be focused on latter of these practices—behavioral strategies, cognitive approaches, and mindfulness—as these provide the most powerful mechanisms to manage and prevent stress as well as providing secondary benefits for protection against the associated elements of a stressful life, i.e., mood disturbances and anxiety disorders.

**Problematic coping strategies.** Stress can also lead to dysfunctional coping mechanisms such as alcohol and substance abuse (Grant & Dawson, 2006; Weitzman, 2004) and avoidance of the problems causing the stress. While temporary retreat from stress-provoking situations can be healthy and allow the body time to recover, chronic avoidance of problems can also be problematic and lead to continued stress. Take for example someone who avoids dealing with a problem with their partner and so
experiences the stress of their behavior day after day. While there is a temporary avoidance of the stress involved with confronting the other person, their behavior continues to lead to stress. Activities that provide relaxation can also become problematic and contribute to greater stress in the long-term such as emotional eating and shopping. These avenues may provide some comfort in the short-term but can also increase future problems by leading to weight gain, other health problems, financial problems, and potentially relationship problems. Alcohol and drug use can also be effective in temporarily decreasing stress but can not only decrease the body’s ability to manage stress but lead to other stressful problems as well such as the consequences associated with abuse (e.g., legal problems, relationship problems, financial problems, and occupational problems).

Behavioral Strategies. Behavioral strategies fall into 2 categories—those that stop the stress response and those that resolve stressful situations. The first category includes intentional methods of relaxation such as progressive relaxation and diaphragmatic breathing. The second category includes structured methods of problem solving and assertiveness training. Each will be discussed and practiced. Note that the behavioral techniques are not taught in the same order as they are discussed herein. The relaxation exercises are taught early in the class while the assertiveness training and the problem solving skills are taught later to take advantage of the mindfulness and cognitive skills that will be helpful in learning and applying these behavioral skills.

Progressive relaxation. Progressive relaxation (PR) was originally developed by Edmund Jacobson (1938) but modified and shortened by Joseph Wolpe (1958) as part of his systematic desensitization. Since that time, further efforts have been made to shorten
the time required to learn this relaxation technique which within Jacobsen’s system could take several months or even years (Bernstein, Carlson, & Schmidt, 2007). Bernstein et al. (2007) further shortened this method by introducing the concept of the tension-release cycle and including each muscle group in each session. Their program begins with 16 muscle groupings that are used for the first three sessions, seven muscle groupings for the next two sessions, and four muscle groups that are used for the next four sessions. By the eighth session, the tension phase is eliminated and the practice can be done in about five minutes.

The theoretical basis of progressive relaxation lies in its ability to reduce the activity of the sympathetic branch of the autonomic nervous system (Jacobsen, 1938). Relaxation of the muscles is thought to provide negative feedback to the reticular activation system and hypothalamus which serves to decrease autonomic activation. Thus, as muscle tension decreases, other aspects of the stress response also decrease including heart rate and blood pressure (Bernstein et al., 2007).

Learning progressive relaxation is like learning any other skill—it takes practice. Only by becoming proficient in the technique will a person gain the ability to manage stress and relax by this strategy. Experience and studies suggest that most people can master this technique after 10 weeks of practice and 10 lessons of instruction (Bernstein et al., 2007). For this course, progressive relaxation will be introduced first but will be replaced by or morph into the body scan which will add an element of focus, awareness and acceptance that is not emphasized as much or even part of the progressive relaxation process or instructions.
**Diaphragmatic breathing.** Diaphragmatic breathing (Otto & Pollack, 2009) can also be used to induce relaxation by instructing individuals to breathe from their diaphragm rather than their chest since chest breathing is associated with anxiety and the stress response. This method can be taught by having the person place one hand on their abdomen and one hand on their chest. As they breathe they should attempt to breathe so that only the hand on the abdomen moves. This technique should be demonstrated as many people have trouble learning to breathe in this manner. Students can also gain increased awareness of chest breathing by interlocking their hands behind their head and push their elbows back. This position places increased tightness in the chest muscles making it more difficult to breathe from the chest. This technique should also be demonstrated before having students attempt it. Students are encouraged to practice this technique for five minutes, three times a day.

**Problem-solving therapy.** Daily life problems as well as major life events are a natural part of life and how we deal with those problems to a large extent will determine our level of well-being and collaterally will play a large role in the development of physical and mental illnesses and disabilities through the accumulation of stress. The social problem-solving model predicts that our broadly construed problem-solving ability mediates the relationship between naturally occurring problems of life and well-being.

D’Zurilla and Nezu (2010) deconstruct problem-solving ability into problem orientation and problem-solving ability. Problem orientation encompasses a person’s attitudes and beliefs that serve as motivation factors. Two problem-solving orientations are identified—positive and negative. A positive problem-solving orientation involves seeing problems as challenges, believing that problems can be solved, believing in
personal abilities to solve problems, acceptance that many problems take time and effort to solve, and a commitment to solving problems. A negative problem-solving orientation is indicated by a view that problems are threats to a person’s emotional, physical, or psychological well-being; doubt about one’s ability to solve problems; and poor emotional regulation and frustration tolerance that impede a person’s ability to approach problems and effectively cope with the challenges that problems present.

There are also three problem-solving styles—rational, impulsive/careless, and avoidant (D’Zurilla & Nezu, 2010). A rational style is a deliberate, systematic application of the problem-solving processes. The rational problem solver collects the necessary information to understand the problem, sets reasonable goals, identifies obstacles, generates a variety of potential solutions, carefully evaluates those solutions against the intended goal, selects the best solutions, implements the solutions, and verifies that the solution has been effective. The problem-solving style is seen as a self-control or meta-process for the problem-solving process and does not include the specific skills necessary to implement the solution. Thus, clinical implementation may focus on the general process or problem-solving or the specific skills required to implement a specific solution. The second style is the impulsive/careless style which is characterized by poorly thought through and unsystematic attempts at solving problems. Lastly, the avoidant style is typified by procrastination (hoping the problem will go away) and dependence (hoping someone else will solve the problem).

This module sets the context for the rest of the course by providing an overarching model of stress management through effective problem-solving. The
remainder of the course will provide skills that will be helpful for overcoming some of the common obstacles and problematic orientations and styles of problem-solving.

**Assertiveness Training.** Alberti and Emmons (2008) define assertive behavior as that which is direct, firm, and positive and which promotes equality between individuals or groups of individuals. People who are assertive act in their own best interests while also considering the interests of others. They stand up for themselves, exercise their personal rights, and are able to express their feelings to others. But being assertive should not be confused with acting aggressively. Assertiveness respects the rights and needs of others and is founded on the principle of equality. When someone acts aggressively without regard for another person’s rights, wishes, or needs they are not acting consistent with this definition of assertiveness and are not behaving in a way that will lead to successful interpersonal relationships.

Non-assertive behavior, by contrast, is when someone denies their own needs, is inhibited in their interpersonal communications, and allows others to make decisions for them (Alberti & Emmons, 2008). When a person acts in a non-assertive manner they are unlikely to get their needs met and may even create feelings of dislike or anger in other people. Many non-assertive people have learned indirect ways of getting their needs met that may be partially successful but also cause significant consequences. These behaviors or styles are sometimes referred to as “passive-aggressive” actually combine the non-assertive and aggressive styles. They act non-assertively in direct communication but aggressively in discreet and non-direct ways such as coming up with other reasons to justify their behaviors or doing things that they would not admit to doing.
Importance of assertive behavior. Learning to be assertive can be one of the most important skills in decreasing the amount of stress one experiences. Non-assertive behavior is associated with high levels of anxiety and stress as a person is reluctant to act in a way that would maximize their chances of having their needs met and makes a person more vulnerable to being controlled by others. Aggressive people, while potentially being successful at getting their immediate needs met, create hostility and resentment on the part of others and so sacrifice long-term relationships and goal attainment for immediate rewards. Thus, they too struggle to achieve their goals over the long-term, especially those of a social nature such as intimacy and friendship (Alberti & Emmons, 2008).

Fundamentals of assertiveness. There are several reasons why people do not act assertively. First, many people have been taught that they should not act assertively. Various sources such as the family, the community, school, work, and even church often reward compliant and submissive behavior and discourage a person from asking questions, attempting to satisfy their own needs, or challenging the status quo. Although assertive behavior is becoming more accepted and even expected in our Western culture, in other cultures such as some Asian cultures assertive behavior may be seen as acting in the interest of the individual before the interest of the group to which they belong such as the family. So certainly, an individual’s experiences and prior learning will influence their thoughts and beliefs about their right to be assertive and these beliefs will need to be challenged and modified before an individual can learn to act in an assertive manner.

Another obstacle to acting assertively is that a person may not know how to be assertive. Assertive communication involves more than just speaking one’s mind. It
involves assertive thinking, postures, facial expressions, voice quality, gestures, and other elements of non-verbal communication. It also involves learning to deal with anxiety and developing strategies that are helpful for diffusing anger and dealing with confrontation.

**Becoming assertive.** People can and do learn to be assertive but it takes time, patients, and practice. Alberti and Emmons (2008) suggest that people wanting to learn to be assertive start a journal so that they can keep notes, track progress, set goals, and work through obstacles. They provide a questionnaire in their book (“Your Perfect Right”) for helping a person gauge where they are at in terms of being assertive with respect to various situations and important people. After assessing where they are at, the next step is developing goals for being assertive and making these goals as specific as possible. It may be helpful for people to think of role models who are effective at being assertive who can models for learning to be assertive. Most importantly, learning to be assertive requires practice and patients. The authors point out that assertive behavior does not always work even for those who have practiced it for many years and so there are likely to be failures for anyone trying to be more assertive. It is helpful to start with situations and people that are more likely to lead to successes and to work up to more challenging situations as one acquires the necessary skills and attitudes.

**Dealing with anger.** Learning to be assertive can also be a powerful way to deal with anger in one’s life. Alberti and Emmons (2008) include a chapter on anger and provide strategies and rationale for learning to minimize anger. They point out that there are several myths about anger that must be corrected in order to discuss effective ways of managing anger. The first is that anger is a universal emotion and that we should never expect or desire to eliminate this emotion from our experience. But, anger is not a
behavior and should never be used to justify a behavior. Releasing our anger by venting or through aggressive acts is also a myth. The idea that anger builds up inside and that if we don’t vent it we’ll explode is false. Certainly we can become angry about more and more things if we don’t resolve them but there is no evidence that just venting anger does anything to resolve that anger. What is important is not venting anger but finding ways of resolving the source of the anger. Anger is an emotion that indicates a perception of unfairness in our lives and can cue us in to people and situations that may be taking advantage of us or treating us unfairly. Being aware and accepting of our anger can help us to recognize situations that we may choose to deal with assertively.

Being assertive is an important strategy for helping resolve and minimize anger in our lives. By acting assertively we can begin to deal with the people in our lives—spouses, bosses, neighbors, family members, kids—that may not always have our personal interests in mind and so treat us in ways that make us feel angry. Alberti and Emmons (2008) point out important things to consider when confronting someone when you are angry. We should first make sure that expressing our anger is for something important to us and that we have a goal in mind other than just speaking our mind. We should take ownership of our feelings and state them directly so the other party is aware of how the situation has affected us. We should stick to the facts of the situation and work towards resolving it, not on assigning blame. We should also accept responsibility for our own actions and seek common ground where possible. Most importantly, we should seek a win-win outcome so that both parties walk away having gained something otherwise we will be competing with the other person for who is going to win.
Although anger is a normal and universal emotion, chronic anger not only leads to high levels of stress and anxiety but is a major risk factor for a heart attack. Thus it is important to learn how to assertively deal with situations and people who cause us to feel angry.

Mindfulness.

**Nature of mindfulness.** There are several ways of defining and describing what mindfulness is and is not. First, mindfulness can be described such as by Kabat-Zinn as, “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment” (Kabat-Zinn 2003, p. 145) and by Bishop et al., “self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment” and “adopting a particular orientation toward one’s experience that is characterized by curiosity, openness, and acceptance” (p. 232). Though definitions sometimes make mindfulness seem like it’s a foreign experience it is actually an experience that is familiar and common to all of us. We experience being mindful when we pay particularly close attention to some experience such that we are very focused on the object of our experience much more so than our thoughts about the experience.

Sometimes it is helpful to define mindfulness by what it is not. Being lost in thought, daydreaming, eating without really paying attention to what we’re eating, or engaging in any number of automatic activities without really be aware of doing them are examples of not being mindful. Often accidents happen when we are not appropriately aware of our actions and we are more likely to engage in self-destructive activities.
Perhaps the best example of not being mindful is when we arrive somewhere and do not remember the trip we took getting there.

Mindfulness can also be described by a number of characteristics or traits that go along with the experience of being mindful. Kabat-Zinn (1990) provides several “attitudes” of mindfulness--beginner’s mind, letting go, trust, acceptance, non-judgment, non-striving, and patients. Beginner’s mind means that when we are mindful, we approach an experience as if it is new and without pre-judging or predetermining what the experience will be like. Letting go implies that we do not hang on to past experiences in a way that clouds or colors our perception of our current experience. Trust indicates that we trust our internal experience and our internal wisdom such as is discussed by Linehan (1993) in her Wise Mind metaphor. Acceptance describes a way of experiencing such that we do not deny, repress, or modify what we experience but accept it for what it is regardless of the consequence. This is not to say that we condone an experience or must like it but simply that we acknowledge that our experience is real and that it has or is happening. The psychoanalytic concept of the defense mechanism where experience, thoughts, and feelings may be denied in any number of ways because of the unacceptable nature of the material is one way to conceptualize what it would mean to be non-accepting of our internal experience. Acceptance goes along with the attitude of non-judgment that takes our experience as a true experience without an immediate and automatic judgment that often serves to block our true perception of things. The mind is almost always labeling things as “good” or “bad” and this activity colors all of our experiences in a way that changes what is actually experienced. What is meant by non-judgment is not that we don’t discern wise from unwise behaviors but that this sort of
discernment comes from a state of true, unbiased perception of the situation and from a place of deeper more reflective wisdom. Non-striving describes a state where we are not trying to get anywhere or accomplish anything but just being aware of what it is that we are experiencing. This attitude can be quite foreign and objectionable to the Western mind that has been taught that we must always be active and productive or engaged in some kind of activity (as for example in the proverb, “an idle mind is a dangerous thing”). With non-striving comes a state of mind that is not trying to get anywhere, prove any point, or solve any problem. The mind is simply in a state of “being” as opposed to “doing” in which it is highly sensitive and intuitive. Lastly, patients reflects the notion of not trying to get to the next moment or to the next experience but being satisfied with the current moment and experience. When we are in a hurry to get to the next accomplishment or the next bite of food or the next milestone in our lives, we miss or minimize our experience with what we have in our life at this very moment. Being patient is about finding contentment with what is as opposed to wanting to get to what’s next.

