SELF-INSTRUCTIONAL TRAINING IN STRESS MANAGEMENT

by

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This dissertation reports an evaluation of Self-instructional training as a stress-management technique for multi-problem clients. Individuals who responded to a newspaper advertisement offering assistance in tension management and who reported that they experienced anxiety in at least two relatively specific situations were assigned to the following treatment conditions:

(1) Self-instructional training (n=11), (2) Awareness (n=11), (3) Skills training (n=11) and (4) Minimal treatment control (n=9).

Therapy was conducted over a six-week period with therapists in the first three experimental conditions meeting small groups for 1½-hour sessions. Clients in all conditions were encouraged to adopt a situational view of anxiety and to record the details of the stressful situations they encountered throughout the course of treatment. In the first condition, Meichenbaum's (1974) treatment manual was used as a guide. Clients were taught to analyze their problems according to a cognitive model of anxiety and to adopt the use of coping self-statements in stressful situations. Clients in condition two received a similar treatment rationale, but did not specifically practice the use of coping self-statements. The third condition provided a combination of role-playing and coaching to assist clients to change their behavior in stressful situations. Finally the minimal treatment group attended a two-hour session in which the self-instructional training procedure was explained to them and was applied to some of their problems.
Analysis of self- and Significant Other reports found no significant differences among treatment conditions, although there was significant change on almost all measures for the client sample as a whole. These inconclusive findings were discussed in relation to differences between the present client sample and clients who have served as subjects in previous research. It was suggested that a promising area for future research might be the investigation of the role of certain client characteristics in determining treatment outcome, especially levels of trait anxiety and the duration and specificity of stressful situations.
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CHAPTER ONE
Fear, Anxiety and Stress

The terms "fear," "anxiety" and "stress" occur with high frequency in the psychological literature, but unfortunately there are still no universally accepted conventions which govern their use. This situation does not exist because definitional problems have been ignored; on the contrary, many theorists have attempted to make meaningful distinctions among these related concepts. Some of their formulations will be briefly discussed below in order to clarify usage in this dissertation.

Often "fear" and "anxiety" are used interchangeably. For example, behaviour therapists have written about "fear of dating" and "heterosexual anxiety." In the same way, "examination anxiety" can be described as "fear of tests." Although these examples indicate that "fear" and "anxiety" can serve as labels for the same emotion, they also illustrate the most common basis for making a distinction between the two: the object of fear is usually fairly specific, while the stimulus situation which provokes anxiety is less circumscribed and often also more abstract and symbolic (Lazarus and Averill, 1972).

In addition to a distinction made on the basis of the stimulus situation, several authors have suggested that fear responses can be differentiated from anxiety responses. Epstein (1972) argues that such response differences are crucial for an adequate understanding of the two emotions. He describes fear as an avoidance motive, and anxiety as a diffuse state of arousal which cannot be channeled into action. Thus, while a person who is afraid will flee or otherwise avoid contact with certain stimuli, an anxious individual is unable to take such action for any of a variety of reasons which might include indecision, or a conflict
between opposing courses of action. Lazarus and Averill (1972) make a rather similar distinction when they suggest that, in the case of fear, there is a tendency to direct action, while anxiety is more likely to evoke intrapsychic (i.e., cognitive) responses.

Are these conceptual distinctions useful in behaviour therapy research? Lazarus and Averill believe that they are. They suggest that, while fear may be successfully dealt with by habituation, anxiety may require a "restructuring of cognitive systems." Reports that systematic desensitization is successful in the treatment of specific fears, but of only limited usefulness when applied to more pervasive anxiety (see, e.g., Marks, Boulougouris and Marset, 1971) support this point of view.

Thus, despite the fact that there is a considerable degree of overlap between the two concepts, it appears that fear and anxiety can be meaningfully differentiated. Such is probably not the case for stress and anxiety since it is possible to use these two terms interchangeably across a variety of situations with little loss of clarity. Appley and Trumble (1967) have noted the great popularity of the concept of stress since its introduction into the literature by Selye in 1936. Selye was initially concerned with the common physiological effects of extreme environmental or internal demands on an organism. He used the term "stress" to describe a response rather than a stimulus. As Appley and Trumble point out, stress is "probably best conceived as a state of the total organism under extenuating circumstances, rather than an event in the environment." Their conclusion is important because stress has, in fact, often been defined in terms of environmental stimuli. This usage can only lead to confusion.
On the basis of the response definition of stress, Martens (1971) has suggested that stress is functionally equivalent to Spielberger's notion of state anxiety. Spielberger (1972a) describes state anxiety as a transitory state in the person which occurs when a situation is interpreted as threatening. He prefers to place "stress" in the environment as a cause of anxiety, but at other times he describes environmental events as "stressors" (Spielberger, 1972b). It would seem that the effect of a stressor should be stress rather than state anxiety. At least in the case of psychologically threatening (rather than physically dangerous) situations, stress and anxiety appear to be equivalent constructs. For this reason, they will be used interchangeably in this dissertation, and events which provoke anxiety will sometimes be described as "stressful."
CHAPTER TWO
Cognitive Factors in Anxiety

