



**PeachTree Professional Education, Inc.**

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## **DIRECTIONS TO COMPLETE THIS COURSE:**

**Step One:** Please use the above address and telephone numbers for ALL correspondence with our office. Our old address may still be on some of the handout pages, and mailing to the wrong address will delay your certificates.

**Step Two:** Please review the materials in this document (print, or scroll down to read).

On the following pages you should find an **Outline**, an **Evaluation of Learning Quiz** form, and a **Grade This Course** form, as well as the **Course Content** itself. Many courses will require that you also listen to an Audio lecture or watch a Video lecture, which you will access on our website in the same place where you obtained this document. Some courses may require that you read sections from the DSM-IV or your Professional Code of Ethics – and in such cases you must provide your own DSM and find your own Code.

**Step Three:** After you have reviewed all of the course content, you will **complete** and turn in the “Evaluation of Learning Quiz” form, the “Grade This Course” page and any requested assignments—either **Online or by Mail or Fax**—along with your payment. If you wish to do the Quiz and Pay Online, you will find the access link at the same place on our website where you obtained this document.

**Step Four:** If you complete the Evaluation Quiz Online, you will instantly receive your CEU Certificate. If you choose to Fax or Mail your Quiz and Payment to us, the same business day we receive it you will be sent a **CEU Certificate** by fax or email, as you indicate on the form. Certificates reflect the approved continuing education hours for the course and our state and national board provider approval numbers.

**Step Five:** Complete the license renewal process with your state board as usual, indicating the hours you have completed via independent home study.

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Your instructor is Richard K. Nongard, LMFT/CCH

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## “Anger, Anxiety and Depression”

### **3 Continuing Education Clock / Credit Hours**

*Instructor: Richard K. Nongard, LMFT/CCH*

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written consent of the author.

#### **Purpose of this Course:**

The purpose of this continuing education course is to provide mental health counselors with practical guidelines for ethical practice.

Most professionals are required to participate in an annual ethics class. This workshop contains both audio lecture and written components and will address many of the issues faced by professionals in clinical practice. These material are guidelines only however, and should be viewed within the context of any legal or regulatory changes. Any ethical decision made in clinical practice should always be made in conjunction with clinical supervisors or other professional peers close to the presenting situation. In the audio lecture, Mr. Nongard has tried to pass along to you ideas that have been helpful to him in avoiding liability and in providing quality care to mental health clients. You should enjoy his presentation and hopefully find solutions from his observations and experiences that can be of value to you.

#### **Course Objectives:**

At the conclusion of this course, the professional will be able to:

- 1) Discuss core components of good therapy practice which serve to facilitate providing ethical care.
- 2) Explain the common principles of codes of professional ethics.
- 3) Understand that it is unethical to have sexual relations with any current or past client, ever.

#### **Course Outline:**

10 Minutes: Course organization and introduction

90 Minutes: Audio lecture

40 Minutes: Reading and synthesis of Professional Codes of Ethics

30 Minutes: Completion of required Evaluation of Learning

10 Minutes: Documentation and preparation

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**180 Minutes (3 Hours)**

If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree** at **(800) 390-9536**.



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# Anger, Anxiety and Depression

**3 Continuing Education Clock / Credit Hours**  
**Instructor: Richard K. Nongard, LMFT/CCH**

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## Purpose of this Course:

The purpose of this continuing education course is to provide professionals in mental health and criminal justice settings with strategies and ideas designed to assess clients in managing behaviors causing impairment related to anger, anxiety and depression.

## Course Objectives:

At the conclusion of this course, the professional will be able to:

- 1) Understand the core diagnostic criteria for Major Depression, Generalized Anxiety and how Anger relates
- 2) Explore practical strategies for impacting emotional difficulties and symptoms
- 3) Create treatment approaches designed to facilitate behavioral changes

## Course Outline:

10 Minutes: Course organization, Documentation and Introduction .

90 Minutes: Audio lecture.

35 Minutes: Reading and synthesis of handout materials.

45 Minutes: Completion of required Evaluation of Learning

=====

**180 Minutes (3 Hours)**

If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree** at **(800) 390-9536**. Your instructor is Richard K. Nongard, a Licensed Marriage and Family Therapist.

## What is Anger?

Before you answer this question, stop and give it some serious thought. The answer may be more involved and complicated than you would first imagine.

First, let us clear some ground by stating up front that *anger itself is neither “good” nor “bad”; it just is.* The “labeling” of anger comes into play when the *forms of anger expression* are expressed.

*Consider these definitions:*

ANGER: An immediate emotional state, expressed from irritation to fury.

RAGE: Strongest form of anger, with the risk of loss of control.

AGGRESSION: Behavior intended to harm or intimidate others.

HOSTILITY: An attitude that sees others as enemies.

RESENTMENT: Stored anger. The opposite of forgiveness.

HATRED: Intense and unwavering dislike of another person.

DEPRESSION: Often the result of anger turned inward.

*Consider these thoughts:*

- Anger is a resource, and a signal, letting us know that something needs to change.
- Anger is a tool. It can manipulate. It can protect.
- Anger is something that we feel, both emotionally, and physically.
- When we are angry, we are always some-other-emotion, too.

*Consider this process:*

- A Situation occurs.
- The Situation produces Emotions within us.
- We are uncomfortable Feeling or Expressing those Emotions.
- We convert or mask those uncomfortable Emotions with Anger.
- We respond to the Situation by expressing the Anger.
- The Situation remains unresolved, because the other underlying Emotions were not addressed.

# **INTERMITTENT EXPLOSIVE DISORDER**

*(Taken from the Impulse Disorder Section of DSM-IV)*

## **DIAGNOSTIC FEATURES:**

The essential feature of Intermittent Explosive Disorder is the occurrence of discrete episodes of failure to resist the aggressive impulses that result in serious assaultive acts or destruction of property (Criterion A).

The degree of aggressiveness expressed during an episode is grossly out of proportion to any provocation or precipitating psychosocial stressor (Criterion B).

A diagnosis of Intermittent Explosive Disorder is made only after other mental disorders that might account for episodes of aggressive behavior have been ruled out (e.g. Antisocial Personality Disorder, Borderline Personality Disorder, a Psychotic Disorder, a Manic Episode, Conduct Disorder, or Attention Deficit Hyperactivity Disorder) (Criterion C).