Another important quality of the mindful state is being in the here and now. This implies that we’re not caught up in our thoughts about past experience or worrying about what may happen in the future and how we’ll react. Here and now means that we are paying attention to our current experience whether that means watching our senses as they bring us information of the external world or watching our internal experiences such as physical sensations, thoughts, and feelings. It means that we are living in this moment, the only moment that actually exists, and are not lost in conceptual thought about the past or future.
The last and most important way of communicating and understanding mindfulness is to actually practice it. Experiences such as the raisin exercise are helpful to apply the attitudes and the descriptions to a real experience. Concepts alone are a poor substitute for real experience and for this and other reasons, teachers of mindfulness should be practiced veterans. Teachers are encouraged to read several different books on mindfulness and meditation both from the mental health community as well as that from the spiritual community (Bayda, 2002; Brach, 2004; Goldstein, 2003; Kabat-Zinn, 1990; Kabat-Zinn, 1994; Kornfield, 2008; Shapiro & Carlson, 2009). Teachers should also have their own mindfulness practice so that they are familiar with more than just the concepts but with the experience of mindfulness itself and have experienced the benefits of mindfulness personally.

**Origins of mindfulness.** As mindfulness is a natural element of human experience, it has no single source with which to trace its roots. Several religious traditions have practiced elements of mindfulness as have philosophical traditions such as Phenomenology (Brown and Cordon, 2009). However, of these many traditions, it is from the Buddhist tradition that mindfulness has been most thoroughly explored, explained, and espoused. Buddhism prescribes meditation as a way of cultivating mindfulness and freeing a person of the attachments that bring suffering.

**Mental health applications of mindfulness.** Mindfulness has been widely employed in the mental health field over the past few decades with research on mindfulness interventions expanding exponentially. Research has supported the effectiveness of mindfulness in the treatment of chronic pain (Kabat-Zinn, Lipworth, & Burney, 1984), recurrent depression (Hofmann et al., 2010), anxiety disorders (Hofmann
et al., 2010), ADHD (Zylowska, Smalley, Schwartz, 2009), substance abuse/dependence (Bien, 2009) as well as in the treatment of several health conditions such as cancer (Lengacher et al., 2009), heart disease (Sullivan et al., 2009), … A recent meta analysis of mindfulness found it to have medium to large effective size for the treatment of anxiety and depression, comparable to that of other treatments including CBT and medication (Hofmann et al., 2010).

**Neurological evidence supporting effectiveness of mindfulness.** Long term practice of mindfulness has also been shown to be associated with physical changes in the brain. Neurological evidence from electroencephalogram and imaging studies provide structural and electrical evidence of brain changes as a result of meditation. Cahn and Polich (2007) found that meditation practice increased theta and alpha wave activation which is associated with increased mental alertness. They also found increased cerebral blood flow and metabolic activation in the areas of the anterior cingulated gyrus and the prefrontal cortex—areas associated with a number of important executive control functions such as controlling emotions, stopping impulsive behaviors, planning and organizing tasks, and maintaining attention. Lazar et al. (2005) used neuroimaging methods with experienced insight meditators and found increased thickness of the prefrontal cortex and the right anterior insula that correlated with length of meditation practice.

**Mindfulness practice.** There are an infinite ways and means of practicing mindfulness and the experienced practitioner can be creative in devising new ways of helping people remember to be mindful. However, for the purposes of the course, several common practices used in the Mindfulness-based Stress Reduction program (Kabat-Zinn,
1990) are included as standard practices. Detailed instruction for leading these practices are provided in Kabat-Zinn (1990) and Stahl and Goldstein (2010).

*Raisin exercise.* The first of these is the Raisin Exercise or what is also referred to as mindful eating. This exercise introduces mindfulness by having the student experience eating a raisin as if for the very first time. This is a good practice to help describe what mindfulness is and to provide experience to go with the seven attitudes of mindfulness (Kabat-Zinn, 1990).

*Body scan.* The body scan is similar to a progress relaxation practice but focuses more on being in the present moment, focusing on the sensations provided by different areas of the body. This is a good practice to use in the beginning as it helps induce relaxation, is typically done lying down, and starts to develop the awareness of how thoughts often take us away from our immediate experience.

*Mindful breathing.* This is also a good practice to teach up front as it can be used almost immediately by most people to help manage stress. This practice fits well with the discussion of diaphragmatic breathing introducing the here and now component that will help increase the effectiveness of the practice for relieving stress.

*Sitting meditation.* Although more difficult to learn, sitting mediation almost always serves as the core or sole practice of long-term meditators. This is so because it is a position that can be maintained for longer periods of time and facilitates alertness and awareness through the maintenance of posture. However, sitting meditation can also be more difficult for some students to learn and may be accompanied by the anxiety of silence and boredom. It is best introduced after one to two weeks with the body scan.
Sitting meditation can also be practiced in a number of ways though in general there are three basic types (Siegel, Germer, & Olendzki, 2009). The most common method of meditation is a concentration mediation in which the mind is focused on a single experience such as the sensation of breath, either in the nose, the chest, or the abdomen. Other sensations can also be used as the focus such as pains or itches. A mantra or a phrase repeated silently can also be used as the object of focus. The other method is simply called mindfulness meditation and in this form the mind remains open and alert to all experience including thoughts, emotions, and sensations. This is a more difficult form of mediation because the mind is more easily distracted by thoughts and it is more difficult to maintain the mind in a state of open awareness. Loving kindness meditation can be considered a third form in which one focuses on repeating a phrase with the intention of being compassionate towards the self and others.

**Walking meditation.** Walking mediation is another popular form of meditation and is often used by people who have difficulty sitting still and also as a way of breaking up periods of sitting during longer practice sessions as during retreats. In this meditation, the movements of the legs and body as well as the sensations involved in walking (foot striking floor, shifting of weight, balance, etc.) serve as the focus of attention. This practice is also difficult for many people who find it challenging to focus on something they have always done unconsciously and automatically.

**Learning acceptance, non-judgment, and equanimity.** We create stress in our lives when we unnecessarily put negative judgments on our experiences and allow ourselves to react to situations with anger, frustration, worry, dread, and sadness. Being mindful and learning to accept our experience without judging it means that we allow
things to happen without reacting to them in our habitual pattern. Our spouse or partner says something negative to us and we want to react with anger, hurt, and defensiveness. Yet if we’re mindful we can watch these feelings unfold inside of us and accept that we are hurt and want to strike back, and we can then stay present in this moment, stay engaged with our partner, and explore more fully what this comment is about and how we might best respond to it. Perhaps we discover upon deeper inquiry that our partner is having a bad day and so we can now dispense with our anger and provide our partner with love and acceptance. Or perhaps this comment represents some bottled up frustration that our partner is experiencing as a result of our own behavior. Being mindful means opening up to this experience of learning about ourselves and how we are in the world. It means being open to the possibility of change, to the impact of our behaviors, and to our own needs as well as to the needs of others.

There is no easy, straightforward way to teach how mindfulness can be used to deal with difficult situations. Using examples that students provide, examples from one’s own life, and stories of others can be useful anecdotes to help convey how mindfulness and the attitudes of acceptance and non-judgment can be used to diffuse situations that cause stress and painful emotions.

**Dealing with stress.** One of things we can benefit from early in our development of mindfulness skills is the awareness of when we are stressed. Tension headaches, irritability, back aches, and other signs of stress do not just “turn on” at some point in the day. These tensions arise gradually as we maintain a state of stress throughout the day. We are typically so caught up in our actions and thoughts that we do not notice how the stress is accumulating or the warning signs from our bodies that our muscles are tired.
from being tense. As we start to practice mindfulness, we begin to become more aware of the slow buildup of stress and tension before our bodies are exhausted which allows us to then take measures to decrease the stress, stop the sympathetic branch of the nervous system, and slow down to give way to the healing and rejuvenating processes of our bodies. Feeling stress sooner allows us to become mindful of our attitudes and thoughts that are fueling anxieties and worries and also to take breaks, go for a walk, and practice some mindful breathing.

Working with thoughts and attitudes will be discussed more in the cognitive section but if we can become mindful when we’re feeling stressed or anxious, we can focus on the thoughts and beliefs that lie behind these feelings so that we become more objective about them. Perhaps in our previous example of being criticized or insulted by our partner we become very angry. If we can become mindful and aware of this feeling, we might also become aware of the belief behind the feeling such as “this isn’t fair,” or “my partner doesn’t love me anymore,” or perhaps even the activation of deeper held beliefs about ourselves such as “there’s something wrong with me.” The point is that when we can become aware of these thoughts and beliefs we can then deal with the source of the stress which is likely to be something different from what we thought it was. We want to believe the source of stress is our partner’s comment, but if we can be mindful of our internal reactions and beliefs, we will find that we are in control of our own reactions and feelings and that we don’t have to let this event cause us stress or make us anxious.

**Going towards anxiety.** One of the typical reactions many people have in response to stressful situations, specifically situations that cause anxiety, is to avoid. At
times this is a wise action as we need to get away, calm ourselves down, clear our head, and determine what meaningful action to take. At other times, avoiding anxiety-provoking situations causes us more stress in the long run because we are not dealing with the situations that are causing us stress such as a rude coworker or problems with a teacher or seeing a doctor about symptoms that are bothering us out of fear that it could be something serious.

Mindfulness can be a way of learning to recognize anxiety and become aware of the avoidance strategies that are being used to get away from it. When we become aware that we are avoiding we can also then reflect on and develop more valued, meaningful, and healthy courses of action. The anxiety-avoidance relationship is often one that we are unaware of and by being more mindful we can break this automatic connection and create a space where we can determine a more intentional response. Mindfulness also helps us to tolerate the anxiety by focusing on it as a set of physical sensations in response to fearful thoughts that may or may not be true and accurate. We often encounter forms of anxiety when we are just sitting in meditation such as the feeling that we need to get up and do something or feeling that we are bored or that we need to move or scratch an itch. While we can certainly give ourselves permission to do all of these things, it can be insightful to just watch them as well to see how the body wants to react. Often in the process of watching these experiences and opening up to them, we find that they change or go away entirely.

**Physical pain.** Physical pain is another experience that can cause stress and anxiety. Typically we respond to physical pain with some fear and anxiety because we think that this pain might be associated with some serious health concern such as cancer.
or we may believe that the pain will never go away. The worry about the source of the pain will actually make the perception of pain more severe. We might also have a number of beliefs about the pain such as that it isn’t fair, or that it is going to ruin the quality of our life, or perhaps even that we are being punished by God or somehow deserve this pain. All of these beliefs will serve to increase the distress encountered as a result of the pain.

Kabat-Zinn et al. (1984) were able to show that when people actually focused on the sensation of pain itself, the perception of pain and the limitations caused by the pain both decreased. He reasoned that by focusing on the pain itself, patients were able to separate the physical sensation of pain from the thoughts and feelings about the pain and that it was actually these thoughts and feelings that contributed more to the perception of pain that the sense of pain itself. So patients were able to identify and separate the “story” around the pain, feeling sorry for themselves, and even the pain that had become part of their identity from the pain itself. This separation provided a great sense of freedom for these patients who often felt that their pain was the end of their happiness and enjoyment of life. This isn’t to say that the pain itself went away but for most it became something that was tolerable and not debilitating.

**Thoughts.** Watching our thoughts is one of the most difficult yet one of the most powerful experiences of mindfulness. Normally we have thousands of thoughts that go on in our minds at any given moment and we are typically aware or conscious of very few of these thoughts. But mindfulness gives us an ability to look more deeply into our minds and to watch as our thoughts unfold. When we sit in meditation, especially a mindful meditation, we attempt to watch these thoughts without getting caught up in
them or reacting to them but just seeing them as thoughts that go through the mind. Metaphors are sometimes helpful here. One is to watch the thoughts go through the mind as clouds going through the sky (Linehan, 1993). The clouds are not the sky, that is our pure awareness, and they are not permanent or definite. They are temporary objects that move across the sky and then disappear. The same is true of thoughts. They do not represent some ultimate reality as we often believe they do. They are sometimes right and sometimes wrong, sometimes helpful and sometimes unhelpful. In meditation we just sit and watch them go through our minds like clouds going across the sky.

Another metaphor is that we are standing on a train platform watching the train cars go by (Kabat-Zinn, 1990). As long as we are on the platform we can watch these cars from a distance. But inevitably we find ourselves on one of these cars and no longer aware that the car is really a car. Only when we get back on the platform can we again watch the car go by and see it for what it is. The same is true of thoughts. When we watch our thoughts we are aware of them as thoughts and can see them objectively. But when we become attached to the thought we lose awareness and become identified with the thought. Now, in a sense, we are this thought and under its control.