There appears to be a growing consensus among personality and clinical psychologists that cognitive factors play a critical role in anxiety. While many authors have emphasized the importance of such processes as expectancy, appraisal and evaluation (e.g., Arnold, 1970; Epstein, 1972) the cognitive view of anxiety has become most firmly associated with the writings of Lazarus (Lazarus and Opton, 1966; Lazarus, Averill and Opton, 1970; Lazarus and Averill, 1972). Lazarus and his associates view cognition as a mediator between stimulus situations and the phenomenological and physiological aspects of emotion. In the case of anxiety, they suggest that cognitive responses can occur at three levels of appraisal. At the first level, primary appraisal, the person makes a judgement that a situation is likely to pose a threat. Then, he forms an opinion about the availability of coping mechanisms which might be used to deal with possible danger (secondary appraisal). Finally, he reappraises the situation on the basis of any new information which he may have acquired, and in light of the likely effectiveness of his coping strategies. Appraisal at all levels is affected by (1) the immediate stimulus situation, (2) the environmental context within which that situation is embedded, and (3) enduring personality dispositions.

The outcome of appraisal can be either direct action or further cognitive activity. In the former case, an anxious person may attempt to deal with his feeling by attacking or avoiding. In the latter, anxiety may be handled by adopting a more realistic view of the situation or through the use of various defenses.
Lazarus and his coworkers have demonstrated the importance of appraisals and defense mechanisms in a series of experiments employing motion pictures as stressors (see Lazarus et al., 1970, for a review of this work). For example, Lazarus, Speisman, Mordkoff and Davison (1966) showed subjects a movie which depicted primitive subincision rites. Appraisal was manipulated by varying the soundtrack in different experimental conditions. Results indicated that soundtracks which promoted intellectualization, denial, reaction formation or trauma produced different levels of anxiety. In general, physiological measures indicated less arousal in the defensive soundtrack conditions.

Lazarus and Averill review more recent experiments performed in their laboratory which highlight the roles of anticipation and uncertainty in anxiety arousal. In one such study, Nomikos, Opton, Averill and Lazarus (1968) cut and spliced a woodshop safety film to create different anticipation intervals preceding accidents which caused physical injury. In one version of the film, subjects were given 20 and 26 seconds in which to anticipate two accidents. Anticipation intervals of only 4 and 7 seconds were used in the second version. Nomikos et al. found that longer intervals produced greater anxiety (as measured by heart rate and skin conductance changes). Most of the autonomic change which was observed in both cases occurred during anticipation periods rather than during the accident scene itself.

To assess the effect of uncertainty, Monat, Averill and Lazarus (1972) conducted an experiment in which the threat of shock was used to provoke anxiety. In two "uncertainty conditions," subjects were informed either that (1) there was a 50% chance that they would receive shock, but that they would receive it at a particular time if it was given (event uncertainty),
of (2) there was a certainty that they would be shocked, but the time of the shock was not specified (time uncertainty). In the first condition, physiological and self-report indices followed a U-shaped curve with greatest anxiety occurring initially and immediately preceding the shock. Subjects in the time uncertainty condition showed an initial small increase in anxiety followed by a general decline. Data on coping strategies used by subjects to deal with shock threat suggested that this decline was associated with an avoidance of thoughts about shock. Apparently such avoidance was possible only when the time of the noxious event was unknown.

Epstein and Roupenian (1970) have also manipulated an aspect of uncertainty about the occurrence of shock. In their study, subjects were asked to draw a card from a deck and then informed that the card selected would determine whether they received a shock. They were further informed that this shock would occur (if they had selected the "shock card") at the count of ten in a count-up. Subjects were assigned to 5%, 50% or 95% shock expectancy groups. Heart rate showed a greater increase for the first two conditions, than for the 95% expectancy group suggesting that more uncertainty produces greater arousal.

