PRACTICUM

A Group Approach to the Management of Stress for Employees of the Manitoba Telephone System

by

Allyson Shpirko Welby

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Abstract

This social work practicum involved the development and implementation of an educational, preventative, individual-level stress management program for interested employees at the Manitoba Telephone System. The purpose of the program was to help participants enhance their ability to cope with stress by helping them to learn more about stress and to become familiar with several methods of stress management. The method of intervention involved making use of the structured group approach in the context of traditional social group work.

Variables evaluated were self-esteem, attitude toward stress management, intent to practice stress management, and degree of symptom discomfort. Participants were also asked to indicate the degree to which they developed understanding and gained experience in relation to pertinent areas of stress and stress management. Measures included the Hudson Index of Self-Esteem, two self-anchored scales, a Symptoms Checklist and a Learning Objectives measure, both essentially self-anchored scales. A combination of the one-group pretest-posttest design and the "one-shot case study" constituted the evaluation design.

Evaluation results indicate that to varying degrees the program was successful in facilitating the fulfillment of objectives. The majority of

participants said that they developed an understanding of content and gained experience in the use of methods. Three out of four participants who had low self-esteem at the start of the program indicated a significant improvement in this area while all participants said they experienced some degree of significant relief from symptom discomfort. The program's effectiveness appeared limited in helping participants develop a more favorable attitude toward stress management and a stronger intent to practice it although it is hypothesized that they may have been helped to sustain the initial positive intent of these factors.

Several recommendations are made concerning future programming.

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INTRODUCTION

The Nature of the Practicum

The social work practicum upon which this report is based involved the development and implementation of an educational, preventative, individual-level stress management program for a group of interested employees and their families at the Manitoba Telephone System (MTS). The purpose of the program was to enable participants to enhance their ability to cope with stress by helping them to become more knowledgeable about stress and to become familiar with several methods of stress management. The recognition that stress can have potentially negative health consequences constitutes an important rationale for taking steps toward reducing the probability of stress-related illness or dysfunction by providing people with resources that they can draw on to cope more effectively. As the primary tool for intervention, the structured group approach facilitated the operationalization of the program's purpose.

The focus of the program was considered more preventative than residual for the reason that members were not solicited on the basis of having stress-related problems; any MTS employee or employee family member was eligible to participate. This emphasis on prevention is reflected in the more progressive elements of industrial social work (Shain, Suurvali, Boutilier, 1986).

Entitled Increasing Power Over Stress, the program was composed of ten weekly, two-hour sessions and was offered under the auspices of Tele-Cope, a counselling service for all MTS employees and their families, from February 4 to April 8, 1986.

Assumptions, Personal Objectives, and Program Objectives

The writer's initial assumptions about stress, stress management, and the potential educational function of social work, her personal learning objectives, and objectives for the program played a strong role in determining the nature of the practicum and they are therefore important to identify.

Initial assumptions, serving as an early context for study and subsequently found to be largely supported in the literature, were:

a) that the experience of stress can have deleterious consequences for health and well-being,

b) that the more effective a person's coping skills, the less chance that stress will have deleterious consequences,

c) that stress management programs for individuals can facilitate the acquisition of knowledge and skills which can then be used to cope more effectively with stress,

d) that social work can have a preventative, educational function that can serve to facilitate increased competence in coping.

The personal objectives of the writer arising from these assumptions were:

a) to become knowledgeable about and to develop an understanding of pertinent issues associated with stress and stress management,

b) to increase her range of practice competency by gaining experience with groups (the most common form of stress management program delivery) and,

c) to develop and implement a social work intervention that is primarily preventative and education-oriented.

The following program objectives were articulated prior to group formulation (a feature of the structured group approach):

1. Members will develop an understanding of:

a) how integrated patterns of psychological and biological responses to environmental demands characterize the stress response,

b) how the stress response has become a potential cause of disease,

c) common, potential occupational and life stressors.

2. a) Members will develop an awareness of the role social support plays in modifying the stress response.

   b) The program will enable members to identify personal supportive relationships and to identify steps for improving their relationships.

3. Members will develop an understanding of and gain experience in the use of the following stress management strategies:

   a) progressive relaxation

   b) stress inoculation

   c) combating distorted thinking

4. Members will report a heightened sense of self-worth as measured by the Hudson Index of Self-Esteem.

5. Members will report a reduction in the degree of discomfort attributed to specific stress-related symptoms as measured by the Symptoms Checklist.

6. Members will report a more favorable attitude toward the personal use of stress management strategies as measured by a self-rating scale.

7. Members will report an intent to use stress management strategies beyond the time period of the program as measured by a self-rating scale.

The first three program objectives provide a brief description of the program content which was divided

into "theme" and "skill" components, and represent some fundamental aspects of stress and stress management. The latter four objectives are descriptive of the outcome anticipated and are useful primarily for evaluation purposes. The variables represented in the objectives, their relationship to stress and to the program are explored in the literature review and in the program evaluation section of this report.

The Setting

The Manitoba Telephone System and Tele-Cope

The Manitoba Telephone System, the setting for Increasing Power Over Stress, employs a total of approximately 4600 staff in Manitoba; 3500 in Winnipeg and 1100 throughout the rest of the province. There is an equal distribution of male and female employees.

In order to effectively compete in the field of tele-communications, the "System" experiments with new technologies and requires from its employees an accompanying change in work skills. As this climate can be stress-producing for both the employee and the organization, the "System" attempts to develop policies that will meet the needs of both parties (Newman, 1983:84). One such policy has involved the incorporation of Tele-Cope.

Initially, Tele-Cope began as part of a project in 1978 when Demonstration Grants Directorate, Health and

Welfare Canada, funded a demonstration by the School of Social Work, University of Manitoba, of workplace counselling. Subsequent to the demonstration phase, MTS adopted the program as it was seen to be utilized and popular.

Staffed by two full-time social workers, Tele-Cope is located off-site and is administered by an advisory committee. It offers accessible, confidential social work services in the form of crisis intervention, information and referral services, employee advocacy, individual and family counselling, and group interventions. Its central philosophy is one of voluntary self-referral.

Need for a Stress Management Program Within MTS

Historically, Tele-Cope has provided stress management programs in response to an on-going need identified within MTS. Increasing Power Over Stress (hereafter referred to as "the Tele-Cope program" or simply "the program") came in response to a specific indication of that need, a 1984 random needs survey which revealed that 72% of persons responding were interested in taking part in a stress management program.

Since earlier programs had been short-term, the staff of Tele-Cope decided that a more comprehensive intervention should be made available. The Tele-Cope

program was therefore designed to include greater depth in subject matter and a stronger skill component than what had previously been offered.

Practicum Report Overview

The report has thus far provided a description of the program and its purpose, the property of stress that constitutes a need for stress management, the primary tool for intervention, the reason behind the program being considered preventative, and some details regarding the program's structure. It has identified the writer's assumptions, personal objectives, and program objectives. The report has also described the setting for the program as well as the setting's need for a stress management intervention.

Following this introductory chapter, the report will offer a review of the literature in chapter two. The purpose of the review was to obtain a basis for the development of the program's design and content through a process of investigating the primary avenues of research and opinion in relation to stress and stress management. The process of investigation took the form of an extensive computer and library search which yielded material from which items having particular empirical, theoretical, and/or practical significance were selected for use.

Following the literature review, chapter three will consider the methodology of the program in the context of group phases. The process by which members were recruited and the composition of the group will be described and each of the program's ten sessions will be discussed in detail.

Chapter four on evaluation will discuss the variables evaluated, the measures used to evaluate, the evaluation design, and how the data was interpreted. Also to be included here is a presentation of individual and group results, a discussion of the outcome, and conclusions and recommendations for future programming.

A REVIEW OF THE LITERATURE

Introduction

The following review of the literature will explore the topics of stress, potential consequences of stress, and common, potential sources of stress. The issue of stress management will also be explored together with the four strategies of stress management featured in the program - combating distorted thinking, stress inoculation, progressive relaxation training, and social support. Finally, the review will consider the educational function of social work, the structured group approach, and social group work as these areas relate to the program.

Stress

Early Conceptualizations and Current Traditions

The literature reveals three early conceptualizations of stress which have been discussed by Appley and Trumbull (1967) and McGrath (1970) among others. In the first, stress is regarded as a stimulus (Mason, 1975b:28; Cox, 1978:12), similar to the engineering concept which looks at stress as an external force directed at a physical object, the result being strain (Lazarus, 1966:12). The second conceptualization regards stress as a response. The third views stress as a combination of stimulus-response (Cox, 1978:4,17).

Two basic traditions of stress research - the biological and psychological traditions - have emerged from these conceptualizations and together represent the stress process as it is currently defined. This discussion will describe the stress process by focusing on the nature of these traditions, and identifying how they differ and where they connect. In addition, the life events approach to stress measurement will be discussed for the reason that it has held a notable place in the field.

Prior to the discussion it is important to point out that this report follows Lazarus' (1966:27) example of using the word "stress" as a "generic term for the whole area of problems that includes the stimuli producing stress reactions, the reactions themselves, and the various intervening processes". In this way the complexity that tends to accompany attempts to define stress precisely is avoided (Zegans,1982:137).

The Biological Tradition

It is assumed that the biological use of the term "stress" began with the research of Hans Selye in the 1930's, however as early as 1914, Walter Cannon used the term in his physiological research (Mason, 1975a:6). Both Cannon and Selye are regarded as the orginators of the stress field and both viewed stress as a response.

An important contribution of Cannon to the stress field involved his conceptualization of the "fight or flight" response. Represented by an arousal of psycho-physiological systems, the response enabled our ancestors to react defensively to physical threats, such as attacks by wild animals (McLean, 1979:27). An increased heart rate, lung expansion, and pupil enlargement are some physical changes that characterize the response (Girdano and Everly, 1979:24). Significantly, the same physical response is precipitated by symbolic threats which are more prevalent in modern society than are physical threats. Because arousal-dissipating action is not warranted in the face of a symbolic threat, arousal lasts longer and becomes more capable of producing organ fatigue (Girdano and Everly,1979:25-37). Herein lies the continued relevance of Cannon's concept today.

Selye (1956) has described in detail his research which included the discovery of particular changes in lab animals that supported his view of stress as a syndrome. He concluded that this syndrome represented a "nonspecific" response of the body to any harmful stimuli or demand. The notion of "nonspecificity" has been Selye's key contribution to the field (Lazarus, 1966:393).

While Selye viewed stress as a syndrome, he also conceived of it as an adaptational process that enabled

the body to resist the stressor (stimuli). In order to explain this process he developed his General Adaptation Syndrome (GAS) formulation which is divided into the following three stages and accompanying biological processes:

a) the alarm stage: the adrenal glands are stimulated but no organs are specifically affected,

b) the resistance stage: the stress response is aimed at the organ system most capable of dealing with it and thus the adaptation process begins,

c) the exhaustion stage: the energy of the targeted organ system becomes depleted and the task of resistance is shifted to a stronger system.

The potential exhaustion of bodily systems is elemental in Selye's view of stress-related diseases as "diseases of adaptation".

Some writers are critical of Selye's theory of nonspecificity. For instance, Mason (1975b:30) speculates whether nonspecific responses are in fact not a function of the common element of emotional arousal found in all circumstances experienced as stressful. Coyne and Lazarus (1980:152) suggest that varying thought processes can produce different patterns of hormone and tissue response, a concept

differing from Selye's "syndrome" perspective. These speculations raise a potentially important issue: if the nonspecificity concept were disproved, the implication of Selye's work would be shifted to the field of psychological stress (Mason, 1975b:30).

While focusing primarily on the body's physical response to stress, the biological tradition is limited in that it does not fully acknowledge the role of psychology or the function of coping in the stress process (Holroyd and Lazarus, 1982:27). It therefore does not represent the dynamic nature of stress. In contrast, the psychological stress field maintains that responses are diverse and can only be understood when cognitive factors are taken into account (Fleming, 1981:55-56).

The Psychological Tradition and the Transactional Model of Stress

The psychological tradition in the stress field was developed about thirty-six years ago as a means of understanding the breakdown of adaptive behavior in extreme circumstances (Holroyd and Lazarus, 1982:21). The transactional model of stress appears to characterize the psychological tradition today and it is this model which will provide the focus of the discussion.

A need had been identified in the field for a model of stress that would serve to integrate existing knowledge (Scott and Howard, 1970; McGrath, 1970). In response to this need, Richard Lazarus (1966) developed the transactional model of stress as an outgrowth of the reiterative appraisal model set forth by Magda Arnold (1960). The model represented a solution to what some authors viewed as the inadequacy of the three conceptualizations identified earlier (ie. stress as a stimulus, a response, or a combination of the two) which all assumed that the person and environment were static phenomena, existing in a linear, unidirectional relationship (Mason,1975b:32). In contrast to these, the transactional model accounts for the various psychosocial variables such as coping that intervene between demand and response and views the person and the environment in a "dynamic, mutually reciprocal, bidirectional relationship" (Lazarus and Folkman,1984:293).

The transactional model defines stress as "a relationship between the person and environment that is appraised by the individual as taxing or exceeding his or her resources and as endangering well being" (Folkman, 1984:840). This definition was featured in the Tele-Cope program. Key elements of the model include the external and internal forces that can precipitate a stress response and the intervening

variables that can influence it (Lazarus,1966:13). The discussion will now turn to the concept of cognitive appraisal as a key element in the transactional model.

Cognitive appraisal. The most important intervening variable in the transactional process is cognitive appraisal which refers to the continuously re-evaluated judgements about demands and resources (Breznitz and Goldberger, 1982:3; Magnusson, 1982:236; Lazarus, 1966:44). There is a distinction between primary and secondary appraisal, with the former referring to an evaluation of the importance of a transaction to one's well-being and the latter referring to an evaluation of personal coping resources (Coyne and Lazarus, 1980:151-153). The degree of stress experienced is shaped by an interaction of primary and secondary appraisals (Lazarus and Folkman, 1984:35).

The process of primary appraisal serves to define the stressor as irrelevant, benign-positive, or stressful; with stressful appraisals involving judgements of harm/loss, threat, or challenge. Of the three, the threat appraisal has the most significance to the experience of stress because most stress reactions occur when an event is anticipated and threat has a definite future-focus (Lazarus, 1966:35). Threat involves the experience of negative emotion and the potential for loss while challenge involves the

experience of positive emotion and the potential for gain; these concepts paralleling Selye's notion of "distress" and "eustress" (Coyne and Lazarus, 1980:152).

In the view of some writers, primary appraisal can be shaped by such personal factors as committments, beliefs about control, and religious beliefs (Folkman,1984:841; Lazarus and DeLongis,1983:252). It is suggested that the degree of importance a committment has to one's well-being will influence appraisal, that while experiencing a feeling of control one is more likely to appraise the environment as challenging, and that faith in a higher order helps to maintain hope.

Secondary appraisal is an evaluative process that takes into account the availability of coping options, the likelihood that a given coping option will be successful, and the likelihood that one will be able to apply a particular coping option effectively (Lazarus and Folkman, 1984:35). "Coping" is defined as "those behaviors and thoughts which are consciously used by an individual to handle or control the effects of anticipating or experiencing a stressful situation". (Stone and Neale, 1984:893).

The dimensions of coping include social resources, psychological resources, "concrete efforts" (Pearlin and Schooler, 1978:4) and physical/ material resources

(Folkman, 1984:842). In the view of Coyne and Lazarus (1980:155) coping can be emotion-focused, involving the regulation of distressful emotions, or problem-focused, involving direct problem-solving. Other writers conceptualize a third function for coping, that involving efforts to control the meaning of a stressful experience after it has occured but before it causes distress (Billings and Moos, 1984:879; Pearlin and Schooler, 1978:6).

Empirical testing of the transactional model.

Theory and research in relation to the transactional model has been predicated on five main variables: stress, appraisal, coping, person and environment antecedents of stress and coping, and short- and long-term adaptational outcomes. Only the first three have been the focus of empirical measurements (Lazarus and Folkman, 1984:306).

In regard to the "stress" variable, one study stands out. Kanner et al (1981) developed an approach to stress measurement based on the ordinary "hassles" (ie. "irritating, distressing demands") that arise from every day transactions with the environment. A regression-based comparison of life events and daily hassles showed that hassles are superior to life events in predicting symptoms. Findings also demonstrated that an individual's life circumstances (ie. social and economic factors) affect what transactions will be

perceived as "hassles" or "uplifts", those positive experiences which are opposite to hassles.

In order to study the cognitive appraisal process, the second variable, Lazarus and his associates in the 1960's used motion picture films as a means of generating stress for subjects. In this extensive research project, subjective feelings of stress as well as autonomic (central nervous system) upsets were monitored. The project demonstrated that cognitive appraisal processes do affect stress response levels (Lazarus and Folkman, 1984:39-40). For a review of early research demonstrating the role of cognitive processes in stress, the reader can refer to Lazarus (1966).

In regard to the third variable "coping", Folkman and Lazarus (1980) developed a "Ways of Coping" checklist that assesses coping by having people reconstruct stressful experiences and then describe what they thought, felt, and did in response. The nature of the checklist reflected the belief of these authors that global assessments of coping must be exchanged for more specific measures that are better predictors of short-term outcomes. The checklist was administered to one hundred middle-aged adults and results showed that subjects used both problem- and emotion-focused coping strategies to deal with stressful circumstances.

The transactional model in relation to social work. A rationale for adopting the transactional model of stress for use in a social work intervention can be found in Berlin's (1980) perspective on "cognitive learning" for social work. Significantly, the cognitive focus of the transactional approach supports the ecological concept of person-environment interaction (social work's primary conceptual model) and is only different in that it suggests specific variables such as thoughts, emotions, and behavior by which the interaction takes place (Berlin, 1980:538). Thus, from an ecological stand point, the transactional model of stress would appear to be the most comprehensive model available.

The Issue of Linkage Between Psychological and Biological Processes

It is generally assumed that the entire stress process involves an integration of psychological and biological responses (Fleming, Baum and Singer, 1984:941), however, Mason (1975a:11) regards this "linkage" issue as a question that has yet to be resolved. As it stands, the primary distinction between psychological and biological stress is this: biological stress refers to the body's response to harm already done while psychological stress refers to anticipated harm. The key point of convergence is that

psychological stress results in the same biological responses as those produced by noxious stimuli (Lazarus,1966:31,422).

The Life Events Approach

The life events approach to stress measurement assumes that those life events involving significant degrees of change or transition (ie. marriage, divorce, death of a spouse, gaining or losing employment etc.) are likely to cause stress-related problems for the individual. It seeks to measure the intensity of events as a way of predicting the probability of negative health outcomes. Because this approach has dominated the area of stress measurement it is worthwhile to note some aspects of research and opinion in relation to it.

The results of one study by Schroeder and Costa (1984) concluded that the reported relationship between major life events and physical illness is a function of other independent variables and that therefore life events cannot be said to have been the direct cause of illness. One major review of the life events literature concludes: "In practical terms....life event scores have not been shown to be predictors of the probability of future illness" (Rabkin and Struening, 1976:1015). Other authors maintain however, that illness occurs in association with stressful life

events more often than by chance (Minter and Kimball, 1980:205; Sarason, Johnson and Siegel,1979:131).

The life events approach has been described as "conceptually deficient" for the reason that variables that may intervene between the occurence of life events and illness (ie. cognitive appraisal and coping) are not accounted for (Monroe, 1982:190; Rabkin and Struening, 1976:1016), nor is the desirability or nondesirability of events (Zegans, 1982:138). As well, Lazarus and DeLongis (1983:247) point out that "nonevents" (those "unnamed" stressful events such as reaching the plateau of one's career) are not included in life event measures, thus indicating the narrow focus of the approach. Even advocates recognize the need to improve the means of measurement in various ways (Perkins, 1982:327; Sarason, Johnson and Siegel, 1979:132). "Improved" life event measures however, are regarded as being characterized by "technical weaknesses" (Dohrenwend et al, 1982:361).

The popularity of the approach can be accounted for by the fact that researching stress in more complex ways is difficult (Kanner et al, 1982:2), and due to the fact that because many events are potentially stressful, events themselves have been viewed as determinants of stress (Holroyd and Lazarus, 1982:21).

Consequences of Stress

Two Areas of Consequence

The potential consequences of stress for both the individual and the organization constitute an important rationale for the development and implementation of a stress management program. "Human" consequences of stress represent those health-related conditions which are of primary importance to the individual, while organizational consequences of stress represent those conditions associated with the effectiveness of the workplace and which are of primary interest to the organization (Beehr and Newman, 1978). The following discussion will focus on both areas of stress consquence.

Individual Consequences

The World Health Organization defines "health" as the presence of physical and emotional well-being, and the cost of stress is largely determined by its effect on well-being (Cox, 1978:91). While the experience of challenge can be stressful, according to Girdano and Everly (1979:4) most debilitating aspects of stress begin with those circumstances appraised as threatening. Beehr and Newman (1978) maintain that stress can have a detrimental effect on physiological

health, psychological health, and on behavior; each of these aspects will now be considered.

Physiological effects. The wide range of stress effects is accounted for by the fact that any bodily system can become involved in the stress response through a process of stimulation. The central nervous system and the endocrine system are always involved and operate in the stress response in the following way: The central nervous system is made up of two parts, the voluntary system and the autonomic system. The former manifests the processes of appraisal and emotion while the latter sends involuntary signals through the body via the sympathetic and parasympathetic systems. The sympathetic system stimulates the endocrine system which then secretes hormones such as adrenaline which is responsible for "fight or flight" or alarm stage capacities. The parasympathetic system can either stimulate or inhibit bodily systems and both processes can lead to the breakdown of organs. The whole process requires the use of protein which is taken from cells. If the stress response is continuous, white blood cells and antibodies may not receive the protein they require to function and the immune system may then become dysfunctional. These stress "products" continue to stimulate organs until they become used or reabsorbed. (Girdano and Everly, 1979).

Girdano and Everly (1979:9-13) offer this classification of stress-related disease processes: a) organic diseases, caused by infection or degeneration, b) conversion reactions, which represent emotional disorders manifested as functional disabilities, and c) psychosomatic diseases, which can be either "psychogenic psychosomatic" (disease caused by emotional stress), or "somatogenic psychosomatic" (emotional stress lowers the body's immunity).

Some conditions which the body's response to stress has been found capable of causing include gastrointestinal (ulcers), cardiovascular (hypertension), respiratory (allergies), musculoskeletal (arthritis), and skin disorders (eczema) (Everly and Rosenfeld, 1981:36-42). Some headache types are believed to be caused by stress (Sargent, 1982:599) while significantly, cancer, as a disease that often involves a breakdown of the immune system, is also thought to be related (Pelletier, 1977:173).

Psychological and psychiatric effects. The literature presents an array of evidence with respect to the relationship of stress to many psychological and psychiatric variables several of which will be cited here.

In the view of Pearlin et al (1981:340) stress can result in the diminishment of self esteem (a variable

selected for evaluation in the Tele-Cope program), as well as the extent to which an individual feels in control.

Moss (1981) describes the psychological symptoms of "burnout" which in his opinion is a stess-related concept representing a feeling of exhaustion resulting from the experience of too much pressure and too little satisfaction.

Some evidence indicates that stress can contribute to the psychological state of depression but that the association is small (Rabkin,1982). At least one study however did find an association between work-related events, depression, and suicides (Paykel,1976).

There has been relatively little research done on the assessment of psychiatric disorders in relation to stress (Rabkin, 1982:568) however in the opinion of Jaco (1970:210) the relationship of stress to mental illness has been accepted in the psychiatric field as a result of the related process of anxiety becoming established as a cause of neurosis. Psychiatric research indicates that the conditions of "brief reactive psychosis" and "post-traumatic stress disorder" can be precipitated by such extreme situations as military combat, and that the experience of stress can affect the timing of schizophrenia (Rabkin, 1982).

Behavioral effects. Behavioral changes which can accompany stress include alcohol and drug abuse, accident proneness, and what Levi (1981) classifies as "active" and "passive" behaviors.

Referring to the most "pervasive" of stress-related problems, the National Council on Alcoholism (U.S.) has estimated that between 6 and 10 percent of employees are alcoholics (Warshaw, 1974:95). A study by Ojesjo (1980) suggests that occupation may be the most significant factor in determining alcohol-related problems. While the research in relation to stress and alcoholism appears to be inconclusive, Peyser (1982:594) makes the following deduction in his review of relevant studies: "The use of alcohol develops in response to stress, and serves to alleviate it, but as the pattern progresses into alcoholism, drinking becomes a source of stress as well."

Referring to drug abuse, Quick and Quick (1984) maintain that while the extent of the problem and related costs are unknown, its potential impact on absenteeism, productivity and accidents make it a factor worthy of concern.