**Emotions.** Much like we watch thoughts, we can also learn to accept our emotions through our mindfulness practice. Often we only want to be happy and we chase this happiness by engaging in activities that normally make us happy. And this can be a positive thing. But when we avoid, ignore or try to suppress other emotions, emotions that we typically judge as being “bad” or “negative,” we can become cutoff from ourselves and our true state of being. While most people do not enjoy feeling sad, being angry, or experiencing anxiety, these are normal feelings that we all have and the
more that we can accept them, learn from them, and allow them to run their course, the less running and avoiding we will have to do. And often, running or hiding from our true emotions can lead to a great deal of stress and dysfunctional coping behaviors.

In mindfulness, the goal is to watch and accept whatever it is we’re feeling, knowing that it is not a permanent state, but like a thought, something that will come and go. Emotions are reactions to our environment that indicate whether experiences or situations are “positive” or “negative” for our wellbeing. But as will be discussed in the cognitive module, emotions are based on the beliefs we have about the world and the past experiences we’ve had dealing with the world. These experiences form out expectations about people, places, and events and what the consequences will be of specific actions and behaviors. And like thoughts, if we can allow there to be space between our emotions and our actions we will often find new experiences that will open us and enhance our lives. For example, have you ever had the experience where you dreaded something but then when you actually did it you found it to be a very positive experience? At the same time, emotions can alert us to things that are wrong in our life and motivate us to take action. The oppression that many people face in our society can lead to a reaction of anger and this emotion can motivate us to become agents of social change or to become assertive and standup for our equality.

In mindfulness, there is not clear cut answer in how to respond to emotions other than to be open to them, to experience them, and to accept them. Once we have allowed them space to exist we can then learn from them and find out what they are telling us about our lives or our world. By providing space, we can also be intentional about how we choose to respond to the situation.
Cognitive Strategies.

Efficacy and applications of cognitive strategies. Cognitive Therapy was developed in the 60’s and 70’s by Aaron Beck (2005) as a response to both psychoanalytic theory and behaviorism. At the same time, Albert Ellis (1962) developed a similar theory that he called Rational Emotive Behavior Therapy (REBT). Both theories focused on the importance of a person’s thinking on their emotions and behaviors. They recognized that people react to situations in very different ways based on their beliefs about themselves and the situation.

Since that time, Cognitive Therapy has been shown to be efficacious in the treatment of several mental disorders and conditions and along with behavioral theory, which is often practiced together with Cognitive Therapy, has more research support than any other theory. It has been shown to be specifically efficacious in the treatment of mood and anxiety disorders (Beck, 2005; Beck & Emory, 1985). Cognitive Therapy has also been shown effective when provided in a “non-therapeutic” environment such as in a workshop or through a self-help book such as Feeling Good (Burns, 1980). In the largest of these studies (Jamison & Scogin, 1995), 70 percent of the participants who initially met criteria for major depressive disorder no longer met criteria after only four weeks of reading Feeling Good and this rate went up to 75 percent after three months suggesting that it was not just a “feel good” book without any real therapeutic value. In support of its therapeutic value, Feeling Good is the book most often recommended by mental health workers for their clients followed by The Feeling Good Handbook (1999). Although this course will use ideas, techniques, and language from other source of
Cognitive Theory, it will primarily follow the language and format provided in *The Feeling Good Handbook* to facilitate student learning.

**Cognitive model -- relationship between thoughts and emotions.** As mentioned previously, the focus of Cognitive Therapy is the thoughts and beliefs a client holds that affect their perception and reaction to events in their lives. Emotions such as anger, frustration, anxiety and depression are natural consequences of the thoughts we have about the world. If we believe a situation is dangerous, we will feel anxiety. If we think that we are being treated unfairly, we will be angry. If we believe that we cannot succeed and be happy in life, we will be depressed. If we want to change how we are feeling we need to change the way we are thinking about life.

**Beliefs.** Beck (2005) talks about how each person has a set of rules that guide how they react to situations and which provide the standards by which people judge the themselves and the world. These rules also provide a framework for how we understand life situations and the meaning we ascribe to situations and events. Judith Beck (1995) refers to these ideas as beliefs and indicates that they are learned starting in childhood. She distinguishes between our *core beliefs* which are fundamental to who we are as a person and *intermediate beliefs* which are rules that govern how we act and how we judge things in the world as well as attitudes that reflect how we see and interpret our world. Another word in the lexicon is that of *schema* which reflects the idea that we develop a mental model of how the world works so that we can develop expectations about cause and affect relationships. These schema govern not only how a person will perceive and interpret the world but what they do in order to obtain a specific outcome.
Rules, beliefs, and schema are all very similar concepts and all important to how we can learn to influence our mood by changing the way we think about ourselves and the world.

*Cognitive Distortions.* Because our beliefs about the world are constructed from our limited experience and because situations are rarely the same, the process of perception is never a perfect process and is often influenced by distorted thinking. Our brains, while extremely capable, are none-the-less limited in their capacity to process real-time information and make split-second decisions. Thus, the process of perception takes shortcuts and this process is largely done outside of a person’s awareness. In order to understand how thinking influences feelings then we must become more deliberate about how we perceive situations and the thoughts that guide our reactions. In Cognitive Therapy this is done my examining the thoughts that go along with particular moods or behaviors or what are called *automatic thoughts.* Once these thoughts have been captured they can then be examined to determine if they are really accurate and realistic thoughts about the situation. Often these thoughts are distorted in some way and reflect the fact that we are seeing the world through a biased lens and that it is this bias that leads to negative feelings. Burns (1999) and Beck (1995) do a good job of explaining these various cognitive distortions though at times the application of a specific distortion may seem somewhat arbitrary. It is often possible to apply several different distortions and it is not necessarily important that everyone agree on the specific distortion but that the distortions selected sufficiently expose the inaccuracy so that it can be corrected and replaced with a more accurate and realistic thought. A list of cognitive disottrations discussed by Burns (1999) and Beck (1995) are discussed below.
• **All-or-nothing thinking** – seeing things in black and white categories such as feeling like a failure for getting a “B.”

• **Overgeneralization** – seeing a single negative event as a never-ending pattern of defeat.

• **Mental filter** – only paying attention to the negative aspect of a situation and disregarding the positive.

• **Discounting the positive** – discounting the important of positive experiences such as receiving positive feedback and doing well on some project.

• **Jumping to conclusions** – interpreting things negatively, especially how future events will turn out. **Mind reading** is concluding how other people will react or what they’re thinking and **Fortune-telling** is predicting that things will turn out badly (also catastrophizing).

• **Magnification** – Exaggerating the importance of problems and shortcomings.

• **Emotional reasoning** – believing something is true because it feels like it is true.

• **“Should” statements** – telling ourselves that we “should” do something or act a certain way. These statements bring a moral tone to things that are not moralistic and create perfectionistic expectations about our own feelings and behaviors as well as that of others.

• **Labeling** – calling ourselves or others names that inaccurately reflect the situation and imply a great deal of meaning that is not only inaccurate but unhelpful.

• **Personalization and blame** – taking the blame for something that wasn’t your fault.
Strategies for changing distorted thoughts and beliefs. Burns (1999) discusses several strategies in his book for working with distorted thoughts in order to change the resulting feelings. These are listed and briefly discussed below.

- **Identify the Distortion** – This is often the primary method of cognitive therapy and involves listing the automatic thoughts and identifying the distortions. After the distortions are understood, a more rational thought is substituted for the distorted thought. Burns uses a *Daily Mood Log* to facilitate this process but this has been changed to a “thought worksheet” for the course.

- **Examine the Evidence** – examine the evidence that this thought is true and accurate. Use two columns to list the evidence both supporting the thought and refuting the thought. If the thought is found to be inaccurate, determine what a more accurate thought would be.

- **The Experimental Technique** – If the evidence is not conclusive or is unavailable, conduct an experiment to collect the information necessary to test the validity of the thought.

- **The Double-Standard Method** – Determine the validity of the thought by asking yourself if it would be accurate if applied to a friend in the same situation.

- **Thinking in Shades of Grey** – This one works particularly well for all-or-nothing thinking and asks the person to develop a continuum and to determine where they would be on this continuum.

- **The Survey Method** – this is similar to the experiment method in that it is a way to find out what other people actually think instead of assuming what they think and how they will react.
• **Define Terms** – when derogatory labels are used it is helpful to define specifically what these labels mean in terms of personality and behavior.

• **The Semantic Method** – This method has a person replace “should” statements with more realistic statements such as “it would be nice if” and helps soften the moralistic and compulsory nature of these thoughts.

• **Re-attrition** – has a person think about all of the causal events that went into a particular outcome and to reweight their personal contribution to what happened.

• **Cost-benefit Analysis** – This method has the person weight the advantages and disadvantages of holding a particular thought or engaging in a specific behavior. This helps identify what advantages a feeling or behavior holds for a person and at the same time what they must give up in order to get these advantages.


*Step 1: identify the upsetting event.* Write a brief description of the scenario or the problem that led to the negative feelings.

*Step 2: Record your negative feelings.* Record each negative feeling and rate each one from a scale of 0 to 100 with 100 being the most intense experience of that emotion. Be careful not to confuse feelings and thoughts. Feelings are generally described with one word—angry, frustrated, guilty, anxious, sad, and depressed.

*Step 3: The Triple-Column technique.* Now write down the thoughts that are associated with the bad feelings or the thoughts that were going through your head when the bad feeling started. These should not be interpretations or analyses of the feeling. For each automatic thought, identify the distortions in that thought. After the distortions
have been identified, come up with a more accurate and realistic thought for the situation. Then ask yourself how much you believe this new thought (0-100). The rational response must not only be accurate and realistic, but it must be believable in order to be helpful.

Step 4: Outcome. Now that a new thought has been created and the distortions identified in the automatic thoughts, rerate your belief in each of the automatic thoughts. This will let you know if you’ve sufficiently uncovered the distortion in the automatic thought. Finally, reassess the emotions identified at the start to see if they have changed.

Building proficiency. This objective can be accomplished through discussion of the process, going through examples in class, assigning home practice and reviewing that practice the next session, and ensuring students are reading the examples in the book. Practice and feedback are key to helping students gain mastery of this process.

Integrating Behavioral, Mindfulness, and Cognitive Strategies.

The integration of mindfulness, cognitive strategies, and behavioral skills can provide an even more powerful ability to deal with stress and strong emotions. This section will talk briefly about the strengths each of these parts can bring to the whole and how each can enhance the effectiveness of the others.

Mindfulness as a core skill. Mindfulness provides many core skills that help enable the other strategies. It provides an ability to monitor the level of stress, increases one’s ability to recognize automatic thoughts, helps one develop the ability to distance themselves from their thoughts, and helps one handle distressing emotions such as anxiety which is helping in and of itself but also in learning a new skills such as
assertiveness or in conquering social anxiety. Lastly mindfulness can help us develop the ability to accept the things that we cannot change.

*Cognitive strategies.* Working with our thoughts provides a powerful skill that helps us identify and change the thoughts and beliefs that contribute to stress. While mindfulness alone can help us identify these thoughts, it does not provide us with a way of modifying them into something more in-line with our personal values and goals. Being able to work with the thoughts that we identify through mindfulness can help us deal with stressors and problems in our life. Cognitive strategies can also help one to modify problematic behaviors by understanding the beliefs and motivations such behavior is built upon.

*Behavioral.* Behavioral strategies provide the “how to” skills to deal with stress-inducing situations such as interpersonal communications, anger, problem solving, and procrastination. While mindfulness and cognitive strategies are internal strategies, behavioral strategies are helpful in our interactions with others and in solving the real problems we face in life.

*Summary.* This guide has provided an overview of the concepts and skills taught in the class and attempted to show how they can be used alone or when integrated together to help overcome the causes of stress in people’s lives. Of course stress and negative emotions are normal parts of life so it would be counterproductive to believe that these techniques and strategies will ever eliminate stress from one’s life. In fact the pursuit of such a goal is sure to lead to more stress as one encounters stress and then judges oneself for falling short of their goal. It is hoped, however, that the use of these skills will lead to a reduction in stress for those who put the time and energy into learning
these strategies and incorporating them into their repertoire of life skills. Beyond the treatment of stress, the skills as taught in the course have also been shown to be effective in resolving and preventing both anxiety and depressive mood disorders.