From another perspective, social psychology research has shown that the strength and direction of emotional responses depend not only on a person's appraisal of a situation, but also on his perceptions of his physiological responding. In their well-known experiment, Schacter and Singer (1962) found that subjects who attributed an altered state of arousal to the effect of a drug were less likely to behave in an emotional manner than subjects who believed that their heightened arousal was the
result of a social situation. On the basis of such findings, Schacter (1972) has concluded that "given a state of physiological arousal for which an individual has no immediate explanation, he will label his state and describe his feelings in terms of the cognitions available to him" (p. 16).

In the Schacter and Singer study subjects were misled about the causes of their emotion; more recent research has deceived subjects about the extent of their emotion. Beginning with an experiment by Valins and Ray (1967), there have been several attempts to reduce fear through the use of false physiological feedback. In the initial misattribution study, the experimenters successfully increased approach behaviour in snake phobics. However, several attempts to replicate this finding have failed. In reviewing this research, Kopel and Arkowitz (1975) concluded that false feedback manipulations will be successful only when levels of arousal are fairly low. Nevertheless, from a theoretical perspective the misattribution research indicates that beliefs about the strength of one's own emotion can affect behaviour in certain cases.

In addition to studies in misattribution, experiments conducted within the framework of Bem's (1972) self-perception theory support the view that beliefs affect emotion. For example, Kopel and Arkowitz (1974) have reported that subjects who role-play "upset" behaviour show decreased pain thresholds and lower tolerance for shock. It is as though people in this situation observe their own behaviour and reason that they must be upset because they are displaying signs which are characteristic of distress.
In summary, there is considerable support for the theoretical position that cognitions play a major role in anxiety arousal and maintenance. The research of Lazarus and his associates indicates that the experience of anxiety is in a large part determined by an individual's belief that a situation poses a threat to him. This appraisal is most likely to occur when he anticipates a noxious stimulus about which there is some degree of uncertainty. Misattribution and self-perception studies provide evidence that beliefs about present level of coping are also important.

The research cited above points toward several kinds of therapeutic intervention in anxiety: (1) decreasing uncertainty and ambiguity in stimulus situations, (2) assisting clients to change their appraisals of threatening situations, and (3) providing clients with feedback which indicates that they are coping successfully. The first of these approaches is employed in therapeutic programmes which use cognitive and behavioural rehearsal. Lazarus' research is relevant to the second, since it illustrates the anxiety-reducing effect of changing the way one views a threatening situation. Under certain conditions, it should be possible to confront stimuli which once provoked anxiety in a calmer state because of altered appraisals. Finally, false feedback studies suggest that the belief that one is coping well can reduce fear (at least in low-fear situations). It may be that a treatment which helps clients to focus on the successful aspects of their behaviour will have the effect of reducing anxiety. The next section will discuss therapies which have employed such cognitive strategies.
Cognitive techniques are rapidly gaining popularity in the practice of behaviour therapy. Mahoney (1977) suggests that this development indicates an emerging rapprochement between traditional intrapsychic/interpersonal approaches and a strictly behavioural perspective. Cognitive behaviour therapists acknowledge the causative roles of both private events — expectations, attitudes, memories, etc. — and environmental contingencies in human experience and behaviour. However, it is important to note that they differ from traditional therapists in their treatment of mental contents. While the latter have typically considered the modification of cognitions to be a complex and time-consuming process, cognitive behaviour therapists treat cognitions as directly modifiable entities. They assert that a person can replace one thought with another in much the same way as he can replace one behaviour with another (see, e.g., Meichenbaum, 1972, 1974).

To some extent cognitive behaviour modification — had its origins in the learning laboratory, and, in fact, several cognitive techniques reported in the literature closely resemble earlier behavioural strategies. For example, in covert modelling the fearful client is asked to imagine another person engaging in coping behaviour involving the phobic stimulus. This procedure is directly borrowed from modelling studies which have used live or filmed models (Bandura, 1969). In a similar way, cognitive behavioural rehearsal parallels overt behavioural rehearsal; instead of actually rehearsing a behaviour in the presence of the therapist, clients rehearse the event mentally.
Although the principles and paradigms of learning were important in the development of cognitive behaviour modification, other influences are also apparent. Several investigators have adopted and elaborated the Rational-emotive therapy of Ellis (1961). It is Ellis' view that emotional disturbance is caused by irrational beliefs which people hold about the nature of the world and their place in it. These beliefs are an important cause of guilt and anxiety because they lead to unrealistic expectations. For example, an individual who believes that he must be loved or approved of by virtually everyone will often fail to gain the sweeping positive regard which he expects and may accordingly feel that he is not a worthwhile person. Ellis' therapy challenges such irrational thinking and attempts to provide the client with a more realistic view of life.