The Aggressive episodes are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease) (Criterion C).

The individual may describe the aggressive episodes a "spells" or "attacks" in which the explosive behavior is preceded by a sense of tension or arousal and is followed immediately by a sense of relief. Later the individual may feel upset, remorseful, regretful, or embarrassed about the aggressive behavior.

## **ASSOCIATED FEATURES AND DISORDERS**

Signs of generalized impulsivity or aggressiveness may be present between explosive episodes. Individuals with narcissistic, obsessive, paranoid, or schizoid traits may be especially prone to having explosive outbursts of interpersonal relationships, accidents (e.g., in vehicles), hospitalization (e.g., because of injuries incurred in fights or accidents), or incarcerations.

## **PREVALENCE and COURSE**

Reliable information is lacking, but Intermittent Explosive Disorder is apparently rare. Limited data are available on the age at onset of Intermittent Explosive Disorder, but it appears to be from late adolescence to the third decade of life. Mode of onset may be abrupt and without a prodromal period.

# ANXIETY

## ***How Common Are Anxiety Disorders?***

- Anxiety disorders are the most common mental illness in America: more than 19 million are affected by these debilitating illnesses each year.
- Panic disorder with and without agoraphobia is a debilitating condition that will afflict at least 1 out of every 75 people in this country and worldwide during their lifetime. *National Institutes of Health (NIH) Consensus Statement 1991*
- An estimated 10-20% of the American population suffers from some degree of an anxiety condition. *National Mental Health Association.*
- Anxiety disorders cost the U.S. \$46.6 billion in 1990 in direct and indirect costs, nearly one-third of the nation's total mental health bill of \$148 billion.

## ***What Are the Different Kinds of Anxiety Disorders?***

- **Panic Disorder** - Characterized by panic attacks, sudden feelings of terror that strike repeatedly and without warning. Physical symptoms include chest pain, heart palpitations, shortness of breath, dizziness, abdominal discomfort, feelings of unreality, and fear of dying.
- **Obsessive-Compulsive Disorder** - Repeated, intrusive and unwanted thoughts or rituals that seem impossible to control.
- **Post-Traumatic Stress Disorder** - Persistent symptoms that occur after experiencing a traumatic event such as war, rape, child abuse, natural disasters, or being taken hostage. Nightmares, flashbacks, numbing of emotions, depression, and feeling angry, irritable, distracted and being easily startled are common.
- **Social Phobia** - Extreme, disabling and irrational fear of something that really poses little or no actual danger: the fear leads to avoidance of objects or situations and can cause people to limit their lives.
- **Generalized Anxiety Disorder** - Chronic, exaggerated worry about everyday routine life events and activities, lasting at least six months: almost always anticipating the worst even though there is little reason to expect it. Accompanied by physical symptoms, such as fatigue, trembling, muscle tension, headache, or nausea.

## **GENERALIZED ANXIETY DISORDER**

Generalized Anxiety Disorder (GAD) is characterized by 6 months or more of chronic, exaggerated worry and tension that is unfounded or much more severe than the normal anxiety most people experience.

People with this disorder usually expect the worst; they worry excessively about money, health, family, or work, even when there are no signs of trouble. They are unable to relax and often suffer from insomnia.

Many people with GAD also have physical symptoms, such as fatigue, trembling, muscle tension, headaches, irritability, or hot flashes.

### ***How Common is GAD?***

- About 2.8% of the U.S. population (4 million Americans) has GAD during a year's time.
- GAD most often strikes people in childhood or adolescence, but can begin in adulthood, too.
- It affects women more than men.

### ***What Causes GAD?***

Some research suggests that GAD may run in families and it may also grow worse during stress. GAD usually begins at an early age and symptoms may manifest themselves more slowly than in most other anxiety disorders.

### ***What Treatments Are Available for GAD?***

Treatments for GAD include medications and cognitive-behavioral therapy.

### ***Can People with GAD Also Have Other Physical and Emotional Illnesses?***

Research shows that GAD often coexist with depression, substance abuse, or other anxiety disorders. Other conditions associated with stress, such as irritable bowel syndrome, can accompany GAD. Patients with physical symptoms such as insomnia or headaches should also tell their doctors about their feelings of worry and tension. This will help the patient's health care provider to recognize that the person is suffering from GAD.

## PHOBIAS

Specifically, Phobias afflict as many as 12 percent of all Americans. They are the most common psychiatric illness in women and the second most common in men over age 25.

Phobias are not all the same. There are three main groups which include:

- **Specific (simple) phobias**, which are the most common and focus on specific objects,
- **Social phobia**, which causes extreme anxiety in social or public situations, and
- **Agoraphobia**, which is the fear of being alone in public places from which there is no easy escape.

**Agoraphobia** causes people to suffer anxiety about being in places or situations from which it might be difficult or embarrassing to escape - such as being in a room full of people or in an elevator. In some cases, panic attacks can become so debilitating that the person may develop agoraphobia because they fear another panic attack. In extreme cases, a person with agoraphobia may be afraid to leave their house.

**Specific or Simple Phobias** produce intense fear of a particular object or situation that is, in fact, relatively safe. People who suffer from specific phobias are aware that their fear is irrational, but the thought of facing the object or situation often brings on a panic attack or a severe anxiety.

Specific phobias strike more than 1 in 10 people. No one knows what causes them, though they seem to run in families and are slightly more prevalent in women. Specific phobias usually begin in adolescence or adulthood. They start suddenly and tend to be more persistent than childhood phobias; only about 20 percent of adult phobias vanish on their own. When children have specific phobias-for example, a fear of animals-those fears usually disappear over time, though they may continue into adulthood. No one knows why they persist in some people and disappear in others.

Examples of specific phobias include persistent fear of dogs, insects, or snakes; driving a car; heights; tunnels or bridges; thunderstorms; and/or flying.

**Social Phobia** can produce fear of being humiliated or embarrassed in front of other people. This problem may also be related to feelings of inferiority and low self-esteem, and can drive a person to drop out of school, avoid making friends, and remain unemployed.

Although this disorder is sometimes thought to be shyness, it is not the same thing.

Shy people do not experience extreme anxiety in social situations, nor do they necessarily avoid them. In contrast, people with social phobia can be at ease with people most of the time, except in particular situations. Often social phobia is accompanied by depression or substance abuse.