In regard to another type of substance use, it is known that employees under stress at work often increase their tobacco consumption. In one study of U. S. Navy officers, Conway et al (1981) found a

significant correlation between occupational stress and cigarette smoking.

On the subject of accident proneness, Hirschfeld and Behan (1963,1966) found in studies of industrial accidents that stress was a significant contributing factor to the occurrence of accidents leading to disability.

Finally, although it is not known by the writer if the following have been empirically tested, Levi (1981:75) suggests that behavioral consequences of stress can include such "active" behaviors as grievances, strikes, turnover, and reluctance to assume certain jobs, and such "passive" behaviors as resignation, low motivation, indifference and absenteeism.

Organizational Consequences

According to Quick and Quick (1984:79), individual stress consequences can lead to organizational consequences for the reason that an individual experiencing extreme stress has difficulty working to achieve organizational goals.

Mirvis and Macey (1974,1982) have attempted to identify some potential economic costs of employee behavior to the organization however historically it appears that a relationship between these variables has been difficult to measure. These authors place such

potential costs in the categories of participation and membership, and job performance.

Participation and membership. Referring to the first category, Mirvis and Macey (1974,1982) believe that absenteeism and work stoppages can lead to loss of production, turnover, opportunity costs, and a disruption in the quality of work relations. In the view of Warshaw (1979) absenteeism is a primary cause of lost productivity as well as a symptom of organizational stress. Indeed, an exhaustive study of Canadian blue collar workers demonstrated a direct, significant correlation between the frequency and severity of stress and the degree of absenteeism (Byles and Harsanyi, 1981). A study by Lyons (1971) revealed that perceived role ambiguity among nurses sometimes leads to voluntary turnover.

Job performance. Mirvis and Macey (1982) classify in this category the factors of amount and quality of production, grievances, accidents, machine repair and downtime, supply overutilization, and loss of inventory. One study by Sales (1970) found that employees experiencing job overload accomplished a greater amount of work but made more errors in the process. A study by House and Rizzo (1971) supports the hypothesis that excessive stress can result in decreased job performance by rendering employees less

capable of performing optimally. Indirect costs for the organization have not been systematically determined however in the view of Quick and Quick (1984:89-92), such factors as loss of vitality, communication breakdown, and faulty decision-making also represent important potential organizational stress consequences.

Potential Sources of Stress

Introduction

The first stage of coping with stress is the recognition of what precipitates stress and it is therefore important in a stress management program to consider potential sources of stress as well as a means whereby personal stressors can be identified (Shinn et al, 1984:865; Everly, 1985:64). A comprehensive series of self-assessment measures are included in Girdano and Everly's (1979:51-119) "Stress Profile" and were utilized by members in the Tele-Cope program.

Two major areas - stress arising from life cycle transitions, and occupational stress - were selected as group themes to represent areas commonly experienced as stressful. The topic of life cycle transitions was chosen for the reason that the writer believed it to be universal and non-labelling while the topic of occupational stress was included for the reason that

the setting for the group was occupational and preliminary discussions with groups of employees revealed widespread interest in this topic. The following discussion of these subject areas reveal why they represent potential sources of stress and therefore why they were appropriately selected as program themes. It is important to point out that in identifying these issues as potential sources of stress, the writer is not referring nor subscribing to the life events approach to stress measurement which does not account for transactional processes. While the discussion will serve to highlight the taxing nature of two common areas of stress it should be emphasized that stressful circumstances precipitate negative consequences only by way of a complex transactional process as previously discussed and not due to any inherent qualities that they might contain.

Life Cycle Transitions

Factors associated with the life cycle (ie. the cycle of life from birth to death) can influence the susceptibility to, experience of, and reaction to stress (Beehr and Newman, 1978:674; Pearlin, 1980:351). Golan (1981b:12) for instance views a life cycle transition as "a period of moving from one state of certainty to another, with an interval of uncertainty and change in between." The normal transitions of life

(ie. to early adulthood, mid-adulthood, and late adulthood) are often regarded as stressful because they represent a disruption in equilibrium (Adams, 1980) and necessitate the making of crucial decisions which determine important consequences (Golan, 1981a:74). Transitions involve the experience of confusion, ambivalence, anxiety, and loss, and can become marked by crisis (Golan, 1981b,1978).

The issue of "timing" appears to be an important indicator in regard to whether or not events associated with the life cycle become stressful. For instance, Lazarus and Folkman (1984:108-109) discuss Neugarten's notion that people expect certain events to occur at certain times as part of their concept of the normal life cycle; events can thus be perceived as "on time" and "off time." They suggest that an "off time" event can be more threatening for the reasons that one may feel deprived of peer support if an event (ie. giving birth) occurs too early or too late, that an event occuring too early may mean that a person does not have sufficient time for role preparation, and that an "off time" event such as a late promotion may mean less satisfaction than if the event had occured at the expected time.

Exactly how the dynamics of stress and coping change in response to aging processes is obscured by individual and group differences. However it has been

suggested that while expectations and commitments change throughout life, appraisals shift, resulting in changed stress and coping patterns (Lazarus and DeLongis, 1983:248-252). Further, changes in coping may not be a result of aging per se, but a response to changing sources of stress (Lazarus and Folkman, 1984:172-173). The developmental view holds that through the resolution of life stages, coping resources are gradually accumulated, therefore earlier coping affects later coping (Moos and Billings, 1982:213).

The aging process of course, cannot be divorced from the fact that the meaning one attributes to aging is a function of social values (Karp and Yoels, 1982:viii). As an illustration, the stress associated with the "mid -life crisis" can perhaps be best understood against a backdrop of a culture fixated on youth (McLean, 1979:59; Pelletier, 1977:84).

For further considerations of change, adaptation, and stress in relation to transitional processes, the reader is referred to studies by Levinson (1978), Lowenthal, Thurnher, and Chiriboga (1976), and Sheehy (1974).

Occupational Stress

Because work is so vital to the well-being of people, strong potential exists for occupational stress

to occur and in the view of McLean (1984:1) it is commonplace.

Most occupational stress research focuses on three elements associated with occupational stress - personal qualities, environmental qualities, and person-environment (P-E) fit (Schuler, 1980:188; French, 1974:316). Significantly, Lazarus and Folkman (1984:292) as transactional theorists, are critical of the P-E fit model as it follows a pattern similar to the antecedent-consequence approach which they maintain is inadequate for the reason that it does not account for intervening variables such as appraisal and coping. The approach is discussed here in recognition that it does not represent the transactional viewpoint but that it does constitute the research paradigm of occupational stress.

The P-E fit paradigm. This perspective maintains that characteristics of the person and environment interact and the outcome is either effective coping or negative consequence (Beehr and Newman, 1978:676). French, Rodgers and Cobb (1974:317) identify two varieties of "goodness-of-fit" between the person and the environment. First, they maintain that the goodness-of-fit between job demands and the individual's ability to meet them will influence levels of stress and second, that the goodness-of-fit between

the needs of the individual and the degree to which the workplace satisfies them will also influence stress.

Two well-known studies conducted at the Goddard Space Flight Centre and the Kennedy Space Centre tested the theory that both types of "misfit" can precipitate symptoms of poor mental health. They concluded that P-E fit is significantly related to job satisfaction, job-related threat, anxiety, and depression (French, 1974:16-17). While these studies will again be referred to in the discussion of environmental factors, the "person" side of the equation will first be considered.

Personl qualities. In regard to the literature dealing with personality in relation to stress, the most prolific has been that relating the "type A" personality (ie. aggressiveness, competitiveness) to increased risk of coronary disease (Stanley and Saxon, 1980:57).

Other personal characteristics besides personality having an influence on stress include age and the aging process, as has been discussed, as well as physical condition. For example, men in good physical condition and non-smokers were found in one study to be capable of maintaining a low heart rate during a normally stressful workday while others were not (Beehr and Newman, 1978:681).

Such personal needs and values found in studies to have an influence on perception and thus on stress include those related to achievement, feedback, self control, certainty, predictability, fairness, interpersonal recognition and acceptance, ethical conduct, responsibility, purpose, personal space, and stimulation. Studies also show that the factors of personal experience and ability relate to stress in that they reduce the individual's perception of uncertainty (Schuler, 1980:193).

Not to be overlooked are sex differences in relation to how stress is experienced. For example, the results of one study of sex differences in stress levels in managerial, executive, and professional personnel, indicate that women in the study perceived most work and familial situations as more stressful than their male counterparts for the reason that they seemed to be less defensive, less self protecting, and more sensitive to social and emotional cues (Staats and Staats, 1982). In the opinion of Belle (1982) the traditional feminine role of providing support to others and not necessarily receiving it constitutes a particularly stressful condition for women.

Environmental factors. Several writers offer their conceptualization of what can precipitate stress at work. Quick and Quick (1984) maintain that most stressful factors are manifested through task demands,

physical demands, and interpersonal demands. Gross (1970) suggests three primary categories: a) organization career stress, referring to the general "subjection" of oneself to the tensions of the workplace, b) task stress, referring to the difficulties inherent in task performance, and c) structural stress, referring to the group nature of organizations. Schuler (1980) conceptualizes work place stressors in the context of whether or not they are perceived as missed opportunities, constraints, or demands, thus bringing both positive and negative concepts into play. Cooper and Marshall (1976) offer a comprehensive model of stress at work which serves as a framework for an examination of the research linking occupational sources of stress to coronary heart disease and mental ill health. Parker and DeCotiis (1983) offer a model of stress similar to that of Cooper and Marshall but without including individual characteristics as moderating factors.

In addition to these models and categories, a noted program of research on the influence of certain large organizations on employee stress identified the following specific factors found in studies to lead to the development of risk factors in heart disease: role ambiguity, role conflict, quantitative and qualitative overload, organizational territoriality, responsibility for people, poor relations, and low participation.

Begun in 1957 by the Institute for Social Research at the University of Michigan, the program is considered by Newman and Beehr (1979:20) to be the best in the field.

The discussion here will focus on the program's findings with respect to these individual factors however a word of caution is in order. The factors cannot be assumed to be stressful for any individuals other than those who participated in the studies. The appraisal process is the most important determinant of stress and no objective criteria are sufficient to define a situation as stressful (Cooper and Marshall, 1975).

It also cannot be assumed that the condition opposite each factor (ie. role ambiguity - role clarity) is not stressful. Indeed, the inverted "U"-shaped curve, also known as the Yerkes-Dodson law, points out that too much or too little of any work-place influence can precipitate stress (Quick and Quick, 1984:7). For example, the Goddard study showed the "expected" "U"-shape, with most satisfaction occurring where the degree of role ambiguity experienced and the amount desired were matched (French, 1974:16).

The manner in which French and Caplan (1980) define the factors may also be situation-specific. It would appear that some factors could be a function of a

greater variety of circumstances than those discussed by these authors. For instance, role ambiguity may be a function of work roles which are inherently less prescriptive and not only a result of "lack of information".

Therefore, keeping in mind that the findings cannot be generalized, the following are the results of the program's research:

a)Role ambiguity refers to a state in which an individual lacks the information necessary to adequately fulfill the requirements of his or her role in the organization (French and Caplan, 1980:49). A study of six large American corporations indicated that role ambiguity can result in lower job satisfaction and higher levels of tension (Kahn et al, 1964). The Goddard study which involved scientists, engineers, and administrators revealed in part that role ambiguity can lead to feelings of being unable to cope and to the under - utilization of human resources (Caplan, 1971; French and Caplan, 1980:51).

b)Role conflict refers to a situation in which the information that an individual has to perform his or her organizational role contains conflicting demands (French and Caplan, 1980:51). (Role conflict might also include conflict in relation to a hierarchy of demands as well as conflict between personal and organizational roles.) The Kahn et al (1964) study revealed the same

findings for role conflict as it had for role ambiguity. Five other studies carried out by the University of Michigan research team demonstrated that role conflict can lead to job dissatisfaction, job tension, feelings of futility, physical anxiety, poor relations, job-related threat, a need for support, and an increased heart rate (French and Caplan, 1980:55).

c)Quantitative and qualitative role overload; the former refers to too much work to do in too little time while the latter refers to work being overloading because it is too difficult (French and Caplan, 1980:55). Several studies show that various forms of workload can produce at least nine types of individual "strain", four of which (job dissatisfaction, elevated cholesterol, elevated heart rate and smoking) are risk factors in heart disease (French and Caplan, 1980: 55-60; Kahn, 1973:8).

d)Organizational territoriality involves being required to make contacts across organizational boundaries, and working in an environment where the dominant occupation is different from one's own (French and Caplan, 1980:62). The Goddard study indicated that both conditions can contribute to low self-actualization (French and Caplan,1980:62). The Kahn et al (1964) study found that contact made across organizational boundaries is associated with role conflict.

e)Responsibility for people rather than for impersonal organizational factors such as budgets constituted the greater source of work-related stress in the Goddard study. People having either more or less responsibility for others than what they desired were found to have relatively high cholesterol levels (French and Caplan, 1980:63-64).

f)Poor relations with other members of the workplace (defined as low trust, low supportiveness, and low interest in attempting to deal with problems that involve others) were found in both the Goddard and Kahn studies to be precipitated by conditions of role ambiguity and to generate job dissatisfaction and feelings of threat (French and Caplan, 1980:64-65).

g)Low participation, defined as the extent to which an individual can influence decision-making in the organization, was found in the Goddard study more likely to produce job dissatisfaction, feelings of threat, and low self-esteem than any of the other factors studied (French and Caplan, 1980:65-68).

Stress in Relation to Type of Occupation

A significant factor in relation to occupational stress is that different jobs involve different kinds and amounts of stress (French and Caplan, 1980:73). One study of a Canadian organization examined the factors that precipitated stress in a variety of

subsystems. It revealed that due to the dominance of bureaucracy accompanied by an absence of power, the staff and operations groups experienced a high incidence of stress, while management, because they were less susceptible to uncertainty and feelings of helplessness were better able to cope, thereby limiting their experience of stress (Zaleznik, Kets de Vries, and Howard, 1977). Another study found that quantitative workload, role conflict and skill utilization were highly related to stress for a white-collar group while the incidence of stress for a counter-part blue-collar group was more related to variation in workload and job security (Axelrod and Gavin, 1980).

Extra-Organizational Variables

In the view of some writers, extra-organizational factors can be sources of stress within the work environment (Schwartz, 1980:101). Such factors as family stress (Croog, 1970), life crises (Golan, 1978), financial problems etc. may operate, according to Cooper and Marshall (1976:22), in a feedback loop between the larger environment and the workplace. While not a great deal of research has been done in this area, recent work by Smith and Reid (1986) on the high degree of role overload and role strain experienced by married women who are employed full-time

is perhaps indicative of an increasing research focus on "combined" sources of stress.

Stress Management

Who Is Responsible?

The literature features a range of perspectives regarding whether the individual, the organization or both should assume responsibility for managing stress. In the view of Everly (1985:67), stress management must focus on the individual, as focusing on the workplace makes it "situation specific", when in fact employees should be helped to cope with stress from any source. According to Schwartz (1980:105), while stress management methods for individuals are useful in response to static environments, industry must ultimately bear the responsibility for achieving a balance between job demands and the ability on the part of employees to cope. Adams (1981:66) maintains that stress management is the joint responsibility of both. Newman and Beehr, (1979:38) caution against generalizing, maintaining that because stress is systemic in nature, so must be the strategies for dealing with it.

A Preventative, Generic Approach

The philosophy of preventative management put forth by Quick and Quick (1984) represents a generic

approach as well as a useful context for clarifying the nature of the Tele-Cope program.

Prior to discussing the philosophy, it is worthwhile noting that in the view of several writers, prevention is a desirable focus for an occupational stress management program. Their rationale is that debilitating aspects of stress can be prevented from reaching an unmanageable level (Cooper and Marshall, 1975:30; Levi, 1981:31, Adams, 1981:65). Murphy (1984:3) considers a program which does not actively solicit employees with stress-related problems as preventative in nature. This was the case in the Tele-Cope program.

According to Quick and Quick (1984:146), both individuals and organizations should assume responsibility for their actions and thus preventative management is best aimed at the promotion of individual and organizational health and at the minimization of individual and organizational stress, thereby necessitating consideration of both organizational-level and individual-level preventative management strategies.

The three stages of preventative management in these authors' formulation include: a) organizational or individual interventions aimed at the stressor (primary prevention), b) at the stress response

(secondary prevention), and c) at the resulting symptoms of stress (tertiary prevention).

Significantly, the type and level of intervention is often situationally determined and a function of the goals of the organization and of available resources (Quick and Quick,1984:153,291). Since resources available to the writer (ie. knowledge and mandate) allowed only for the development of an individual-level program, the generic approach was not fully operationalized, thus reflecting an important program limitation. While Quick and Quick maintain however that individual-level programs should not be used to buffer the consequences of "correctable" organizational demands, and that a balance of approaches is the optimum, they also recognize that much stress is unavoidable and in this light, individual-level methods alone are valuable.

While the writer supports the notion of the organization assuming responsibility for primary prevention in the workplace, she also supports the merit of individual-level programs as a means of enhancing general competence and tends to agree with Lazarus and Folkman's statement:

> "The issue as to whether to focus on the individual or on social structures need not be treated in an either-or fashion; both directions of intervention lie open

> to those who want to ameliorate suffering and improve competence and well-being." (1984:350).

Here the discussion of stress management will focus briefly on organization-level methods as a means of underlining the importance of the generic viewpoint, and more extensively on the individual-level perspective as this was the perspective of the Tele-Cope program. Within the context of the latter, a generalized set of program guidelines around which the program was structured will be identified and the specific stress management strategies featured in the program - combating distorted thinking, stress inoculation training, progressive relaxation training, and social support - will be explored.

The Organization-Level Perspective

While the Tele-Cope program did not include stress management at the organization level, it is useful to briefly consider the nature of the methods that this level might offer.

Generally, organizational strategies are aimed at removing unnecessary stressors (such as environmental factors described earlier) while assisting employees to cope with necessary demands in a positive way (Quick and Quick, 1984:156). The range of specific methods includes task redesign with the goal of improving the

person-job fit, increasing employee participation in decision-making, implementing flexible work schedules with the aim of enhancing the employee's sense of control, structuring avenues for career development so as to encourage individual challenge and growth, and designing physical settings with the goal of minimizing stressful environmental influences (Quick and Quick,1984:163). Other strategies reviewed by Newman and Beehr (1979:20-31) include changing organizational processes (decentralizing the hierarchy, changing the way resources are distributed), role characteristics (changing role activities or resources available for performing a role), and task features (changes in complexity, work load, responsibility etc).

The Individual-Level Perspective

Components of a Stress Program

Individual-level stress management programs are aimed at improving the individual's ability to cope with demands, thus increasing the probability of a healthy response to stress (Quick and Quick, 1984:146).

While structured prototypes for stress management programs by authors such as Adams (1981) are available in the literature, the writer found Everly's (1985:62-67) "components of a stress program" to be most useful in the design of the Tele-Cope intervention for the reason that they represent a generalized set of

guidelines, flexible enough to fit any organizational setting and to accomodate the writer's own input. In some respect, the program incorporated each of Everly's generic components: an explanation of stress, an explanation of the implications of distress and eustress, a method for identifying personal symptoms of stress, a method for identifying personal causes of stress, and an explanation of, and practice in various stress management strategies organized around a rational structure. It is more effective to include a variety of strategies so that participants ultimately have a choice (Murphy, 1984:9; Adams, 1981:62) and for the different benefits that combinations of methods can offer (Woolfolk and Lehrer, 1984:343).

Significantly, group approaches to the management of stress are the most popular and most effective modes of intervention because of the social support the group can provide (Everly, 1985:62; Warshaw, 1974:161). As will be demonstrated later, social support is an important and effective method of managing stress.

The discussion will now explore the specific stress management strategies featured in the Tele-Cope program.

Cognitive-Behavioral Approaches to Stress Management

Cognitive methods for altering perceptions, beliefs, or expectations in relation to stressful

transactions represent an individual-level preventative strategy that is stressor-directed and thus an example of primary prevention (Quick and Quick, 1984:217). Such methods are based on the concept that an upset emotional state is frequently precipitated by the way in which an individual evaluates or labels a situation and not by the situation itself. They are concerned with helping individuals to recognize the connections between thoughts, emotions, behavior, and the environment and to substitute "rational" thoughts for those "distorted" thoughts that represent "faulty conclusions" about the world (Goldfried, 1980:94; Goldfried and Goldfried, 1975:91).

According to Lazarus and Folkman (1984:340), cognitive methods have close conceptual ties to, and are compatible with, the transactional model because they focus on the cognitive processes that are important factors in appraisal.

Berlin (1980:549-550) maintains that while social problems are not merely cognitive distortions, cognitive techniques have long been utilized in casework and are not antithetical to social work's concern with social impact.

"Combating distorted thinking". "Combating distorted thinking" or the "cognitive restructuring approach" represents a major cognitive-behavioral method featured in the Tele-Cope program. Two

theorists who have contributed most to the method's development are Albert Ellis and Aaron Beck (McKay, Davis and Fanning, 1981:18). In his 1961 book, A Guide to Rational Living, Ellis outlined his pioneering "ABC" model to describe how emotions arise from one's interpretation of events and not from events themselves. In his 1967 book, Depression:Clinical, Experimental and Theoretical Aspects, Beck explored the relationship between distorted thinking styles and depression and how a change in interpretation can result in a positive change in mood.

Interpretation of experiences can precipitate such affective stress responses as anxiety, anger and depression and it is in relation to these target areas that cognitive restructuring has typically been used (Goldfried and Goldfried, 1975; Novaco, 1979; Burns, 1980; Beck, 1984).

Research has primarily focused on and confirmed that modification of irrational beliefs can lessen speech, interpersonal and test anxiety (Goldfried, 1980). Goldfried and Goldfried (1975:94, 100) maintain however that the cognitive restructuring approach can be appropriately used in response to any negative emotional or behavioral pattern that is thought to be associated with unrealistic beliefs and that this method lends itself well to group settings where members can model progress. For these reasons and

because early, culturally-determined social learning experiences commonly induce the development of particular cognitive "sets" among people in general (Goldfried, 1980:92), the writer came to the conclusion that a cognitive restructuring component was appropriate for use in the Tele-Cope group. Significantly, the writer came across no evidence indicating where this cognitive method should not be used. In certain therapeutic circumstances however, particular issues must be given special consideration (Goldfried and Goldfried, 1975:102).

The primary resource utilized in the Tele-Cope program was a chapter taken from the comprehensive workbook of McKay, Davis and Fanning (1981) entitled "Combating Distorted Thinking" which includes a listing of fifteen distorted thinking styles, exercises to practice identifying them, and a means whereby "rational" thoughts may be substituted for thought "distortions."

Stress inoculation training. Another stress management strategy containing cognitive-behavioral components and featured in the Tele-Cope program was stress inoculation training (SIT). The basic procedures underlying the approach were first developed as "coping skills training" by Marvin Goldfried in 1973 as an extension of Wolpe's work with muscle relaxation and systematic

desensitization and were further developed by Meichenbaum and Cameron in 1974 (McKay, Davis and Fanning, 1981:93). The theoretical framework for the general SIT model can be found in Michenbaum (1977). SIT is modelled after the biological concept of immunization and involves a process whereby an individual becomes exposed to manageable levels of stress while making use of various coping skills that have been acquired through education, rehearsal and applied practice (Berlin, 1980:547).

According to Meichenbaum's (1985) clinical guide, SIT is not a single technique but a generic term referring to a stress management regimen that can vary widely. It typically combines elements of teaching, discussion, cognitive restructuring, problem solving, relaxation training, behavioral and imaginal rehearsal, self monitoring, self instruction and self reinforcement and efforts at environmental change. (Because it does represent a regimen of individual elements, one limitation of the approach may be that it is difficult to evaluate. This was not problematic in the Tele-Cope program due to the use of relatively less rigorous methods of analysis.) There are three phases of training in SIT: a) the conceptualization phase which involves helping individuals to understand stress in transactional terms, b) the skills acquisition and rehearsal phase, which involves the practice of a

variety of coping skills, and c) the application and follow-through phase, involving rehearsal and the employment of coping skills in real life situations (Meichenbaum, 1985).

Clinically, SIT has been found effective in enhancing pain tolerance and in reducing multiple phobias (Berlin, 1980:547) and in the treatment of anxiety and anger (Novaco, 1979:265).

Several studies in relation to occupational groups are worthwhile noting. Forman (1982, 1983) first used the approach with school psychologists in 1981 and obtained results showing a decrease in anxiety and an increase in job satisfaction and later with urban secondary school teachers with results showing that self-reported stress and anxiety had been significantly reduced. SIT was also found to be effective in helping police officer trainees develop coping skills as assessed by ratings on stressful mock scenes and on self report measures (Sarason et al, 1979).