**Detailed Outline**

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<th>Details</th>
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<td>1. Course Introduction</td>
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<tr>
<td>1.1. Introductions &amp; Ice Breaker</td>
<td>15 min</td>
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<tr>
<td>1.2. Course overview / Questions</td>
<td>15 min</td>
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<tr>
<td>1.3. Pre-assessments (BDI, BAI, Perceived Stress Measure, Mindfulness)</td>
<td>60 min</td>
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<tr>
<td>1.4. Experiential - Diaphragmatic Breathing</td>
<td>15 min</td>
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<tr>
<td>1.5. Assign Home Practice</td>
<td>5 min</td>
</tr>
<tr>
<td>1.5.1. Read stress article</td>
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<tr>
<td>1.5.2. Diaphragmatic Breathing, 3 min, 2x per day, complete practice log</td>
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<tr>
<td>2. Nature of Stress</td>
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<tr>
<td>2.1. Review of Previous Lesson</td>
<td>5 min</td>
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<tr>
<td>2.2. Discussion and Review of Home Practice</td>
<td>10 min</td>
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<tr>
<td>2.3. Lecture</td>
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<tr>
<td>2.3.1. Nature of stress</td>
<td>60 min</td>
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<tr>
<td>2.3.2. Problem solving</td>
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<tr>
<td>2.4. Experiential – Progressive Muscle Relaxation</td>
<td>20 min</td>
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<tr>
<td>2.5. Assign Home Practice</td>
<td>5 min</td>
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<tr>
<td>2.5.1. PMR, 1x/day for 20 min</td>
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<tr>
<td>2.5.2. Readings: MBSR Workbook Chapters 1 &amp; 2</td>
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<tr>
<td>3. Intro to Mindfulness</td>
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<tr>
<td>3.1. Review Previous Lesson</td>
<td>5 min</td>
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<tr>
<td>3.2.</td>
<td>Discuss Home Practice</td>
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<td>3.3.</td>
<td>Lecture – Mindfulness 1</td>
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<td>3.4.</td>
<td>Experiential – Mindful eating</td>
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<tr>
<td>3.5.</td>
<td>Assign Home Practice</td>
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<tr>
<td>3.5.1.</td>
<td>Positive experience</td>
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<td>3.5.2.</td>
<td>PMR, 1x/day for 20 min</td>
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<tr>
<td>3.5.3.</td>
<td>Reading Mindfulness Intro, Ch 3, 4, &amp; 5</td>
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<td>4.</td>
<td>Intro to Mindfulness Practice</td>
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<tr>
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<td>Review Previous Lesson</td>
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<tr>
<td>4.2.</td>
<td>Discuss Home Practice</td>
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<tr>
<td>4.3.</td>
<td>Lecture – Intro to Practice</td>
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<tr>
<td>4.4.</td>
<td>Experiential – 3 minute breathing space</td>
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<td>4.5.</td>
<td>Lecture – Sensations</td>
</tr>
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<td>4.6.</td>
<td>Experiential – body scan</td>
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<td>4.7.</td>
<td>Assign Home Practice</td>
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<td>4.7.1.</td>
<td>Body scan 1x/day for 20 min, complete practice log</td>
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<td>4.7.2.</td>
<td>3-minute breathing space 2x/day, complete practice log</td>
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<td>4.7.3.</td>
<td>Reading MBSR Intro, Ch 6</td>
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<td>5.</td>
<td>Mindfulness and Thoughts</td>
</tr>
<tr>
<td>5.1.</td>
<td>Review Previous Lesson</td>
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<tr>
<td>5.2.</td>
<td>Discuss Home Practice</td>
</tr>
<tr>
<td>5.3.</td>
<td>Lecture – Thoughts</td>
</tr>
<tr>
<td>5.4.</td>
<td>Experiential – sitting meditation</td>
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<td>5.5.</td>
<td>Assign Home Practice</td>
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<tr>
<td>5.5.1.</td>
<td>Sitting meditation, 1x/day for 20 min</td>
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<td>5.5.2.</td>
<td>Readings: MBSR Ch 7</td>
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<td>6.</td>
<td>Mindfulness and-Emotions</td>
</tr>
<tr>
<td>6.1.</td>
<td>Review Previous Lesson</td>
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<tr>
<td>6.2.</td>
<td>Discuss Home Practice</td>
</tr>
<tr>
<td>6.3.</td>
<td>Lecture – Emotions</td>
</tr>
<tr>
<td>6.4.</td>
<td>Experiential – Walking Meditation</td>
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<tr>
<td>6.5.</td>
<td>Assign Home Practice</td>
</tr>
<tr>
<td>6.5.1.</td>
<td>Walking meditation, 1x/day for 20 min</td>
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<tr>
<td>6.5.2.</td>
<td>Readings: MBSR Ch 8 &amp; 9</td>
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<tr>
<td>7.</td>
<td>Mindfulness – Stress and Distress</td>
</tr>
<tr>
<td>7.1.</td>
<td>Review Previous Lesson</td>
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<tr>
<td>7.2.</td>
<td>Discuss Home Practice</td>
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<tr>
<td>7.3.</td>
<td>Lecture – Dealing with stress and distress</td>
</tr>
<tr>
<td>7.4.</td>
<td>Experiential – Mindfulness Meditation</td>
</tr>
<tr>
<td>7.5.</td>
<td>Assign home practice</td>
</tr>
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<td>7.5.1.</td>
<td>Mindfulness meditation 1x / day for 20 min</td>
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<tr>
<td>7.5.2.</td>
<td>Readings: Feeling Good, Preface and Chapters 1 &amp; 4</td>
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<td>8.</td>
<td>Cognitive 1</td>
</tr>
<tr>
<td>8.1.</td>
<td>Review Previous Lesson</td>
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<tr>
<td>8.2.</td>
<td>Discuss Home Practice</td>
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<tr>
<td>8.3.</td>
<td>Lecture – Intro to Cognitive Strategies</td>
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<td>8.4.</td>
<td>Experiential – mindful practice</td>
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<td>8.5.</td>
<td>Assign Home Practice</td>
</tr>
<tr>
<td>8.5.1.</td>
<td>Identify automatic thoughts and distortions for 2 scenarios</td>
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<tr>
<td>8.5.2.</td>
<td>Mindfulness practice 1x/day for 20 min</td>
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### 9. Cognitive 2

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<tr>
<td>9.1. Review Previous Lesson</td>
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</tr>
<tr>
<td>9.2. Discuss Home Practice (scenarios)</td>
<td>20 min</td>
</tr>
<tr>
<td>9.3. Lecture – Automatic Thoughts</td>
<td>45 min</td>
</tr>
<tr>
<td>9.4. Experiential – mindful practice</td>
<td>20 min</td>
</tr>
<tr>
<td>9.5. Assign Home Practice</td>
<td></td>
</tr>
<tr>
<td>9.5.1. Complete 2 thought worksheets</td>
<td></td>
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<tr>
<td>9.5.2. Mindfulness practice 1x/day for 20 min</td>
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</tr>
<tr>
<td>9.5.3. Reading: Feeling Good Chapters 5 &amp; 6</td>
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### 10. Cognitive 3

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<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>10.1. Review Previous Lesson</td>
<td>10 min</td>
</tr>
<tr>
<td>10.2. Discuss Home Practice (scenarios)</td>
<td>20 min</td>
</tr>
<tr>
<td>10.3. Lecture – Attitudes and Beliefs</td>
<td>45 min</td>
</tr>
<tr>
<td>10.4. Experiential – mindful practice</td>
<td>20 min</td>
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<tr>
<td>10.5. Assign Home Practice</td>
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<tr>
<td>10.5.1. 2 scenarios, do vertical arrow and challenge belief</td>
<td></td>
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<tr>
<td>10.5.2. Mindfulness practice 1x/day for 20 min</td>
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<tr>
<td>10.5.3. Reading: Feeling Good Chapters 7 &amp; 8</td>
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### 11. Cognitive 4

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<tr>
<td>11.1. Review Previous Lesson</td>
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</tr>
<tr>
<td>11.2. Discuss Home Practice (scenarios)</td>
<td>20 min</td>
</tr>
<tr>
<td>11.3. Lecture – Procrastination</td>
<td>45 min</td>
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<tr>
<td>11.4. Experiential – mindful practice</td>
<td>20 min</td>
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<tr>
<td>11.5. Assign Home Practice-</td>
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<td>11.5.1.</td>
<td>Procrastination 5 steps with 1 task</td>
</tr>
<tr>
<td>11.5.2.</td>
<td>Mindfulness practice 1x/day for 20 min</td>
</tr>
<tr>
<td>11.5.3.</td>
<td>Reading: Feeling Good Chapters 11, 12, 14, &amp; 17</td>
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| 12. | Cognitive 5 |
| 12.1. | Review Previous Lesson | 10 min |
| 12.2. | Discuss Home Practice (scenarios) | 20 min |
| 12.3. | Lecture – Anxiety | 45 min |
| 12.4. | Experiential – mindful practice | 20 min |
| 12.5. | Assign Home Practice- | 5 min |
| 12.5.1. | Two thought worksheets for anxiety |
| 12.5.2. | Mindfulness practice 1x/day for 20 min |
| 12.5.3. | Reading: Your Perfect Right Chapters 1-6 |

| 13. | Assertiveness 1 |
| 13.1. | Review Previous lesson | 10 min |
| 13.2. | Discuss Home Practice | 10 min |
| 13.3. | Lecture – Assertiveness | 45 min |
| 13.4. | Experiential - | 20 min |
| 13.5. | Assign Home Practice | 5 min |
| 13.5.1. | Reading: Your Perfect Right Chapters 8, 13-17 |

<p>| 14. | Assertiveness 2 |
| 14.1. | Review Previous lesson | 10 min |
| 14.2. | Discuss Home Practice | 10 min |
| 14.3. | Lecture – Assertiveness | 45 min |
| 14.4. | Experiential - | 20 min |
| 14.5. | Assign Home Practice | 5 min |</p>
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<th>Integrate / Summary</th>
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<tr>
<td>15.1</td>
<td>Post-class assessments</td>
<td>60 min</td>
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<tr>
<td>15.2</td>
<td>Discussion / Scenarios</td>
<td>45 min</td>
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<tr>
<td>16.</td>
<td>Final – No Class</td>
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<tr>
<td>16.1</td>
<td>Final Paper Due</td>
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Appendix B – Course Syllabus

Course Title

*Enhancing College Success through Effective Stress Management*

Course Description

This course teaches students effective strategies to both manage and decrease the stress they experience in their lives. By learning and applying these strategies students will be able to increase their emotional, mental, physical, and spiritual health by being happier, less anxious and stressed, and more proactive in pursuing the goals in their life. The strategies presented in this course go well beyond those that teach basic relaxation or ways of better tolerating stress but are proven ways of resolving the causes and sources of stress. This course integrates a basic understanding of stress with proven strategies of mindfulness, cognitive restructuring, and assertiveness training into an integrated ability to face and resolve fears, concerns, and reactions that lead to stress, anxiety, depression, anger and other unpleasant emotions. This course teaches the skills necessary for students to develop and maintain positive and resilient mental health, contributing to overall health and wellbeing.

Course Objectives

- Students will understand the physiological and psychological mechanisms of stress and the mental and physical consequences that too much stress can lead to.
- Students will gain understanding and experience with methods for managing stress and inducing relaxation.
• Students will learn the importance and fundamentals of assertive communications and learn to be assertive in personal situations

• Students will learn effective problem solving strategies to help eliminate sources of stress and allow more effective and intentional living.

• Students will gain experience with mindfulness practice as a way of managing stress, tolerating and accepting difficulty emotions, and helping to resolve sources of stress

• Students will develop the ability to identify and challenge thoughts, beliefs, attitudes, and internal rules to be able to modify distressing emotions.

Course Resources


Course Outline

Adopt from outline provided in Course Guide (Appendix A) based upon number of sessions, session length, grading plan, and other customizations.
Appendix C – Course Slides

MODULE 1
NATURE OF STRESS AND STRESS MANAGEMENT
Enhancing College Success through Effective Stress Management

What is Stress?

- Stressor – anything that requires from a person some kind of unusual demand or response
  - Can be to a positive event or dangerous situation
  - Can range from mild to severe (traumatic) such as a threat, a failure, or even a success
- Stress – body’s response to a stressor
  - Includes physical, mental and emotional changes
  - Can be beneficial to performance and survival
Stressors
- What are the things that cause you stress?

Spend time brainstorming stressors.

Effects of Stress
- In what ways does stress affect you?
- How does it impact your life?
- Explore advantages and disadvantages of stress

Spend time brainstorming advantages and disadvantages of stress and how it impacts us.

Stress and Performance

Stress Performance Connection

[Graph showing the relationship between stress and performance]

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Nervous System

**Functions**

- **Sympathetic**
  - Activates body systems to meet demands of environment
  - Increases energy availability, oxygen
  - Stops non-essential functions such as digestion and tissue repair

- **Parasympathetic**
  - Recovery and renewal
  - Digestion
  - Rest
  - Repair

Endocrine System
Immune System
- Protects body from foreign invaders including viruses and bacteria
- Important in keeping a person healthy by fighting off infections

Stress Response
- Adaptive response to a potential threat – “fight or flight” response
- Increased heart rate and blood flow
- Increased respiration
- Release of stress hormones adrenaline, norepinephrine, and cortisol which facilitate energy availability
- Activation of the immune system to thwart potential invaders

Symptoms of Stress
- Chest pain / heart pounding
- Quick, shallow breathing
- Dizziness / light-headed (hyperventilation)
- Sweating / Chills
- Nausea / stomach ache
- Heavy legs
- Sense of being overwhelmed
- Worry and catastrophic thinking
Prolonged or Chronic Stress

- Chronic stress can cause or contribute to a broad range of health problems
  - Infectious disease
  - Heart disease
  - Depression
  - Cancer
  - Weight gain
  - Diabetes
  - Osteoporosis
  - Arthritis
  - Aging

Anxiety, Fear, and Stress

- Fear – thought of danger
  - May be something tangible like a snake
  - May be something conceptual like death or poverty
  - You can have a fear of something without getting anxious
- Anxiety – emotional response to a fear
- Stress – physical response that typically accompanies anxiety
  - Can also experience stress without anxiety
  - Chronic stress typically associated with anxiety

Causes of Stress

- Physical
  - Demands on body such as exercise, work, pollution
  - Illness, pain
- Psychological
  - Pressure or demands on time, resources, ability
  - Fear and anxiety
  - Anger and frustration
  - Sadness and loss
Appraisal process

- Lazarus (1966) – stress is determined by how we think about a situation
- Appraisal – unconscious assessment of a situation to determine if it is safe or dangerous
- Reappraisal – assessment of one’s ability to cope with the situation
- Explains why people experience different degrees of stress to the same situation
- Applies to fear and anxiety as well

Coping with Stress

- What are ways we cope with stress?
  - Positive / Healthy?
  - Counterproductive?