*People suffering from social phobia may:*

- View small mistakes as more exaggerated than they really are
- Find blushing as painfully embarrassing
- Feel that all eyes are on them
- Fear speaking in public, dating, or talking with persons in authority
- Fear using public restrooms or eating out
- Fear talking on the phone or writing in front of others

## **POST-TRAUMATIC STRESS DISORDER**

Post-traumatic stress disorder (PTSD) is an extremely debilitating condition that can occur after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that can trigger PTSD include violent personal assaults such as rape or mugging, natural or human-caused disasters, accidents, or military combat.

Military troops who served in Vietnam and the Gulf Wars; rescue workers involved in the aftermath of the Oklahoma City Bombing; survivors of the 1994 California earthquake, the 1997 South Dakota floods, and hurricanes Hugo and Andrew; and people who witness traumatic events are among the people who develop PTSD. Families of victims can also develop the disorder.

Fortunately, through research supported by the National Institute of Mental Health (NIMH) and the Department of Veterans Affairs (VA), effective treatments have been developed to help people with PTSD. Research is also helping scientists better understand the condition and how it affects the brain and the rest of the body.

### ***What Are the Symptoms of PTSD?***

Many people with PTSD repeatedly re-experience the ordeal in the form of flashback episodes, memories, nightmares, or frightening thoughts, especially when they are exposed to events or objects reminiscent of the trauma. Anniversaries of the event can also trigger symptoms. People with PTSD also experience emotional numbness and sleep disturbances, depression, anxiety, and irritability or outbursts of anger. Feelings of intense guilt are also common. Most people with PTSD try to avoid any reminders or thoughts of the ordeal. PTSD is diagnosed when symptoms last more than a one month.

### ***How Common is PTSD?***

At least 3.6% of U.S. adults (5.2 million Americans) have PTSD during the course of a year. About 30 percent of the men and women who have spent time in war zones experience PTSD. One million war veterans developed PTSD after serving in Vietnam. PTSD has also been detected among veterans of the Persian Gulf War, with some estimates running as high as 8 percent.

### ***When Does PTSD First Occur?***

PTSD can develop at any age, including in childhood. Symptoms typically begin within 3 months of a traumatic event, although occasionally they do not begin until years later. Once PTSD occurs, the severity and duration of the illness varies. Some people recover within 6 months, while others suffer much longer.

### ***What Treatments Are Available for PTSD?***

Research has demonstrated the effectiveness of cognitive-behavioral therapy, group therapy, and exposure therapy, in which the patient repeatedly relives the frightening experience under controlled conditions to help him or her work through the trauma. Medications have also been shown to help ease the symptoms of depression and anxiety and help promote sleep. Scientists are attempting to determine which treatments work best for which type of trauma.

### ***Do Other Physical or Emotional Illnesses Tend to Accompany PTSD?***

Depression, alcohol or other substance abuse, or anxiety disorders are not uncommon, co-occurrences for people with PTSD. The likelihood of treatment success is increased when these other conditions are appropriately diagnosed and treated as well.

Headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, or discomfort in other parts of the body are also common. Often, doctors treat the symptoms without being aware that they stem from PTSD. NIMH, through its education program, is encouraging primary care providers to ask patients about experiences with violence, recent losses, and traumatic events, especially if symptoms are recurring. When PTSD is diagnosed, referral to a mental health professional who has had experience treating people with the disorder is recommended.

### ***Who is Most Likely to Develop PTSD?***

People who have been abused as children or who have had other previous traumatic experiences are more likely to develop the disorder. Research is continuing to pinpoint other factors that may lead to PTSD.

### ***What Are Scientists Learning From Research?***

NIMH and the VA sponsor a wide range of basic, clinical, and genetic studies of PTSD. In addition, NIMH has a special funding mechanism, called RAPID Grants, which allows researchers to immediately visit the scenes of disasters, such as plane crashes or floods and hurricanes, to study the acute effects of the event and the effectiveness of early intervention.

Research has shown that PTSD clearly alters a number of fundamental brain mechanisms. Because of this, abnormalities have been detected in brain chemicals that mediate coping behavior, learning, and memory among people with the disorder. Recent brain imaging studies have detected altered metabolism and blood flow as well as anatomical changes in people with PTSD.

***The following are also recent research findings:***

- Some studies show that debriefing people very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of 12,000 schoolchildren who lived through a hurricane in Hawaii found that those who got counseling early on were doing much better two years later than those who did not.
- People with PTSD tend to have abnormal levels of key hormones involved in response to stress. Cortisol levels are lower than normal and epinephrine and norepinephrine are higher than normal. Scientists have also found that people with this condition have alterations in the function of the thyroid and in neurotransmitter activity involving serotonin and opiates.
- When people are in danger, they produce high levels of natural opiates, which can temporarily mask pain. Scientists have found that people with PTSD continue to produce those higher levels even after the danger has passed; this may lead to the blunted emotions associated with the condition.
- It used to be believed that people who tend to dissociate themselves from a trauma were showing a healthy response, but now some researchers suspect that people who experience dissociation may be more prone to PTSD.
- Animal studies show that the hippocampus - a part of the brain critical to emotion-laden memories - appears to be smaller in cases of PTSD. Brain imaging studies indicate similar findings in humans. Scientists are investigating whether this is related to short-term memory problems. Changes in the hippocampus are thought to be responsible for intrusive memories and flashbacks that occur in people with this disorder.
- Research to understand the neurotransmitter system involved in memories of emotionally charged events may lead to discovery of drugs that, if given early, could block the development of PTSD symptoms.
- Levels of CRF, or corticotropin releasing factor - the ignition switch in the human stress response - seem to be elevated in people with PTSD, which may account for the tendency to be easily startled. Because of this finding, scientists now want to determine whether drugs that reduce CRF activity are useful in treating the disorder.

## **OBSESSIVE - COMPULSIVE ANXIETY DISORDER**

People with obsessive-compulsive disorder (OCD) suffer intensely from recurrent unwanted thoughts (obsessions) or rituals (compulsions), which they feel they cannot control. Rituals such as hand washing, counting, checking, or cleaning are often performed in hope of preventing, obsessive thoughts or making them go away. Performing these rituals, however, provides only temporary relief, and not performing them markedly increases anxiety. Left untreated obsession and the need to perform rituals can take over a person's life. OCD is often a chronic, relapsing illness.