According to Meichenbaum (1985:23,26), the strengths of SIT include its flexibility, portability and the fact that it can be easily combined with other interventions. As it has been applied on both a treatment and preventative basis to a wide variety of clinical and nonclinical populations, it was deemed appropriate for the Tele-Cope program.

It is worthwhile to note that while an abbreviated version of SIT was employed in the program in one particular session, the entire program, with its emphasis on teaching, discussion, cognitive strategies and relaxation training, might be viewed as an application of SIT. Again the primary resource for the group was a chapter taken from the workbook of McKay, Davis and Fanning (1981) entitled "stress inoculation" which features practical steps that can be taken toward learning to "relax away" tension while using "stress coping thoughts" in real life and which will be described in greater detail in the "methods" section of this report.

Progressive Relaxation Training

Progressive relaxation training (PRT) is a further stress management strategy used both as a single method and as a basic behavioral component of stress inoculation training in the Tele-Cope program. Because it is aimed at helping individuals to manage their response to stressful situations, it is an example of individual-level, secondary prevention (Quick and Quick, 1984:217).

As the first structured relaxation method to be recorded in the literature, PRT was developed by Edmund Jacobson in the 1920's and 1930's and emphasized physical relaxation through direct muscle control as a

means of preventing and treating anxiety (Quick and Quick,1984:238). The approach increased in popularity when Wolpe designed an abbreviated method as an alternative to Jacobson's strategy of employing more than fifty training sessions (King, 1980:150). An abbreviated method of PRT, set out in a manual by Bernstein and Borkovec (1973) and geared for use by the helping professions, was utilized in the Tele-Cope program.

Essentially, the abbreviated method of Bernstein and Borkovec involves

> "learning to sequentially tense and then relax various groups of muscles all through the body, while at the same time paying very close and careful attention to the feelings associated with both tension and relaxation." (1973:20).

The results of one study indicate the importance of using muscle tension release if tension is to be successfully reduced (Borkovec, Grayson and Cooper, 1978).

The question of difference in effectiveness between Jacobson's method and the abbreviated techniques has been raised by Lehrer and Woolfolk (1984:406). They indicate that only one unreplicated study carried out on a non-clinical population by P. E.

Turner (1978) showed a small "general" advantage for Jacobson's longer method, perhaps because it involves a greater number of sessions, but that no conclusions can be drawn from this amount of data. (Also, the relatively long time period required by Jacobson's method would have provided opportunity for the occurence of other independent variables.) Although these authors do not state directly that the results of both approaches are equivalent, they conclude that

> "The modified techniques are so widely accepted as equivalent to Jacobson's that they are routinely described as 'Jacobsonian' relaxation." (Lehrer and Woolfolk, 1984:444).

In regard to the effectiveness of PRT, Lehrer and Woolfolk (1984:407) indicate that approximately half the studies carried out on behalf of this method conclude that it makes for greater decreases of physiological arousal than do control conditions.

The function of PRT can be clarified by viewing it in relation to the stress response as previously outlined. If the stress response involves the arousal of psycho-physiological systems following a threat appraisal, then this method can be used to reduce autonomic arousal by altering skeletal muscle tension; as muscle tension drops, such autonomic factors as

heart rate and blood pressure are also reduced (Bernstein and Given, 1984:44).

An important factor associated with PRT is the issue of "live" versus "tape-recorded" training sessions. Of the seven studies reviewed by Lehrer and Woolfolk, only one showed significant results for "taped" presentation. Similarly, one well known study by Paul and Trimble (1970) concluded that tape-recorded relaxation procedures produced "significantly inferior" results compared with "live" procedures. These researchers hypothesized that immediate feedback to participants and "response-contigent" training were the factors constituting the advantage related to "live" PRT. This information, together with Bernstein and Borkovec's (1973) requirement that their procedure be directed by the facilitator or therapist, prompted the writer to conduct training in the group in a "live" manner without the use of tapes.

PRT is not without potential disadvantages. Everly (1985:60) outlines such possible adverse side effects as the ability of the state of deep relaxation to functionally increase the dosage of drugs and to induce panic states in some people. Bernstein and Borkovec (1973:12) indicate that PRT perhaps should not be used in a therapeutic capacity if there is an organic basis for tension, if the client is on medication, if problem solving seems to be the more

effective coping method, or when the situation calls for other methods to be used in conjunction with PRT (if tension is related to specific environmental stimuli, a program of stress inoculation training may be more effective).

These factors were discussed with group members however because PRT was presented in an educational and not a therapeutic capacity they were not controlled for. The onus was on each member to make a personal decision regarding the use of any featured stress management method based on the information provided and on their own circumstances.

People likely to experience the most significant benefits from PRT are those with high tension levels, however Bernstein and Borkovec (1973:10) conclude from their practice training programs with volunteers, that anyone who experiences tension could find PRT useful. Although PRT is most often used with individuals (Toseland and Rivas, 1984:221), Bernstein and Borkovec's format has been effectively used with groups (Kindy and Patterson, 1980) as in the Tele-Cope program.

Social Support

One of the most common and effective ways to manage stress has to do with receiving social support from friends, family, and co-workers. While such a strategy can be initiated by individuals, the organization can also play an active role in helping people to receive the support they might need (Quick and Quick, 1984:189) (ie. through the facilitation of social support networks). Social support therefore, has the distinction of being both an individual-level and organization-level method of preventative management and represents another area of stress management to be offered to the Tele-Cope group.

In defining social support, Gottlieb and Todd state: "People solve personal problems, accomplish tasks, develop social competencies, and address collective issues through an on-going exchange of resources with members of their personal community. This exchange of resources, whether tangible goods or emotional nurturance, can be viewed broadly as social support." (1979:183)

Social support can influence occupational stress and well-being in three basic ways: a) it can directly enhance health and well-being by meeting important human needs for love, belonging, security etc., b) it can directly diminish levels of occupational stress by

minimizing such potential stressors as role conflict, and c) it can buffer the impact of occupational stress on health (House, 1981:31-32). The "buffering" hypothesis states that as levels of social support increase, the relationship between occupational stress and stress-related illness should diminsh (House and Wells, 1978:10).

Several significant studies have been carried out on the effects of social support on levels of stress and health. For instance, in their study of industrial workers who became unemployed Cobb and Kasl (1977) found strong evidence to support the capability of social support to buffer against the stress associated with unemployment. In a study of the buffering effects of social support on stress and health levels among male employees of a tire and rubber manufacturing firm, House and Wells (1978) found that social support can act to directly reduce work stress and thus improve health indirectly while buffering workers against the negative impact of stress. An important study by Caplan et al (1975) of the effects of support in twenty-three occupations, found the results of the above studies to be carried over to these occupations. In a re-analysis of the Caplan findings, LaRocco et al (1980) found that in relation to occupational stress, all employees could benefit from social support. Type of occupation and associated stressors however were the

factors which determined the source of the most potentially effective support. These researchers concluded:

> "In sum, it appears that indicators of job-related stress and strain are primarily affected by job-related sources of support, and that the effects are largely main effects rather than buffering effects. In contrast, more general health outcomes are affected by a wider range of sources of support, and the effects are more likely to be buffering than main effects(1980:213).

Finally, in his review of the literature, House (1981:83) maintains that data has consistently been in support of the ability of social support to reduce work stress, enhance health, and buffer the effect of work stress on health. Other evidence indicates that supportive relationships can protect against the health consequences of stress associated with life cycle transitions (Cobb, 1971), and that levels of social support are more capable that life event measures of predicting stress-related symptoms (Lin et al, 1979).

Aside from the obvious benefits of social support, why is it advantageous to include this strategy in a stress management program? First, in the view of Adams (1980), modern socialization processes do not encourage the development or maintenance of supportive networks

and therefore people may need to make a concerted effort to either sustain, create, or improve personal relationships. Second, according to Heller and Swindle (1983:91), social support does not influence people unidirectionally but rather people can play a vital transacting role in the development and utilization of a supportive network.

Keeping in mind that educational activities are used for the purpose of increasing awareness of social support as well as promoting network improvement (Gottlieb, 1983) Tele-Cope members were given access to Adams (1980) "Support Network Review" and "Support Network Improvement Plan", two exercises designed to facilitate the assessment and improvement of social networks. One advantage of the network approach is that it highlights strengths and solutions within the context of one's own social sphere (Saulnier, 1982:18).

According to Heller and Swindle (1983:97) social support can play a role in the coping process in two ways: first, during secondary appraisal, social support (like other individual-level strategies reviewed) may become a salient focal point to be considered as a coping resource; and second, through the unsolicited actions of others in the form of direct action on the environment or the provision of information or resources, an individual can be helped to cope with stress.

Conclusion to the Discussion of Stress

To conclude this discussion of the various topics associated with stress, Lazarus and Folkman make the following important statement on the value of the therapeutic process. While the focus of the statement is therapy, the writer believes that education is also relevant in the context of these author's message.

> "Indeed it is quite possible to view all therapy as a procedure that could generate new ways of evaluating the sources of stress and ways of coping that characterize the person's life outside the therapeutic context. Viewed in this light, it is not merely what the therapist or the client does in the treatment setting that matters, but that therapy facilitates the complex natural process of finding new and more serviceable ways of appraising and coping. These processes of change can and do occur without treatment in the normal course of living." (1984:345)

The last part of the review will focus on the method of intervention employed in the Tele-Cope program to facilitate the process of education about stress and stress management.

The Method of Intervention

The Process of Arriving at a Preventative, Educational, Group Focus

As an introduction to the method of intervention, it is useful to first review the basis for a preventative group approach as previously discussed and then to go on to explain how the educational focus was arrived at.

Regarding the prevention aspect, the program was considered preventative because members were not selected on the basis of having stress-related problems, in response to agency preference. In addition, the literature was supportive of stress management programs having a prevention focus.

Regarding the group aspect, the Tele-Cope survey showed that group-oriented stress programs were of interest to the majority of respondents. The literature also states that group approaches to stress management are popular and effective because of the social support involved. And as will be discussed, group formats are desireable for use in workplace settings.

After it was decided that a preventative, group approach would be the best approach based on this information, the group purpose needed to be determined. Toseland and Rivas' (1984:20-21) framework of group

purposes indicates that groups having "education" or "remediation" as their purpose could be appropriately applied to the problem of stress. The two purposes will now be briefly discussed and compared as a means of clarifying the program's function.

The goal of a remediation group is therapeutic in nature and Lazarus and Folkman (1984:368-369) define a traditional therapeutic goal as "deconditioning and relearning, changing unserviceable beliefs that underlie faulty coping, and/or acquiring new modes of understanding and coping." A distinctive quality of therapy is that a specific problem must be identified and treatment tailored to the dynamics of the individual (Lazarus and Folkman,1984:357).

Remediation or therapy was not selected as the program's purpose for the reason that the sponsoring agency did not allow for the initial assessment of problems that this approach requires. Nor was it compatible with the prevention perspective for the reason that while it may provide preventative benefits, its function is to address specific problems that have already developed. Lastly, the remediation approach was not compatible with the writer's personal objectives which were geared toward the development of a preventative intervention.

The goal of adult learning (in place of the term "education") refers to both the process which

individuals go through as they attempt to change or enrich their knowledge, values, skills, or strategies, and to the resulting knowledge, values, skills, strategies, and behaviors processed by each individual (Brundage and Mackeracher, 1980:5). The enrichment of knowledge and skill as a purpose was seen to be highly compatible with the agency's preferred style of group composition, with the prevention perspective, and with the writer's own objectives and was thus selected as the program purpose. Indeed, Simpson (1980:459) notes that education has been effectively used in the past to help prevent the further development of problems or issues. Also, social work has historically featured educational goals (Northen and Roberts, 1976:370) while social group work made early use of a framework drawn from the adult education movement (Hartford, 1976:48).

A keypoint in clarifying the program purpose is revealed by a comparison of the therapeutic and adult learning goal definitions. In the definition of the therapeutic goal, the learning process appears to be strongly geared toward the achievement of enhanced coping and other forms of personal change. The adult learning goal however refers to the process of learning and to the resulting knowledge but does not specify functions to which they might apply. The program was defined as primarily educational in that its main purpose was to help members learn about stress and

stress management. The learning process and not substantial personal change as a purpose for learning characterized the program's intent. The program however also had a therapeutic function in that it encouraged members to make use of their knowledge in coping.

The Structured Group Approach-Overview

Under the auspices of education is the structured group approach (SGA) which the social work profession has made extensive use of in recent years and which focuses on learning (ie. a process of changing or enriching knowledge) in place of treatment (ie. an attempt to change that which does not serve healthy functioning) (Papell and Rothman, 1980a:16). For this reason it has been deemed valuable for its preventative capacity (Drum and Knott, 1977:17). Conceptualized primarily by Drum and Knott (1977) with Middleman (1981) contributing to its development, this approach represents an alternative to the high degrees of intimacy, emotionality, and personal change inherent in some forms of group work (ie. the remediation group) (Middleman, 1981:185).

In essence, the structured group is time-limited, features a pre-determined purpose, and makes use of the "learning experience" as a means of helping members to resolve problems or meet developmental needs (Drum and

Knott, 1977:14; Middleman, 1981:186). At the center of the structured group is what Middleman (1981:189) terms "the constructed experience", meaning the task or activity which members practice and then discuss as a means of connecting the experience with their own knowledge. Member input in such groups is often limited to the modification of objectives and agendas which have already been developed. Typically, sessions involve educational content, activities, role plays, discussions, task review, and evaluations (Toseland and Rivas, 1984:151). Two studies suggest that the SGA can be more effective than less structured approaches when members share common concerns (Toseland and Rose, 1978; Toseland, Kabat and Kemp, 1983).

Structured Group Types

The SGA features three basic group types: a) those directed toward helping individuals acquire life skills, b) those aimed at helping members to resolve life themes, and c) those whose purpose is to help individuals resolve life transitions. Two types - life theme and life skills groups - were represented in the Tele-Cope program because they best allowed for the operationalization of its purpose. The former reflects the segment of the program that focused on stress while the latter reflects the stress management portion. These will be discussed here in greater detail.

Theme groups. The writer encountered two separate conceptualizations of theme groups and both, in part, were represented in the program. In the first, Drum and Knott (1974:188) regard theme groups as opportunities for individuals to "examine, evaluate and resolve" common problems of everyday living of which stress can be a part (ie. low self-esteem). While examination, evaluation, and resolution did not systematically occur in the group, discussion and activities helped to facilitate an increase in self-awareness among members in relation to personal stress-related issues. Problem-solving also occured, but in a less formal way than what Drum and Knott describe.

The second conceptualization of theme groups, Shaffer and Galinsky's (1974) "theme-centered interactional approach", has as its primary feature the designation of a theme which is kept at the group's forefront and which can represent a learning purpose, as was the case in the Tele-Cope program. In this approach, the main task of the group worker is:

> "...to enable the group to have a maximally enriched experience around the theme wherein each member feels free to express his thoughts and feelings about it, and to relate to others as they similarly struggle to connect with, and associate

to, the theme."

(Shaffer and Galinsky, 1974:262)

Central features of the theme-centered interactional approach are the "I-We-It" triangle, and "dynamic balancing" (Shaffer and Galinsky; 1974:244-253). Regarding the first feature, "I" represents personal thoughts and feelings, "We" represents inter-relatedness, and "It" refers to the theme or purpose around which the group is structured. The concept is relevant to the Tele-Cope group in that it represents its affective, interactional aspects as well as its essential educational function. "Dynamic balancing" refers to the need to balance the three variables so that "attention to one does not result in diminishment of another". The importance of this is reflected in the belief of Toseland and Rivas (1984:71) that the creation of a positive group culture is dependent on the fulfillment of member's socio-emotional needs as well as needs for goal achievement.

Life skills groups. Life skills groups, representing the stress management part of the program, are behaviorally-oriented and make use of the group experience for the practice of behaviors or skills (Middleman, 1981:188). Because life skills groups emphasize skill development over interaction, the leader of such a group is required to be active in

providing a repertoire of structured, skill-related activities (Drum and Knott, 1974:28).

Rationale for Using a Structured Approach in an Occupational Setting

It has been suggested that a group format (and particularly that of a structured group) is desirable for use in an occupational setting. For example, Middleman (1981:185) believes that adults (who compose the membership of the workplace) find groups to be more natural and less stigmatizing than individual sessions for the reason that they are less continuously demanding and offer opportunities for socializing. Lerner's (1980) opinion is that most workers associate therapy with an inability to function and are offended by any suggestion that would appear to question their capacity for independent functionin. Indeed, group therapy is a method of symptom-directed, tertiary prevention (Quick and Quick, 1984:217). As a solution, Lerner advocates the use of preventative occupational stress groups which do not imply the presence of a problem.

In light of these assertions it would seem that the learning emphasis of the structured approach would make it desirable for use in an occupational setting.

A further rationale for use of the SGA in the Tele-Cope setting in particular, has to do with this

agency's preference for member self-selection as its method for composing a group. Because the pre-planned format of the structured group invariably provides potential members with criteria on which to base a decision regarding whether or not to participate, this method of intervention was successful in meeting the needs of the setting regarding group composition.

Potential Limitation of the Structured Group Approach

Lang (1972) distinguishes between three group "orders" in social work: allonomous, autonomous, and allon-autonomous. In her view, the "allonomous" or worker-led group is an "immature" group form for the reason that the purpose of a social work group is to become group-centered or "autonomous." In this context, one limitation of a structured group may be that it may not evolve into an "autonomous" group due to its focus on structure over process (Papell and Rothman, 1980a:18).

The extent to which this does constitute a limitation would appear to be situationally determined. For instance, in some circumstances such as people seeking treatment in an intimate group setting, an autonomous group would seem to be optimal. On the other hand, some reasons why employees might prefer a more structured setting have already been discussed. While Lang does credit the autonomous group form with

being the most developed, she does agree that group purpose and the needs of the client population should determine the type of group to be used (Lang, 1979:208).

In light of Lang's description of group orders, the Tele-Cope group can most accurately be said to have evolved from an allonomous to a semi-autonomous state over its life span as reflected in the writer's shift from being initially instrumental to the group process to becoming more facilitative of independent group interaction in response to group needs. This pattern which may be valid for all group process, is supported by adult learning theory which maintains that all adults enter a new learning situation with "dependent-type" behaviors and require structure at the outset prior to becoming involved with more independent and inter-dependent activities (Brundage and Mackeracher, 1980:55).

The Structured Group Approach in Relation to Social Group Work

Because the SGA originates from the field of psychology and has not been included in social work's model building efforts with the exception of Middleman, it is regarded by Papell and Rothman (1980a:6) as distinct from "the mainstream model of social work with groups". Recognizing the eclectic nature of social

work however, these authors regard the SGA as an important development from another discipline that can be used to enrich the mainstream model.

While the SGA can be valuable for use in social work, several sources maintain that it must be utilized within the framework of the mainstream model in order to preserve the integrity of the social work profession (Papell and Rothman, 1980a). For example, the ethical stance of social work requires that every practitioner providing group services have mastery of small group theory (Hartford, 1976:60). Lang (1979:207) maintains, "know thoroughly the theory and technology of your own profession before borrowing from elsewhere, and know why you are borrowing." Similarly, Toseland and Rivas (1984:4,12) advocate the use of generic social work skills in all types of groups.

The discussion will now seek to highlight the mainstream model of group work and the SGA by presenting important elements in relation to four variables: the group, the member in the group, the activities of the group, and the worker with the group (Papell and Rothman, 1980a:7). The "methods" section of this report will illustrate how the models were combined operationally.

The group. The mainstream group is characterized by goals, contracts and boundaries that result from group interaction (Papell and Rothman, 1980a:8;

Hartford, 1971:139) and by the presence of mutual aid (Shulman, 1979:110-116; Lang, 1980a:8). The notion of group development, generally described in terms of stages, is a common feature of social group work and is a function of such dynamics as cohesion (Northen, 1969:46, 124), and communication (Konopka, 1978:48), and of such social controls as group norms, roles, status and culture (Toseland and Rivas, 1984:57).

In contrast to the mainstream group, the structured group does not include an initial decision-making process regarding purpose which reflects the format and content of the program as planned by the worker. Participation by members however, is based on their agreement with the purpose.

The member in the group. The member in the mainstream group is active, a social learner, and has the potential to effect group change, a manifestation of "the compound influence forms" in group practice made up of the self, peers, and the practitioner (Lang, 1979:209; Northen and Roberts, 1976:389; Papell and Rothman, 1980a:9). Mainstream practice is also concerned with the need of members to belong as well as their need for individualization (Konopka, 1984:46,73; Papell and Rothman, 1980a:10). Indeed, Toseland and Rivas (1984:69) indicate that compliance to group norms is more likely when such qualities as independence and autonomy are valued in members. Finally, some types of

mainstream groups (ie. the remedial model which emerged in the 1960's) (Northen and Roberts, 1976:369; Shaffer and Galinsky, 1974:21) view the group member as in need of "treatment."

In the structured group, the individual is not perceived as needing "treatment" but as wanting to enhance competency in particular areas (Papell and Rothman, 1980a:19).

The activities of the group. Activities in the mainstream group are both spontaneous and planned meaning that while content emerges spontaneously from group process, individual concerns are transformed in a planned, rational, and skillful way into themes for group consideration (Papell and Rothman, 1980a:10; Shulman, 1979:181). Games and activities have historically been used in mainstream groups to provide an interesting means to goal achievement (Toseland and Rivas, 1984:193).

The structured group is both similar and valuable to the mainstream group in the variety of activities it can offer (Papell and Rothman:1980a:20).

The worker with the group. The worker in the mainstream group has such functional roles to choose from as enabler, broker, mediator, advocate, and educator (Toseland and Rivas, 1984:210). Hartford (1976:61-65) maintains that group workers can be either

directive, facilitative, permissive, or flexible in style. Because the mainstream group is what Lang (1979:211) terms "natural and authentic", the worker must be informal and not given to functioning as a "remote authoritarian", according to Konopka (1978:128).

The worker in the structured group is regarded as "facilitator" rather than "therapist" and as "catalyst and designer" of the learning experience (Middleman, 1981:186,189). It is vital for the worker to be knowledgeable in relevant areas and to invest as much time in the design of sessions as in their implementation (Drum and Knott, 1974:28).

To conclude, while distinctions between the approaches exist, the SGA is compatible with the mainstream model in that it encourages emotional expression and the development of interpersonal skills as well as recognizes the importance of group process and cohesion (Papell and Rothman, 1980a:170; Drum and Knott, 1974:28).

Summary/Conclusion

To summarize and conclude the review of the literature, several important points will be highlighted here.

Early in the review, the stress response was said to involve an integration of psychological and biological processes while the potential negative consequences of stress were identified as providing an important rationale for the implementation of a stress management program.

After a range of perspectives was explored regarding whether the individual, the organization, or both should assume responsibility for managing stress, the position was put forth that a generic approach is the optimum. While it was pointed out that the program was limited in that it focused only on individual-level management, it was concluded that such programs are valuable for the reason that much stress cannot be avoided.

In its discussion of individual-level programs, the review indicated that a group approach featuring a variety of strategies was the most desirable. The various strategies featured in the Tele-Cope program were then explored in terms of underlying concepts and procedures, function in the coping process, stages of preventative management, and appropriate/inappropriate useage.

The review then went on to provide a rationale for the program's preventative, educational, group focus as well as a description of the SGA.

Two types of structured groups - life theme and life skills - were stated to have been represented in the program because they best allowed for the operationalization of its purpose. A structured group format was identified as being desirable for use in an occupational setting and at Tele-Cope.

Finally, the review put forth the position that the SGA was valuable for use in social work but that it needed to be used within the context of group work's mainstream model in order to preserve the integrity of the social work profession.

THE INTERVENTION

Introduction

Toseland and Rivas (1984:19-11) conceptualize group work as consisting of four phases: planning, beginning, middle, and ending. Because certain activities are "stage specific" they regard group work as a sequential process. In this section, a description of the Tele-Cope program, including a detailed exploration of each session, will be provided in the context of these phases. In addition, the group members and their attendance patterns will be described.

The Planning Phase

Three main activities were carried out during the planning phase: assessment of potential membership, establishment of purpose and objectives, and recruitment of group members.

In regard to the first activity, potential membership was assessed by way of referring to the Tele-Cope needs survey which provided an indication of need and interest. Additionally, the Tele-Cope coordinator was consulted in regard to his perception and knowledge of the needs and interests of the employee population which he indicated were in support of a long term stress management program.

Regarding the second activity, the program purpose and objectives were developed during the planning

phase, a feature of the structured group approach as earlier described. It is worthwhile noting that enabling group members to enhance their ability to cope with stress by helping them to become more knowledgeable about stress and to become familiar with several methods of stress management, is a purpose stated in terms of goals to be achieved rather than problems to be overcome (Toseland and Rivas, 1984), thus reflecting the preventative nature of the program.