Stress Management

- Symptoms: Relaxation, Health, Relief
- Causes: Resilience, Sources of Stress
### Symptom-Based Strategies

- Switching from sympathetic activation (fight-or-flight) to parasympathetic (recovery)
- Relaxation
- Laughter
- Socializing
- Other?
- Increasing body’s ability to tolerate stress
  - Exercise
  - Nutrition
  - Sleep

### Symptom-Based Strategies

- Despite being easy to learn and use, people still experience stress more than ever before
  - Obstacles?
    - Not sufficiently concerned about effects of stress
    - Lack of time, space, resources to practice stress management
    - Don’t find strategies useful
    - Strategies become counterproductive (e.g., alcohol)
    - Difficulty getting away from sources of stress (spouse, boss, work, worry)
  - Symptom-based strategies are often insufficient

### Cause-Based Strategies

- This course is primarily focused on teaching more advanced strategies for dealing with the sources of stress in our lives
  - Mindfulness — helps us change our relationship with experience so that we can become less reactive and more intentional in our lives
  - Cognitive Strategies — to really reduce the stress we experience we must learn to change our thoughts and beliefs
  - Assertiveness — skills to help us deal with the biggest source of stress—other people
Benefits

- Research supported
- Same techniques used by many counselors and therapists
- Also effective in reducing and managing anxiety and depression
- Provide protection against future mental and emotional difficulties
- Can lead to happier and more fulfilling lives

Seeking Help

When self-help strategies are not enough

Purpose of this Course

- This course provides strategies that have proven helpful to many to help manage stress as well as symptoms of depression and anxiety
- However, some people might not get as much benefit from this course as they would like
- This module will talk about symptoms that indicate someone should seek additional help and what that help might look like
Symptoms

- Persistent depression or anxiety
- Depression that is accompanied by periods of “mania”
  - Mania is defined as a period of time of inflated self-esteem or grandiosity, decreased need for sleep, increased goal-oriented activity, and excessive involvement in pleasurable activities that may have painful consequences (DSM-IV)
- Suicidal thoughts
  - Significantly reduced ability to participate in normal activities

Symptoms (Cont)

- Persistent or debilitating anxiety
- Anxiety associated with traumatic experiences
  - Nightmares
  - Flashbacks
  - Avoidance of trauma reminders
- Phobias (e.g., social phobia)

Symptoms (Cont)

- Any behavior, mood, thought, or mental state that persistently impedes your ability to effectively engage in and enjoy the activities of your life
  - Drugs and alcohol
  - Other addictions (e.g., sex, computer, gambling)
  - Obsessions and compulsions
  - Disordered thought, delusions, and hallucinations
  - Eating issues
  - Attention problems
  - Problems relating to other people
  - Sleep problems
Treatment Professionals

- Psychologist (Ph.D. or PsyD)
  - Assessment
  - Therapy
- Counselor (LCSW, MFT, LPCC, LCDC)
  - Therapy
- Psychiatrist (M.D.)
  - Medication
  - Therapy (rarely)
- Family or General Physician (M.D.)
  - Medication

Treatment Types

- Psychotherapy or "Talk" therapy
  - Individual
  - Couples
  - Family
  - Group
- Medication
- Best treatment depends on a variety of factors including the specific diagnosis and patient preference

What does therapy look like?

- Many different styles and forms of therapy
- Confidentiality
- Therapy works through
  - Developing a trusting relationship
  - Gaining insight into behaviors and motivations
  - Developing strategies to change behaviors
  - Learning ways to deal with stressors and symptoms
- Typically once a week for 50 minutes
- May be individual, couple, family or group
- Generally last from 4 to 20 sessions
Effectiveness of Therapy

- Surveyed 180,000 readers
- About 4,000 had seen a mental health professional
- Of those feeling very or fairly poor prior to therapy, about 90% were feeling very good, good, or so-so at the time of the survey
- Most people reported improvement as a result of seeking treatment from a mental health professional

Module 2: Behavioral Strategies
Enhancing College Success through Effective Stress Management

Topics
- Diaphragmatic Breathing
- Progressive Relaxation
- Problem Solving
- Assertiveness
Breathing Methods

- **Chest or Thoracic Breathing**
  - Common method of breathing
  - Associated with stress and anxiety
  - Typically shallow and rapid
  - Often accompanied by holding the breath

- **Abdominal or Diaphragmatic Breathing**
  - More natural form of breathing
  - Deeper and slower
  - Activates parasympathetic nervous system which stimulates relaxation and recovery

Diaphragmatic Breathing

- Can be used to:
  - Relieve stress
  - Reduce anxiety
  - Induce relaxation
  - Alleviate headaches
  - Slow down the pulse
  - Ease muscle tension
  - Combat fatigue

Learning to Breathe

- Establish a practice
- Find times and a place to practice 2-3x each day for 5 min where you will not be disturbed
- Can be done sitting or lying down — should be comfortable
- Maintain good posture if sitting — back straight, head balanced on your spine, feet flat on the floor
How to Breathe

- How do you currently breathe?
  - Put one hand on your abdomen (right above the waistline) and one on your chest and breathe normally
  - Notice which hand rises and falls the most
- Diaphragmatic breathing
  - Try breathing so that only the lower hand moves
  - Allow the breath to deepen and slow—count to 5 on inhales and exhales

Things to try if this is difficult

- Force all the air out by sucking in your stomach; then breathe and notice the belly move
- Imagine your stomach is a balloon
- Fold your hands behind your head and allow elbows to fall backward or towards floor

Continuing Practice

- After becoming proficient in diaphragmatic breathing, practice throughout the day
  - Anytime you notice you are tense
  - During breaks
  - At scheduled times during the day
  - First thing in the morning and before bed
Progressive Relaxation

- Also known as Progressive Muscle Relaxation (PMR)
- Dates back to the 1930's as a method used to alleviate stress and anxiety
- Well researched and supported as effective way to reduce stress and anxiety

Theory

- Muscle tension is fed back to the brain through nervous system and plays a role in maintaining the stress response
  - People who are tense will experience a greater sense of anxiety and stress
- Lack of muscle tension (muscle relaxation) leads to a reduction in sympathetic nervous system activation
  - Reduces blood pressure, heart rate, and other symptoms of the stress response

Learning

- Goal: teach you how to induce a relaxed state any time you feel tense
  - Typically does not involve music, imagery or other techniques
  - These distract from learning to sense muscle tension and allow relaxation
- Takes daily practice (over about 10 weeks)
- Involves learning voluntary muscle control much like is involved in learning a new sport
Learning

- Establish practice time and place
  - Free of light, noises and other distractions
- Comfortable position
- Start by taking a few deep breaths
- Tension – Release
  - Like a pendulum that provides momentum to facilitate deeper relaxation
  - Vivid contrast between 2 muscle states

Instructions

- Will focus on one muscle group at a time
- Tense muscle group when you hear “now”
- Try to only tense the muscles in that group
- Relax when told to “relax”
- Will repeat each muscle group once
- Try not to move or talk
- Remove or loosen any items that might cause discomfort

Instructions (Cont)

- Tense for 5 to 7 seconds
- Relax for 30 to 40 seconds
- Note closely the sensations of tension and relaxation
- Repeat once for each muscle group
- Repeat again if there is still tension
- When doing the chest, shoulder, and back take a deep breath before and hold during tension phase; then exhale during relaxation phase
- After all groups are done, allow a few minutes to experience and enjoy state of relaxation
Muscle Groups

- Right hand, forearm, and upper arm
- Left hand, forearm, and upper arm
- All facial muscles
- Neck
- Chest, shoulders, upper back, and abdomen
- Right upper leg, calf, and foot
- Left upper leg, calf, and foot

Problem Solving

Model of Stress
Problem-Solving Model of Well-Being

Stressful Life Events → Problem-Solving Coping → Well-Being

(D’Zurilla & Nezu, 2010)

Research Support

- Numerous studies support the fact that
  - Positive, effective problem-solving leads to happiness and well-being
  - Negative problem-solving leads to increased stress and a broad range of physical and mental problems
  - Problem-solving ability is a teachable skill
  - Leads to improved well-being

Problem Solving Elements

- Problem orientation
- Problem-solving skills
- Implementation skills

(D’Zurilla & Nezu, 2010)
Problem Orientation

- Problem-solving "style"
- Serves a motivational function
- Includes:
  - Degree of optimism
  - Beliefs about self (ability to solve problems)
  - Awareness of problems
  - Inclination to resolve problems

(D’Zurilla & Nezu, 2010)

Problem-Solving Skills

- Activities by which a person attempts to understand and develop effective solutions to problems of everyday life
- Four specific skills:
  - Defining the problem
  - Generating potential solutions
  - Making a decision
  - Implementing and verifying the solution

(D’Zurilla & Nezu, 2010)

Implementation Skills

- Specific skills needed to implement the selected solution
  - Situation specific
  - Interpersonal skills
  - Work skills
  - Physical, mental, emotional abilities
  - Etc.
**Problem Orientation Styles**
- Positive problem oriented
  - See problems as challenges
  - Believe problems are solvable (optimistic)
  - Believe in one’s ability to solve problems
  - Believe that problem solving involves time, effort, and perseverance
  - Commit to solving problems
- Negative problem oriented
  - See problems as threats to well-being
  - Doubt ability to solve problems
  - Easily frustrated

(D’Zurilla & Nezu, 2010)

**Problem-Solving Styles**
- Rational
  - Deliberate and systematic use of problem-solving process
- Impulsive/Careless
  - Active attempts to solve problems
  - Ineffective use of problem-solving process
- Avoidant
  - Procrastination—hopes problems will go away
  - Dependence—hopes others will solve problems for them

(D’Zurilla & Nezu, 2010)

**Effective Problem Solving**
- Problem Orientation
  - Optimism—overcoming negative beliefs
  - Recognizing problems
  - Seeing problems as challenges—Redefining “failure”
  - Managing emotions
  - Being intentional about solving problems

(D’Zurilla & Nezu, 2010)
Effective Problem-Solving

- Problem-Solving Skills
  - Defining and formulating the problem
  - Generating alternatives (brainstorming)
  - Making a decision
  - Implementing and verifying solution

(D'Zurilla & Nezu, 2010)

ADAPT

- A = Attitude. Optimistic, intentional
- D = Define. Collect info, set a goal
- A = Alternatives. Brainstorm options
- P = Predict. Evaluate options
- T = Try out. Act and evaluate

(D'Zurilla & Nezu, 2010)

Assertiveness Training

Enhancing College Success through Effective Stress Management

Why Assertiveness?

- Much of our stress comes from our interactions with other people
- Unassertive people
  - Often feel manipulated
  - Discounted by others
  - Disrespected by others
  - And, are unable to get their needs met
- All of which lead to STRESS!
- Aggressive people also experience stress due to their poor relationships

What is Assertiveness?

- Direct, firm, positive, and persistent
- Promotes equality
- Enables people to:
  - Act in our own best interests
  - Stand up for themselves
  - Exercise personal rights without denying the rights of others
  - Express their feelings honestly and comfortably

<table>
<thead>
<tr>
<th>Non-Assertive Behavior</th>
<th>Assertive Behavior</th>
<th>Aggressive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sender</td>
<td>Sender</td>
<td>Sender</td>
</tr>
<tr>
<td>Self-denying</td>
<td>Self-enhancing</td>
<td>Self-enhancing at expense of another</td>
</tr>
<tr>
<td>Inhibited</td>
<td>Expressive</td>
<td>Expressive</td>
</tr>
<tr>
<td>Hurt, deserving</td>
<td>Feel good about self</td>
<td>Controlling</td>
</tr>
<tr>
<td>Allows others to choose</td>
<td>Chooses for self</td>
<td>Chooses for others</td>
</tr>
<tr>
<td>Does not achieve desired goal</td>
<td>May achieve desired goal</td>
<td>Achieves desired goal by hurting others</td>
</tr>
<tr>
<td>Receiver</td>
<td>Receiver</td>
<td>Receiver</td>
</tr>
<tr>
<td>Guilty or angry</td>
<td>Self-enhancing</td>
<td>Self-denying</td>
</tr>
<tr>
<td>Depressed, victimized</td>
<td>Expression</td>
<td>Hurt, defensive, frustrated</td>
</tr>
<tr>
<td>Achieves desired goal at sender’s expense</td>
<td>May achieve desired goal</td>
<td>Does not achieve desired goal</td>
</tr>
</tbody>
</table>
Elements of Assertive Behavior

- Self-Expressive
- Respectful of rights of others
- Honest
- Direct and firm
- Equalizing – benefiting both parties
- Verbal & nonverbal communication
- Positive & negative affect
- Situation specific
- Socially responsible
- Learned skill
- Persistent as necessary

Barriers to being assertive

- Beliefs about what it means to be assertive
- Beliefs about who is more important or valuable in a society
- Experiences where being assertive was not rewarded or accepted
- Anxiety and fear about the consequences of being assertive
- Lack of skills

Learned Behavior

- Where do we learn to be non-assertive?
  - Family
  - School
  - Work
  - Church
  - Politics
  - Society / Culture
- Messages often heard:
  - "Do what you're told"
  - "Don't ask questions"
  - "Don't cause any problems"
Learning to be more assertive

- Start a journal
- Be honest about where you're at
  - In different situations
  - With key people
  - Your attitudes and beliefs
  - Obstacles
  - Skills
- Set goals
  - Select role models
  - Short, mid, and long-term

Components of Assertive Communication

- Eye contact
- Body posture
- Distance & physical contact
- Gestures
- Facial expressions
- Voice characteristics
- Fluency
- Timing
- Listening
- Thoughts
- Persistence
- Content

Tips

- Start with situations that are more likely to be successful
- Expect some failures
- Watch for negative thoughts
- It's normal to feel anxious – use the tools you've learned
  - Mindfulness
  - Identify and challenge distorted thoughts
- Keep at it and seek help if needed
Changing Negative Thoughts

- Our thoughts can prevent us from being assertive
  - “I’m a failure”
  - “People treat me unfairly”
  - “I have no control over my life”
  - “I’m not able to be assertive”
  - “I’m not an important person”
  - “People won’t allow me to be assertive”
  - “I’ll be fired/punished/rejected if I’m assertive”

- What are the distortions?
- What exercises would you recommend?