Obsessive-Compulsive Anxiety Disorder is *different* than Obsessive-Compulsive Personality Disorder. OCD is often controllable with medications and therapy, where OCPD is a lifelong, unwavering state of being - as opposed to a 'condition' - and does not respond to medications. OCD also has more isolated or specific obsessions and situations in their life.

Differentiation may be seen by the fact that OCD clients generally are aware at some point that their OC is excessive or unreasonable, and the OCPD person does not. Also, the OCD client's OC causes significant anxiety related distress, lasting more than one day, where the OCPD may not notice any distress, but is simply preoccupied with their OC, as this is simply a way of life for them.

### ***How Common is OCD?***

- About 2.3% of the U.S. population (3.3 million Americans) experiences OCD in a given year.
- OCD affects men and women equally.
- OCD typically begins during adolescence or early childhood; at least one-third of the cases of adult OCD began in childhood.
- OCD cost the U.S. \$8.4 billion in 1990 in social and economic losses, nearly 6% of the total mental health bill of \$148 billion.

### ***What Causes OCD?***

There is growing evidence that OCD has a neurobiological basis. OCD is no longer attributed to family problems or to attitudes learned in childhood - for example, an inordinate emphasis on cleanliness, or a belief that certain thoughts are dangerous or acceptable. Instead, the search for causes now focuses on the interaction neurobiological factors and environmental influences.

Brain imaging studies using technique called positron emission tomography (PET) have compared people with and without OCD. Those with OCD have patterns of brain activity that differ from people with other mental illnesses or people with no mental illness at all. In addition, PET scans show that in patients with OCD, both behavioral therapy and medication produce changes in the caudate nucleus, a part of the brain. This is graphic evidence that both psychotherapy and medication affect the brain.

### ***What Treatments Are Available for OCD?***

Treatments for OCD have been developed through research supported by the NIMH and other research institutions. These treatments, which combine medications and behavioral therapy (a specific type of psychotherapy), are often effective.

Several medications have been proven effective in helping people with OCD: clomipramine, fluoxetine, fluvoxamine and paroxetine. If one drug is not effective, others should be tried. A number of other medications are currently being studied.

A type of behavioral therapy known as “exposure and response prevention” is very useful for treating OCD. In this approach, a person’s deliberately and voluntarily exposed to whatever triggers the obsessive thoughts and then, is taught techniques to avoid performing the compulsive rituals, and to deal with the anxiety.

### ***Can People With OCD Also Have Other Physical or Emotional Illnesses?***

OCD is sometimes accompanied by depression, eating disorders, substance abuse, attention deficit hyperactivity disorder, or other anxiety disorders. When a person has other disorders, OCD is often more difficult to diagnose and treat. Symptoms of OCD can also coexist and may even be part of a spectrum of neurological disorders, such as Tourette’s syndrome. Appropriate diagnosis and treatment of other disorders are important to successful treatment of OCD.

## DEPRESSION

### CRITERIA FOR MAJOR DEPRESSIVE EPISODE - *(Taken from the DSM-IV)*

A. Five or more of the following symptoms have been present during the same 2 week period and

B. Represent a change from previous functioning; at least one of the symptoms is either (1) loss of interest or pleasure. (NOTE: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.)

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. NOTE: In children, consider failure to make expected weight gains.
- insomnia or hypersomnia, nearly every day
- psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

C. The symptoms do not meet criteria for a Mixed Episode (see p. 335)

D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

F. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or a psychomotor retardation.

### ***Clinical Depression and Women***

Women experience depression at roughly twice the rate of men. One in four women can expect to develop clinical depression during their lifetime. Regardless of age, race, or income clinical depression can occur in any woman, and can be serious enough to lead to suicide. The good news is that clinical depression is a treatable medical illness. Women with clinical depression need to know that successful treatments are available.

### **The Facts Every Woman Should Know**

- Approximately seven million women in the United States currently have diagnosable clinical depression.
- Only one out of every three women who experience clinical depression will ever seek care.
- Married women have higher rates of depression than unmarried women, with rates peaking during the childbearing years.
- Depression occurs most frequently in women 25-44 years of age.
- Girls entering puberty are twice as prone to depression as boys.
- Elderly women experience depression more often than elderly men.
- Depression is the number one cause of disability in women.
- Research shows a strong relationship between eating disorders and depression.
- Almost 15% of those suffering from severe depression will commit suicide.

### **Why Are Women At Increased Risk For Depression?**

- Biological differences in women may contribute to depression, such as hormonal changes and genetics.
- Social reasons may also lead to higher rates of clinical depression among women, such as greater stresses from work and family responsibilities, the roles and expectations of women, and even the increased rates of sexual abuse and poverty.

### **Women's Attitudes Towards Depression**

According to a recent National Mental Health Association Survey on the public's attitudes and beliefs about clinical depression:

- More than one-half of women surveyed believed it is "normal" to be depressed during menopause.
- More than one-half of women surveyed believe depression is a normal part of aging.

- Many women do not seek treatment for depression because they are embarrassed or in denial about being depressed.
- More than one-half of women surveyed cited denial as a barrier to treatment.
- 41% of women surveyed cited embarrassment or shame as barriers to treatment.

### ***Depression and Older Americans***

Depression is not a normal part of aging, but unfortunately, many older Americans and their caregivers believe it is, and depression in the elderly often goes overlooked and untreated. Although older Americans may experience many losses in later life such as changes in health status or relocation of loved ones, the majority of seniors cope with these losses without becoming clinically depressed. However, if a depressed mood lingers for a long period of time, it may be clinical depression. Oftentimes the symptoms of depression are missed because they coincide with other illnesses of later life. Depression takes the pleasure out of daily life, it can often aggravate other medical conditions found in later life, and when overlooked it can lead to suicide. But it doesn't have to: clinical depression can be treated successfully in over 80% of all cases.