Regarding the third activity, the recruitment of members, two strategies were employed in the planning phase. The first involved open house meetings for employees at which two films related to the subject of stress entitled "The World of Hans Selye" and "Health and Lifestyle" were screened, followed by discussions. The discussions focused on the value of enhancing one's ability to cope with stress and were intended to generate reflection and interest in stress management. The meetings were advertised by way of newsletter and took place at the following MTS locations: Cordyon Avenue building (November 19 and 29), Empress building (November 26 and 27), Bestlands building (December 3 and 4) and the Tele-Cope office (December 5 and 6). On the respective dates attendance figures were three, nine, twenty, eighteen, nine, seven, three and seven. While a majority of people participating in the discussions maintained that learning more about stress

and stress management would be of personal value, it was later discovered that only one group member had attended an open-house meeting thus indicating the limited effectiveness of this recruiting strategy. One limitation may have been that meetings were held at midday, over the span of a lunch hour, thus only employees having coinciding free time and willing to devote such free time to a workplace-sponsored activity attended. Also, the discussions may not have made a strong impact as they were limited to a relatively short time period. The second recruitment strategy involved the distribution of an information/registration form (Appendix A) throughout all Winnipeg MTS locations. Reflecting the program's predetermined purpose and content, the form was intended to provide potential members with criteria whereby they could match their interests with those of the program. Of the two strategies, this proved to be the more successful as all group members stated that the form had encouraged them to participate.

In addition to these activities, the writer made a selection during the planning phase of sources that would serve as effective guides to practice within a group milieu that sought to integrate the mainstream and structured approaches. (As stated in the literature review on groups such integration is important when the group model being utilized was

developed outside of social work.) The first, An Introduction to Group Work Pracice, by Toseland and Rivas (1984) provided comprehensive guidelines to assessment, intervention, and evaluation from a mainstream social group work perspective. The second, The Instructor's Survival Kit by Peter Franz Renner (1983) provided an array of techniques and activities geared to the field of adult education and highly useful within structured groups. While the material outlined in the literature review provided the content for the Tele-Cope program, these sources together provided a basis for effective group leadership.

The Group Members and Attendance

The information/registration form indicates that two simultaneous offerings of the program were originally scheduled for Tuesday and Thursday evenings. Prior to the starting date however it was decided that the program would be offered only once due to the amount of preparation time required for each session.

Overall, twenty persons registered for the program, seven for the proposed Thursday sessions and thirteen for the Tuesday sessions. Due to the reduction in the number of program offerings and because more people registered for Tuesdays than for Thursdays, all "Thursday" registrants were asked to shift to "Tuesday". While all stated a willingness to

make the shift, attendance for some became sporadic or impossible on those evenings. Indeed, four registrants attended no sessions, thus bringing the working number of people to sixteen.

At session one, the group was composed of seven female MTS employees, two male employees, one female spouse of an employee, two married couples in which the men were employees and their spouses not, and one married couple in which the woman was an employee and her spouse not. Two singly attending female employees and one male employee who was attending with his wife, left the group after session one, citing election involvement, family responsibilities, and out-of-town work as the individual reasons that they could not continue. The working number then became thirteen from session two on. Attendance fluctuated between eight and thirteen with the large marjority of sessions being attended by nine or ten people. Five female employees, two male employees, one married couple, and the female spouse of an MTS employee were the most regular attenders.

The Beginning Phase

Session One

As discussed earlier, the preventative, educational focus of the Tele-Cope program did not necessitate a preliminary interactive process with prospective members as preferred by the sponsoring agency. At the start of the program therefore, the group had no knowledge of what to expect aside from the information indicated on the registration form. Renner (1983:13) suggests that a setting of chairs around tables provides a sense of security and it was this setting, in a rectangular form, that was used in sessions one and two as a means of alleviating the insecurity that a lack of knowledge may have promoted.

At every session, refreshments such as coffee, juice, and muffins were offered, a common group work strategy for making a group more attractive (Toseland and Rivas, 1984:239). Indeed, the fact that sessions occured at a time of day when member's energy levels may not have been optimal, made the creation of a hospitable environment seem even more important.

As previously stated, the Tele-Cope program was intended to reflect an integration of mainstream social group work and the structured group approach and therefore all program activities have their origin in either one (or both) of these models. This description

of session one (and subsequent sessions) will seek to describe the operational integration of the two approaches.

In the beginning phase of group work, Toseland and Rivas (1984:20-21) maintain that a primary objective must be for members to become acquainted. Two structured activities at the start of session one sought to achieve this objective.

The first activity, adapted from "What's In a Name?" (Renner, 1983:23) involved requesting members to write their first names on cards and then display them. The second activity was a variation of the exercise "Interview" (Renner, 1983:27), in which members paired off and interviewed one another in regard to the following areas adapted from the exercise "I Am..." (Renner, 1983:25) a) full name, b) "I am..." (members were asked to complete this sentence in four different ways), c) "I am a resource..." (members were asked to identify three areas of expertise), and d) "Why are you taking this course?" Following the interviews, the group reconvened and the partners took turns relaying information about one another to the group. In this manner of bringing strengths to light, the group was defined as one of competence.

Following this process, several other structured activities were carried out in a beginning attempt to meet important goals of social group work - meeting the

needs of group members and enabling members to influence the group's direction. The importance of these goals lies in the fact that meeting the needs of the membership contributes to group attractiveness and cohesion and when a group is attractive to members, they become more committed to helping it function in a positive way. Also, enabling members to influence the group's direction is a form of group empowerment and a desirable feature of group leadership (Toseland and Rivas, 1984:67-69, 80).

The first step toward meeting these goals involved an assessment of the extent to which the group was in support of the program's purpose. In accordance with the structured group approach the purpose had been formulated prior to the group convening and had provided important criteria on which potential members could base a decision regarding whether or not to participate. While it could be assumed that members were at least partly in support of the purpose as they had chosen to become part of the group, further assessment was felt to be needed.

The "Speedy Memo" exercise (Renner, 1983:49) helped to determine the degree of group support for the program's purpose. In the exercise, members were asked to indicate their response to the purpose in one word on a small piece of paper. Papers were collected, shuffled and read aloud and further feedback was

solicited. The majority of responses read "yes" while others indicated "how?" or "hopefully". No response indicated disagreement. This proved to be an effective contracting method as members quickly became aware, as their memos were compiled and revealed, that the group had reached consensus regarding support for the group's purpose. The act of achieving consensus may also have had the beneficial effect of promoting a sense of social support within the group.

In connection with the broad goal of meeting member's needs is the assertion of Toseland and Rivas (1984:159) that motivation to work toward goal achievement in groups is determined by member's expectations regarding the worker's role, processes that occur, and what can be achieved. Issues associated with these areas were therefore seen as important to explore in the beginning phase.

Regarding the worker's role, members became involved in a process of listing and discussing expected worker functions, some of which were "be knowledgeable and clear", "be available for personal consultation", and "help the group to learn". These expectations may be seen to be further indication that members were in support of the group's educational purpose as they are clearly linked to the process of learning. The writer agreed to fulfill these

expectations and thus further contracting was carried out.

Following discussion of the worker's role, the issue of group processes was addressed through several activities.

First, handouts listing program objectives and session themes (which like the purpose had been formulated previously without group input, in accordance with the program's structured focus) were distributed and reviewed.

Second, a small group exercise entitled "Gang-Up-On-Peter" (Renner, 1983:19) was employed to facilitate questions and feedback regarding the program in general and the objectives and themes in particular. In this exercise, the large group was asked to form small groups of four or five, to select a recorder/spokesperson, and then to "brainstorm" questions while compiling a list on a flipchart. Following this, each group selected and asked one question of the writer before going on to the next group. In this manner, the circle of small groups was "gone around" three times. As Renner points out, this exercise is instrumental in allowing members to receive the information they want.

Third, the writer made a point to state that a function of the group was to meet the needs of members and that member input could help determine the

direction of the group. Members were then requested to identify their individual goals as a take-home task using Renner's (1983:29) "Expectation Survey" (Appendix B) which is a tool for identifying desired outcomes. It was explained that upon completion of the Expectation Surveys, the fit between members' goals and the worker's suggestions for objectives and themes would be assessed and further contracting would then take place.

Other procedures and processes which were contracted for in session one included issues around confidentiality, time and place, evaluation procedures etc. According to Toseland and Rivas (1984:134) these factors are especially important in the beginning phase.

As a result of the contracting process, it was agreed that personal disclosures would be confined to the group, that the practicum report would include no identification of group members beyond that which is included, that the program would consist of ten weekly sessions held at the Tele-Cope office, and that members would attempt to devote some time between sessions to tasks and to the practice of stress management methods. In addition, copies of the evaluation measures (see chapter on evaluation) were distributed and the writer explained their nature and purpose and answered questions in response to them. An appeal was made to

the group to assist in the practicum endeavor by completing the evaluations.

At the close of session one, members were asked to complete the Expectation Surveys as well as the "before" measures in the week ahead. An article entitled "How You React To Stress" (Davis, McKay, and Eshelman, 1982:5-6) was provided as a way of promoting interest in the stress theme.

The Middle Phase

Activities

The discussion will now briefly turn to two broad activities that help to characterize the middle phase of group work: preparing for meetings and structuring the group's work (Toseland and Rivas, 1984:192).

Traditionally in structured groups, a good deal of session preparation time is required and the writer did in fact find that the designing of agendas, selection and development of activities, assessment of the previous session, and the learning and rehearsal of presentations, skills and exerecises constituted a full-time endeavor. One benefit of thorough preparation is an enhanced belief on the part of the membership in the worker's leadership ability (Toseland and Rivas, 1984:77) and indeed, an appreciation of the extent to which the writer was prepared is reflected in the final evaluation.

The writer also made an effort to follow the suggestions of Toseland and Rivas (1984:197) regarding how to structure the group's work. For instance, the use of agendas provided a structuring element while the ends of sessions were used to conclude interactions rather than introduce new content. Other guidelines such as estimating the amount of time required for each activity proved more difficult to incorporate, however as the program progressed, a better fit was achieved between planned activities and available time. Other strategies to provide structure included attempts to summarize interactions before continuing, and having meetings begin and end on time while providing some degree of flexiblity.

Session Two

As discussed in the review of the literature on structured groups, two types of structured groups - life theme and life skills - were represented in the Tele-Cope program because they best allowed for the operationalization of its purpose. Sessions two through four were primarily "theme-oriented" as they featured for group consideration, themes related to the topic of stress while sessions five through nine were primarily "skill-oriented" as they focused on gaining familiarity with methods of stress management. The designated theme for session two was the stress

response and how it is characterized by integrated patterns of psychological and biological responses. Enabling group members to develop an understanding of this and other themes encompasses an important program objective.

Prior to discussing the group activities, it is important to mention that efforts were made in session two to increase the level of the group's cohesion in recognition that a cohesive group is generally more attractive to its members than one that is non-cohesive. Such intervention was felt to be needed after it was assessed in session one that the "high status" men (ie. men in professional positions) were the group's strongest contributors while other members appeared reluctant to contribute. As it is a function of cohesive groups to facilitate participation by all members and to increase member's status (Toseland and Rivas, 1984:65) the writer appealed directly in a non-threatening manner to non-participating members for input, thus facilitating a wider range of representation.

As a way of helping members to transfer their attention from the day's activities to the session, the group was immediately engaged at the start of session two in a body awareness exercise as outlined by Davis, McKay and Eshelman (1982:17-18). Following this, members were asked to submit the completed Expectation

Surveys and measures distributed in the first session. Some general discussion took place and members were thanked for their efforts. Approximately two thirds of the group submitted completed forms and an appeal was made to others to complete the tasks.

Following an agenda review, the writer posed the question, "what does stress mean to you?" and general responses were given as a way of setting the stage for the session's theme. It is a function of the theme-centered interactional approach (one of two types of theme groups represented in the Tele-Cope program to enable group members to make a personal connection to the theme at hand and this exercise helped to begin to facilitate the process.

As a prelude to a structured presentation, two activities occured. First, an engineer was asked to explain to the group the relationship between stress and strain in relation to physical objects (thereby also describing an early conceptualization of human stress). The group was then asked to identify the difference between objects and people. When the comment "the ability to think" was provided, it indicated that the members themselves had begun conceptualizing the most basic component of the transactional model of stress which was the model emphasized in this session (and identified earlier as the most comprehensive model of stress available).

Following this, the writer sought to explain the stress response by presenting the major points in relation to it (and which are covered in the literature review on stress). They included:

a) the concept of the person-environment relationship.

b) the transactional notion that stress represents an imbalance between perceived demand and perceived ability to cope.

c) the three stress-related appraisals: harm/loss, threat and challenge.

d) the function of coping.

e) the fight/flight response and Selye's General Adaptation Syndrome.

f) mind-body interactions.

The presentation followed the guidelines of Renner (1983:37) which indicate that such an exercise should be limited to thirty minutes, accompanied by visual aids, and followed by a transition from passive to active behavior on the part of members. For instance, a flip chart and overhead projector on which diagrams, keywords, etc. were displayed were used to supplement the presentation. Also, at two integral points, a transition from passive to active behavior was facilitated with the use of "buzz groups" (Renner, 1983:35). In this activity, members were asked to form small groups and "buzz" (discuss) for approximately

five to ten minutes in relation to a particular topic and then make a brief presentation to the whole group. The topics for the two "buzz groups" were:

a) Briefly describe some situations involving threat and challenge which you have experienced.

b) Identify some ways in which you cope with threatening situations.

This exercise is recommended as a means of relating theory to personal experience and through it, members were again helped to make a personal connection to the theme.

Toward the end of session two, an animated film entitled, "Understanding Stresses and Strains" was shown, and following this, members were asked to identify the issues in the session that had been distinctive for them. This process served to punctuate central concepts and allowed the writer to assess what was particularly important to members.

Lastly, as a way of helping the group to develop an understanding of how the stress response has become a potential cause of disease, a further program objective, three handouts taken from Girdano and Everly (1979) were made available. Those entitled "The Body's Response to Stress" and "What Disease Is" were intended to provide the group with information regarding the potential, damaging effects of stress. A series of

self-assessment exercises, entitled "What Causes Stress and What Is Your Stress Profile?" enabled members to gain some insight into how potential sources of stress influenced them.

Session Three

In session three, responding to an increased sense of group comfort and awareness facilitated through the activities of sessions one and two, the setting was changed to a circular pattern without tables. Consultation with the group revealed support for the change. Generally, group-centered interaction patterns (such as the circular pattern) in which communication can occur freely among members, contribute to group morale (Toseland and Rivas, 1984:60). Indeed, with the new setting, a greater level of communication and enthusiasm was observed.

Following an agenda review, the individual goals that had been compiled from the Expectation Surveys were presented to the group for discussion. There was no apparent discrepancy between these goals and the group purpose and objectives which had been discussed in session one. There may, however, have been a tendency on the part of members to respond in ways that they viewed as socially acceptable or in ways that reflected too little knowledge of the field to respond in alternative ways. Despite these limitations that

are perhaps inherent in a process which invites group members to formulate goals which may be in contrast to those already devised, the group agreed to support the pre-planned objectives with the idea that by doing so, their own goals as stated were being facilitated. The following is a representative sample of member's individual goals:

- be able to recognize stress and manage it
- practical application of skills
- to participate but to experience no pressure regarding the sharing of personal issues
- to share personal experiences
- develop more self-confidence
- gain general knowledge about stress
- become involved in role-play
- learn about relaxation training and stress inoculation
- become involved in group activities
- gain more awareness of personal stress reactions
- help to put other group members at ease
- explore "good" and "bad" stress
- develop supportive relationships with group members

Following this period of contracting, the "Stress Profile" exercise which had been distributed in session

two was addressed. It was discovered that only a few members had completed the task, with others citing "lack of time" as the main reason for noncompletion (a pattern which was to emerge in relation to all take home tasks; see p. for discussion of this matter). As a means of promoting sharing, the writer imparted her own findings and other members then discussed what the exercise had revealed for them.

The main themes for sessions three and four respectively dealt with two areas that represent common, potential sources of stress - life cycle transitions and occupational stress. The review of the literature on these areas indicates why they are often stressful for people and thus why they were selected as themes for group discussion.

In session three, as an introduction to the themes, the identification and awareness of stressors was stated as an important first step to stress management. The issue of "change" as a common source of stress was then explored with members citing personal examples of how change had proven stressful for them.

Following the introduction, two structured activities took place which were sequenced so as to address general issues before specific ones. Again reflective of the theme-centered interactional approach, the activities enabled members to make a

personal connection to the theme. In the first activity, the group discussed the three developmental transitions and five of the eleven "psychosocial" transitions as outlined by Golan (1981) in terms of their own thoughts, feelings, and experiences. (Presented on a flip chart they included the transition to early adulthood, to mid-adulthood, and to late adulthood; work, career choices and shifts; transition to marriage/couplehood, transition to parenthood, geographic moves and migrations, separation and divorce, remarriage.) The second activity took the form of an individual exercise and as a manner of introduction a first-person account of a geographic move entitled "Normal Problems of Normal People" (Golan, 1981:3) was distributed and read aloud by one member. Participants were then requested to record and present a personal transitional account, taking care to describe thoughts, emotions and behavior as a way of fully exploring the stress inherent in the situation. As each individual presented, general discussion took place in relation to each account and the writer attempted to point out similarities as a means of facilitating and reinforcing group cohesion.

At the close of session three, members were requested to complete the "before" column of the Symptoms Checklist (see chapter on evaluation) at home. This measure was employed in the program primarily as a

means to increase self-awareness in regard to how one responds to stress.

Session Four

After a review of the agenda in session four, the group was introduced to another common, potential source of stress - the theme of occupational stress. Questions initially posed to members were: "What is occupational stress?", and "Does it represent threat, challenge, or both?" As in previous sessions, these questions helped members to begin considering the theme in a personal context as well as to view it in the larger context of stress.

The group was then presented with seven potential occupational stressors found in a program of research to be capable of leading to the development of risk factors in heart disease (the literature review on occupational stress provides a discussion of the program's findings). As in the session three discussion of life cycle transitions, members explored these and other occupational stressors in terms of their own thoughts, feelings, and experiences.

While this process again reflects the theme-centered interactional approach, features of Drum and Knott's (1974) conceptualization of theme groups also became evident here. (As discussed in the literature review, two separate approaches to theme

groups were represented in the Tele-Cope program.) Their approach emphasizes the examination, evaluation, and resolution of problems and in this context the group became involved in a spontaneous process of helping one another to problem solve around stressful situations experienced at work. This process may have occured here and not during the previous session's discussion of life cycle transitions because the workplace factor was the one which the group held most strongly in common. The group's strength as a provider of mutual aid was evident during this problem solving process.

The group was then asked to form small groups and to design a five to ten minute presentation that would "teach" something about occupational stress. This was intended to validate the importance of each member's experience by placing them in the role of "experts" (Renner, 1983:71) and to encourage the group to further explore the theme within a personal context. The approach was assessed as being unsuccessful in this session for the reason that several people chose to work individually and the small groups which did form appeared conflictual as they were either nonproductive, or were in disagreement over what the final product should be (one person said she had wanted to develop a role-play but could get no cooperation). Two possible reasons for this occur to the writer. First, members

may have felt that their experiences were too individual and/or personal to be generalized within a small group milieu or to be lent to the influence of group norms. (Indeed, members who did work alone produced substantial, creative work.) Second, beginning in session four, members expressed a preference for the whole-group setting (perhaps indicative of greater cohesion). The "small group" format of the exercise therefore was likely a major reason for the relatively non-productive outcome.

As a way of more thoroughly assessing attitudes, members were encouraged to relay their thoughts and opinions in regard to the session via the completion of session evaluation forms (Appendix C). Toseland and Rivas (1984:213) maintain that making use of session evaluations in group work is a valuable way of obtaining feedback which can then be used to develop or modify interventions.

Session Five

The first portion of session five was devoted to addressing feedback from the session evaluations. The major points presented included a common preference for the whole-group setting, a need for more discussion time, as well as more time to integrate new content. "Discussion" and "sharing" were identified as the most valuable activities and it was agreed that future

sessions would attempt to incorporate these elements to an even greater extent.

It is important to note that as a result of this feedback, from session five on the program shifted in emphasis from a primary focus on theme and task to a greater regard for the thoughts, feelings and social needs of members in providing what the group requested in terms of more opportunity for group interaction. This shift is reminiscent of the "dynamic balancing" that should take place in regard to the individual, the group, and the theme as outlined in an earlier discussion of the theme-centered interactional approach.

In addition to being the session where group needs began to significantly impact on group direction, session five also represented the point in the program where the theme focus changed to a skill focus. While the stress management skills featured were similar to themes in that they were discussed as concepts before being practiced, the major emphasis in sessions five through eight was on gaining practical stress management experience through the use of structured activities.

Members in session five stated that they were indeed ready to become active in learning stress management skills and that they had been exposed to enough of what they described as "theoretical" content.

This favorable attitude toward beginning the skill segment of the program indicates perhaps not only that members had had enough "theory" but that they strongly perceived the program as a vehicle whereby stress could be learned to be managed more effectively in a practical sense. The introduction of progressive relaxation training was therefore timely in terms of group needs. Central issues around progessive relaxation training, the first structured relaxation method to be recorded in the literature, are discussed in the literature review. It is worthwhile to note here that the abbreviated version of PRT used in the Tele-Cope program represents a progressive development in the area of relaxation.

Bernstein and Borkovec's (1973) manual provides a detailed account of the relaxation procedures employed in sessions five and six. Basically, this approach involves the systematic tensing and relaxing of various muscle groups while focusing on and learning to discriminate the sensations of tension and relaxation. As recommended, the writer provided a thorough explanation of procedures as a way of increasing member's awareness and confidence. The following list represents the order of muscle groups tensed and relaxed during the "basic procedure" used in session five:

1. Dominant hand and forearm
2. Dominant biceps
3. Non dominant hand and forearm
4. Non dominant biceps
5. Forehead
6. Upper cheeks and nose
7. Lower cheeks and jaws
8. Neck and throat
9. Chest, shoulders and upper back
10. Abdominal, or stomach region
11. Dominant thigh
12. Dominant calf
13. Dominant foot
14. Non dominant thigh
15. Non dominant calf
16. Non dominant foot

For each muscle group, the following steps were carried out: a) each member focused attention on the muscle group, b) at the leader's signal, the muscle group was tensed, c) tension was maintained for five to seven seconds, d) at the leader's signal the muscle group was released, and e) each member continued to focus on the muscle group as it relaxed. Using a set of relatively standard statements, the writer directed these events while members engaged in the exercise. Following this, reactions were expressed and the group was unanimous in reporting a positive experience.

A written summary of the basic procedure was distributed for take-home, with the suggestion that for mastery to occur, practice twice per day was recommended.

Session five was repeated on a separate evening for three people who were unable to attend the regular Tuesday session.

Session Six

Although enthusiasm was expressed for the progressive relaxation training covered in session five, only two or three members reported having practiced at home. "Lack of time" and "other committments" were the two most commonly cited reasons.

The tendency throughout the program on the part of most members to not work between sessions but yet to appear enthusiastic and willing to work in-session, attests perhaps to some personal definition on the part of members of what they wanted to gain from the program, and not necessarily to a lack of motivation. The committment to learn within the program boundary seemed to be part of most members frame of reference and thus there was motivation to do so. Work outside that boundary however was seen increasingly by the writer as fundamentally nonacceptable to members and therefore motivation may not have entered in as a salient factor. Clearly, the writer's expectation that

the group devote time at home to program material was not rooted in the actual needs and desires of the majority. The exceptions to the trend were two group members who were committed to mastering the skills on their own initiative. It was primarily for this reason that the writer continued to develop and distribute take-home tasks and practice sheets, however it is not known whether or not "nonpracticing" members chose to make use of these at another time, or in fact gave them to family members or friends, all reasons which in the writer's view, would have justified making them available.

In session six the group became involved in practicing PRT procedures designed to decrease the amount of time and effort needed to achieve relaxation. For instance, the basic procedure was varied by combining the sixteen muscle groups into seven, and then into four (Bernstein and Borkovec, 1973:33-34). "Relaxation through recall" (Bernstein and Borkovec, 1973:35) a further abbreviated method that does not require the exertion of tension but rather a focusing on existing tension in muscle groups prior to relaxing, was introduced and practiced. The group members generally expressed a preference for these shorter methods, indicating that for their purposes, the basic procedure was too detailed and too time consuming.