Anger

- Anger and stress often go hand-in-hand
- Important to learn to deal with anger in order to decrease stress
- Assertive behavior can help you to resolve the source of your anger

Myths About Anger

- Anger is a behavior
- Anger must be vented or it will explode
- Ventiing is good for your health
- Anger needs to be expressed
- Anger should be expressed to a 3rd party
Facts About Anger

- Anger is a universal emotion
- Anger can lead to aggressive and destructive behaviors, but behaviors are a choice
- Resolving anger is the important thing
  - Venting, letting off steam, or acting aggressive are unlikely to help unless they serve to resolve the source of anger
- Chronic anger is not only stressful but increases the risk of heart attack

Suggestions for Managing Anger

- Minimize anger in your life
  - If you're angry, figure out why
- Cope before you get angry
  - Leave situation, practice acceptance, relax, breath, identify thoughts
- Be assertive when you need to be
  - Anger is associated with the belief that things are fair—being assertive is taking action in the pursuit of fairness and equality
- Try to resolve conflict when it occurs

Conflict Resolution

- Be honest and direct
- Avoid personal attacks
- Start with points of agreement and common goals
- Accept responsibility for your feelings
- Seek a win-win outcome
- Listen, listen, listen (paraphrase)
- Discuss perceptions of the situation and facts that other may be unaware of
- Clarify needs of each party
- Seek solutions, not blame
- Negotiate towards compromise as necessary
Before you Assert yourself…

- Do you understand the situation?
- Is it important?
- Is what you want possible?
- Do you really want change or just to be heard?
- What are your options?
- Are your goals based on equality and fairness?
- Do you have the skills?
- Are you in control of your anger?
- Would it be a good idea to think it over?
- Will you regret not taking action?
- What are the risks?

Module 3: Mindfulness

Enhancing College Success through Effective Stress Management

Objectives

- Learn what mindfulness is and how it can help alleviate stress
- Learn different ways of practicing mindfulness
- Incorporate mindfulness practices and strategies into your life to help manage and alleviate stress
Outline
- Introduction
  - Description of mindfulness, research, history
- Intro to practice
  - Formal & informal; 3 minute breathing space
- Working with sensations
  - Body scan
- Working with thoughts
  - Sitting meditation (focused)
  - Sitting positions
- Working with emotions
  - Walking meditation
- Strategies for working with stress and distress
- Other practices
  - Accepting emotions, watching thoughts, here and now

What is Mindfulness?

Mindfulness: What is it?
- Natural human ability
- Moment to moment awareness of our experience
- Being an observer of our experience—thoughts, sensations, feelings
- Awareness without being lost in conceptual thought
Mindfulness Experiment

- Let's try it!
- Be aware of the sounds and notice how there are sounds and there are thoughts about the sounds.
- Now, feel the sensations in your dominant hand, scanning the fingers, the palm, the back of the hand.
- What thoughts are going through your mind at this moment?

Discussion Questions

- What was that like?
- Are you normally mindful?
- What’s different about being mindful?

Characteristics

- Here and Now
  - When we are mindful we are aware of what is happening in this moment, right here.
  - In contrast, our thinking mind typically wants to be in the past or the future.
- Not “thought” based
  - Experiencing the moment vs. thinking about what happened in the past or is going to happen.
- Accepting whatever happens
  - Not analyzing and judging.
Attitudes of Mindfulness

+ Non-judging
+ Patients
+ Beginner’s Mind
+ Trust
+ Non-striving
+ Acceptance
+ Letting Go

Potential Benefits

+ Lower level of perceived stress
+ Improved health
+ Greater sense of peace and happiness
+ Improved mood
+ Decreased anxiety
+ Improved sleep

But, most of us must cultivate our ability to be mindful to enjoy these benefits

Cultivation

+ Natural ability, but...
  + Not necessary for survival
  + Not naturally developed in Western societies
  + Most of us are not very mindful
+ Mindfulness can be cultivated through:
  + Practice
  + Discussion
Mindfulness is common in religion, philosophy, literature and history.

Cultivation of mindfulness primarily comes from Buddhism.

The Buddha taught that learning to become mindful through the practice of meditation could liberate one from suffering.

Medical and mental health communities have embraced mindfulness as a way to alleviate stress, increase healing, and prevent disease.

Reduction in worry or future-oriented thought

Reduction in rumination or past-oriented thought

Increase in insight

Increase in executive control functions

Emotional control

Planning, organizing

Inhibiting automatic behaviors (impulse control)
Changes in the Brain
- Brain wave changes
  - Increased theta and alpha activity associated with increased alertness
- Increased blood flow, metabolism, and cortical thickness in prefrontal regions of the brain that control behavior

Moments of Awareness
- Often we remember times when we were very aware of our experience in the moment
- Examples?

Practice
- Mindful Eating
  - Intro
  - Practice
  - Discussion
Home Practice
- Pick something you do every day that you enjoy doing (e.g., showering, drinking coffee)
- Pick something that is relatively free from distractions
- Try to be mindful each day when you do this activity
  - Focus on the activity and the sensations of it
  - If your mind wanders off, just bring it back
- Note activity and comments in your log

Mindfulness
Introduction to Practice

Practice Discussion
- What activity did you choose?
- How often were you able to remember to be mindful during your chosen activity?
- What did you notice during the activity?
- If you didn’t remember to be mindful, what do you make of that?
### Need for Practice
- Natural ability
- Not normally developed in most people
- Mindfulness is like learning any other skill
- Takes practice
  - Regular, consistent practice is most helpful
  - In order to benefit, must gain some proficiency

### Types of Practice
- **Formal practice**
  - Specific periods of time set aside to practice
  - May be alone or with a group
  - Specific practice: body scan, sitting meditation, etc.
- **Informal practice**
  - Practicing being mindful during normal activities or at random periods during the day
  - Typically harder to learn this way because most people don't remember to be mindful

### Tips for formal practice
- Time of day
- Distractions
- Giving yourself permission
- Trusting in the value of practice
- Timer
- Positions
- Props
Practice

- 3-minute Breathing Space
  - At least 3 times during the day when free of distractions
  - Give yourself permission not to think or worry about anything
  - Find comfortable position
  - Close your eyes
  - Focus on breathing — sensations in airway, chest, or abdomen
  - At first, notice how you are breathing
  - Don’t force breathing to change but watch breathing and see if it slows and becomes deeper
  - Notice if you breath from the chest or the diaphragm
  - It is normal for the mind to wander — just acknowledge it and return to watching the breath (when you notice that you’re making progress!!)

- Slows us down during the day (parasympathetic vs. sympathetic)
- Helps us become aware of our stress
- Provides body and mind a rest break
- Starts building awareness and attention of what’s going on inside of us

Benefits

- Slows us down during the day (parasympathetic vs. sympathetic)
- Helps us become aware of our stress
- Provides body and mind a rest break
- Starts building awareness and attention of what’s going on inside of us

Working with Sensations & Body Scan
Practice Discussion

- How often were you able to complete the 3-minute breathing space?
- What did you notice during and after the practice?
- Were there things that made the practice difficult?
- What things did you do to make it easier to practice?
- If you weren’t able to practice, what kept you from practicing?

Working with Sensations

- Body sensations are common experiences to work with in developing mindfulness
  - Always available
  - Bring us into the moment—the here and now
  - Have already worked with the breath—most common focus of meditation
  - Normal sensations in the body—feelings of tension, energy, tingling, pain
  - Distressing sensations: pain, itch, urge to move

Body Scan

- Introduction
- Practice
- Discussion
Dealing with Challenges

- Distractions – try to prevent, then accept
- Falling asleep – time of day
- Frustration: “I’m not doing it right” or “I’m no good at this”

Normal reactions
- Nature for the mind to wander – the practice of mindfulness is noticing and bringing attention back

Discomfort – ok to move if you experience pain
- Naturally, if we can alleviate discomfort we should
- Pause first and notice the sensation and urge to move
- Boredom – notice that boredom is just a thought and return to sensations

Mindfulness has been shown to be effective in helping patients learn to live with chronic pain
- Counter-intuitive – focusing on the sensation of pain helps reduce the distress of it

"Pain" – sensation or judgment?
- What reactions does the word “pain” cause?
- By focusing on the sensation we can begin to separate the sensation of pain from the thoughts and feelings about it

Working with Chronic Pain

- Mindfulness has been shown to be effective in helping patients learn to live with chronic pain
- Counter-intuitive – focusing on the sensation of pain helps reduce the distress of it

Home Practice

- Make time in schedule to practice
  - 15 to 30 min, 1-2 times per day
- Give yourself permission to not do anything else
- Guided or unguided
- Lie on your back on the floor or bed (comfortable but not too comfortable)
- Move through body noticing the sensations in each body part and allowing each muscle to relax
- When you become lost in thought and you notice it, just return to the sensations of your body
Discussion
- Were you able to practice the body scan?
- Did you try practicing at different times?
- Were certain times better than others?
- What did you notice during and after the practice?
- Was there anything difficult about the practice?
- If you missed practices, what things prevented you from practicing?

Working with Thoughts
- What is conceptual thought?
  - Mental representations of events, objects, places, people, ideas, etc.
  - Element of time—past and future
  - Based on experiences
  - Related to intelligence
  - Promotes survival
  - Consciousness and awareness
Problems with conceptual thought
- Worry: Lion can always be chasing us in our mind
- Rumination: reliving the past, over and over again
- Not always accurate based on past experience
- Mind takes shortcuts to process quickly
- Biases experience - we see what we expect to see
- Comes to dominate life—think about life much more than we actually experience it
- Life happens in the moment but our thoughts are normally in the past or the future

In mindfulness, we try to give ourselves space outside of conceptual thought by:
- Focusing on sensations or other direct experience
- Noticing when we're lost in thought and returning to the focus of the practice
- Seeing thoughts as just thoughts and not reality

Helpful metaphors:
- Thoughts as clouds in the sky
- Watching train cars go by from the platform

How might mindfulness help reduce stress?
- Develops an increased awareness of stress in the body
- Provides insight into thoughts that cause stress
- Helps reduce the impact of stress-producing thoughts
- Generates space between an event and our response—interrupts automatic reactions to things that happen
- Allows us to be more intentional in how we live
Sitting Meditation

- Common form of mindfulness practice
- Initial Goals
  - Learn to maintain attention on direct experience
  - Discern state of thought vs. state of experiencing
  - Become aware of being “lost in thought”
- Guided or unguided
- Options for body position
- Focus on the sensation of breathing
- When the mind wanders off, gently bring it back to the breath

Practice

- Introduction
- Practice
- Discussion

Dealing with Challenges

- Distractions – try to prevent, then accept
- Feeling drowsy – focus on keeping back straight
- Frustration: “I’m not doing it right” or “I’m no good at this”
  - Normal reactions
- Natural for the mind to wander – the practice of mindfulness is noticing and bringing attention back
- Discomfort – ok to move if you experience pain
- Naturally, if we can alleviate discomfort we should
- Boredom – notice that boredom is just a thought and return to sensations
Home Practice
- Set an intention to practice and schedule time
- Find a space and necessary props
- 1x per day for 20 min
  - If too difficult, start at 5 min and increase 5 min/day
- Give yourself permission to do nothing else
- Set a timer or use the CD
- Afterward, log sessions and make notes about experience

Emotions & Walking Meditation

Discussion
- Were you able to practice the sitting meditation?
- Did you try practicing at different times?
- Were certain times better than others?
- What did you notice during and after the practice?
- Was there anything difficult about the practice?
- If you missed practices, what things prevented you from practicing?
What are emotions?
- Body’s reactions to events and situations
- States that motivate behaviors
- Indicate values and meaning
- Based upon values, beliefs, thoughts, attitudes, assumptions, and perception
- Different type of knowing and intelligence

Common Emotions
- Happiness
- Sadness
- Anger
- Frustration
- Guilt
- Shame
- Depression
- Peacefulness
- Anxiety

Working with Emotions
- Painful emotions are often difficult to work with
- Propel us into some sort of automatic response
- Action or withdrawal; attack or escape
- May be very appropriate responses, but many times our responses make things worse
- Mindfulness can help us tolerate the emotion and learn from what it is trying to tell us
- The more we practice being mindful the easier it will be to work with emotions, but it is never easy
Working with Emotions

- Mindful methods of working with distressful emotions
- Allow and accept this experience of emotion
- Notice where you feel the emotion in your body
- Notice if there are any judgments about the emotion that are working against acceptance
  - "I don’t want to be sad"
  - "It’s not ok to be angry"
- Learn from the emotion; be open to what it is telling you
  - What thoughts are associated with the emotion?
  - Notice but don’t analyze right away

Walking Meditation

- Use the sensation of walking as our focus
- Initial Goals
  - Learn to maintain attention on direct experience
  - Discern state of thought vs. state of experiencing
  - Become aware of being "lost in thought"
- Guided or unguided
  - Typically back and forth in a room but also outside
  - Can walk very slow and deliberately or normal pace
  - Eyes typically open but focused slightly in front
  - Focus on the sensations of walking and movement
  - When the mind wanders off, gently bring it back to the movement

Dealing with Challenges

- Distractions – more distractions if outside
- Balance – can be very difficult at first
- Frustrations – walking meditation is usually harder at first because there is more happening
Home Practice
- Set an intention to practice and schedule time
- Find a space
- 1x per day for 20 min (may combine with other practice)
- Give yourself permission to not do anything else
- Set a timer or use the CD
- Afterward, log sessions and make notes about experience

Dealing with Stress and Distress & Mindfulness Meditation

Discussion
- What was your experience with walking meditation?
- How do you compare it with the other practices?
- Are you noticing any changes in your life?
- Do you experience or react to things any differently?
When you notice you're feeling stress or distress, focus on the sensations.
- Where do you feel it? What do you feel?
- Focus on your breath for 3 minutes (or even 1 breath)

Deal with the immediate situation:
- Accept that you're feeling stressed
- Ask: does anything need to be done in this moment?
- Ask: what needs to be done in this moment?
- Do one thing at a time
- Remember to breathe

Non-judging
Patients
Beginner’s Mind
Trust
Non-striving
Acceptance
Letting Go
Practicing these attitudes can help deepen our mindfulness and allow us to better deal with stress.