### **Get the Facts**

- Depression is not a normal part of aging, but over 58% of Older Americans think it is.
- Late-life depression affects some 6 million Americans, most of them women, but only 10% of these persons ever get treated.
- Depressive symptoms occur in approximately 15% of community residents over 65 years of age. Rates of depression in nursing homes are up to 25% in some areas.
- Depression often goes undetected because patients do not report their symptoms, and when they do, they are often misinterpreted as symptoms of a medical illness.
- Older adults are considered the group most at risk for suicide. The suicide rate in older Americans is more than 50% higher than young people or the nation as a whole. Many of these suicides (up to two-thirds) are often attributed to depression that went untreated or misdiagnosed.
- A quarter of all suicides occur in the elderly and are particularly associated with depressive disorder. White men over age 80 are six times more likely to commit suicide than any other demographic group.
- Older patients with significant symptoms of depression have roughly 50% higher healthcare costs than non-depressed seniors.
- Clinical depression can be triggered by other chronic illnesses common in later life such as diabetes, stroke, heart disease, cancer, chronic lung disease, Alzheimer's disease, Parkinson's disease and arthritis.
- Reoccurrence is a serious problem, up to 40% of people continue to experience depression over time.

### **Attitudes of Seniors Towards Depression**

- 68% of Americans aged 65 and over know little or almost nothing about depression.
- Only 38% of Americans aged 65 and over believe that depression is a “health” problem.
- If suffering from depression, older Americans are more likely than any other group to “handle it themselves”. Only 42% would seek help from a health professional.

### ***Depression in The Workplace***

Clinical depression has become one of America’s most costly illnesses. Left untreated, depression is as costly as heart disease or AIDS to the US economy, costing over \$43.7 billion in absenteeism from work (over 200 million days lost from work each year), lost productivity and direct treatment costs. Depression tends to affect people in their prime working years and may last a lifetime if untreated. More than 80 percent of people with clinical depression can be successfully treated. With early recognition, intervention, and support, most employees can overcome clinical depression and pick up where they left off.

### **Know the Facts**

- Depression ranks among the top three workplace problems for employee assistance professionals, following only family crisis and stress.
- 3% of total short term disability days are due to depressive disorders and in 76% of those cases, the employee was female.
- In a study of First Chicago Corporations, depressive disorders accounted for more than half of all medical plan dollars paid for mental health problems. The amount for treatment of these claims was close to the amount spent on treatment for heart disease.
- The annual economic cost of depression in 1995 was \$600 per depressed worker. Nearly one-third of these costs are for treatment and 72% are costs related to absenteeism and lost productivity at work.
- Almost 15% of those suffering from severe depression will commit suicide.

### **Employees Attitudes Towards Depression**

- Often times a depressed employee will not seek treatment because they fear the affect it will have on their job and they are concerned about confidentiality.
- Many employees are also unaware they have depression or they fear their insurance is inadequate to cover the costs.
- Most employers will refer a depressed employee for help if they are aware of the symptoms. 64% of NMHA Survey respondents said they would refer and employees to an EAP health professional.

### **General Mental Health**

In a recent survey regarding the causes of mental illness

- 71% believed that mental illness is caused by emotional weakness
- 65% believed that mental illness is caused by bad parenting
- 35% believed that mental illness is caused by sinful or immoral behavior
- 43% believed that mental illness is brought on in some way by the individual

**One in five adults has a diagnosable mental disorder.**

**One in four families will have a member with a mental illness.**

### **Children and Adolescents**

- Mental health problems affect one in every five young people at any given time (*U.S. Department of Health And Human Services*).
- An estimated two-thirds of all young people with mental health problems are not getting the help they need (*U.S. Department of Health And Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services*).
- Less than one-third of the children under age 18 with a serious disturbance receive any mental health services. Often the services they receive are inappropriate (Children's Defense Fund).
- Recent studies show that, at any given time, as many as one in every 3 children may have clinical depression. The rate of depression among adolescents may be as high as one in eight (*Center for Mental Health Services*).
- Suicide is the third leading cause of death for 15-24 year olds and the sixth leading cause of death for five-15 year olds (*American Academy of Child & Adolescent Psychiatry*).
- Schizophrenia is rare in children under 12, but occurs in about three out of every 1,000 adolescents (*U.S. Department of Health And Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services*).
- It is estimated that between 118,700 and 186,600 youths who are involved in the juvenile justice system have at least one mental disorder (*Responding To The Needs Of Youth In The Juvenile Justice System - Cocozza, J.J. The National Coalition for the Mentally Ill in the Criminal Justice System, November 1992*).
- According to a 1994 OJJDP study of juveniles' response to health screening conducted at the admission of juvenile facilities, 73 percent of juveniles reported having mental health problems and 57 percent reported having prior mental health treatment or hospitalization (*Conditions Of Confinement: Juvenile Detention And Correctional Facilities, OJJDP, August 1994*).
- Of the 100,000 teenagers in juvenile detention, estimates indicate that 60 percent have behavioral, mental or emotional problems (*Department of Justice, Office of Juvenile and Delinquency Prevention, 1994*.)

## THREE COMMON APPROACHES TO ANGER:

- VENTILATIONIST APPROACH
- RATIONAL EMOTIVE / COGNITIVE-BEHAVIORAL
- ANGER MANAGEMENT APPROACH

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### TERMS TO DEFINE:

- ANGER
- RAGE
- AGGRESSION
- HOSTILITY
- RESENTMENT
- HATRED
- DEPRESSION AND ANXIETY

# IMPULSIVITY

- AWARENESS
- INCREASE IN TENSION
- ACTION TO RELIEVE TENSION
- PLEASURE / RELIEF
- REGRET / CONSEQUENCES

## HEALTHY ASPECTS OF ANGER



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# Anger Management



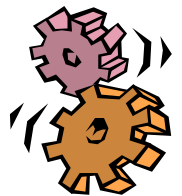
Through Changed Cognitions

Through Distress Tolerance Training



Through Replacement Imagery

Through Creating Options



Through Practicing New Behaviors

Through Accountability



Through Awareness of Other Emotions

# **WHAT DO YOU FEAR ??**

## ***PRESENTING PROBLEMS :***

1. **FEAR:**

2. **ANXIETY:**

3. **COMPULSIONS:**

## ***FIVE ELEMENT OF ANXIETY RELATED DISTRESS:***

1. **IMAGES**

2. **THOUGHTS**

3. **FEELINGS**

4. **SENSES**

5. **BEHAVIORS**

## **TAKING ACTION TO RELIEVE Misery**

**THOUGHTS:** Many people who feel miserable or depressed have dark, gloomy negative pictures floating around in their heads.