It is important to note that Bernstein and Borkovec's essentially therapeutic method of PRT was adapted to the educational purpose of the Tele-Cope program. For instance, rather than utilize ten sessions for the mastery of all relaxation procedures as their manual suggests, the basics were put before the group in two sessions and mastery was left up to the independent efforts of individuals. As for all of the stress management strategies featured in the Tele-Cope program mastery was left up to member's independent efforts.

Although it was assessed that program work outside of sessions was fundamentally nonacceptable to most members, it was seen as important to facilitate some discussion of the issue of possible obstacles to goal achievement and ways that these might be overcome as some members had previously raised this topic (by identifying personal obstacles such as "lack of time"). By framing the presence of obstacles as common and somewhat inevitable, it was felt that members might be encouraged to problem solve around possible salient issues without fear of stigmatization.

Throughout the discussion, in order to further maximize the group's potential as a mutual aid system, a group-centered interaction pattern was increasingly facilitated through the process of requesting members to look solely to one another for suggestions and

comments. Here, the group experienced a further shift away from the structured format (an earlier, smaller shift can be seen to have occured when the request of the group for more interaction was fulfilled) toward that of mainstream group work with its focus on group centeredness. From this interchange came such ideas for overcoming obstacles as "getting support from family and friends", "believe in the method", and "make it a habit".

A second evaluation was completed by members at the close of this session and comments indicated enthusiasm for PRT, particularly the shorter procedures, a desire for more in-session practice time and a desire to learn about "combating distorted thinking". "Discussion" and "sharing" were again mentioned as the most valued activities. A summary of relaxation procedures was distributed for use at home.

Session Seven

Session seven saw the introduction to the group of another strategy of stress management - an abbreviated version of stress inoculation training as put forth by McKay, Davis, and Fanning (1981). Important issues related to this and to the original, more comprehensive version are presented in the literature review.

As stated earlier in a discussion of cognitive-behavioral approaches to stress management

(of which stress inoculation training is an example) upset emotions can be precipitated by a person's thoughts toward a situation and not necessarily by the situation itself. This concept was seen as important for the group to initially review as it provides a basis for a full understanding of how stress inoculation training can be effective.

Following a review of the concept, the group was presented with the information that this approach to stress inoculation training involves compiling a hierarchy of personal stressful situations, then making use of relaxation skills while imagining each situation; constructing a personal list of stress coping thoughts, and then using the relaxation skills and stress coping thoughts in real life. Following a discussion of a sample stress events hierarchy, members were asked to individually list two or three stressful situations likely to occur in the near future and then to rank them from the least to the most stressful. McKay, Davis, and Fanning (1981) suggest that a personal hierarchy be composed of ten to twenty items and therefore members were encouraged to complete the exercise at home.

After completion of the beginning hierarchies, members suggested such ways to help a "scene" become vividly imagined as, "use the senses", "use the memory", and "play a movie in my mind". The group then

became involved in an imagery and relaxation exercise in which each member constructed a scene in his or her imagination, noticed the body's reaction, and then used the reaction as a signal to relax. A debriefing period occured around this exercise and then the concept of stress coping thoughts was introduced and examples were discussed.

Following this, members became engaged in an exercise intended to enable them to gain an understanding of how stress coping thoughts can help to positively change unpleasant, stress-related emotions. Here, the group was asked to select a stressful situation from their hierarchies and to recall, and to identify on paper, the accompanying thoughts and emotions. The connections between these components were then explored. From this came a recognition in some instances that upset emotions had been precipitated by how a situation had been evaluated. Members then suggested some stress coping thoughts that might be used to replace the "negative" thoughts that they had identified in their own scenarios.

As session time did not permit, it was recommended that members create their own list of stress coping thoughts at home as well as review the application of skills to real life situations using the guidelines outlined in McKay, Davis and Fanning (1981).

Session Eight

Another cognitive-behavioral approach to stress management - combating distorted thinking - was presented to the group in session eight. This approach shares with stress inoculation training the central notion that an upset emotional state can be precipitated by the way in which an individual evaluates or labels a situation. While having this notion in common, the combating distorted thinking approach may be viewed as more specific in that it defines several "styles" of negative or "distorted" thinking and provides a structured method for removing thought distortions. A discussion of the approach may be found in the literature review.

Using McKay, Davis and Fanning's (1981) version of "combating distorted thinking" in this session, the group became active in exploring the following fifteen styles of distorted thinking: filtering, polarized thinking, over-generalization, mind-reading, catastrophizing, personalization, control fallacies, fallacy of fairness, blaming, shoulds, emotional reasoning, fallacy of change, global labeling, being right, and heaven's reward fallacy. As a means of maximizing participation, each member was given a written description of a particular "style", asked to study it, and then to explain to the group in his or her own words the style's meaning. Leadership was

shared in this manner as all members had equal responsibility to teach an important piece of content. As the meaning of each style was relayed, the group interacted around such issues as whether or not that style of distorted thinking was recognized as something personally experienced and in what circumstances. Members reacted with much enthusiasm as they began to recognize their own thought patterns among the ones explored.

Following this, members worked individually or in pairs to complete two short exercises intended to facilitate a greater awareness of distorted thinking. The first, a matching exercise, involved connecting descriptive sentences with the corresponding thought distortion while the second involved choosing and circling the correct distortion exemplified by a descriptive statement. The results of the exercises were then discussed.

The remainder of the session was spent reviewing the "three column technique" so that members could make use of it independently. The technique is a structured method for examining thoughts, identifying distortions, and then rewriting the thought or statement without the distortion. The group was then requested to complete session evaluations at home.

Session Nine

Although only two evaluations were completed and returned in session nine, both indicated positive responses toward the method of stress management presented in session eight - combating distorted thinking. The verbal reports of other members indicated the same.

Session nine served as an opportunity for members to develop an awareness of the role social support plays in modifying the stress response and to explore ways in which social networks might become enhanced. These areas reflect important program objectives and are explored in the literature review.

The session began with general discussion of a presented statement selected to elicit suggestions by the group of what is required for social support. The statement read, "People are said to have social support if they have a relationship with one or more persons that is characterized by relatively frequent interactions, by strong and positive feelings, and by an ability and a willingness to give and take emotional and/or practical assistance in times of need." (McLean, 1979:92).

One issue which evolved from this activity was whether women or men generally make the greater use of social support, and whether or not men find it easier to form friendships with women than with men. While the ensuing discussion featured a variety of opinions in relation to these and other gender issues, the writer took the opportunity to help conclude the discussion by emphasizing the common need for social support thereby helping members to be aware of the importance of its exchange.

Another issue which arose involved the question of risk in forming new relationships. The consensus in the group seemed to be that while the risk of rejection is present when people attempt to form new relationships, the consequence of not risking is loneliness. Members agreed that taking such risks was necessary in the long run for the achievement of personal well-being.

Following this exercise, a handout featuring two illustrations was distributed. The first illustration depicted the "main" and "buffering" effects of social support on stress, as shown by House (1981:31) and as explained on p. . The second offered Quick and Quick's (1984:205) depiction of a social network. These were generally discussed within the group. Then, four types of social support as outlined by House (1981:23-25) - emotional support, appraisal support,

informational support, and instrumental support - were presented and members suggested examples of each that they had been involved in either offering or receiving from family and friends.

The writer then facilitated an interchange regarding what skills are necessary for effective network development and more specifically what is required for the enhancement of social support at work. One member volunteered to record the suggestions for subsequent discussion. Initially, the group became split over whether the term "skills" or "efforts" was the more accurate to describe what was required to form a network and it was agreed that a combination of the two was optimum. (In retrospect, although this issue was not raised, the term "skill" in relation to social support may have carried the connotation of depersonalization while "efforts" may have been seen to be more manageable and accessible.) Some "skill" suggestions were "eye contact", "listening", and "ability to engage in small talk". Regarding the issue of social support at work, the discussion centered around the influence of hierarchy and some individuals maintained that variations in status made the giving and receiving of support between "levels" difficult. One suggestion made to overcome this was the organization of more social activities for employees from all ranks.

The purpose of the session's last exercise, a role-play, was to increase member's awareness of how social networks might become enhanced. Following Renner's (1983:61-62) guidelines for "structured role-playing" the group was provided a scenario (Appendix D) which outlined the roles of two protagonists and observers. Members then volunteered for the various roles. Following the exercise, the group was asked to summarize what the role-play had conveyed to them about network enhancement.

Finally, as a means of enabling group members to become more aware of their own networks and to identify steps for network improvement as mentioned in the literature review, Adams' (1980) "Social Network Review" and "Support-Network Improvement Plan" were discussed and made available.

The Ending Phase

Session Ten

The final session of the Tele-Cope program involved three activities: a group discussion, an appeal to the group to complete the posttest evaluations and to return them by an agreed-upon date, and a catered dinner. While the writer had intended to raise several questions for evaluation purposes, members were more eager to socialize and to experience the session as an informal get-together.

While an evaluation by way of discussion did not occur to a large extent, many comments indicated a positive response to the program. For instance, several members indicated that they felt stronger and more in control as a result of having participated. One individual said that the group had represented a real transition for her in terms of strengthening her ability to cope. Another expressed appreciation by presenting the writer with a floral arrangement.

Members raised and endorsed the idea that the program should be offered again at Tele-Cope as they felt that a definite need existed for employees to become more knowledgeable in the areas of stress and stress management and that the program had satisfied that need for them. They spent some time discussing strategies for reaching the maximum number of people in the Manitoba Telephone System via advertising, outreach, etc.

For several reasons the group was assessed as being ready to terminate. First, there was no evidence of sadness or regret at ending the program and the group generally expressed satisfaction in relation to what had been learned and accomplished. Second, some members appeared to facilitate their own closure by making plans to meet with one another on future occasions. Third, members could identify no purpose for which the group should continue, and last, the

atmosphere of celebration was assessed as being the group's way of marking the end, of saying they indeed had had a positive experience.

EVALUATION

Variables Evaluated

Variables evaluated in the practicum and reflected in the program objectives were self-esteem, attitude toward the use of stress management strategies, intent to practice stress management strategies, and degree of symptom discomfort. In addition, members were asked to indicate the degree to which they developed understanding and gained experience in relation to pertinent areas of stress and stress management.

Self-esteem was chosen as a variable to be evaluated for the reason that excessive stress can result in the diminishment of self-esteem as people may not feel in control (Pearlin et al, 1980:340). Mastery in response to stress can involve developing new resources (ie. knowledge and skill) that may lead to a change in the person-environment relationship and gaining mastery can lead to recovery of self-esteem (Caplan, 1981:417). The program was viewed by the writer as a way of helping people to increase their level of competence in coping with stress and thus raise their level of self-esteem.

Attitude and behavioral intent were selected as variables at the suggestion of Feldman (1985:235). While he cites a more favorable attitude toward reducing stress as an appropriate quantifiable outcome measure for a stress management program, he also maintains that behavioral intent has been shown to be a

better predictor of health behavior than changes in attitude. Both variables were therefore included.

Symptom discomfort was another variable selected for evaluation. As consequences of stress and stress management have already been addressed, these topics will not be discussed further here other than to say that a logical effect of using stress management may be a reduction in the level of symptom discomfort.

Lastly, because education was the program's central purpose, it seemed essential to provide a means whereby members could indicate how well learning objectives had been met for them.

Measures

Hudson Index of Self-Esteem (ISE)

This standardized questionnaire (Hudson,1982) (Appendix E) was specifically designed for single system research and while it is recommended as a repeated measure, it can also be administered less frequently (Bloom and Fischer, 1982:161). Respondents indicate their response to twenty-five items on a five point Likert scale ranging from 1 (rarely or none of the time) to 5 (most or all of the time). The clinically significant cutting score is 30, meaning that people who score over 30 generally have problems in the area being measured.

The scale has high internal and test-retest reliabilities (stability) of 0.90 or more, high face, concurrent, and construct validity, and is an accurate and reliable measure of self-esteem (Bloom and Fischer, 1982:149).

All self-report measures (which were the only type used in the Tele-Cope program) have as a limitation, a susceptibility to reactivity (changes in the problem due to the act of recording) (Bloom and Fischer, 1982:204), however self-reports are the only type of measure that can reflect the client's subjective experience (Jehu, 1985:15). Paper and pencil instruments are also open to sources of error in that clients may misunderstand questions or respond in ways that are socially desirable (Jehu, 1985:14).

In order to minimize these limitations, members were encouraged to be honest. This is seen as an appropriate way to help guard against "desirability" bias (personal consultation).

Self-Anchored Scales

Self-anchored scales are used to measure the intensity of problems, situations, or internal thoughts and feelings that other measures cannot tap (Bloom and Fischer, 1982:169).

The program utilized a nine-point and a five-point scale (Appendix F). In regard to the first, members

responded to the question, "How positively do you feel about using stress management strategies?" on a scale ranging from 1 (feel not at all positive) to 9 (feel completely positive). The cutting score was arbitrarily set at 5 (feel moderately positive) and a score of 5 or more was interpreted as a positive feeling toward stress management with each interval representing an increase in the intensity of positive feeling. In regard to the second scale, members responded to the statement, "I intend to use stress management strategies beyond the time period of the program." on a scale ranging from 1 (strongly disagree) to 5 (strongly agree). The cutting score was arbitrarily set at point 4 (agree) and a score of 4 or more was interpreted as a positive intent to use stress management, again with the interval representing an increase in intensity. While both suggested cutting scores are arbitrary, they do have face validity.

One strength of self-anchored scales is that they have high face validity and can be used as often as needed either as a primary measure or in conjunction with other measures (Bloom and Fischer, 1982:169-170). The scale is easy to construct and easy for clients to understand and complete as well as being a flexible and sensitive instrument (Jehu, 1985:13).

A limitation of such scales is that reliability data cannot be obtained as they are developed

individually. A strong potential also exists for the client to distort his or her ratings given the subjective nature of the instrument (Bloom and Fischer, 1982:169).

Symptoms Checklist

The checklist used in the program was made up of a combination of two checklists; one by McKay et al (1981:6-7) and the other by Davis et al (1982:12-13) (Appendix G). The combined checklist was composed of fifty-one items.

On a ten-point scale ranging from 1-3 (slight discomfort) to 8-10 (extreme discomfort), respondents rate the degree of discomfort associated with personal stress-related symptoms. An arbitrary cutting point for each symptom was set at 3 meaning that people who score over this figure are experiencing discomfort of some clinical significance.

As the respondent is being asked to rate him or herself on specific variables, the Symptoms Checklist is a series of self-anchored scales and is therefore subject to the same strengths and limitations.

Learning Objectives Measure

This instrument (Appendix H) was obtained from the Civil Service Commission Development and Training

Branch and re-titled for use in the Tele-Cope program. It enables respondents to rank objectives according to their degree of importance, to evaluate on a scale of 0 (low) to 10 (high) how well each objective had been met, and then to arrive at an "index of objective fulfillment" score by multiplying the degree of importance by the degree of fulfillment of each objective and adding the resulting figures. The Commission used the cutting score of 750, meaning that any score above this figure would indicate a general feeling that objectives were adequately fulfilled and this guideline is followed here.

This measure would appear to include such strengths of self-anchored scales (to which it is similar) as high face validity and such limitations as the potential for responding in a socially desirable way. An important difference is that change is not measured by this instrument; rather data is solicited only after the fact of the intervention.

Program Evaluation

At the completion of the intervention, program evaluations (Appendix I) were administered which gave group members the opportunity to evaluate the effectiveness of methods, group leader effectiveness, the general program, to make recommendations for improvement, and to present additional comments. Items

included in the evaluation were obtained from several questionnaires.

Again, social desirability is a potential source of error however members were encouraged to be honest in their feedback.

Evaluation Design

The program utilized a combination of the one-group pretest-posttest design and the "one-shot case study" (Isaac and Michael, 1981).

One-Group Pretest-Posttest Design

This quasi-experimental design was used to evaluate the data of the Hudson Index of Self-Esteem, the self-anchored scales, and the Symptoms Checklist. Unlike the one-shot case study, it has the advantage of facilitating a comparison between responses by the same group of subjects before and after the intervention. It also controls for selection and mortality (ie. drop out) variables, provided that the same subjects are pre and posttested.

The design has a major disadvantage in that it can offer no assurance that the intervention is the only or primary factor accounting for the difference between the pre and posttest. Several "rival hypotheses" (ie. history, maturation, etc.) can in fact come into play (Isaac and Michael, 1981:64-65).

The "One-Shot Case Study"

This design was used to evaluate the Learning Objectives Measure and involves exposing subjects to an intervention and then administering a posttest. While the design can have quasi-experimental status, from the perspective of this level of research it features an absence of control, no internal validity, and no basis for comparison other than intuition (Isaac and Michael, 1981:54,63-64). Therefore no defensible conclusions can be drawn from it in research. The strength of such a design is that it can be an effective part of "action research" which involves exploring for new problems, or developing ideas or skills, as opposed to more scientifically rigorous quasi-experimental research (Isaac and Michael, 1981:64).

Rationale

It would appear that less rigorous methods of analysis are appropriate provided that findings are not misconstrued as definitive evidence. Feldman (1985:246-247) maintains that such methods are suitable for "demonstration programs, small projects, or programs of modest budgets" such as the Tele-Cope program. A rationale for using the "one-shot case study" design has to do with the fact that the purpose of the Tele-Cope program is similar to the purpose of action research which is, "to develop new skills or new

approaches and to solve problems with direct application to the classroom or working world setting" (Isaac and Michael, 1981:55).

It was also assessed that other quasi-experimental designs more rigorous than the one-group pretest-posttest, such as those making use of randomization, a control group, or a repeated series of measurements, would not have met the preferences of the setting.

Interpretation of Data

The data obtained by the Hudson Index of Self-Esteem, the self-anchored scales, and the Symptoms Checklist is displayed by way of bar graphs (Bloom and Fischer, 1982:88-89). The charting of data allows for change to become immediately apparent through visual inspection (Jehu, 1985:49).

Generally, a distinction is made between the baseline and intervention phases when data is graphed (Bloom and Fischer, 1982:89). In response to agency preference, no preliminary assessment and thus no baseline phase was carried out in the Tele-Cope program. The intervention phase was the only phase of client contact. Using the one-group pretest-posttest design, two scores for each measure were obtained at the outset and termination of the program. A

comparison of scores indicates whether change has occured between the two points of assessment.

In circumstances where the results of repeated measures obtained across phases are charted, three important properties of charted data must be considered in order to effectively interpret outcome (Bloom and Fischer, 1982:429) Level refers to the magnitude of data, stability referes to the extent to which a prediction can be made about the direction of data based on prior patterns, and trend refers to whether an increase, decrease, or flat level of magnitude is apparent. Depending on what outcome is desired, the properties of trend and level are combined to ascertain what makes up improvement or deterioration.

Within this framework, the data obtained on the pretest-posttest measures are interpreted according to an increase, decrease, or no change in magnitude between scores. The concept of stability is not applicable when only two data points are in use as no opportunity exists for predictions to be made based on previous phases.

Hudson Index of Self-Esteem

It was desired and expected that an increase in self-esteem reflected by a decrease in the level of scores between the pretest and posttest would occur during the intervention. The "clinical significance of

change" (Kazdin, 1980:364-370) is indicated when scores located above the cutting point on the pretest fall below on the posttest, suggesting amelioration of the problem.

Self-Anchored Scales

It was desired and expected that people would feel more positively toward the personal use of stress management and would increase their intent to use it after having participated in the program. On both scales an increase in magnitude of scores represents improvement while a decrease represents deterioration.

Symptoms Checklist

As with the ISE, greater magnitudes of scores on the checklist were undesired and thus a decrease in level between the pretest and posttest was regarded as an improvement.

Learning Objectives Measure

No change is indicated by this measure therefore the use of graphs is not applicable. The index of objective fulfillment for each respondent will be compared with the suggested cutting score of 750; again, any score over this indicating subjective fulfillment of learning objectives.

Individual Results

Respondent #1

Hudson index of self-esteem. As shown in Figure 1, there was no indication of clinically significant low self-esteem on either administration of the ISE. An improvement in this area however is evident on the posttest as indicated by a decrease in the level of scores following the intervention.

Self-anchored scale #1. On the scale measuring attitude, the highest possible score was indicated on both the pretest and posttest (see Figure 2), demonstrating that the respondent felt completely positive toward the personal use of stress management before and after the program. No change in attitude occured.

Self-anchored scale #2. Similarly, no change was indicated in the intent to make use of stress management following the program. Both administrations of the scale revealed the highest possible score (see Figure 3).

Symptoms checklist. Thirty-one symptoms were rated at the start of the stress management portion of the program. These symptoms as well as the results are shown in Table 1.

At the pretest, 22 symptoms were rated in the 4-7 point range (moderate discomfort)and 9 were placed in

the 8-10 point category (extreme discomfort). At the posttest, 11 symptoms were rated in the moderate, and 2 in the extreme discomfort categories. Scores either stayed the same or decreased in level.

Data obtained at termination indicated that clinically significant change (ie. change from above the cutting point to below, or change from moderate or extreme discomfort to slight discomfort) had occured in 35% (11) of the symptoms. These symptoms caused only slight discomfort after the intervention.

Table 1

Symptoms Checklist Raw Scores for Respondent #1

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort

Symptoms	Pretest	Posttest
Anxiety re: deadlines	4	3
Anxiety re: spouse	7	4
Anxiety re: friends	7	5
Anxiety, general	5	4
Depression	9	8
Hopelessness	7	4
Powerlessness	7	4
Poor self-esteem	6	4
Hostility	6	5
Anger	7	6

Irritability	7	4
Resentment	5	3
Obsessions	6	4
Muscular tension	7	3
Procrastination	7	4
Overeat	6	6
Physical pain/illness	8	7
Insomnia	7	3
Sleeping difficulties	7	3
Fatigue	8	3
Unwanted sexual behavior	8	3
Perfectionism	7	5
Ineffective problem solving	5	4
Headaches	9	7
Neckaches	9	4
Backaches	9	4
Indigestion	8	3
Irritable bowel	6	3
Muscle spasms	6	3
Tics	7	2
Obestiy	10	10

(Figure 4 shows the percentage of symptoms for each respondent that caused a clinically significant degree of discomfort both before and after the intervention.)

Learning objectives measure. Based on the recommended cutting score of 750, an index of objective fulfillment score of 800 would indicate that the respondent felt that important learning objectives had adequately been met. The two objectives rated as most important were given moderate to relatively high scores on the scale of 0 (low) to 10 (high) while other objectives of lesser importance received moderate to high scores in terms of fulfillment. Some less important objectives were fulfilled to a higher degree than the more important however all were fulfilled to an adequate degree. Results are shown in Table 2 and the objectives as well as instructions for completing this measure can be found in Appendix H.

Table 2

Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	10	10	100
b	10	7	70
c	10	10	100
2. a	10	9	90
b	20	6	120
3. a	20	8	160
b	10	7	70
c	10	9	90
			800

Respondent #2

Hudson index of self-esteem. Results of the ISE obtained at the start of the program (see Figure 1) do not indicate low self-esteem. Posttest data reveal that the level of self-esteem slightly increased during the time of the intervention.

Self-anchored scale #1. A comparison of before/after measures (see Figure 2) indicates a deterioration in the intensity of attitude toward the personal use of stress management. At the outset of the program the respondent felt highly positive while at termination felt moderately positive. The posttest score was placed at the cutting point.

Self-anchored scale #2. As with the first scale, deterioration took place although was not as pronounced (see Figure 3). The intention to use stress management was rated the highest possible score at the pretest but decreased by one interval over the course of the program. This member was therefore more likely to use stress management before the program than after.

Symptoms checklist. Twenty-three symptoms were responded to on this measure. The symptoms and results are displayed in Table 3.

At the pretest, only 1 symptom was rated in the slight discomfort range, 11 in the moderate range, and 11 in the extreme range. Posttest data reveals 2

symptoms rated in the slight discomfort category, 14 in the moderate range, and 7 in the extreme.

At termination of the stress management program, clinically significant change was shown to have occured in relation to "depression" and "hopelessness", 9% of the symptoms rated. Interestingly, deterioration took place in regard to "smoking" as the degree of discomfort associated with this symptom increased from slight to moderate over the course of the program, making it problematic for the individual from a clinical standpoint.

Table 3

Symptoms Checklist Raw Scores for Respondent #2

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort

Symptoms	Pretest	Posttest
Anxiety re:deadlines	9	9
Anxiety re:children	9	7
Anxiety, general	5	5
Depression	6	3
Hopelessness	4	2
Powerlessness	8	7
Poor self-esteem	6	4
Hostility	9	7
Anger	9	7

Irritability	5	5
Resentment	6	6
Muscular tension	8	8
Procrastination	8	8
Smoking	2	4
Problem drinking	7	7
Overspending	9	9
Compulsions	8	8
Insomnia	4	4
Sleeping difficulties	4	4
Fatigue	6	6
Unwanted sexual behavior	6	6
Ineffective problem solivng	9	9
Obesity	9	9

Learning objectives measure. Indicated by an index score of 875 is a general feeling that objectives had been fulfilled. Four of the six objectives rated as most important received the highest possible fulfillment ratings while two received moderate scores. Two relatively unimportant objectives were given moderate and high ratings respectively. Generally, content objectives (1 and 2), which held the most importance for the respondent, received high fulfillment scores while skill objectives (3) were given moderate scores indicating that the level of

understanding and experience gained in relation to these was just adequate. Results are shown in Table 4.