Recently there has been an attempt to conceptualize Rational-emotive Therapy within a cognitive behaviour modification framework. Goldfried, Decenteceo and Weinberg (1974) have described a procedure they label "systematic rational restructuring" which has five components: (1) exposure to an anxiety-producing situation in either real-life or fantasy, (2) self-evaluation of anxiety level in this situation, (3) identification of anxiety-producing thoughts which the client has in the situation, (4) rational evaluation of these thoughts, and (5) noting anxiety level changes after reevaluation. Although in this paper the authors stress the modification of specific anxiety-producing thoughts, a later discussion of rational restructuring by Goldfried and Davison (1976) describes the modification of irrational belief systems (a la Ellis) as well as specific thoughts.

Several studies have supported Ellis' contention that irrational
beliefs are an important cause of anxiety. Rimm and Litvak (1969) had college students read selected Ellis "triads" (e.g., my grades may not be good enough, I may fail out, that would be awful). This group showed significantly greater changes in respiration rate (in the direction of emotional arousal) than a control group who read neutral triads to themselves. Goldfried and Sobocinski (1975) have reported a correlation between the tendency to hold certain irrational beliefs and questionnaire scores for social, speech and test anxiety. These investigators also found that emotional upset in imagined social situations was greater for subjects who subscribed to irrational beliefs about these situations. Finally, Newmark, Frerking, Cook and Newmark (1973) have reported that neurotic psychiatric patients endorsed a larger number of irrational statements than either patients who had been diagnosed character disorder or normal college students.

Additional support is given to the Rational-emotive Therapy formulation by the generally positive results of treatment studies with speech anxious clients (Trexler and Karst, 1972; Karst and Trexler, 1970; Straatmeyer and Watkins, 1974; Thorpe, Amatu, Blakey and Burns, 1976). Wein, Nelson and Odom (1975) have also reported a procedure called "cognitive restructuring" to be effective in reducing snake fear. In their study, systematic desensitization and the cognitive procedure were equally effective in increasing approach behaviour, but only the latter had the effect of reducing experienced fear. In interpreting this finding it is important to bear in mind that the treatment described by Wein et al. did not focus directly on irrational beliefs; instead
the experimenters attempted to bring about a reattribution of fear from external events to internal cognitions. While this approach is related to Ellis' work, their experimental results support the efficacy of Rational-emotive Therapy only in a general way.

In contrast to Ellis' emphasis on the role of belief systems in anxiety, Meichenbaum (1972, 1974a) has developed a treatment procedure to modify specific thoughts. His approach, self-instructional training, conceptualizes thoughts as self-statements, i.e., as statements made to oneself. Meichenbaum suggests that anxiety-producing self-statements emitted by a person in certain problem situations contribute in a major way to the discomfort which he experiences. The goal of therapy is to make the client aware of the nature of his negative thinking, and to have him replace anxiety-engendering thoughts with coping self-statements.

In the first study to apply self-instructional training to anxiety treatment, Meichenbaum, Gilmore and Fedorovicius (1971) worked with speech anxious students who responded to a campus newspaper advertisement. Subjects were assigned to one of three treatment conditions: insight-oriented psycho-therapy, systematic desensitization, or a combination of the two; or they became part of one of two control conditions: placebo-discussion or waiting list. They met in small groups for eight sessions. The psychotherapy condition "emphasized the rationale that speech anxiety is the result of self-verbalizations and internalized sentences which are emitted when thinking about the speech situation. Subjects were informed that the goals of therapy were for each person to become aware (gain insight into) the self-verbalizations and self-instructions which he emitted in
the anxiety-producing interpersonal situations, and, in addition, to produce both incompatible instructions and incompatible behaviour." The investigators decision to label this condition "insight-oriented" is unfortunate since it clearly includes a cognitive change component as well as promoting insight.

Results of this study indicated that both treatments were superior to the control conditions, but the effects of cognitive modification (or insight) were not significantly different from those produced by systematic desensitization on either self-report or behavioural measures. A post hoc analysis revealed that, while systematic desensitization was more effective for subjects who suffered only from speech anxiety, cognitive therapy was superior for subjects who experienced anxiety in a wider range of social situations.

In a subsequent experiment, Meichenbaum (1971) combined self-instructional training with modelling in the treatment of animal phobia. Fearful subjects observed either a "mastery" or "coping" model approaching a snake. The mastery model was fearless and unhesitating while the coping model showed a degree of fear and reluctance. Both behavioural and self-report measures indicated greater fear reduction in the coping model condition, and the superiority of this treatment was especially apparent when the model provided an example of coping self-instructions as well as coping behaviour.