Often, a persons feelings of misery and depression can be relieved or even altered when their gloomy pictures are replaced with more up-lifting, brighter pictures.

**DO THIS:** Go through your stuff, or go to the store and get a box of 8 crayons. Throw away the black and brown ones. That should leave you with Red, Orange, Yellow, Green, Blue and Purple.

**THEN:** Use these bright crayons to create a picture in the space below.

This picture can be of your hopes, dreams, or just a “sunny day”. It should be a happy, bright picture.

**THEN:** Carry the picture with you, or tape it to your bathroom mirror, or on the refrigerator. Throughout the day, or whenever you are feeling miserable or depressed, you can look at this picture, and think about what positive, uplifting things it represents to you.

**GET NEW PAPER, AND DO THIS AGAIN, EVERY DAY.  
DO THIS AS MANY TIMES A DAY AS YOU WOULD LIKE.**



# **TARGETED ANXIETY INTERVENTIONS**

**MAKE YOURSELF PANIC**

**CHANGE YOUR MENTAL CHANNEL**

**PREPARE FOR DISASTER**

**FIGHT, DON'T FLIGHT**

**FLIGHT, DON'T FIGHT**

**BREATHING EXERCISES**

**START LISTENING TO THE NEWS**

**HARMLESS OBSESSIONS**



# Guided Goal-Setting for Personal Success

*I Can't Change Everything at Once,  
So I'm Seeking Progress...  
Not Perfection*

## A GOOD GOAL MUST:

- Be Clear and Specific**
- Be Beneficial to Me**
- Have a Reasonable Time Frame**
- Have Concrete Planned Objectives**
- Be Truly Attainable**

## Objectives:

- 1.
- 2.
- 3.
- 4.
- 5.

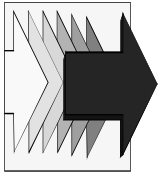
# 3 Ideas to Help Manage ANGER And Other Emotions

## **Learn to pay attention to the quality and intention of other people's value systems.**



It is not always necessary or wise to agree with other people all the time, but sometimes it is helpful to at least listen and consider what other people have to say, and why they believe what they do. We learn and grow from experiencing new things, including listening to and trying to understand the opinions and beliefs of others.

- ◆ **DO THIS:** The next time someone offers their opinion or discusses their value system with you, resist the temptation to immediately argue with them or discount what they have to say.



Instead, make a conscious effort to really hear the person, and to understand where they are coming from. Ask honest questions, and listen to the answers, rather than ignoring them or engaging in conflict. In the end, you still may not agree or be swayed, and that is okay.

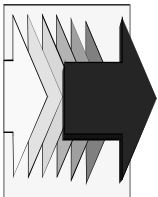
Hopefully, however, you may at least have a greater understanding and respect for the person in general.

## **Be aware of the physical symptoms of emotions, including anger, depression and anxiety.**



When we feel emotions, we also feel and react physically. When we are becoming angry, our pulse may accelerate, our muscles may tense, and our voice patterns may change drastically. When we are becoming depressed, we may be irritable, we may feel ill, and we may be lethargic. When anxiety creeps in, we may be edgy, we may be impulsive, and we may fidget or pace. Learning to recognize these physical symptoms when they first begin can help us to recognize the need to manage our emotions before we engage in behaviors that have negative consequences.

- ◆ **DO THIS:** Practice being consciously aware of your body and its physical changes throughout the day, and especially when your emotions change.



Notice what it feels like physically to be relaxed; learn to recognize the physical sensation of your muscles tightening when you feel stressed, angry or anxious.

Look at your appearance in the mirror when you are experiencing different emotions and notice the difference in your stature and facial expression for various levels of sadness or depression, irritation or anger, contentedness or happiness, nervousness or anxiety, and etc.

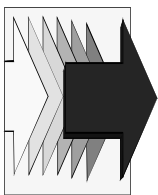
The sooner you become aware of the physical symptoms related to your emotions, the sooner you will be able to recognize that you need to manage your behaviors and do healthy things in response to your emotions.

## **It is important to run your thoughts and ideas through a 'reality check' process, before you act on them.**



Sometimes we act impulsively, or before we think things through. Sometimes we believe things that are not true, and consequently we act on those false beliefs. If we know that the idea or thought was not true or not in our best interests, we most likely would not believe it, and would believe something else instead. But in order to know if what we believe is true or valid or not, we must do a 'reality check'. Taking the time to think carefully about our beliefs before we act upon them can save us a lot of grief.

- ◆ **DO THIS:** When you have an impulse or urge to act, it is usually because you believe something is true.



For Instance: You have an urge to drink a bottle of rum, because you believe it will make you feel better, or solve your problems. Or, perhaps you have an urge to throw a chair thru the window, because your spouse was late coming home from work again.

Before you act on your beliefs, urges and impulses, STOP. Think carefully about what you are wanting to do, and why.

Will the action really solve the problem in a healthy way, or will it actually create more problems down the road?

Are you simply impulsively responding to your uncomfortable emotions, such as shame, pride, hurt, embarrassment, or depression, before thinking the actions through, or considering your healthy options?

**REMEMBER—when you Feel something, you need to always Think before you Act. (F>T>A)**

## Misery Loves Company

**THOUGHTS:** When we are feeling miserable or depressed, we often do things that will reinforce our misery and depression.

- We engage in “Competitive Misery” and tell our problems to others, who then tell us their problems, and we compete to see who is the most miserable.
- We stay in bed, watch sad movies, don’t leave the house, don’t turn on the lights.
- We figure things can’t get any worse and we do something really dumb like drink and drug, commit crimes, hurt ourselves, or hurt other people.

**DO THIS:** Think carefully about the times your are depressed or miserable. Think about all the different things that you do to reinforce your misery and depression.

**THEN:** Make a list of all these things on the left side of this page below. (Use the left side of the back of this page if necessary for more room.)

**DO THIS:** Cross a line through each one of the items you listed.

**THEN:** Next to each item you marked out, write down on the right a **HEALTHY ALTERNATIVE BEHAVIOR** that you could do instead, that would reduce or minimize your misery and depression, or that will at least allow you to function.

**DO THIS:** Keep this page with you. When you are feeling miserable or depressed, look at this list and see that you have positive, healthy behavioral choices.