Table 4

Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	30	10	300
b	5	10	50
c	20	10	200
2. a	10	10	100
b	10	10	100
3. a	10	5	50
b	5	5	25
c	10	5	50
			875

Respondent #3

Hudson index of self-esteem. The first score obtained by the ISE indicated the presence of clinically significant low self-esteem at the start of the intervention (see Figure 1). A significant improvement was revealed in the posttest whereby the score fell well below the cutting point.

Self-anchored scale #1. As displayed in Figure 2, pretest results indicate that the respondent felt completely positive toward using stress management at

the outset of the program and the posttest indicates no change in this attitude.

Self-anchored scale #2. A comparison of the two measures taken of behavioral intent (see Figure 3) reveals an improvement over time. While the respondent expressed agreement to the presented statement at the start of the program, even stronger agreement was expressed after.

Symptoms checklist. The 33 rated symptoms as well as the results are displayed in Table 5. Results of the checklist indicate the occurence of change in the desired direction for many of the symptoms. Prior to learning stress management skills, 5 symptoms were placed in the slight discomfort range, 16 in the moderate, and 12 in the extreme. Posttest results show 20 symptoms rated in the slight discomfort category, 12 in the moderate, and 1 in the extreme. Change was clinically significant in 45% (15) of the cases.

Table 5

Symptoms Checklist Raw Scores for Respondent #3

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort

Symptoms	Pretest	Posttest
Anxiety re: tests	9	7
Anxiety re: deadlines	7	5

Anxiety re: interviews	8	6
Anxiety re: parents	7	5
Anxiety re: friends	7	5
Depression	7	4
Hopelessness	8	2
Powerlessness	8	2
Poor self-esteem	8	2
Hostility	8	2
Anger	8	4
Irritability	8	2
Resentment	8	2
Phobia-confined spaces	8	5
Obsessions	7	2
Muscular tension	7	2
Procrastination	3	3
Overeat	3	3
Overspending	7	3
Physical pain/illness	8	4
Compulsions	5	1
Sleeping difficulties	3	3
Fatigue	3	3
Unwanted sexual fantasies	4	4
Unwanted sexual behavior	7	2
Perfectionism	3	3

Ineffective problem solving	6	3
Headaches	8	8
Neckaches	7	5
Backaches	7	3
Indigestion	7	3
Muscle spasms	7	5
Physical weakness	7	3

Learning objectives measure. An index of objective fulfillment score of 895 indicates an overall feeling that learning objectives had been met. The objectives which were most important to the respondent were the most highly fulfilled while those of moderate importance were moderately fulfilled. Perhaps a greater degree of effort was put into the achievement of those objectives deemed most important. Results are shown in Table 6.

Table 6

Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	5	5	25
b	5	5	25
c	5	5	25

2. a	15	8	120
b	20	10	200
3. a	15	10	150
b	15	10	150
c	20	10	200
			895

Respondent #4

Hudson index of self-esteem. At the pretest, this group member was classified as experiencing clinically significant low self-esteem (see Figure 1). The posttest score indicates a substantial and significant improvement in this area following participation in the stress management program.

Self-anchored scale #1. As shown in Figure 2 the respondent felt completely positive about using stress management at the start of the program. While the posttest score shows a continuing positive feeling, a decrease in intensity is apparent.

Self-anchored scale #2. While the respondent may have felt less positively after the program toward using stress management, his intent to use strategies did not change from the pretest to posttest, as evidenced by both ratings at the top end of the scale (see Figure 3).

Symptoms checklist. The symptoms responded to as well as the raw scores are shown in Table 7. Forty-three items were rated on the checklist.

At the pretest, 1 symptom was rated in the slight discomfort range, 38 in the moderate and 4 in the extreme. At termination, 36 symptoms were considered to be in the slight discomfort range, while 7 were rated in the moderate. Data obtained at the posttest indicated that clinically significant change had occured in relation to 81% (35) of the symptoms.

Table 7

Symptoms Checklist Raw Scores for Respondent #4

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort.

Symptoms	Pretest	Posttest
Anxiety re: tests	5	2
Anxiety re : deadlines	7	5
Anxiety re: interviews	3	2
Anxiety re: spouse	5	2
Anxiety re: parents	5	2
Anxiety re: children	7	2
Depression	4	0
Hopelessness	4	0
Powerlessness	6	2
Poor self-esteem	4	0

Hostility	5	1
Anger	6	2
Irritability	6	2
Resentment	5	1
Fears	4	3
Obsessions	9	4
Muscular tension	8	3
Procrastination	4	3
Overeat	7	5
Overspending	7	4
Physical pain/illness	5	2
Compulsions	5	2
Insomnia	5	3
Sleeping difficulties	4	2
Fatigue	7	4
Unwanted sexual fantasies	7	2
Unwanted sexual behavior	4	2
Perfectionism	8	4
Ineffective problem solving	5	3
High blood pressure	7	2
Headaches	7	4
Neckaches	7	2
Backaches	7	2
Indigestion	4	2

Irritable bowel	4	1
Ulcers	7	0
Chronic constipation	7	0
Chronic diarrhea	8	0
Muscle spasms	6	1
Tics	4	1
Tremors	5	0
Obesity	8	2
Physical weakness	8	2

Learning objectives measure. With an index score of 925, the respondent appears to have felt strongly that objectives had been fulfilled overall. With the exception of one objective, all were similar in their level of importance and all were given the highest possible fulfillment rating with the exception of two goals which were rated moderately. See Table 8 for the results.

Table 8

Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	10	5	50
b	15	10	150
c	10	10	100
2. a	15	10	150
b	5	5	25

3. a	15	10	150
b	15	10	150
c	15	10	150
			925

Respondent #5

Hudson index of self-esteem. The respondent was not assessed as having clinically significant low self-esteem although the pretest ISE score was close to the cutting point. The posttest score (see Figure 1) indicates a substantial improvement in this area.

Self-anchored scale #1. In a comparison of scores, no change in attitude was apparent (see Figure 2). The member felt as positively about using stress management before the intervention as after, as evidenced by the presence of both ratings at the top end of the scale.

Self-anchored scale #2. In the case of behavioral intent, a slight deterioration of one interval is shown in Figure 3 between the pretest and posttest demonstrating less of an intent to practice stress management after having been exposed to various methods. The posttest score is at the cutting point.

Symptoms checklist. Twenty-seven symptoms were rated and they are displayed in Table 9 together with results.

At the initial assessment, 3 symptoms were placed in the slight discomfort category, 10 in the moderate, and 14 in the extreme. At the posttest, 12 symptoms were classified in the slight discomfort category, and 15 in the moderate. Change was clinically significant in regard to 33% (92) of the symptoms and occured in the desired direction in the majority of cases.

Table 9

Symptoms Checklist Raw Scores for Respondent #5

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort.

Symptoms	Pretest	Posttest
Anxiety re: deadlines	3	1
Anxiety re: interviews	5	3
Anxiety re: spouse	5	3
Anxiety re: parents	4	3
Depression	1	1
Hostility	8	5
Anger	8	5
Irritability	8	5
Resentment	7	4
Fears	7	4
Muscular tension	10	6
Procrastination	8	5

Overspending	4	3
Physical pain/illness	8	6
Compulsions	8	4
Insomnia	6	3
Sleeping difficulties	6	3
Fatigue	8	6
Perfectionism	8	5
Ineffective problem solving	8	3
High blood pressure	1	1
Headaches	8	5
Neckaches	8	5
Backaches	9	5
Indigestion	10	7
Irritable bowel	4	3
Physical weakness	5	3

Learning objectives measure. A relatively high index score of 920 suggests a strong opinion that learning objectives had been met. With the exception of objectives 3.b and c which received a more moderate rating in terms of fulfillment, all objectives rated as relatively important to the respondent received the highest possible fulfillment scores. The least important objective also was given a fulfillment rating toward the high end of the scale. Results are displayed in Table 10.

Table 10

Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	10	10	100
b	15	10	150
c	20	10	200
2. a	20	10	200
b	5	8	40
3. a	10	10	100
b	10	7	70
c	10	6	60
			920

Respondent #6

Hudson index of self-esteem. On the basis of the cutting score, no problem in relation to self-esteem was evident either before or after the program (see Figure 1) however a slight deterioration in the level of scores did take place. Following participation in the program, the individual viewed him or herself in a slightly less positive light.

Self-anchored scale #1. Results obtained at the outset indicated a positive attitude toward the personal use of stress management (see Figure 2). The

positive feeling increased by one interval at the posttest and was rated at the top end of the scale.

Self-anchored scale #2. As revealed by before/after scores (see Figure 3), no change occured in regard to behavioral intent. The highest possible score was shown at both assessment points.

Symptoms checklist. Twelve symptoms were rated and these along with results are shown in Table 11.

At the pretest, 7 symptoms were classified in the slight discomfort range, 4 in the moderate, and 1 in the extreme. At termination, 8 symptoms were place in the slight discomfort category, 3 in the moderate, and 1 in the extreme. Ratings either stayed the same or decreased in level. Clinically significant change occured in relation to 8% (1) of symptoms however "smoking" remained extremely discomforting.

Table 11

Symptoms Checklist Raw Scores for Respondent #6

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort.

Symptoms	Pretest	Posttest
Anxiety re: deadlines	5	2
Anxiety re: spouse	5	4
Anxiety re: parents	5	4
Anxiety re: children	5	4

Depression	2	1
Anger	1	1
Irritability	2	1
Procrastination	1	1
Smoking	10	10
Fatigue	2	1
Perfectionism	2	1
Ineffective problem solving	2	1

Learning objectives measure. An index of objective fulfillment score of 820 suggests that in the opinion of the respondent, generally, objectives were met. The data indicates that those objectives most important to the group member were fulfilled to a relatively high degree. Those of lesser importance were less fulfilled with the exception of one relatively important objective which received the highest fulfillment score. Again the trend would suggest that the more important an objective, the more effort might be put into its achievement, however evidently objectives having little importance can also be fulfilled. See Table 12 for results.

Table 12

Objective	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	5	10	50
b	5	2	10
c	12	10	120
2. a	10	8	80
b	8	5	40
3. a	20	10	200
b	20	8	160
c	20	8	160
			820

Respondent #7

Hudson index of self-esteem. As shown in Figure 1, pretest data shows the presence of clinically significant low self-esteem. A significant improvement however is demonstrated by a drop in the level of scores, between the pretest and posttest, to below the cutting point.

Self-anchored scale #1. At the start of the program, a strong positive feeling toward the use of stress management was indicated (see Figure 2) however deterioration occured as shown by a decrease of two

intervals on the posttest score. Both ratings however remained above the cutting point.

Self-anchored scale #2. There was no change in the respondent's intent to use stress management before or after the intervention (see Figure 3). Agreement was indicated on the pretest and posttest measures although ratings were at the cutting point.

Symptoms checklist. Thirteen stress-related symptoms were rated by the respondent and these, along with results, are shown in Table 13.

Pretest data indicates 1 symptom in the slight discomfort range and 12 symptoms in the moderate range. Some change in the desired direction is evident on the posttest with 3 symptoms rated in the slight and 10 rated in the moderate discomfort category. Change is clinically significant in regard to 15% (2) of the symptoms.

Table 13

Symptoms Checklist Raw Scores for Respondent #7

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort.

Symptoms	Pretest	Posttest
Anxiety re: deadlines	5	5
Anxiety re: spouse	3	3
Anxiety re: children	6	6

Anxiety, general	5	5
Depression	6	6
Hopelessness	6	6
Irritability	6	5
Fears	7	6
Obsessions	7	6
Muscular tension	6	4
Physical pain/illness	6	4
Backaches	6	2
Irritable bowel	5	2

Learning objectives measure. An index score of 740, because it falls below the recommended cutting point of 750, indicates that learning objectives were not adequately met for the individual. The data shows that the main factor influencing the low score was the fact that neither of the two most highly rated objectives in terms of importance were perceived as fulfilled to the highest degree; one highly important objective in fact was seen to have been fulfilled in only a moderate way. The less important objectives were placed in the moderate to high range of fulfillment. Results are shown in Table 14.

Table 14

Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a			
b	10	10	100
c	20	8	160
2. a			
b	10	6	60
3. a	30	8	240
b			
c	30	6	180
			740

Respondent #8

Hudson index of self-esteem. As displayed in Figure 1, clinically significant low self-esteem is indicated on both the pretest and posttest measures with no change occuring in the level of scores. Thus no improvement or deterioration took place in relation to this variable.

Self-anchored scale #1. Based on a comparison of scores, the respondent initially felt quite strongly at the start of the program in favor of using stress management methods (see Figure 2) however the intensity of feeling decreased by two intervals, bringing the

posttest score to the cutting point. This would indicate a definite change of attitude in an undesired direction.

Self-anchored scale #2. While the degree of positive attitude lessened over the course of the program, there was no change in the degree of positive intent to practice stress management (see Figure 3).

Symptoms checklist, Twenty-four symptoms were responded to and these together with results are shown in Table 15. Prior to learning some strategies of stress management, 9 symptoms were classified in the slight discomfort range while 15 were rated as moderate. On the posttest discomfort was seen to decline in intensity or stay the same with 18 symptoms rated in the slight discomfort category and 6 in the moderate. Nine symptoms, or 37%, changed over the course of the program in a way that was clinically significant.

Table 15

Symptoms Checklist Raw Scores for Respondent #8

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort.

Symptoms	Pretest	Posttest
Anxiety re: tests	5	3
Anxiety re: deadlines	6	4

Anxiety re: interviews	3	3
Anxiety re: spouse	2	1
Anxiety re: parents	4	3
Depression	3	1
Hopelessness	1	1
Powerlessness	2	2
Poor self-esteem	2	2
Hostility	5	3
Anger	5	3
Irritability	6	4
Resentment	4	3
Fears	4	3
Obsessions/unwanted thoughts	2	2
Muscular tension	7	4
Procrastination	3	2
Overeat	5	4
Physical pain/illness	7	4
Sleeping difficulties	5	3
Fatigue	5	3
Headaches	2	2
Backaches	7	4
Muscle spasms	5	3

Learning objectives measure. A final index score of 705 shows that learning objectives were not adequately met in this case. Data indicates that objectives varied in the degree of importance each held

for the respondent and no relationship is evident between how important an objective was and how fulfilled it became. No objective received the highest possible fulfillment rating and scores were fairly evenly distributed along the top half of the scale. Influencing the low rating to a large degree was the highly important 3.b objective which was given a relatively low fulfillment rating. Results are displayed in Table 16.

Table 16

Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	5	7	35
b	5	8	40
c	10	8	80
2. a	15	6	80
b	5	6	30
3. a	25	9	225
b	25	5	125
c	10	9	90
			705

Respondent #9

Hudson index of self-esteem. As shown in Figure 1, self-esteem was not problematic for this individual

either before or after the program however some deterioration did take place as indicated by an increase in the level of scores between the pretest and posttest. The individual evidently saw herself in a less favorable way after the program than before.

Self-anchored scale #1. At the start of the program, the feeling toward the use of stress management was only moderately positive (see Figure 2). An increase in the level of scores however constituted an improvement in attitude over the course of the intervention.

Self-anchored score #2. As with the first scale, there was stronger agreement to use strategies after the program than there was before (see Figure 3). A comparison of pretest and posttest data shows an improvement of one interval, bringing the posttest score to the top of the scale.

Symptoms checklist. Shown in Table 17 are the symptoms and results indicated on two administrations of the checklist.

Of 12 symptoms rated, on the pretest 2 were placed in the slight discomfort category while 10 were rated as causing moderate discomfort. Improvement in relation to 10 symptoms took place with all 12 symptoms rated in the slight discomfort range after the program. Clinically significant change occured in relation to 83% (10) of symptoms rated.

Table 17

Symptoms Checklist Raw Scores for Respondent #9

Note: Scores 1-3 = slight discomfort, 4-7 = moderate discomfort, 8-10 = extreme discomfort.

Symptoms	Pretest	Posttest
Anxiety re: spouse	3	1
Anxiety re: parents	7	3
Anxiety re: "sister and family"	5	2
Anxiety, general	5	2
Powerlessness	6	3
Anger	4	2
Irritability	5	2
Muscular tension	4	2
Physical pain/illness	3	1
Sleeping difficulties	4	1
Fatigue	4	1
Neckaches	5	2

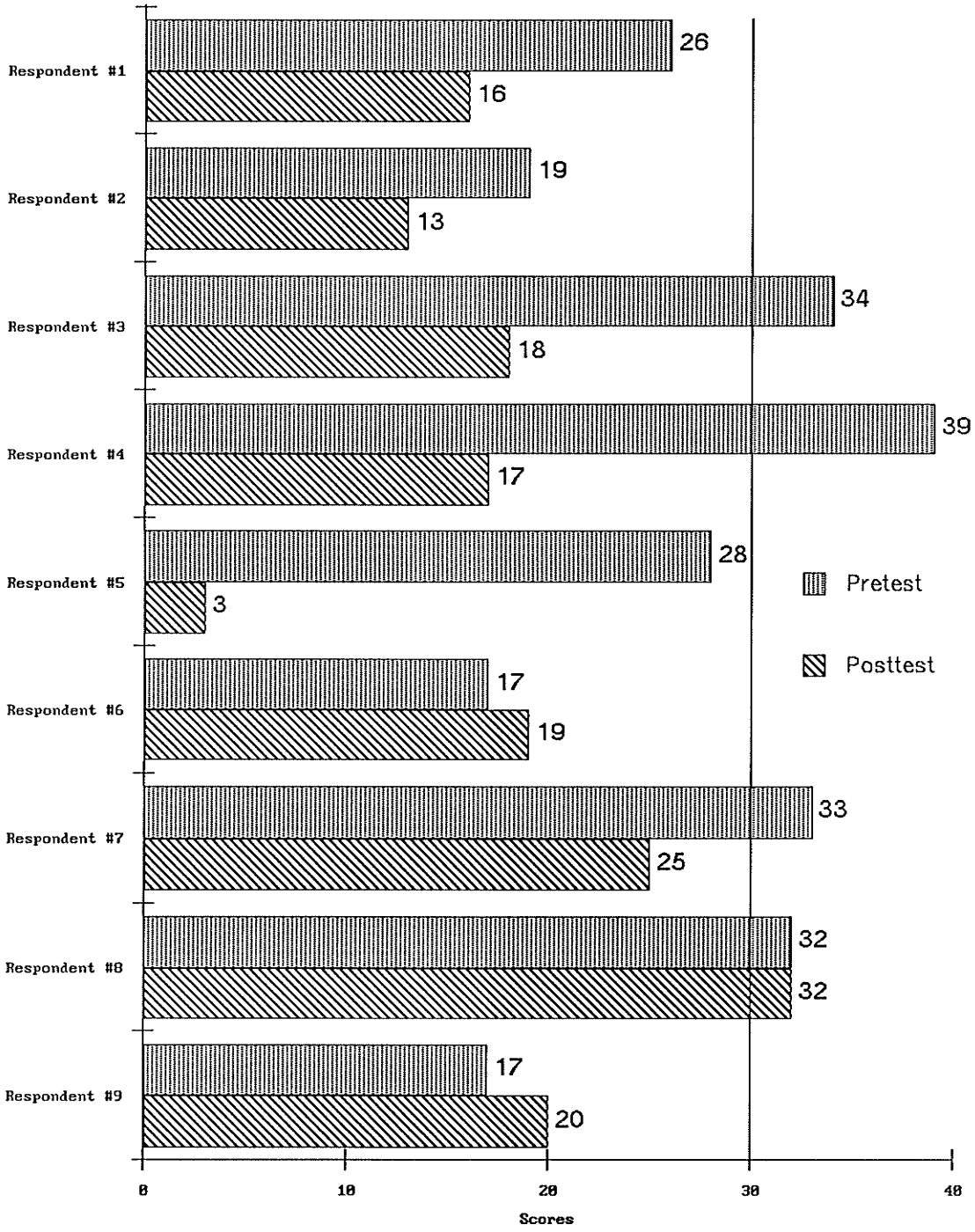
Learning objectives measure. Presenting an index score of 660, the respondent evidently felt the lowest sense of objective fulfillment out of all the group members. While the two most important objectives received relatively high ratings, the remainder were rated either moderately or toward the low end of the scale. This pattern would indicate that little effort

was given to understand content deemed less important however low fulfillment of objectives could also be due to a wide variety of possible factors such as too much content presented in too little time (overload), or lack of clarity in its communcation. The fact that this respondent attended all ten sessions would indicate that the apparent lack of learning objective fulfillment did not have a discouraging effect. Table 18 shows results.

Table 18

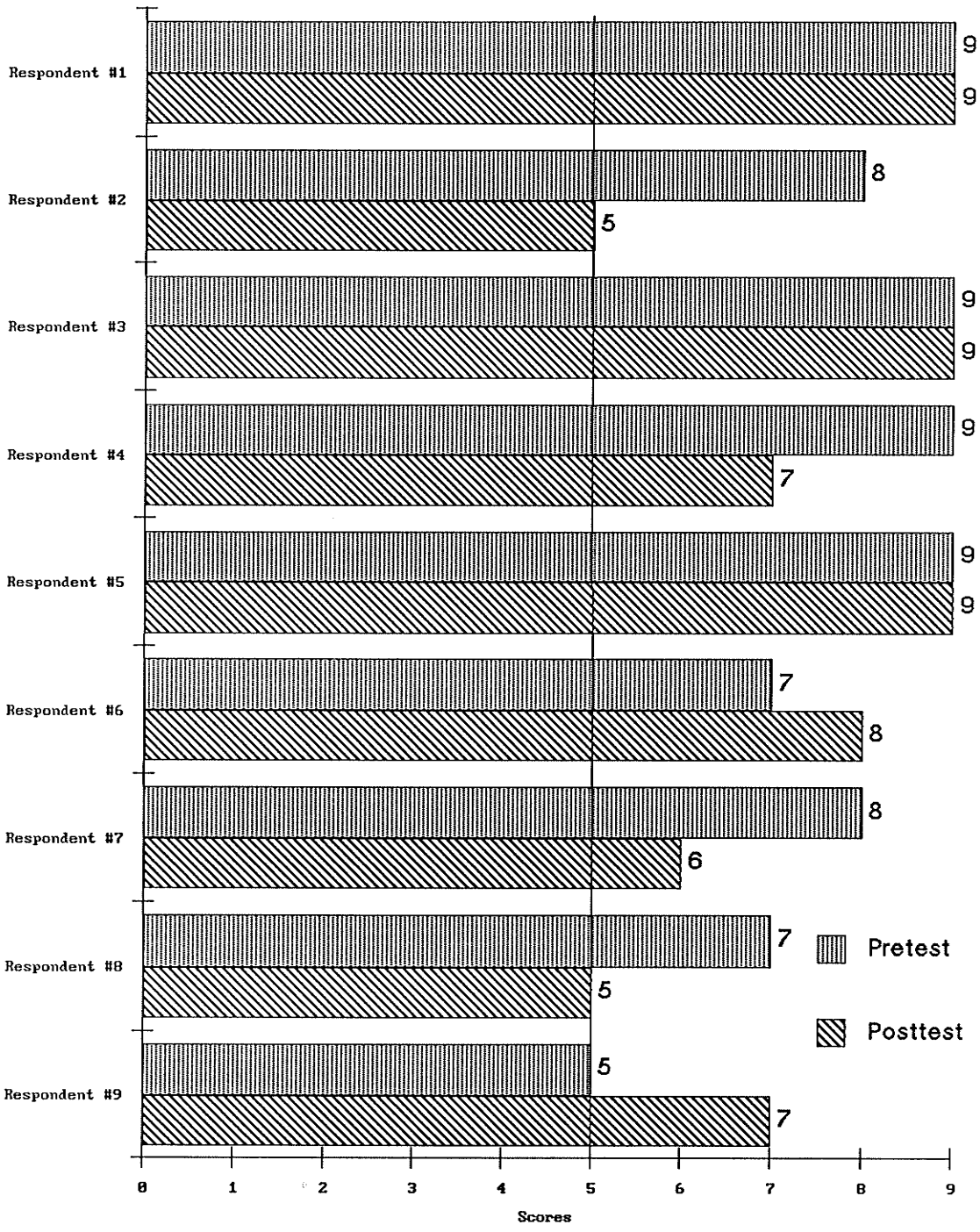
Objectives	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
1. a	20	8	160
b	10	3	30
c	5	4	20
2. a	5	6	30
b	10	6	60
3. a	25	9	225
b	15	5	75
c	10	6	60
			660