Meichenbaum (1972) next investigated the relative efficacy of desensitization and self-instructional training in the treatment of test anxiety. Therapy was conducted in small groups which met for one hour per week of an eight week period. An analysis of treatment
outcomes favoured self-instructional training; subjects in this condition had significantly lower scores on an anxiety checklist and showed better performance in an analogue testing situation. They also obtained a greater improvement in grade-point-average.

A more recent study by Holroyd (1976) essentially replicated these findings. Following a treatment procedure developed by Wine (1971) Holroyd's cognitive modification condition provided test anxious subjects with training in focusing on task-relevant self-instructions while ignoring task-irrelevant thoughts. In practice this strategy is likely to result in the replacement of anxiety-producing thoughts with coping self-instructions. It was significantly more effective in reducing test anxiety in an analogue testing situation, and in improving grade-point average than either systematic desensitization or a combination of the two treatments.

Meichenbaum and Cameron (1973) have also used self-instructional training to treat clients with fears of both snakes and rats. The major innovation in this research was the introduction of a "stress-inoculation" procedure. Clients were seen individually for one hour weekly sessions over six weeks. Those assigned to the inoculation condition were taught to view their anxiety in terms of the Schacterian model of emotion and received training in self-instruction. During the last two sessions they practiced the coping skills they had learned in a random shock situation. Other subjects in this study were assigned to an instructional rehearsal condition, in which they were treated in a fashion similar to subjects in the inoculation condition except that they did not practice in the shock situation, a systematic desensitization condition, in which they
received treatment for either rat fear or snake fear (all subjects feared both animals), or a waiting list control.

The stress-inoculation treatment was superior to all others in terms of performance on a behavioural approach task. Desensitization was significantly more effective than instructional rehearsal for the treated phobia, but less effective for the untreated phobia. That is, subjects who had been desensitized to rats were more likely to handle rats than subjects in the instructional rehearsal condition, but they were also less likely to handle snakes than the latter group. These findings suggest that the beneficial effects of a cognitive treatment are more likely to generalize to extra-therapy situations in the client's daily life.

The research described above provides support for the therapeutic effectiveness of self-instructional training in the treatment of speech anxiety, test anxiety, and phobias. However, it does not indicate which aspects of the treatment procedure are responsible for observed improvement. Self-instructional training can be conceptualized as having three components: (1) a treatment rationale which attributes the cause of anxiety to negative thoughts, (2) an insight or awareness factor, and (3) specific training in the use of positive self-statements. It may be that all three aspects are essential for the success of treatment, or that only one or two are necessary. The following section will discuss several experiments which provide some data on this issue.

Component analysis of self-instructional training

Only a few studies in the literature are directly concerned with
analyzing the components of self-instructional training. In his dissertation, Barrett (1975) investigated the relative importance of awareness of unproductive thinking and specific training in substitution of coping self-statements for anxiety-producing thoughts. Speech anxious inmates in a correctional institution were randomly assigned to the following treatment conditions: (1) awareness only, (2) self-instructional rehearsal, (3) a combination of awareness and instructional rehearsal, or (4) no-treatment control. Therapists in the first condition explained the role of negative self-statements and assisted clients in identifying the anxiety-producing thoughts which occurred during public speaking situations. In the second condition, subjects imagined public speaking situations and practiced task-oriented self-statements. Condition three combined the procedures for the other two conditions and the control group was seen only at pre- and post-assessment. Analysis of behavioural, physiological and self-report measures failed to reveal a significant reduction in anxiety for any of the treatment conditions. So, unfortunately, it was not possible to assess possible differences among them.

A recent study by Thorpe, Amatu, Blakey and Burns (1976) provides data which suggest that self-instructional rehearsal may be less important than insight in effecting a reduction in anxiety. These investigators conducted five training sessions for highschool students who volunteered for a programme offering assistance for public speaking anxiety. Subjects met in small groups for eight 30 minute sessions. The first treatment condition (general insight) provided for a discussion of a variety of
irrational beliefs. Condition two (specific insight) dealt with four irrational beliefs which were considered to be especially relevant to speech anxiety. Students in the third condition (instructional rehearsal) focused on four ideas which were the opposite of those discussed in condition two. The final condition combined specific insight and instructional rehearsal.