DO the things you wrote down on the right side of the page,  
instead of the things on the left that you crossed out.

## **WHAT GOES IN... MUST COME OUT**

**THOUGHTS:** When people are miserable or depressed, they often tell themselves negative and gloomy things about themselves that reinforce their misery and depression. On the other hand, people who tell themselves positive, truthful, and up-lifting things about themselves, generally feel better about themselves, and their life in general. In other words... 'what goes in, must come out'.

**DO THIS:** Think about what you say to yourself, aloud or silently, when you are feeling miserable or depressed. Make a list of the words or sentences or even scenarios that you tell yourself.

**THEN:** Look over the items you have listed carefully and honestly. Are any of these statements Negative? Untrue? Exaggerated? Degrading?

**DO THIS:** Cross a line through the statements that are negative, or serve to reinforce your misery and depression.

**THEN:** On another sheet of paper, make a detailed list of positive, truthful, and up-lifting things about yourself. Ask others for help with this, if you find it difficult. Tape this list to your bathroom mirror, carry it with you or hang it on the refrigerator.

**DO THIS:** Make a conscious effort throughout the day, or whenever you are feeling miserable or depressed, to look at your list of positive truth in them. AND, Make a conscious effort to not think or say the negative, gloomy things on this page.

**ALSO:** Another really good way to reinforce these positive statements about yourself, in addition to the above lists, is to make a cassette-tape recording of your positive statements. Then you could play it around the house, on headphones, or in the car throughout the day, and when you're feeling miserable and depressed. Just make sure that you record your positive, up-lifting statements in your own positive, up-lifting, believable tone-of-voice.

## **YOU ARE... WHAT YOU EAT**

**THOUGHTS:** It has been said that one of the fastest, most powerful mood-altering substances is...MUSIC. Miserable and depressed people often force-feed their misery and depression by listening to miserable and depressing music. This can be a very unhealthy 'diet', as... "you are what you eat".

**DO THIS:** Make a list below (and on the back if necessary) of the music you seek out when you are feeling miserable and depressed. You can do this by listing category flavors, band names, or specific songs.

**THEN:** Look carefully and honestly at what you have written. Is this music depressing in nature, by way of either the sound or the lyrics? Are there specific bands or songs you seek out that remind you of certain situations or people, that reinforce your feelings of depression and misery? Do the lyrics present scenarios similar to miserable things in your life?

**DO THIS:** Cross a line through each item you have listed that is probably adding to your misery and depression when you listen to it.

**THEN:** Think about some other types of music, or bands or songs that are more uplifting and positive. Ask others for help in this area, if necessary.

**DO THIS:** On another sheet of paper, make a list of these more positive and uplifting musical selections, even if you have never heard of them. Make a conscious effort to seek out the music on this new list frequently throughout each day, and especially when you are depressed or miserable.

**AND,** Make a conscious effort to avoid the music you have listed on this page.

## CONTROL ISSUES

Identify the situation or event producing anger, depression, anxiety or distress.  
Focus on the situation, people, places and fears regarding potential outcomes:

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*People, Places and Things I Can Control:*

*People, Places and Things I CANNOT Control:*

*People, Places and Things I am Trying to Control, that have No Real Effect on Outcomes:*

**Describe the event, change or situation causing your depression or anxiety:**

Identify the *worst* possible outcomes to the above situation. Then evaluate the honest likelihood of these outcomes coming true. Rate them on a scale from 1 - 5, (1 being the *least* likely and 5 being the *most* likely to come true.) Draw a line through those that *definitely won't* come true or *most likely won't* come true.

- 1.)
- 2.)
- 3.)
- 4.)
- 5.)
- 6.)
- 7.)

Identify any people, coping strategies or ideas that *could* help you, if any of the above fears did become a reality:

People who could help me:

Actions I could take to help myself cope:

## **EDUCATIONAL SERVICES AVAILABLE FROM PEACHTREE PROFESSIONAL EDUCATION INC.**

PeachTree offers numerous Training Seminars that teach practical and effective intervention and assessment strategies on issues of substance abuse, personality disorders, depression, family issues, anger and violence, professional ethics, brief therapy techniques... and more. Training topics and uplifting Keynote subjects can be developed and customized to meet the needs of your professional group.

### ***CLIENT AND PROFESSIONAL RESOURCES:***

#### **The Nongard Strengths and Resources Inventory (NSRI)**

A one page self-report questionnaire, focusing on identification of client strengths and resources. This is a practical general assessment tool, useful for strategizing therapeutic intervention starting points, based on the adult and adolescent client's personal attributes, resources and abilities.

#### **The Nongard Substance Addiction Screening (NSAS)**

A self-report preliminary addiction screening tool, with both adult and adolescent versions. The NSAS's format is practical and easy to administer, complete, score and interpret, and it follows the DSM-IV diagnostic criteria for Substance Dependency.

#### **The Nongard Depression Index (NDI)**

A self-report preliminary screening tool for depression, with both adult and adolescent versions. The simple "survey" format encourages honesty, and the content follows the DSM-IV criteria for Major Depression.

#### **The Nongard Couple's Conflict Questionnaire (NCCQ)**

This self-report screening tool covers sixteen areas of life and is useful for both Individual and Couple's counseling settings. Clients are asked to mark statements that they identify with, and also to mark statements they feel their partner would relate to, if asked. Great for quickly identifying presenting problems of relationship difficulties.

#### **The First Three Steps...A Guide for Recovery Utilizing the AA and NA Texts**

This workbook is designed as a tool to assist in the recovery of both singularly and dually-addicted adults and adolescents, and incorporates both AA and NA text readings. It is written in a modern, simple language for the benefit of all populations, and may be especially useful for adolescents, young adults, and those who may be developmentally challenged.

#### **The Family Peace and Sanity Treaty**

This workbook is similar on the surface to common 'family contracts', yet it goes much further to instill responsibility and respect for authority by helping parents to thoroughly address and plan strategies step-by-step for handling all aspects of a young person's life, from curfews to school to attitude to chores to spiritual awareness, etc., and is written in a relaxed, understanding, 'there is hope' manner.