FIGURE 1
Individual Scores for the Hudson Index of Self-Esteem
(Hudson, 1982)



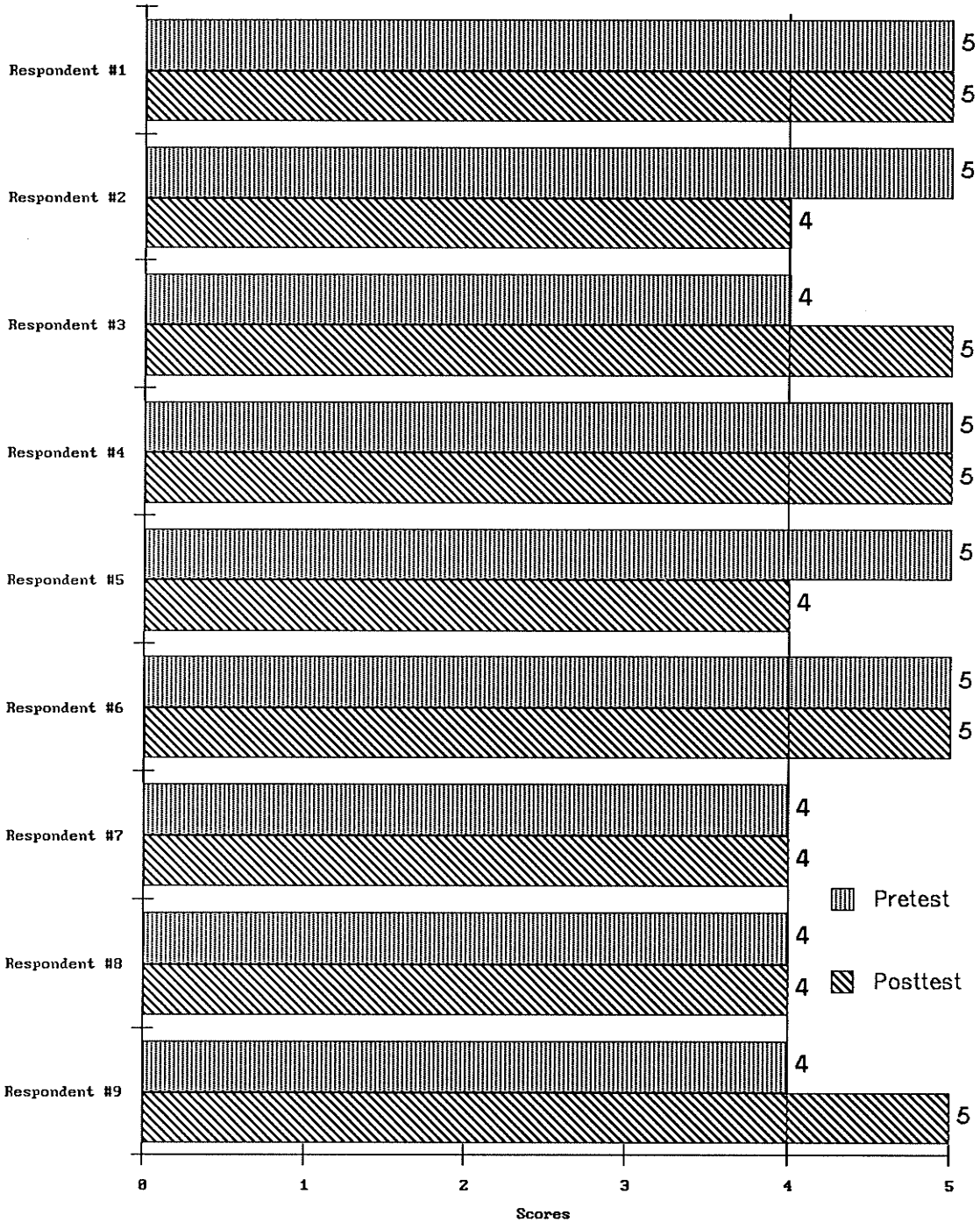
>=31 = Clinically Significant Problem
<=30 = No Clinically Significant Problem

FIGURE 2
Individual Scores for the Self-Anchored Scale Measuring Attitude



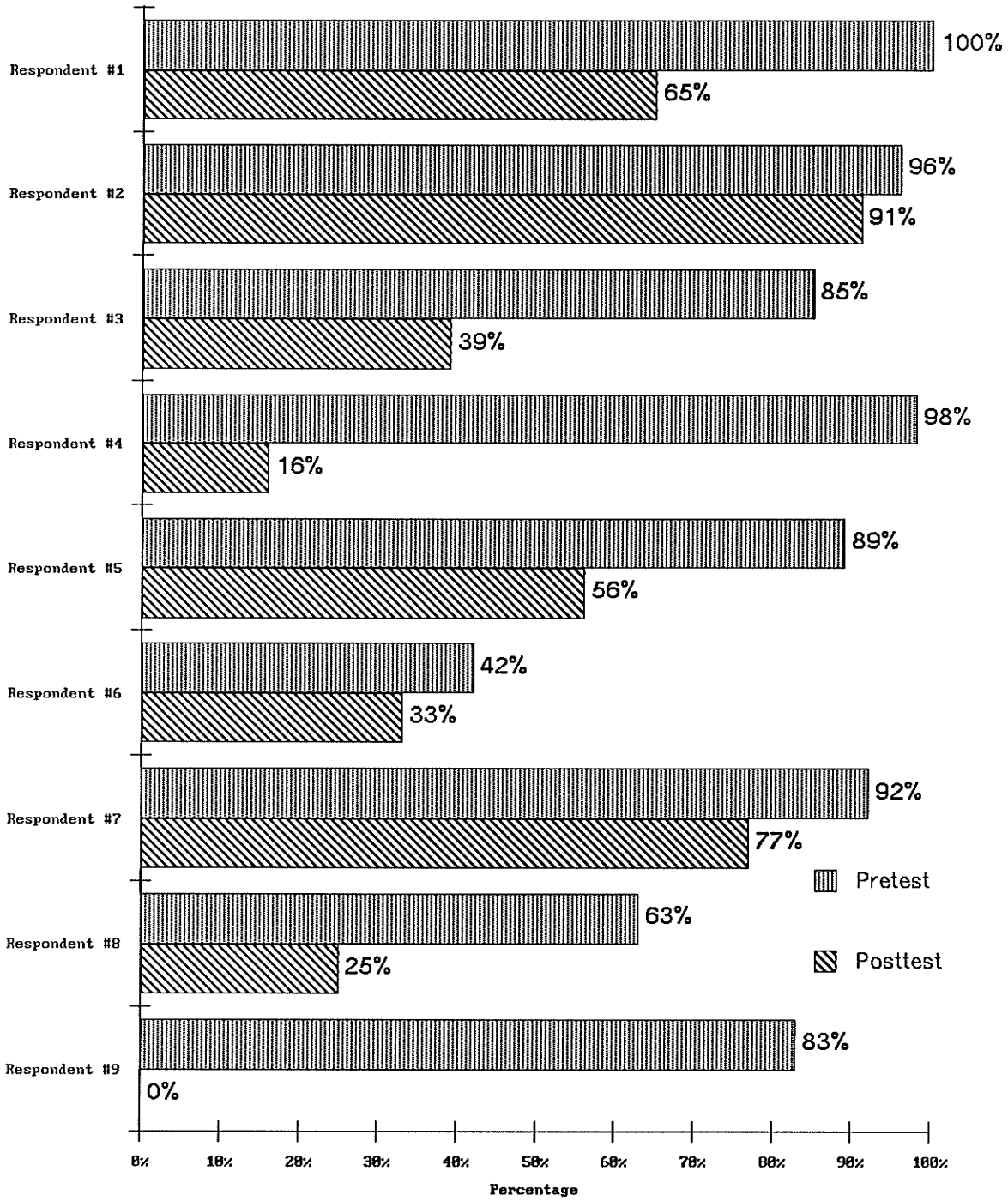
>= 5 = A Positive Attitude Toward Using Stress Management Strategies
<= 4 = No Positive Attitude Toward Using Stress Management Strategies

FIGURE 3
Individual Scores for the Self-Anchored Scale Measuring Behavioral Intent



>= 4 = Intent to use Stress Management Strategies
<= 3 = No Intent to use Stress Management Strategies

FIGURE 4
Percentage of Symptoms for Each Respondent that Caused a Clinically Significant Degree of Discomfort
(Moderate or Extreme Discomfort)



Results of the Program Evaluation

The program evaluation (Appendix I) is divided into three sections: a) effectiveness of methods, b) group leader effectiveness, and c) the general program. A general discussion of results relating to these sections is provided here followed by a display of results in Table 19. General comments and suggestions by group members are also provided.

All of the respondents rated the large group discussions, in-session exercise, group leader presentation, and aids as being effective to extremely effective. The small group discussions were given lower ratings. The majority of respondents found the take-home exercises effective however two were neutral on this subject.

In terms of being effective overall, knowledgeable, well-prepared, responsive, communicative, encouraging, and facilitative of communication, all group members found the group leader to be very

In response to the various statements presented about the program in general, the large majority of respondents indicated agreement or strong agreement. One individual was neutral in terms of whether information desired had been received while another was neutral in response to the clarity of content.

Intertestingly, seven respondents felt that ten sessions was <u>just right</u> while two felt that this number was <u>too few</u>.

Table 19

Program Evaluation

For each of the following items, please circle the rating that best represents your opinion. (Numbers in brackets indicate number of respondents.)

EFFECTIVENESS OF METHODS

	Extremely Non-Effective	Very Non-Effective	Non-Effective	Neutral	Effective	Very Effective	Extremely Effective
3. Large Group Discussions	1	2	3	4	5 (3)	6 (3)	7 (3)
4. Small Group Discussions	1	2	3 (2)	4 (3)	5 (3)	6 (1)	7
5. In-session Exercises	1	2	3	4	5 (2)	6 (4)	7 (3)
6. Take-home Exercises	1	2	3	4 (2)	5 (3)	6 (4)	7
7. Group Leader Presentation	1	2	3	4	5	6 (6)	7 (3)
8. Aids (flip chart, film, overhead, handouts)	1	2	3	4	5 (2)	6 (6)	7 (1)

GROUP LEADER EFFECTIVENESS

9. Overall, was the group leader effective?	1	2	3	4	5	6 (6)	7 (3)
10. Was the group leader knowledgeable about stress and selected stress management methods?	1	2	3	4	5	6 (4)	7 (5)
11. Did the group leader help you learn about stress and selected stress management methods?	1	2	3	4	5 (1)	6 (4)	7 (4)

GROUP LEADER EFFECTIVENESS CONT'D

	Extremely Non-Effective	Very Non-Effective	Non-Effective	Neutral	Effective	Very Effective	Extremely Effective
12. Was the group leader well prepared?	1	2	3	4	5	6 (3)	7 (6)
13. Was the group leader responsive to the needs of group members?	1	2	3	4	5	6 (5)	7 (4)
14. Was the group leader an effective communicator?	1	2	3	4	5	6 (4)	7 (5)
15. Was the group leader effective in helping the group maintain its focus?	1	2	3	4	5 (1)	6 (5)	7 (3)
16. Was the group leader effective in guiding group interaction?	1	2	3	4	5 (2)	6 (4)	7 (3)
17. Was the group leader effective in involving all group members in discussion?	1	2	3	4	5 (1)	6 (4)	7 (4)
18. Did the group leader encourage the expression of members' thoughts and feelings on topics relevant to the group?	1	2	3	4	5	6 (5)	7 (4)
19. Was the group leader effective in facilitating communication among group members?	1	2	3	4	5	6 (4)	7 (5)

20. Additional Comments: _____

_____

_____

_____

THE GENERAL PROGRAM

Please circle the rating which represents your level of agreement regarding the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
21. The information presented about stress and stress management was meaningful to me personally.	1	2	3	4 (3)	5 (6)
22. I am more aware of stress in my daily life as a result of having participated in the program.	1	2	3	4 (3)	5 (5)
23. My ability to cope with stress has increased as a result of having participated in the program.	1	2	3	4 (4)	5 (5)
24. I received the information I wanted from the program.	1	2	3 (1)	4 (2)	5 (6)
25. The content was appropriate to the time available.	1	2	3	4 (3)	5 (6)
26. The content was useful to me.	1	2	3	4 (3)	5 (6)
27. The content was clear.	1	2	3 (1)	4 (2)	5 (6)
28. The content was well organized.	1	2	3	4 (2)	5 (7)
29. Overall, I am satisfied with the program.	1	2	3	4 (3)	5 (6)

30. In your opinion, the number of sessions was (check one):

1. Too many ____ 2. Too few 2 3. Just right 7

31. How can the program be improved? _____

_____

_____

32. Additional Comments: _____

_____

April 7, 1986

Comments

Respondent #1. "Our group leader was very helful to all group members. She was sensitive and flexible enough to become just another group member when appropriate, or to maintain control and direct the group when needed. Her actions conveyed a relaxed, postive attitude in general. She seemed to practice what she preached which in turn assured me that increasing power over stress was in the realm of the possible."

Suggestions for improvement. "a) add weekly PRT exercises, b) add a couple of stress inoculation exercises, c) reduce classroom time spent on 'what is stress' in order to allow for exercises, e.g. session 1-4 could be speeded up just a bit."

Respondent #2. "Group leader was trying a little too hard at first to gear the course to the needs of the class. After a couple of classes the group leader showed much more confidence and direction (possibly trying to figure out the needs of the class)."
"Handouts are excellent."

Suggestions for improvement. "Possibly fewer classes for 3-4 hours."

Respondent #3. "I found the group leader encouraging comments from all members of the group - no one member dominated the group. I believe everyone

felt comfortable - it was an excellent group to participate in. The information was very thorough, interesting, and obviously a lot of effort had been put into collecting, preparing, and researching. The effort was most appreciated."

Suggestions for improvement. "I would like to see an advanced course developed in order to strengthen stress coping techniques plus further my education about stress. It is obviously a very complex subject with many avenues yet to explore. I believe an advanced course would in fact actually put into practice much of what was learned in this course as well as deepen the understanding of stress. To me it would be the total and complete enhancement of the course."

Respondent #4. "I would like to attend more programs like this one."

Suggestions for improvement. "Repetition."

Respondent #5. (no comments)

Respondent #6. "I felt the leader was well prepared and able to lead the group effectively. This was my first stress conference and I did not have any preconceived ideas of what it would or should contain and therefore did not personally have any set goals."

"I felt the handouts were excellent and intend to re-read them. Unfortunately I was unable to read them all during the sessions."

Suggestions for improvement. "I realize the need in this program (thesis) for the time spent on program objectives, but feel in future this could be just a short introduction."

Respondent #7.

Suggestions for improvement. "Need more time to cover take-home material in class."

Respondent #8. "The group leader (volunteered) to have a session for several group members who could not attend the regular session in order to prepare the members for the upcoming session."

Respondent #9. (no comments)

Group Results

Hudson Index of Self-Esteem

Group results for the ISE are shown in Table 20. At the pretest, five (56%) group members presented scores below the cutting point indicating the presence of high self-esteem. Of these, three (33%) experienced an increase in self-esteem while two (22%) presented scores showing a slight deterioration over the course of the program. All five individuals however were

classified as having high self-esteem at both the pretest and posttest. At the start of the intervention, four (44%) group members were assessed as having low self-esteem and of these, three (33%) experienced a clinically significant improvement in this area while one (11%) continued to have low self-esteem at the posttest.

Table 20

Group results for the

Hudson Index of Self-Esteem (Hudson, 1982)

		> = 31	<= 30
N	Pretest	4	5
	Posttest	1	8

Note: > = 31 = Clinically significant problem

< = 30 = No clinically significant problem

Self-Anchored Scale Measuring Attitude

As shown in Table 21, all nine (100%) group members felt positively toward using stress management strategies at the outset and termination of the intervention. Three (33%) members felt completely positive both before and after the program while four (44%) remained positive but indicated a decrease in the degree of positive feeling at the posttest. Two

members (22%) presented posttest scores showing that an improvement in attitude had occured (see Figure 2).

Table 21

Group results for the

Self-Anchored Scale Measuring Attitude

		> = 5	<= 4
N	Pretest	9	0
	Posttest	9	0

Note: >= 5 = A positive attitude toward using stress management strategies

<= 4 = No positive attitude toward using stress management strategies

Self-Anchored Scale Measuring Behavioral Intent

All respondents (100%) at the pretest and posttest said that they intended to use stress management strategies beyond the time period of the program, as shown in Table 22. Five (56%) members presented no change in their level of agreement with the presented statement over time while two (22%) indicated a decrease in the extent to which they agreed. Two respondents (22%) agreed more with the statement after the program than before, showing improvement (see Figure 3).

Table 22

Group results for the

Self-Anchored Scale Measuring Behavioral Intent

		>= 4	<= 3
N	Pretest	9	0
	Posttest	9	0

Note: >= 4 = Intent to use stress management strategies

<= 3 = No intent to use stress management strateiges

Learning Objectives Measure

Group results are shown in Table 23. Reflecting the results of the one administration of this measure, six (67%) respondents presented index of objective fulfillment scores that indicated the opinion that learning objectives had been adequately fulfilled. Three (33%) individuals gave scores below the cutting point, indicating that overall, objectives had not been adequately met for them. The reader is asked to refer to the individual results of this measure as well as to the "conclusion" portion of this report for more detailed data concerning individual objectives.

Table 23

Group results for the

Learning Objectives Measure

	>= 751	<= 750
N Single Administration	6	3

Note: >= 751 = Indication of objective fulfillment

<= 750 = Indication of inadequate objective fulfillment

DISCUSSION

Review of Purpose and Objectives

This practicum involved the development and implementation of a stress management program for interested employees at the Manitoba Telephone System. Employing the structured group approach as the mode of intervention, the purpose of the group was to facilitate the acquistion of pertinent knowledge about stress and to enable group members to gain experience in the use of stress management methods that could serve to enhance their ability to cope with stressful situations.

The evaluation results indicate that to varying degrees the intervention was successful in facilitating the fulfillment of objectives. Conclusions to this effect will now be discussed and the objectives are re-stated as follows:

1. Members will develop an understanding of:
    a) how integrated patterns of psychological and biological responses to environmental demands characterize the stress response,
    b) how the stress response has become a potential cause of disease,
    c) common, potential occupational and life stressors.
2. a) Members will develop an awareness of the role social support plays in modifying the stress response.

b) The program will enable members to identify personal supportive relationships and to identify steps for improving their relationships.

3. Members will develop an understanding of and gain experience in the use of the following stress management strategies:
   a) progressive relaxation,
   b) stress inoculation,
   c) combating distorted thinking.
4. Members will report a heightened sense of self-worth as measured by the Hudson Index of Self-Esteem.
5. Members will report a reduction in the degree of discomfort attributed to specific stress-related symptoms as measured by a Symptoms Checklist.
6. Members will report a more favorable attitude toward the personal use of stress management strategies as measured by a self-rating scale.
7. Members will report an intent to use stress management strategies beyond the time period of the program as measured by a self-rating scale.

Developing an Understanding of Important Stress-Related Content

In an earlier discussion of individual results, the results of the Learning Objectives Measure

(Appendix H) were discussed mainly in terms of the index of objective fulfillment scores which are composite scores that take into account the degree of personal importance that each objective has as well as the degree to which each is fulfilled.

In this discussion of the intervention's success in meeting objectives, the degree to which members felt that each objective represented in the Learning Objectives Measure was fulfilled will be examined more closely. Such examination is important in light of the fact that more specific information regarding objective fulfillment is revealed when results in relation to each objective are considered individually. Also, while the index score is said to reflect a general feeling of objective fulfillment (taking into account the personal importance of objectives), it does not reflect member's feelings of how well individual objectives had been met for them.

On the Learning Objectives Measure, members were asked to rate how well each objective had been met for them on a scale of 0 (low) to 10 (high). Results in relation to each objective will now be discussed in terms of a suggested cutting score of five, meaning that people who scored five or more felt that the objectives had been met.

Results from the Learning Objectives Measure indicate that the majority of group members did develop

an understanding of how integrated patterns of psychological and biological responses characterize the stress response. Four (44%) respondents said that for them, this objective had been met to the highest degree while four (44%) said that they had developed understanding although to a variety of lesser degrees. One member did not present a rating. Thus all group members who rated the objective (89%) felt that they had acquired understanding in relation to the stress response, although one respondent felt that the level of understanding had been only moderate.

Understanding in relation to how the stress response has become a potential cause of disease was developed to a lesser extent for some members. Four (44%) respondents indicated that the highest degree of understanding in relation to this objective was obtained while three (33%) said they had gained understanding, although to a more moderate degree. Two (22%) group members, presenting low scores, evidently felt that they did not gain adequate understanding of how stress leads to disease.

Most respondents said that they had developed a relatively high degree of understanding in regard to potential occupational and life stressors. Five (56%) said that they had developed the highest degree of understanding while two (22%) presented high, although more moderate scores. One (11%) respondent said that

the level of understanding gained had been only moderate while another (11%) indicated the acquisition of an inadequate degree of understanding.

Awareness of Social Support and Identifying Steps for Improving Relationships

All group members appear to have developed an adequate level of awareness of the role social support plays in modifying the stress response as indicated by all scores presented above the cutting point. Specifically, six (67%) respondents gave relatively high scores indicating a high level of awareness gained while two (22%) presented lower scores indicating that a more moderate level of awareness had been developed. One member did not respond.

The overall feeling was not as strong that group members had been adequately enabled to identify personal supportive relationships and to identify steps toward relationship improvement. Only three (33%) members gave a relatively strong indication that this objective had been met while six (67%) felt that they had been enabled to carry out these functions in a more moderate way.

Gaining Understanding and Experience in Relation to Methods of Stress Management

A large majority of group members gave a relatively strong indication that they felt they had developed an understanding of and gained experience in progressive relaxation training.

Four (44%) members said that this objective had been fulfilled to the highest degree while four (44%) presented relatively high scores indicating a strong degree of objective fulfillment for them. Only one (11%) respondent said that the objective had been moderately met.

The understanding and experience gained in regard to stress inoculation appears less strong overall than it was for progressive relaxation training. Only two (22%) respondents felt that the objective had been fulfilled to the highest degree while three (33%) presented relatively high scores. Three (33%) respondents gave scores at the cutting point indicating that the level of understanding and experience gained had been only moderate while one member did not respond.

The level of understanding and experience gained in relation to combating distorted thinking was rated as being relatively high by five (56%) group members. One (11%) respondent presented a score at the cutting point while two (22%) gave slightly higher scores

indicating adequate but more minimal fulfillment of the objective.

To summarize the data obtained by the Learning Objectives Measure, results indicate that the intervention was successful in facilitating the achievement of the learning objectives for the majority of group members. A large majority of respondents indicated to varying degrees that they had developed an understanding of how integrated patterns of psychological and biological responses characterize the stress response. How the stress response has become a potential cause of disease was not adequately understood by some members however the majority said that the development of understanding in relation to this subject was adequate to a moderate or high degree. Most respondents indicated that they had developed an understanding of potential occupational and life stressors to a moderate to high degree while a small majority felt that the fulfillment of this objective was inadequate.

Most members gave a relatively strong indication that they had developed an awareness of the role social support plays in modifying the stress response. There was a positive but less strong feeling that members were enabled to identify personal supportive relationships and to identify steps for improving their relationships.

Developing understanding and gaining experience in relation to progressive relaxation training was the objective most highly rated in terms of fulfillment. This may have been due to the fact that the method is inherently pleasant and that two sessions were devoted to its practice.

Respondents felt less strongly that they had developed understanding and gained experience in relation to stress inoculation although the members who rated the objective gave it moderate to high fulfillment scores. In relation to combating distorted thinking, respondents felt for the most part that they had achieved adequate understanding and experience.

While it appears that the Tele-Cope program succeeded in facilitating the achievement of the learning objectives for the majority of group members, it seems useful to speculate on reasons why some members developed a moderate or low degree of understanding in relation to featured topics. For instance, as was pointed out earlier, close inspection of the Learning Objectives Measure indicates that in some instances, the less importance an objective was rated as having, the less fulfilled it became. One hypothesis to explain this may be that members might not have put forward the effort required to fulfill an objective that was of little personal importance.

As well, the topics of stress as a cause of disease and the identification of supportive relationships and steps for relationship improvement (areas which were given lower fulfillment ratings) were presented primarily as take-home articles and exercises; only a minority of members said they had had the time to review such material. Lastly, as reflected in the feedback obtained by the Program Evaluation, some participants felt the degree of content included in the program to be excessive and therefore perhaps stress-producing, thus possibly preventing adequate integration.