Mindful Yoga
Tai Chi
Qigong
Martial arts
Centering Prayer
Mantra meditation
Loving kindness meditation
Other?

Mindful Yoga
Tai Chi
Qigong
Martial arts
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Mantra meditation
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Other?

Other Mindfulness Practices
Obstacles to Practice

- Common reasons
  - "Waste of time"
  - "Should be doing something productive"
  - "Too busy...can't find the time"

- If we really believed that mindfulness could make us more relaxed, peaceful, happy and productive would we then be able to find the time?
- Must take it on faith at first to give it a chance to prove its benefits
- Generally people will begin to notice the benefits in 4 to 8 weeks of regular practice

- Common reasons
  - "It's boring"
  - "I don't like it"
  - "I can't sit there that long; I'll go crazy"

- We are use to being bombarded with stimulation and activity (music, TV, cellphones, games, conversations, food, drink, drugs, sex, etc.)
- Stimulation withdrawal?
- Peace is not that far away

Mindfulness Meditation

- Practice sitting meditation with mind focused on the breath
- After a few minutes, allow your awareness to open up so that it is not focused on anything but open to all experiences
- Allow the mind to become the impartial observer of experience
- When a thought happens, try noting it ("I'm having the thought about what I need to do") and go back to an open awareness
Home Practice
- Mindfulness Meditation
- 20 mins once per day
- Complete log and make notes

Module 4 – Cognitive Strategies

Outline
- Session 1 – Introduction to cognitive strategies
- Session 2 – Working with automatic thoughts
- Session 3 – Working with attitudes and beliefs
- Session 4 – Procrastination
- Session 5 – Managing Anxiety
Session 1: Introduction to Cognitive Strategies

History & Research Support
- Cognitive Therapy was developed by Aaron Beck in the 60’s and 70’s
- The basic premise of cognitive therapy is that our feelings and our behaviors are determined to a large degree by our thoughts and perceptions
- Cognitive therapy has more research support than any other method of intervention for common mental health problems including depression, anxiety, and stress.
- Although typically taught within a therapeutic relationship, research supports the effectiveness of cognitive therapy through educational formats

Feeling Good
- The most popular self-help book which is based on cognitive therapy and the one most recommended by therapists for treatment of depression is Feeling Good by Dr. David Burns
- Several studies have shown that depressed individuals can resolve their own depression in as little as 4 weeks by reading and doing the exercises in this book
- Even at 3-year follow-up, 70% of those who completed the initial study were not depressed
- Although focused on depression, cognitive therapy has been shown to be as effective for anxiety and stress

• Ask if anyone is comfortable sharing any experience with cognitive therapy
Feeling Good

- Feeling Good: The New Mood Therapy (1980 & 1999)
- Original book focused on depression
- Revised edition that includes chapters on anxiety and relationship issues
- Additional exercises
- Both version are thick but many sections are optional
- Language still primarily focused on mood and depression but just as appropriate and helpful for stress and anxiety

Understanding Cognitive Therapy

- Common Beliefs
- Moods are biological and beyond our control
- Stress is the result of our environment
- Anxiety is a natural reaction based on chemistry of our brain
- Our heredity and early childhood determine how much anxiety and stress we will experience
- Only prolonged therapy or medication can change our mood or experience of stress and anxiety
- The truth
  - These are true to a certain extent
  - But, we can learn to influence our mood and our experience of stress and anxiety by changing our thoughts

Example

- You’re getting ready to take an important test. How might your thoughts impact how you feel?
- You believe that you’ll fail the test and think out
- You believe that if you fail the test it means you’re stupid and will never be able to succeed
- You think you’ll fail because you went to a party instead of studying
- You don’t think the test should be so soon after the break
- You think you’ll fail because you know the test won’t be fair
- You think that you’re well prepared
- In each case, what you think about the test will affect how you feel

- Show book and discuss readability
- This course follows the newer Feeling Good Handbook
- Build the slide and ask students what determines our moods before exposing the beliefs. Ask what causes us to be stressed, depressed, anxious, angry, etc.
- Show only the first bullet and ask students what thoughts they might be having before an important test. Then build the slide and ask how they would feel based on each of these thoughts.
Thoughts Behind Negative Feelings

- Every negative feeling has a specific negative thought

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Thought</th>
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<tbody>
<tr>
<td>Sadness and Depression</td>
<td>Thoughts of loss</td>
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<tr>
<td>Frustration</td>
<td>Unfulfilled expectations</td>
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<tr>
<td>Anxiety and Panic</td>
<td>Thoughts of danger</td>
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<tr>
<td>Guilt</td>
<td>Thoughts you are bad</td>
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<tr>
<td>Inferiority</td>
<td>Inadequate</td>
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<tr>
<td>Anger</td>
<td>Unfairness</td>
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- Thoughts that lead to negative feelings are often distorted or inaccurate in some way.

Process of Perception

- The process of perception is the process of trying to make sense of and determine expectations about our environment.
- This process...
  - Is largely influenced by experience (beliefs & schema)
  - Works on limited information
  - Happens nearly instantaneously
  - Is mostly unconscious
  - As a result it is sometimes inaccurate and distorted

- In order to understand how we can change our thoughts, we have to understand a little about what the process of “perception” is and how it works.
- The important point is that it is not a perfect process and is prone to error.
- Slide will build
- Discuss how we tend to believe the situation causes our feelings
- Then after mouse click, discuss that it is really our thoughts about a situation that determine how we feel
- Another mouse click and discuss our beliefs as the source for our automatic thoughts
- Last click, discuss our experiences as the source of our beliefs about the world and ourselves

- Each will be discussed in future slides
- Emphasize the need to read the book and the many examples that are provided

- Ask for examples and emphasize how the thought would lead to a negative emotions
Cognitive Distortions

- Jumping to Conclusions
- Believing you’ll know that someone will react negatively (mind reading)
- Predicting that things will turn out badly (fortune telling)
- Thinking others will reject you for stating your opinion
- Magnification
  - Magnifying the significance of problems
- “I’m too good because I can’t get a job”
- Emotional Reasoning
  - Believing something is true because you feel that it is
  - I feel like a loser so I must be one

- Magnification
  - Magnifying the significance of problems
- “I’m no good because I can’t get a job”

- “Should” Statements
- You believe things “should” be a certain way and become upset or disappointed when they are not
- “Musts,” “oughts,” and “have tos” as well
  - I must always be liked by others

- Labeling
  - Attaching a negative label to ourselves or another
  - I’m a loser; he’s an idiot

- Personalization and Blame
  - Holding oneself responsible for something that isn’t fully in our control and taking blame for it
  - Blaming someone else for all of one’s problems
  - It’s all my fault the marriage didn’t work out

- There’s not always a right answer for which cognitive distortion is involved. Sometimes we can pick from several depending on how we apply it to the thought. It’s not important that we agree on the specific distortion but that the distortion that we pick exposes the distortion and leads to a more realistic and accurate response.

- Scenario - Anger
- Seth was very angry at his girlfriend Emily because he felt she was always talking to other guys
- What thoughts might he be having?
  - Seth discovered the following automatic thoughts
  - I hate it when she does that; it’s just not right!
  - She’s dating me and shouldn’t be talking to other guys
  - She’s so disrespectful of my feelings
  - If she’s talking to other guys she must not really like me
  - If she talks to other guys then she will end up cheating on me or dumping me
  - What cognitive distortions are in these thoughts?

- Ask class what thoughts Seth might be thinking
- Take the opportunity to distinguish between thoughts and emotions and also to discourage interpretations
Scenario - Anger

- I hate it when she does that; it’s just not right!
  - Emotional reasoning – because he doesn’t like it, it’s wrong
  - She’s dating me and shouldn’t be talking to other guys
    - Should statement; where did this rule come from?
  - She’s so disrespectful of my feelings
    - Emotional reasoning – based on his feelings
    - Mental filter - discounting the positive
    - Overgeneralization – How often does it really happen? Does she do more things?
  - If she talks to other guys she must not really like me
    - Fortune telling
  - If she talks to other guys then she will end up cheating on me or dumping me

Scenario - Stress

- Mary feels stressed out due to all the school work that she has to do. Every time she thinks about school or her studies her chest tightens up and she feels sick to the stomach.
  - What cognitive distortions might be contributing to her stress?
  - Mary reveals the following thoughts associated with her stress
    - "I’ll never get all of this work done"
    - "I’m so horrible at school"
    - "I should be able to keep up like everyone else"
    - "I’m going to flunk out and will never be able to get a job"
    - "These papers are too difficult and will take forever"
    - "I’m such a failure"

- "I’ll never get all of this work done"
  - Jumping to conclusions – fortune-telling
  - "I’m so horrible at school"
    - Mental filter - focusing on amount of work to do
    - Dismissing the positive – ignores how she has done in past
  - "I should be able to keep up like everyone else"
    - Should statement – it’s not always easy to keep up
    - Overgeneralization – is everyone else really keeping up?
  - "I’m going to flunk out and will never be able to get a job"
    - Jumping to conclusions – fortune-telling
  - "These papers are too difficult and will take forever"
    - Jumping to conclusions – fortune-telling
  - "I’m such a failure"
    - Labeling
Scenario - Anxiety

- Alex becomes very anxious when he is called upon in class and is terrified about an upcoming presentation before the class.
- Possible cognitive distortions?
  - Thoughts that go through Alex's head when he becomes anxious:
    - "I'll make such a fool out of myself"
    - "I don't have anything interesting to say"
    - "The last time I had to give a speech I stuttered some of my words"
    - "People will laugh at me and think I'm an idiot"
    - "If I mess up it will be so terrible that I will have to quit school"

Scenario - Anxiety

- "I'll make such a fool out of myself"
- Fortune-telling (jumping to conclusions)
- "I don't have anything interesting to say"
- Discounting the positive
- "The last time I had to give a speech I stuttered some of my words"
- Mind reading
- "People will laugh at me and think I'm an idiot"
- Magnification

Should you change?

- Sadness, anger, stress, frustration, guilt and other feelings that we might label as "negative" are often natural reactions to life events
- Saying we "shouldn't" ever feel sad or angry is an unrealistic expectation
- Anger is a normal reaction to being treated unfairly
- Sadness is normal when we do lose something important
- So, where do we draw the line between healthy and unhealthy feelings?
Questions

- Is my stress healthy in that it’s motivating me or helping me accomplish what I want to accomplish? Or is it beating me down, making me tired, and affecting my health and happiness?
- Am I just sad over something that happened or has this sadness gone on long enough that I’m really depressed and no longer really know what I’m depressed about?
- Is my anxiety keeping me from doing things that are important to me and that would make my life more fulfilling?
- Is my anger really appropriate and am I channeling it into a positive activity?

Home Practice

- Complete 2 of your own scenarios
  - Situation
  - Feelings
  - Automatic Thoughts
  - Cognitive Distortions

Session 2
Working with Automatic Thoughts
In order to work with our feelings and thoughts, it is important to write them down for several reasons:

- Writing allows us to be more thorough and complete.
- Writing helps us be more objective.
- Writing forces us to use a structured process that will improve the chances of being successful.
- Writing provides a record we can refer to in the future if the same scenario comes up again.
- Writing makes it easier to get feedback.

The most common way to work with our thoughts is to use a thought worksheet, otherwise known as a thought record or a Daily Mood Log.

Thought Worksheet

<table>
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Complete the thought record when you are experiencing feelings that you find distressing.

Step 1: Describe the situation that evoked the feeling and note the date and time.

Step 2: List the feelings and rate each on a scale from 0 to 100.

Step 3: Determine what automatic thoughts went through your head at the time and that are going through your head now as you experience these feelings.

Important: Feelings are typically one word: anxious, sad, angry, etc.
- Thoughts imply more about why we feel the way we did (though are not interpretations).
- Ask how much you believe each thought (0-100).
Thought Worksheet

1. Step 4: For each thought, determine if there are any cognitive distortions and if so list what they are.
   - This can be difficult since our thoughts can seem so real and accurate.
2. Step 5: For each distorted thought, list a rational alternative.
   - Indicate how much you believe the alternative (0-100).
3. Step 6: Go back and rate the automatic thoughts.
4. Step 7: Go back and rate the feelings.
   - Did the intensity change?

Identifying Automatic Thoughts

- We are typically not aware of the thoughts that automatically flow through our brains in response to situations.
- But, we can typically recall them when we ask ourselves, "what was going through my mind when I got angry or when I felt really anxious?"
- Or, "what might I have been thinking when I felt that way?"
- Sometimes these thoughts come in the form of images.
- Be careful to avoid interpretations of why you were feeling the way you were feeling.
- "I think I was feeling sorry for myself" or "being insecure".
- These don’t help get to the thought that led to the feeling.

Challenging Thoughts

- Distorted thoughts can be difficult to see and unravel.
- They seem accurate because of our emotional response.
- They often have a grain of truth to them.
- It’s difficult to be objective.
- Strategies:
  - Try to become a scientist and be very objective.
  - Look for distortions.
  - Examine the evidence.
    - What is the evidence for and against the specific thought?
    - What would you tell a friend in the same situation?
    - Conduct an experiment – is there a way to test it out?
  - What is the value of believing this thought?
Troubleshooting

- There are often many different cognitive distortions and there is certainly overlap between them.
- It’s not important that we agree on the specific distortion.
- What is important is that distortions you select help you see what’s not accurate or realistic in the negative thought.
- The distortion should lead to a rational response that is true and realistic (thus it should be rated pretty high).
- Expose the lie in the negative thought (when rated should go down).
- If you still believe the negative thought you probably haven’t exposed the distortion or come up with a good alternative.