#### **Getting Along... A Guide for Healthy Interactions with Others**

This 60 page workbook goes beyond simple communication strategies and addresses both verbal and non-verbal expression patterns, listening skills, and altering automatic or reactionary behaviors. *Getting Along* is crammed with worksheet assignments designed to increase awareness, create options and change both unhealthy habitual and intentional behaviors that cause distress in all forms of relationships.

#### **Therapeutic Relaxation**

This 4-track audio CD guides the listener through a series of Progressive Muscle Relaxation techniques, Breathing exercises, and Creative Visualization. These tapes are not designed to put the listener to sleep, but to teach the listener how to recognize their physical stress and how to actively relax, with or without the cassettes. Both tapes have both male and female voice sides, for client preference, and the introductory tape has no background sounds, while the second tape does.

**Please contact PeachTree Professional Education, Inc., (800) 390 - 9536 for further information about available services or professional resources.**

**We Have What You Need**

**APPROVED**

**FastCEUs.com**

**PeachTree Professional Education, Inc.**

**PeachTree Professional Education, Inc.**  
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**15560 N. Frank L. Wright Blvd, #B4-118**  
**Scottsdale, AZ 85260**  
**(800) 390-9536 Fax (888) 877-6020**  
[www.FastCEUs.com](http://www.FastCEUs.com)

## EVALUATION OF LEARNING QUIZ PAGE 1 of 2

**PRINT and FAX or MAIL THIS PAGE AND THE ANSWERS PAGE TO OUR OFFICE**  
**\* \* \* \* OR \* \* \* \***  
**>>> You may complete and submit this Evaluation and your payment Online by following the 'Quiz & Pay' link for this course on our website at [www.FastCEUs.com](http://www.FastCEUs.com).**

**PLEASE NEATLY PRINT THE FOLLOWING INFORMATION:**

**NAME** as you want it on your CEU Certificate: \_\_\_\_\_

Professional cert/license type with numbers: \_\_\_\_\_

**ADDRESS** to keep in our board records: Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

**DAYTIME TELEPHONE** Number: (\_\_\_\_\_) \_\_\_\_\_

**NEATLY Print YOUR FAX Number OR EMAIL Address to receive your CEU Certificate — Certificates will NOT be mailed:**

 (\_\_\_\_\_) \_\_\_\_\_

*(If you FAX us your Evaluations do NOT also mail them. Please WRITE NEATLY !!)*

**CREDIT CARD and BILLING INFORMATION:**

*(Certificates will not be provided until payment is received by our office.)*

### **"ANGER, ANXIETY AND DEPRESSION"**

**This 3 Hour CEU Course is \$49.00**

Please make checks out to PeachTree Professional Education and mail to the address above.

**Circle:** MC    Visa    Discover    Amex    Check Enclosed

Credit Card Number: \_\_\_\_\_

Credit Card Expiration Date: \_\_\_\_\_ 3-4 Digit Code: \_\_\_\_\_

Signature: \_\_\_\_\_

## EVALUATION OF LEARNING QUIZ — page 2 of 2

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### **Course Title: “Anger, Anxiety & Depression”**

#### **3 Hours of Approved Continuing Education Credit**

*The purpose of the following Evaluation of Learning questions is to:*

- A.) Verify that you have read and/or listened to the required course materials,
- B.) Demonstrate an understanding of the practical application of the course materials,
- C.) Officially document your participation and completion of this course.

#### **CIRCLE THE ANSWER TO THE FOLLOWING 20 TRUE/FALSE EVALUATION OF LEARNING QUESTIONS**

- T F 1.) I have read the required course notes that accompany this class.
- T F 2.) I have listened to the entire audio lecture presentation for this course.
- T F 3.) Problems associated with Anger are reflected in Intermittent Explosive Disorder.
- T F 4.) Nongard views Anger, Anxiety and Depression as essentially the same emotion with different manifestations.
- T F 5.) The ventilationist approach should never be used in counseling.
- T F 6.) The goal of treating the angry client is to eliminate anger.
- T F 7.) With all anxiety disorders, many of the symptoms are physically based.
- T F 8.) Interventions with anxious clients must address distressing mental imagery.
- T F 9.) Distressing mental images reinforce unhealthy behaviors in anxious clients.
- T F 10.) Depression is an extremely powerful emotion.
- T F 11.) Depression is not a normal state of human emotion.
- T F 12.) Depression is often assessed through the therapist’s own frame of reference rather than by the DSM criteria.
- T F 13.) Depression can be a regulator for physical functioning.
- T F 14.) Specific treatment ideas can be adapted from general principles.
- T F 15.) Written worksheets are great for clients at any level of functioning, even low functioning.
- T F 16.) Paradoxical intention can be effective with anxious clients.
- T F 17.) Reframing or changing clients’ mental pictures is a useful tool in managing catastrophizing in anger, depression or anxiety.
- T F 18.) Teaching rational beliefs to overcome irrational fears is always the best approach.
- T F 19.) In America, you are allowed to be strange.
- T F 20.) Teaching clients in their own language is essential for teaching Distress Tolerance Training.



**Richard K. Nongard, Executive Director**  
**PO BOX 121 ANDOVER, KS 67002**

**"Blue Sheet"**  
**Grade This**  
**Class!**

Please complete this short course evaluation.

Please mail or fax this page to us along with your completed course documentation.

DATE: \_\_\_\_\_ Homestudy Course Title: \_\_\_\_\_

**On a scale of 1-5 (5 being "highest" and 1 being "lowest) please answer the following questions:**

LOW -----> HIGH

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1) The instruction appeared knowledgeable of the materials: | 1 | 2 | 3 | 4 | 5 |
| 2) The course objectives for this class were met:           | 1 | 2 | 3 | 4 | 5 |
| 3) Appropriate teaching methods were utilized:              | 1 | 2 | 3 | 4 | 5 |
| 4) The handout materials were useful:                       | 1 | 2 | 3 | 4 | 5 |
| 5) Sound / Video quality was acceptable:                    | 1 | 2 | 3 | 4 | 5 |
| 6) How much of this material was new to you:                | 1 | 2 | 3 | 4 | 5 |
| 7) The overall quality of this course was:                  | 1 | 2 | 3 | 4 | 5 |

8) Please feel free to make any additional comments below:

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**Thank you for your participation!** Please sign here if you give permission for your comments to be used on our website or other advertising materials.

\_\_\_\_\_  
 Name or Initials

\_\_\_\_\_  
 City, State