Developing a Heightened Sense of Self-Worth

Results of the Hudson Index of Self-Esteem (Hudson, 1982) (Appendix E) indicate that most group members increased their level of self-esteem during the time that they participated in the Tele-Cope program. Data reveals that three out of four participants who reported the presence of low self-esteem at the start of the program experienced clinically significant improvement in this area during the time that the group was active. The fourth member reported the same level of low self-esteem both before and after the program. Change was therefore clinically significant in 33% of the total number of subjects or in 75% of subjects initially indicating low self-esteem.

Of the five group members who did not have low self-esteem at the program's outset, three said that they improved in this area despite not having difficulty to begin with. Two members reported a slight deterioration in their level of self-esteem following the intervention although not nearly enough to indicate the presence of any difficulty.

It is important to note that the low starting scores of those respondents not having low self-esteem would have the effect of limiting the degree of improvement that was likely to occur (Bloom and Fischer, 1982:434). Thus an individual having high self-esteem prior to the intervention would not experience a substantial improvement in this area as there would not be significant opportunity to improve. In fact the greatest degree of change did occur in those subjects who reported self-esteem as problematic to begin with.

It is hypothesized that the process of learning about stress and becoming more aware of various resources that can be used to gain mastery in response to stress helped to raise these group member's sense of self-worth. Also, the process of being part of a mutual aid system such as that found in group work may have helped members to experience a sense of significance in relation to attempting to facilitate a positive change in the lives of others.

Reducing Discomfort Associated With Stress-Related Symptoms

As shown by the results of the Symptoms Checklist (McKay et al, 1981:6-7; Davis et al, 1982:12-13) (Appendix G), all group members reduced their level of discomfort felt in relation to at least some stress-related symptoms to a degree that was clinically significant during the time of their participation in the program. The fact that all members benefitted to some degree in this regard would be a further indication of the program's effectiveness (Jehu, 1985:52).

While the results do indicate a positive outcome in relation to this objective, it is interesting to note that all members reported some degree of clinically significant symptom relief even though a majority said that they did not practice the stress management skills outside of the program sessions. Three possibilities come to mind to explain this circumstance: the amount of skill members did acquire enabled them to achieve symptom relief, health-promoting measures independent of the program were taken to achieve symptom relief, and/or the intervention had a placebo effect meaning that if members believed the strategies were effective then they probably were for a time.

Independent measures and/or the placebo effect likely were factors to some degree as indicated by the fact that relief was reported to have occured in relation to some symptoms - ie. physical weakness and overeating - which would likely not have been influenced by the featured methods.

It is possible and desirable (although unknown) that the program did have the positive side effect of influencing members to practice general health-promoting behavior and in future studies this would be an interesting variable to evaluate.

Developing a More Favorable Attitude Toward the Personal Use of Stress Management Strategies

The stress management program had a limited impact on the development of a more favorable attitude toward the personal use of stress management among group members as shown by results obtained by the self-anchored scale measuring attitude (Appendix F).

The starting scores of three (33%) participants were at the highest level to begin with and while the program does not appear to have facilitated a deterioration in attitude it also may not have helped to heighten enthusiasm although any improvement could not be measured due to the maximum starting scores. While it is desirable that participants would have a highly positive attitude both before and after the

program, in the context of the objective the intervention cannot be said to have helped develop a more favorable attitude for these subjects. The program however, may have helped to sustain the positive attitudes.

A comparison of results of two (22%) group members shows that they did experience an increase in positive attitude over the course of the program. While these individuals were assessed as having a positive attitude at the start of the program as shown by scores at, or above the cutting point, their attitudes became even more positive.

While all scores of all members were presented at, or above the cutting point, indicating the presence of a positive attitude, deterioration did occur in relation to four (44%) group members meaning that they felt less positive toward the personal use of stress management after having been exposed to various methods. In comparing the scores of the self-anchored scale measuring attitude with the Learning Objectives Measure scores, for three of the members who experienced a deterioration in attitude, it does not appear that deterioration occured as a result of not understanding the methods. For one member who experienced deterioration, it seems that lack of understanding may have been a factor. It can be

concluded that the intervention had a limited impact on improvement of attitude toward using stress management.

An Increase in Intent to Use Stress Management Strategies

Data obtained by the scale measuring behavioral intent (Appendix F) shows that the program had a limited impact on whether or not participants intended to make use of stress management after the time period of the intervention.

Three (33%) participants strongly intended to use stress management both before and after the program and while the program was not seen as a factor contributing to an increase in intent (no increase could be recorded due to the limits set by the highest starting scores), like the possible relationship to attitude it may have helped to sustain these levels of strong intention. It is seen as positive that no deterioration in behavioral intent occured.

Two (22%) members expressed an intention to use stress management both before and after the program however they did not increase their degree of intent even though an opportunity to record improvement existed. Again the program may have had the effect of helping these members to sustain their levels of intent but did not appear to have helped increase them.

This circumstance of non-change for these members should be viewed in the context of high starting scores. Even though there was an opportunity for improvement perhaps it was unrealistic to have expected that all members would develop a "strong" intent to use stress management. Perhaps the levels indicated were "right" for the client and best "fit" his or her particular needs, personality, and agenda. Lack of improvement when both scores already reflect what is desired cannot be seen as a limitation of the intervention. Rather perhaps it can be seen more realistically as a success in light of the fact that no deterioration occured even though much opportunity was available on the scale to reflect this.

Two (22%) participants who intended to use stress management at the start of the program increased their level of intent over time. The program may have had a reinforcing effect in these cases.

Two (22%) other members however did not sustain their initially very strong intention to use stress management and while their posttest scores reflect a continuing positive intent, some deterioration did occur.

After the program it was encouraging to see that all participants still intended to use stress management and that the program may have had the desired effect of helping to sustain or increase

already positive levels of behavioral intent for the majority.

Summary

It can be concluded that over the course of the Tele-Cope program, the majority of group members did develop an understanding of pertinent stress-related content and awareness of the importance of social support in modifying the stress response. Members also gained understanding and experience in relation to the featured stress management strategies. Most members who had low self-esteem at the start of the program made a significant improvement in this area over the course of the sessions while all participants experienced some degree of significant relief from stress-related symptom discomfort. The program's effectiveness appeared to be limited in terms of helping members to develop a more favorable attitude toward the personal use of stress management and a stronger intent to make use of stress management although it is hypothesized that it may have helped members with initially strong attitudes and behavioral intent to sustain the intensity of these factors.

It should again be emphasized that causation cannot be concluded due to the type of research designs used in the Tele-Cope program.

Conclusions and Recommendations for Future Programming

This discussion of conclusions and recommendations will focus on those areas of particular salience to the writer following the practicum process.

The first point deals with an area of personal learning. After making use of the structured group approach in the context of social group work, it would seem that this combination of methods is a desirable practice mode for a beginning group worker. The combination is recommended for "beginners" (provided it is appropriate to purpose) because it allows for group exposure and initial skill development while entailing less ambiguity and greater predictability of process than a full mainstream approach. An important benefit to the worker is that it allows freedom to risk making use of developing skills while providing a "safety net" of planning, preparation, and a greater level of control than what is desirable in traditional group work. Another benefit inherent in this combination of models is the opportunity for the relinquishment of structure to a more group-centered style once the worker's sense of confidence and comfort in the group milieu becomes established and again, depending on group needs.

In addition to being a useful practice mode for workers beginning to develop group work skills, the

Tele-Cope experience emphasizes the need for any worker to have the resources available to shift from a structured approach to one that is group-centered. Because the group was so strongly in favor of "discussion and sharing", future structured groups would do well to assess the need for this and then to provide adequate opportunity for it to occur. This is not antithetical to the structured approach particularly when it is required to be used in the context of traditional social group work.

A second area of personal learning has to do with the distinction between learning and therapy. While some confusion over these concepts was present early in the practicum process, the group provided a context for the development of a clearer and more accurate understanding. At the beginning these concepts were assumed to represent mutually exclusive group purposes, however as the group progressed a close relationship between them became more evident. Like the structured and traditional group work models, the functions of learning and therapy came to be seen as complimentary, with group defintions becoming understood as a question of emphasis toward one or the other and not necessarily "either/or" as originally assumed. To illustrate, the Tele-Cope program was first defined as solely educational however because members engaged in problem-solving processes and because it is in the

nature of stress management interventions to encourage people to apply learning to stress-related problems, it was increasingly seen to also have a therapeutic function even though the emphasis remained on the learning process. A greater shift toward therapy in other stress management programs would likely mean more direct attempts to target and change individual problems through a more concerted process of mastering and applying skills. The outcome of this learning is a greater awareness on the part of the writer that educational and therapeutic group purposes need not be regarded in an "either/or" fashion and that a variety of group purposes may be possible depending on how the functions are combined and where the emphasis lay. Having a clear understanding of how group purposes might relate enables a group worker to be both more flexible and clear in determining a group's function.

Apart from these areas of personal learning, future attempts to develop and implement a program of stress management could benefit from several observations and recommendations arrived at through the process of carrying out the Tele-Cope program.

To begin, it is important to be aware that programs generally geared to groups of people may not adequately address the individual vulnerabilities that could precipitate participation to begin with. Lazarus and Folkman (1984:361-363) deal with this issue

extensively and it was originally brought to the writer's attention via the results of the Symptoms Checklist which indicated that all group members were experiencing some degree of significant stress-related symptom discomfort. As discussed in the evaluation section of this report, many symptoms were not amenable to the stress reduction techniques offered. This awareness underlines the importance of defining how programs created for "people in general" might be useful and this issue will now be considered.

First, in agreement with Lazarus and Folkman (1984:369), some people may be more amenable to dealing with personal problems through learning than through therapy (this point is also supported in the literature review) and general programs can help people obtain the knowledge they need in an atmosphere that is non-labeling. Second, if stress management were conceptualized as a series of stages (indeed, one group member indicated in her feedback a desire to participate in a more "advanced" program) the value of general programs may be in a) acting as a beginning stage in helping people to become more aware of stress and what can be done to manage it, and b) helping people to assess their own circumstances and motivating them to engage in a more therapeutic process if the general learning approach is insufficient. A general program could also provide an opportunity for the

worker to assess the needs of individuals and then to develop other forms of intervention based on the assessment. (For instance, the Learning Objectives Measure provided an opportunity for members to identify what objectives were important; these results could be highly useful in planning further directions for people in stress management.) While general programs can be useful for the reasons cited and perhaps for other reasons, it should be emphasized that such interventions should not be considered sufficient to meet certain levels of individual vulnerability.

Keeping in mind the potential strengths and limitations of general stress management programs, future similar programs could also benefit from the Tele-Cope group member's suggestions for improvement. For instance, content overload should be avoided by providing only that amount which can be easily integrated. Also, judging from a) the fact that most members did not complete take-home tasks, and b) the results of the Learning Objectives Measure which indicated that those areas of content provided to members in the form of take-home material were rated as not being well understood, future programs might do well to deal with content primarily in-session. Take-home tasks could be made available to those members wanting to increase their level of knowledge and skill.

A similar issue and one which was raised by some members in their feedback involves the amount of skill practice time that should be offered during program sessions. It is felt that Tele-Cope members were perhaps divided on this issue while some indicated a desire for more practice time, for others regular attendance seemed to be tied to the prospect of a new theme or skill offered each week. In the future a way of addressing this might be to ensure that the fundamentals of each stress management strategy be covered in-session and that sufficient practice time be provided so as to enable members to carry on independently while at the same time offering extra time to those interested in mastering the skills and/or in applying them to probems or issues in a more comprehensive way. In this respect a program could have an equal learning and therapeutic emphasis. Or as mentioned earlier, more "advanced" programs featuring a greater opportunity for mastery and for addressing concerns could be made available. The worker should be sensitive to member's needs regarding what they want from the intervention.

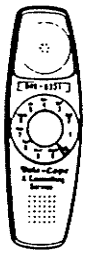
Another area to consider which became evident through group feedback involves group composition and the importance of using effective methods of outreach. The area is significant in the context of the Tele-Cope program because of the two outreach methods used to

attract participants (film/discussions and information/registration forms) only the forms were seen as being effective. This circumstance indicates the importance of assessing (ie. researching and determining what may have been effective previously) the best methods of outreach in a particular setting and of making use of more than one method. As the Tele-Cope experience clearly shows, individuals might respond to one method while not responding to another.

As the final and perhaps most important guideline for future stress management programs, the writer recommends a more generic, systemic, and balanced approach where the organization and the individual share the responsibility for managing stress. Emphasis in the Tele-Cope program was on helping to increase the coping capacity of individuals. In addition to this individual focus, future interventions should facilitate the removal of stressors from the workplace and from other social environments (primary prevention) in order to minimize those demands which people look for ways to manage.

APPENDIX A

INFORMATION/REGISTRATION FORM



Tele-Cope

(BT400) BOX 6666, 4th. FLR. - 200 PORTAGE AVE., WINNIPEG, MAN. R3C 3V6

WHAT IS TELE-COPE'S NEW PROGRAM? INCREASING POWER OVER STRESS

Your opportunity to explore stress as it relates to you personally.

A group effort to help you build on your own coping resources.

A chance to "explore-by-using" stress coping strategies such as muscle relaxation.

A valuable occasion to learn:

- about stressors in your life
- how thoughts can contribute to feelings of distress
- that stress is a result of your relationship with your environment
- how your mind and body come together to form a stress response
- the value of giving and receiving social support

The best learning takes place when we involve ourselves and when we take responsibility for our own personal development. "Increasing Power Over Stress" will emphasize group interaction, the active use of stress coping strategies and working together to increase our understanding of stress.

STRESS IS THE FOCUS . . . but mostly the Workshop is a unique way to learn about yourself. Each workshop consists of 10 sessions beginning the week of January 20, 1986. Spouses are welcome! Both offerings will be held at Tele-Cope, 4th Flr. Scotia Bank Bldg., 200 Portage Ave. on Tuesdays - 5:00 P.M. - 7:00 P.M. and Thursdays - 7:00 P.M. - 9:00 P.M.

Group Facilitator: Allyson Shpirko, in conjunction with Ken Theule
(For more information call Tele-Cope - 949 - 0331.)

REGISTRATION FORM

Forward registration form to Tele-Cope, BT 400 by THURSDAY, JAN. 2/86

Name: _____ Mail Code: _____

Name of Spouse, if planning to attend: _____

Workshop Selection: Tuesdays - 5-7 _____ Thursdays - 7-9 _____

Telephone Number: Business _____ Home _____

Allyson Shpirko will contact you by telephone prior to the program. Please circle the location at which you prefer to be reached.

APPENDIX B

EXPECTATION SURVEY

EXPECTATION SURVEY

1. What would you like to learn during this course in terms of information and skills?

2. What kinds of activities would you prefer not to get involved in?

3. What kinds of activities would make this course most enjoyable for you?

4. What would SUCCESS look like for you at the end of this course?

5. How can the instructor be most useful to you in your learning?

6. What contributions do you think you can make to the learning of others in the class?

APPENDIX C

SESSION EVALUATION

SESSION QUESTIONNAIRE

1. What do you consider to have been today's most valuable experience?

Why?

2. What aspect of today's program could have been strengthened?

How?

3. Any additional comments?

APPENDIX D

ROLE-PLAY SCENARIO

ROLE-PLAY

You are two acquaintances who meet at work periodically over coffee. You share some common interests and values and sometimes ask one another for advice regarding problems experienced in your respective departments.

Player #1: You have just experienced a very stressful situation and want to talk it over with your acquaintance. You also wish to become better friends with this person in the process. Role-play how you might go about eliciting the support you need while at the same time developing this potentially close friendship.

Player #2: You also wish to build on this friendship and are eager to lend support. Role-play the supportive behaviors you would deem appropriate in this situation.

Observers: Identify and write down "friendship building" skills displayed as well as types of supportive behaviors shown. You will be asked to describe the actual behaviors you saw and heard after the role-play.

APPENDIX E

HUDSON INDEX OF SELF-ESTEEM

INDEX OF SELF ESTEEM (ISE) **Today's Date** _____

NAME: _____

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 A good part of the time
5 Most or all of the time

Please begin.

1. I feel that people would not like me if they really knew me well _____
2. I feel that others get along much better than I do _____
3. I feel that I am a beautiful person _____
4. When I am with other people I feel they are glad I am with them _____
5. I feel that people really like to talk with me _____
6. I feel that I am a very competent person _____
7. I think I make a good impression on others _____
8. I feel that I need more self-confidence _____
9. When I am with strangers I am very nervous _____
10. I think that I am a dull person _____
11. I feel ugly _____
12. I feel that others have more fun than I do _____
13. I feel that I bore people _____
14. I think my friends find me interesting _____
15. I think I have a good sense of humor _____
16. I feel very self-conscious when I am with strangers _____
17. I feel that if I could be more like other people I would have it made _____
18. I feel that people have a good time when they are with me _____
19. I feel like a wallflower when I go out _____
20. I feel I get pushed around more than others _____
21. I think I am a rather nice person _____
22. I feel that people really like me very much _____
23. I feel that I am a likeable person _____
24. I am afraid I will appear foolish to others _____
25. My friends think very highly of me _____

3,4,5,6,7,14,15,18,21,22,23,25

FIGURE 6.3.

APPENDIX F

SELF-ANCHORED SCALES

1. How positively do you feel about using stress-management strategies?

1	2	3	4	5	6	7	8	9
Feel Not At All Positive				Feel Moderately Positive				Feel Completely Positive

---

2. I intend to use stress management strategies beyond the time period of the program.

1	2	3	4	5
Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree

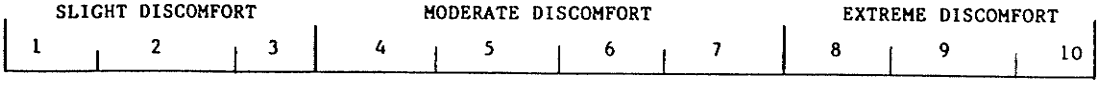
APPENDIX G

SYMPTOMS CHECKLIST

SYMPTOMS CHECKLIST

Symptom relief can be achieved through the use of stress intervention techniques. So that you can determine exactly which symptoms you want to work on, complete the following checklist. This symptoms checklist will tell you a great deal about how you respond to stress. Depending on the nature of stress in your life and your unique response to it, different techniques will be more helpful to you than others. After you have mastered the stress intervention techniques that work best for you, return to this checklist and use it to measure your symptom relief.

Rate your stress-related symptoms below for the degree of discomfort they cause you, using this 10 - point scale.



Symptom (Disregard those you don't experience)	Degree of Discomfort (1-10) NOW	Degree of Discomfort (1-10) after Mastering Stress Intervention Techniques
Anxiety in specific situations		
Tests		
Deadlines		
Interviews		
Other _____		
Anxiety in personal relationships		
Spouse		
Parents		
Children		
Other _____		
Anxiety, general - regardless of the situation or the people involved		
Depression		
Hopelessness		
Powerlessness		
Poor Self-esteem		
Hostility		
Anger		

	Degree of Discomfort (1-10) NOW	Degree of Discomfort (1-10) after Mastering Stress Intervention Techniques
Irritability		
Resentment		
Phobias - specify object or situation		
_____		
_____		
Fears		
Obsessions, unwanted thoughts		
Muscular tension		
Procrastination		
Overeat		
Smoking		
Problem drinking		
Gambling		
Overspending		
Physical pain/illness		
Compulsions		
Insomnia		
Sleeping difficulties		
Fatigue		
Unwanted sexual fantasies		
Unwanted sexual behavior		
Perfectionism		
Ineffective problem solving		
High blood pressure		

	Degree of Discomfort (1-10) NOW	Degree of Discomfort (1-10) after Mastering Stress Intervention Techniques
Headaches	_____	_____
Neckaches	_____	_____
Backaches	_____	_____
Indigestion	_____	_____
Irritable bowel	_____	_____
Ulcers	_____	_____
Chronic constipation	_____	_____
Chronic diarrhea	_____	_____
Muscle spasms	_____	_____
Tics	_____	_____
Tremors	_____	_____
Obesity	_____	_____
Physical weakness	_____	_____
Other _____		
_____ . . .	_____	_____

Important: Physical symptoms may have purely physiological causes. You should have a medical doctor eliminate the possibility of such physical problems before you proceed on the assumption that your symptoms are completely stress - related.

(A note about guilt: Guilt has not been included in the symptoms checklist because it is a hybrid emotion. Guilt is usually a combination of anxiety and anger. You are afraid you'll be rejected for your actions, or that you'll lose self-esteem in your own eyes. You also may feel angry with the person who "makes you feel guilty".)

APPENDIX H

LEARNING OBJECTIVES MEASURE

"INCREASING POWER OVER STRESS"

INSTRUCTIONS:

1. Check off those objectives which are important to you. (Column "B")

2. Rank your objectives by distributing 100 points among objectives checked. e.g. most important objective - highest number of points. (Enter into Column "C") (Must add up to 100 points)

3. At the conclusion of the seminar, evaluate each objective checked on a scale of 0 (low) to 10 (high), to indicate how well each objective was met for you. (Column "D")

4. Multiply Column "C" x Column "D" and enter figures into Column "E".

5. Add up Column "E". (it should total 100 or less.)

OBJECTIVES:	B	C x	D	E
1. To develop an understanding of:	Check	Degree of Importance	Degree of Fulfillment	Index Objective Fulfillment
(a) how integrated patterns of psychological and biological responses to environmental demands characterize the stress response,				
(b) how the stress response has become a potential cause of disease,				
(c) common, potential occupational and life stressors.				
2. (a) To develop an awareness of the role social support plays in modifying the stress response.				
(b) To enable group members to identify personal supportive relationships and to identify steps for improving their relationships.				
3. To develop an understanding of and gain experience in the use of the following stress management strategies. (a) progressive relaxation,				
(b) stress innoculation,				
(c) Combating distorted thinking.				
		100		

APPENDIX I

PROGRAM EVALUATION

Program Evaluation

For each of the following items, please circle the rating that best represents your opinion.

EFFECTIVENESS OF METHODS

	Extremely Non-Effective	Very Non-Effective	Non-Effective	Neutral	Effective	Very Effective	Extremely Effective
3. Large Group Discussions	1	2	3	4	5	6	7
4. Small Group Discussions	1	2	3	4	5	6	7
5. In-session Exercises	1	2	3	4	5	6	7
6. Take-home Exercises	1	2	3	4	5	6	7
7. Group Leader Presentation	1	2	3	4	5	6	7
8. Aids (flip chart, film, overhead, handouts)	1	2	3	4	5	6	7

GROUP LEADER EFFECTIVENESS

9. Overall, was the group leader effective?	1	2	3	4	5	6	7
10. Was the group leader knowledgeable about stress and selected stress management methods?	1	2	3	4	5	6	7
11. Did the group leader help you learn about stress and selected stress management methods?	1	2	3	4	5	6	7

GROUP LEADER EFFECTIVENESS CONT'D

	Extremely Non-Effective	Very Non-Effective	Non-Effective	Neutral	Effective	Very Effective	Extremely Effective
12. Was the group leader well prepared?	1	2	3	4	5	6	7
13. Was the group leader responsive to the needs of group members?	1	2	3	4	5	6	7
14. Was the group leader an effective communicator?	1	2	3	4	5	6	7
15. Was the group leader effective in helping the group maintain its focus?	1	2	3	4	5	6	7
16. Was the group leader effective in guiding group interaction?	1	2	3	4	5	6	7
17. Was the group leader effective in involving all group members in discussion?	1	2	3	4	5	6	7
18. Did the group leader encourage the expression of members' thoughts and feelings on topics relevant to the group?	1	2	3	4	5	6	7
19. Was the group leader effective in facilitating communication among group members?	1	2	3	4	5	6	7

20. Additional Comments: _____

THE GENERAL PROGRAM

Please circle the rating which represents your level of agreement regarding the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
21. The information presented about stress and stress management was meaningful to me personally.	1	2	3	4	5
22. I am more aware of stress in my daily life as a result of having participated in the program.	1	2	3	4	5
23. My ability to cope with stress has increased as a result of having participated in the program.	1	2	3	4	5
24. I received the information I wanted from the program.	1	2	3	4	5
25. The content was appropriate to the time available.	1	2	3	4	5
26. The content was useful to me.	1	2	3	4	5
27. The content was clear.	1	2	3	4	5
28. The content was well organized.	1	2	3	4	5
29. Overall, I am satisfied with the program.	1	2	3	4	5

30. In your opinion, the number of sessions was (check one):

1. Too many _____ 2. Too few _____ 3. Just right _____

31. How can the program be improved? _____

_____

_____

32. Additional Comments: _____

_____

April 7, 1986

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