Results of self-report measures indicated significantly greater improvement for subjects in the two insight conditions than for subjects in the remaining treatments. There were no differences among groups on behavioural measures. These findings suggest that the actual emission of coping self-statements may be less crucial to therapeutic effectiveness than had been supposed; awareness of unproductive cognitions may be sufficient to bring about change. However, it should be noted that the self-instructional rehearsal procedure described by Thorpe et al. differs considerably from Meichenbaum's (1974) treatment. The latter had subjects utilize positive self-statements which are relevant to a very specific stimulus situation as a replacement for thoughts which had arisen in that situation. In contrast, subjects in the research just described rehearsed rather general self-instructions. Probably self-instructional training will have its maximum therapeutic value when statements are concrete and situation-specific. Nevertheless, Thorpe et al.'s finding of a poorer outcome for groups which rehearsed coping self-statements is intriguing and merits further investigation.

Cognitive therapy and skills training

Behaviour therapy theoretically relies on a functional analysis of
behaviour, followed by attempts to change the environment to elicit and maintain desirable behaviour. However in practice, therapists often encourage clients themselves to modify their behaviour. Current procedures which attempt to directly modify behaviour through providing coping models, behavioural rehearsal and coaching are often referred to as skills training. These techniques have been widely used in assertive training (see Hersen, Eisler and Miller, 1973) and have been successfully employed to increase the frequency of dating behaviour (e.g. Bander, Steinke, Allen and Mosher, 1975; Twentyman and McFall, 1975).

Although the skills training approach has developed side by side with cognitive behaviour modification, there has been little attempt to evaluate the relative effectiveness of the two in dealing with specific problems. It might be expected that the former would be the treatment of choice when the client fails to behave effectively because he does not have the requisite behaviours in his repertoire. On the other hand, cognitive change techniques ought to be more effective when clients know how to perform the desired action but are prevented from doing so by the presence of overwhelming anxiety, or, alternatively, when clients are actually behaving effectively but continue to feel anxious in certain situations. At present there is little research which deals with this question.

In their paper on assertive training, Eisler et al. (1973) reported that repeated exposure to a stressful situation did not lead to an increase in assertiveness. They argue that this occurred because subjects did not know how to behave assertively so that habituation of anxiety had little effect on their level of assertiveness. More recently, Glass, Gottman and Shmurak (1976) designed a direct comparison of self-
Instructional training and skills training in a treatment for dating anxiety. Subjects in all their experimental conditions attended one 90 minute group session followed by three or four one-hour individual training sessions. Those assigned to skills training received modelling and coaching of effective behavioural responses. The self-instructional training conditions provided a model for coping self-statements along with reinforcement for appropriate responses. An additional treatment condition combined the two approaches.

Although self-instructional training and skills training were equally effective in producing changes in performance in role-playing situations for which specific training had been given, subjects in the former treatment condition showed better performance in role-playing situations for which they had not been trained and made a better impression on the women they telephoned as part of the post-treatment procedure. Glass et al. interpret their findings as indicating that, at least for this target problem, the effects of self-instructional training are more likely to generalize to non-therapy situations.
CHAPTER FOUR

Practical considerations in the design of stress-management programmes

Because of the large number of possible applications of stress-management treatment both in traditional psychiatric settings and in public health care, it is not only necessary to develop procedures which are therapeutically effective; we must also be concerned with treatment costs. It is clear that a treatment which requires little therapist time and a minimum of specific training will be more widely used than a more time-consuming and complex procedure if the two approaches result in similar outcomes.

One way to reduce treatment costs is to give the client more responsibility for his own treatment. Clients can be taught certain useful behaviour modification techniques which they can apply to their own problems. A variety of self-management strategies have proved their usefulness with such target problems as obesity (Mahoney, Moura and Wade, 1973; Mahoney, 1974; Jeffrey, 1974), smoking (see Lichenstein and Daraher, 1976) and poor study habits (Moffat, 1972; Jackson and Van Zoost, 1972). In many of these studies, clients have set their own treatment goals, dispensed their own rewards and punishments, applied stimulus control to reduce the frequency of undesirable behaviour and monitored behaviour change. Not only have self-managed treatments been more effective than no-treatment controls, in some cases they have performed as well as therapist-managed treatments. It is particularly interesting to note that even the simple procedure of self-monitoring has had a therapeutic effect in a number of experiments (Johnson and White, 1971; McFall and Hammen, 1971; Mahoney, Moura and Wade, 1973). For this reason self-monitoring should be conceptualized as a therapy technique as well as a method of data collection.
The application of self-management procedures in the treatment of anxiety is not a new phenomenon. Almost a decade ago Rehm and Marston (1968) described the implementation of such a programme for speech anxiety. Subjects assigned to a systematic self-help group were instructed to gradually approach feared situations, objectively structure behavioural goals, use self-reinforcement and self-monitor problem situations. In contrast to control groups who were given either non-specific counselling or minimal urging toward self-help, the former subjects showed greater decreases on several measures of anxiety.