Exercise - Alison

- Alison feels stressed out about work because she feels she is way behind. When she thinks about work her chest tightens up, she feels sick to the stomach, and often cries. She is thinking about quitting and finding another job.
- She reveals the following thoughts associated with her stress:
  - “I’ll never get caught up” (80) – emotional reasoning, fortune telling, all-or-nothing
  - “I can’t do all of this work” (80) – magnification, all-or-nothing, discounting the positive
  - “I should be able to keep up like everyone else” (100) – “should” statement
  - “I shouldn’t be this stressed out about work” (100) – “should” statement
  - “There’s something wrong with me” (100) – labeling, emotional reasoning
  - “I’m such a failure” (90) – labeling, emotional reasoning
  - “I’m going to get fired; I might as well quit and find another job” (70) – fortune-telling, discounting the positive

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- “I’m such a failure” (90) – labeling, emotional reasoning
- “I’m going to get fired; I might as well quit and find another job” (70) – fortune-telling, discounting the positive
Home Practice

- Complete 2 thought worksheets going through the 7 steps that have been discussed

Session 3
Working with Attitudes and Beliefs

Intermediate Beliefs

- As we continue to work with automatic thoughts, we may encounter more central beliefs that take the form of rules, assumptions, and attitudes (Beck 1995)
- If I cry it means I’m weak and not masculine
- If I’m vulnerable I will be taken advantage of
- I must always do my best
- It is horrible to fail at something
- I must work twice hard so that I never fail
- It would be horrible to be rejected
- I must please other people or they will reject me
- It is not ok to have flaws
Vertical Arrow Technique

- Sometimes our automatic thoughts will reveal these beliefs.
- We can also uncover these beliefs using the vertical arrow.
- After working with automatic thoughts, we may notice ones that recur or are particularly powerful.
- Ask yourself, "If this were true, what would it mean to me?"
- Draw an arrow downward and ask the question again.
- After generating 4-6 responses, ask yourself what the statements say about your assumptions, attitudes, and rules.

Scenario - Alison

- Let's look at Alison's situation.

Scenario - Alison

- What do we notice about Alison's belief system?

Assumptions:
- Getting behind means you're not a good worker.
- If you get behind, you won't be promoted.

Attitudes:
- Getting behind is bad.
- Flaws are unacceptable.

Rules:
- I can't ever get behind.
- I can't have any flaws or weaknesses in my work; I must be perfect.
Scenario - Alex

- Automatic thoughts
  - "I'll make such a fool out of myself"
  - "I don't have anything interesting to say"
  - "The last time I had to give a speech I stuttered some of my words"
  - "People will laugh at me and think I'm an idiot"
  - "If I mess up it will be so terrible that I will have to quit school"

- Let's look at Alex’s situation
  - "People will laugh at me and think I'm an idiot"
  - "That there is something wrong with me"
  - "People won't like me and will reject me"
  - "I will be all alone and won't have any friends"
  - "Life will be very lonely and sad"

- What do we notice about Alex’s belief system?
  - Attitudes:
    - It’s terrible to make mistakes
    - It’s horrible to be alone
  - Assumptions:
    - If you make mistakes people will look down upon you and reject you
    - If you make mistakes people will abandon you
  - Rules:
    - I can never make mistakes
    - I must be perfect
    - If I have flaws I must never let anyone see them
Changing Beliefs

- Beliefs can be changed, especially when we state them in the form of assumptions
- "If I make mistakes people will reject me."
- "If I am not perfect I will never get promoted."
- Sometimes we can restate these to make them more obvious
- People who have friends have never made mistakes
- People who get promoted are perfect employees

Cost-Benefit

- Another strategy is to list the advantages and disadvantages of holding this belief
- "If I make mistakes people will reject me."
- Advantages
  - Makes me work harder
  - Keeps me from being laughed at
- Disadvantages
  - Keeps people from knowing me better
  - Makes me very anxious in social situations
  - Prevents me from doing well in school

Test the Belief

- Sometimes you can set up experiments to test whether your belief is accurate or not
- What experiments would you recommend for Alison and Alex?
- How about someone who is afraid of being rejected if they asked someone out on a date?
- This works particularly well with things we’re afraid of
Putting Things on a Continuum

- Works well for all-or-nothing thinking
- Let’s look at Alison’s situation
  - What would the worst employee look like?
  - What would the best employee look like?
  - Where would Alison fall on this continuum?

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Act “As if”

- For some beliefs, it may be possible to see that they’re not true but to still have trouble accepting them
- Negative Belief: If I get rejected when asking someone for a date, it will mean that there’s something wrong with me
- New Belief: If I get rejected when asking someone for a date, there could be many reasons and it doesn’t mean that the next person will reject me or that there’s anything wrong with me
- Even if you can’t fully believe the new belief, go ahead and act as if it is true

Home Practice

- Take 2 of your automatic thoughts and use the vertical arrow until you don’t feel you’re not saying anything new
- List the attitudes, assumptions, and rules that are reflected for you
- For each set of beliefs, come up with at least 2 different ways of changing these beliefs
Procrastination and Stress

- Procrastination can be a major contributor to our stress
- Waiting until the last minute to start a paper or study for a test
- Putting off important tasks that lead to more difficult tasks
- Failing to accomplish preventative care
- Feeling frustrated and guilty for not being productive
- Just as our thoughts and beliefs lead to distressing feelings, so too do our thoughts contribute to our procrastination
- Productive people tend to think differently than those who procrastinate
- There are several mindset's of those who procrastinate

Reasons People Procrastinate

- Expecting to become motivated
- Many people who procrastinate want to wait until they feel motivated to start a task
- In reality, many times motivation does not come until after we start a task
- "Doing" may well come before a sense of "being motivated"
- Avoiding Frustration
- Productive people don’t necessarily feel confident and start tasks with the expectation that they will be easy to complete
- They expect tasks to be difficult and are prepared to endure the frustration, rejection, and failure many tasks involve
- They rise to the occasion when things get difficult
Reasons People Procrastinate

- Fear of Failure:
  - If success is too important, you may not want to start the task because you fear that you will somehow fail.
  - Attitude: “Better to never start than to start and fail”

- Perfectionism:
  - Expecting perfection can make any project seem too difficult to even start.

- Lack of Rewards:
  - Everyone needs to feel some reward for their efforts.
  - Productive people give themselves credit for what they do.
  - Some procrastinators do just the opposite.

- "Should" Statements:
  - Procrastinators often tell themselves they "should".
  - "Should" statements tend to make us feel guilty and resentful.
  - Change the "should" to something else like "it would be nice if".

- Passive Aggressiveness:
  - Procrastination can be a way of frustrating others even when it hurts us as well.

- Unassertiveness:
  - Maybe we're procrastinating because we agreed to do something we don't want to do and weren't able to say "no".

- Control:
  - Procrastination can be a way of gaining some control over a situation when someone is demanding we do something.

- A lack of desire:

- Common cause:
  - But, why don't we want to do something?
  - Maybe there are good reasons.
  - It may be that it's not a real priority, it doesn't really need to be done, or we're not ready to do it.

- Understanding why we're procrastinating can help us either get busy or take the task off our list.
Getting to Work

Step 1: Cost-Benefit Analysis
- Make a list – 2 columns
  - Advantages to procrastinating
  - Disadvantages to procrastinating
- Weigh the advantages and disadvantages on a 100 pt scale
- If the advantages outweigh the disadvantages then go no further

- Make a 2nd list – 2 columns
  - Advantages of starting today
  - Disadvantages of starting today
- Decide if you really want to start today

Step 2: Make a plan
- Decide at what time you are going to start and write it down
- List each obstacle to starting at this time and a solution
- Commit to starting and tell someone else if possible

Step 3: Make the job easy
- Set modest, realistic goals, not grandiose, perfectionistic goals
- Do a little bit at a time
- Plan to work for 15 minutes and then if you are motivated you can work longer

Step 4: Think positively
- Write down your negative thoughts about the task
- Use the thought worksheet to identify, challenge and replace distorted thoughts

Step 5: Give yourself credit
- As soon as you begin the task
- Take stock in the fact that you’re facing challenges
- Reward yourself
Example
- Starting a research paper that is due in 5 weeks

Home Practice
- Pick one thing you are procrastinating about and complete steps 1 – 5.
- If step 1 indicates that you don’t think it’s to your advantage to start right away continue anyway through step 4.

Session
Mastering Anxiety
Anxiety is the emotional and physical reaction to perceived dangers.

According to Beck & Emory (1985) state that fear is a cognitive appraisal that can lead to anxiety.

However, many authors use fear and anxiety somewhat interchangeably with fear often reflecting a specific, known source of fear and anxiety being a lower level of fear response with perhaps a less specific source.

Stress is closely related to anxiety but is a little bit broader and encompasses situations we wouldn’t describe as anxiety provoking.

Much of our stress is due to anxiety so it is important to address anxiety – discuss this relationship and have students provide examples.

**Causes of Anxiety**
- Thoughts
  - Appraisal of situation
  - Appraisal of capability of responding to situation
- Cognitive Distortions
  - Catastrophizing (a form of magnification and discounting the positive)
  - Overestimating (a form of fortune telling and all-or-nothing thinking)
  - Both also involve emotional reasoning – “I feel scared therefore it must be a real danger”
Causes of Anxiety

- Medical / Biological?
  - Rarely, though most people believe otherwise
- Reasons why we want to believe our anxiety is biological
  - Fearing health problems is a common cause of anxiety
  - Symptoms of anxiety are often physical
  - People may prefer to have a medical problem instead of an emotional or psychological problem (which can imply blame)
  - “We do not know of any physical or chemical imbalance that causes anxiety or panic” (Burns, 1999, p. 219)

Panic Attacks

- Episode of intense anxiety accompanied by physical and mental symptoms that occur suddenly
  - Heart racing
  - Hyperventilation
  - Sweating
  - Numbness or heaviness in arms or legs
  - Sweating and chills
  - Trembling or shaking
  - Feeling of choking
  - Chest pain
  - Nausea or dizziness
  - Fear of dying, losing control, having a heart attack

Cause of Panic Attacks

- Some situation causes us to experience anxiety
  - Body initiates fight-or-flight response
  - We experience physical symptoms of stress response
  - Symptoms are misinterpreted as physical danger signals
  - Cognitive Distortions: Emotional reasoning, catastrophizing
  - Fearful thoughts lead to more anxiety, increased stress response, and an increase in physical symptoms of stress
  - Fearful thoughts are believed to be confirmed by increase in physical symptoms
  - Vicious cycle – “fear of fear” cycle
### How to Manage Anxiety

- **Medical evaluation** – rule out the medical cause
- **Experimental method**
  - How could you test your belief when you’re having a panic attack?
  - **Fear of heart attack** – try walking, then jogging
- **Try to have a panic attack**
- **Intentional exposure to panic symptoms** – make yourself dizzy, hyperventilate, increase heart rate
- **Address the social anxiety piece of panic attacks such as by doing something foolish in public to see who notices**
- **Confront the situation** – go towards anxiety

<table>
<thead>
<tr>
<th>Thought worksheet</th>
<th>Identify the distortions and provide responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I’m such an idiot, I’m going to fail this test”</td>
<td></td>
</tr>
<tr>
<td>“I hate flying! I always get so nervous”</td>
<td></td>
</tr>
<tr>
<td>“He called on me, I have no idea what to say! I’m going to look like a complete fool”</td>
<td></td>
</tr>
<tr>
<td>“I’m not smart enough to write this paper—it’s too difficult”</td>
<td></td>
</tr>
</tbody>
</table>

What are the advantages and disadvantages of giving ourselves negative thoughts like these?

### Weighing the advantages and disadvantages

- **Of thinking negatively**
- **Of thinking positively**
- If you believe it’s advantageous to thinking negatively and to worry then you will not want to change and should accept that this is ok for you
- **Distractions** – can be helpful or form of avoidance
- **Acceptance** – “fighting” anxiety can backfire
  - What would it look like to accept anxiety?
  - What beliefs would interfere with our ability to accept anxiety?
Social Anxiety

- Fear of social situations where a person fears doing something that would cause them humiliation or embarrassment
- Common Attitudes
  - Feel you are in the limelight
  - Feel the need to impress people in order for them to like you
  - Strict and rigid beliefs about “right” and “wrong” social behavior
  - Don’t believe people will like the “real” you
  - Believe people will know how you’re feeling inside
  - Believe people are very judgmental and mean
  - Have difficulty expressing negative feelings and avoid conflict

Strategies

- Self-disclosure
  - Allow yourself to be socially anxious and let others know
  - Being able to accept and admit feelings of insecurity and nervousness can be very powerful
  - Counter the belief that people will only accept our strengths and will reject us if they know about our weaknesses
- Experimental technique
  - “What is the worst that could happen?”
- Thought Worksheet

Public Speaking

- Let’s work with some common thoughts associated with a fear of public speaking
  - “I’ll be too nervous to speak.”
  - “My mind will go blank.”
  - “I’ll make a fool out of myself.”
  - “It just isn’t my thing. I’m not like other people who can speak so confidently and calmly.”
### Strategies
- Acceptance
  - It’s perfectly normal to be nervous
  - Allow yourself to be nervous – be “in the moment”
- Thought worksheet
- Problem solving
  - Use an outline
  - Rehearse
  - Predict questions and develop answers
- Unconditional self-esteem
- Reasonable expectations

### Test & Performance Anxiety
- Two causes
  - Fear of failure (conditional self-esteem)
  - Fear of success (maybe not what you want)
- Thought worksheet
- Confront fears
  - Even if you believe you won’t be able to do it, persevere
  - Anxiety can be uncomfortable but it can only prevent you from performing if you believe that it can
  - Competitive athletes all experience anxiety, but the successful one’s cope with it by ignoring it instead of believing that it will prevent them from performing

### Home Practice
- Find 2 situations that cause you anxiety
- Complete thought worksheet for each
- Describe 2 strategies you would use to manage these anxieties
References


Center for the Study of Collegiate Mental Health (2009). CSCMH Pilot Study Executive Summary, Pennsylvania State University, PA.


Higginbotham, H. K., & Rando, R. (unpublished). Trend data in the American College Health Association National College Health Assessment and National College Health Assessment II.