More recently Goldfried and his associates have reconceptualized systematic desensitization (Goldfried, 1971; Goldfried and Trier, 1974) and Rational-emotive therapy (Goldfried, Decenteceo and Weinberg, 1974) as training in self-control. In both cases they suggest that the techniques should be taught as coping skills which can be applied by clients to any number of anxiety-provoking situations. In support of the efficacy of this approach, Goldfried and Trier (1974) found that subjects who were assigned to a condition in which relaxation was presented as a coping skill showed a greater reduction in speech anxiety and also in more general anxiety, than subjects who were informed that relaxation training would automatically reduce anxiety.

Méichenbaum and Cameron's (1973) stress-inoculation procedure is another example of a method which provides the client with a technique which he himself can apply in anxiety-producing situations. It will be recalled that this treatment was more effective for animal phobia than several comparison treatments. This finding has broad implications for stress management since it suggests that practicing newly acquired
self-management skills in the office of a therapist may help a client to control his anxiety in a variety of real-life stressful situations.

The self-management strategies just described have often resulted in a saving in therapist time, although they were not originally designed for this reason. Several recent reports in the area of weight control have more systematically investigated the importance of therapist contact time with the general finding that even minimal therapist involvement can produce therapeutic gains. For example, Hall, Hall, Hanson and Borden (1974) compared the effectiveness of two self-management conditions. Subjects assigned to "simple self-management" met in small groups for 10 to 15 minutes over a 10 week period. A comparison "combined self-management" condition provided 75 minute weekly group meetings. In the simple self-management condition, subjects were provided with wrist counters to monitor daily bites of food and were instructed to gradually decrease the number, while subjects in the combined self-management condition received instruction in a variety of behavioural techniques aimed at weight reduction. Both of these treatments produced greater weight loss than no-treatment control, but they did not differ from each other at either post-testing or follow-up.

Bellack, Schwartz and Rozensky (1974) investigated the therapeutic effects of weight reduction therapy conducted by mail. The mail-contact group self-monitored food intake and sent weekly records to the experimenter. Another group of subjects met with the experimenter for weekly sessions at which they received mild social approval for progress. Results indicated that the two approaches were equally effective and both were superior to a control condition. In a somewhat similar study, Lindstrom, Balch and Reese (1976) maintained weekly telephone contact with one group of overweight
subjects and met personally with another group over a nine week
treatment period. Again there were no differences between the two
therapy conditions, although subjects in both of them lost significantly
more weight than no-treatment control subjects.

In summary, the research described above indicates that treatments
which require a relatively small investment in therapist time are sometimes
effective. Since such therapies are desirable from a cost-benefit
perspective, stress-management research (and indeed all treatment outcome
studies) should ideally include minimal treatment comparison conditions
which teach certain basic skills. This addition may enable investigators
to decide whether the therapeutic gains which result from intensive
treatment actually justify expenditures in therapist time and agency
resources.
CHAPTER FIVE

Statement of the problem

The present research had two major aims: (1) to determine whether self-instructional rehearsal is an essential component of the self-instructional training procedure, and (2) to compare the relative effectiveness of self-instructional training and skills training.

Although the self-instructional aspect of Meichenbaum's treatment is what makes it unique, there is still little evidence that specific training in the emission of coping self-statements actually contributes to anxiety reduction. It may be that the awareness component of self-instructional training is sufficient to explain clinical improvement.

A search of the literature found only two studies which bear directly on this issue. One of these, Barrett's dissertation, failed to demonstrate that a combined awareness and instructional rehearsal condition was more effective than either treatment presented individually. The other, (Thorpe et al.) reported results which suggest that awareness may actually be more important than instructional rehearsal.

The experiment reported below is an attempt to clarify this situation. Because of problems inherent in conducting a group treatment without an awareness component, the role of self-instructional rehearsal was investigated by comparing self-instructional training (awareness plus self-instructional rehearsal) with a treatment aimed only at promoting awareness of the causes and effects of negative self-statements.

With respect to the second purpose of the study, the literature reviewed suggests that self-instructional training is superior to skills
training in stress management although there are few studies which have
directly compared the two approaches. This superiority probably occurs
because skills training is fairly specific to individual problems while
self-instructional training offers a more general approach to anxiety
reduction. When clients have a variety of problems, not all of which
are necessarily dealt with during treatment sessions, the generalization
expected for the cognitive procedure may account for better overall
outcome.

In contrast to most earlier research in self-instructional training,
subjects in the present research did not share a common problem. Instead
they reported significant stress in a variety of situations. This
sample was recruited because it was felt that they would more nearly
resemble a clinical group and thus provide a more stringent test of the
treatments offered.

The following hypotheses were proposed in this dissertation:

1. Self-instructional training produces a greater reduction in
anxiety and a greater ability to cope with stress than an awareness-
oriented treatment.

2. Self-instructional training is superior to skills training in
anxiety reduction and stress-management.
CHAPTER SIX

Method

Subject recruitment and selection

Advertisements announcing a public service stress tension management programme were placed in Vancouver's two major daily newspapers. Inquiries were made by 167 individuals.

In telephone interviews respondents were asked questions about the nature of stress-producing situations, the duration of the problem, current treatment regimens and interest in the type of treatment being offered. Individuals were considered suitable for the treatment programme only if they experienced a significant amount of stress in at least two situations.

The initial pool of 167 people was reduced to 64 through the telephone screening interviews. In some cases inquiries had been made by individuals who expressed only an educational interest in the programme. Other callers intended to be out of town during the treatment period or did not wish to participate in a group treatment. Several prospective clients were currently seeing other therapists and wished to continue doing so, and many individuals described "free-floating" anxiety rather than situation-specific stress.

Respondents who were considered appropriate for treatment then participated in more extensive assessment interviews in which information concerning the following topics was systematically collected:

1. The severity of the problem
   (a) number of stressful situations
(b) amount of time during which the client experienced
an uncomfortable level of anxiety
(c) extent to which anxiety interfered with daily living
2. Description of stressful situations
   (a) specificity of anxiety-producing stimuli
   (b) ability of client to recognize commonalities across
       stressful situations
3. The nature and outcome of past attempts to reduce stress
4. Motivation for treatment:

Following the interview, Likert scales were used by interviewers
to rate the specificity of stressful stimuli, motivation for treatment,
present clinical anxiety level, current level of depression and likeli­
hood of psychosis alcoholism. The ideal client obtained high scores
on the first two dimensions, a moderate score on the third, and low
ratings for the remaining two scales.

Of the 64 people who were interviewed, 59 were rated as suitable
candidates for treatment and were accordingly assigned to experimental
conditions. This group comprised 47 females and 12 males. The sex
disproportion occurred because the initial subject pool contained far
more women than men, not because the rejection rate was higher for men.
A data deposit cheque of $20 was required of clients in group therapy
conditions. All three group therapy conditions were filled before
subjects were assigned to self-help groups. The procedure for telephone
call-back acted to minimize any systematic bias by having interviewers
select blocks of subjects to contact. Thus, the self-help group was
made up of subjects whose names occurred at the end of blocks instead
of comprising only the last people who telephoned the clinic.

At the outset of treatment, 13-16 clients were assigned to each experimental condition.

Description of final sample

Several clients were lost over the course of this study. Of the original group of 59, 52 individuals attended their first scheduled treatment session and 45 completed treatment. The seven clients who discontinued treatment were distributed almost equally across the experimental conditions with two drop-outs in each of the group therapy conditions and one in the self-help condition.

The mean age for the final sample was 41.7 years; clients ranged in age from 21 to 65 years. There were eight males and 37 females. 22% were single, 62.2% married and the remaining 15.6% separated or divorced. The majority reported that their problems were of more than five years duration (60%), and a further 24.4% had experienced a high level of stress for more than one year but less than five. Thus, most of our clients had come for assistance in handling long-standing stress-management problems. Chi-square tests indicated no significant differences among conditions on any of the demographic variables.

The stressful situations which brought clients to treatment included the following: being in elevators or other enclosed spaces, driving in traffic, shopping, taking examinations, meeting job deadlines, public speaking, meeting strangers, being alone, entertaining guests, dealing with supervisors and employees, and attending parties (see Appendix 3 for a complete listing). Most of these logically fall into the categories of
performance anxiety, interpersonal anxiety, or specific fears. Each client presented with two or more problem situations.

Training and supervision of interviewers and therapists

Interviewers for this project were four Master's students in a Clinical Psychology programme, all of whom had completed a practicum course on interviewing techniques. The experimenter met with this group on several occasions before the study began to discuss the purposes of the interview and the general aims of the experiment. Throughout the course of interviewing, any difficulties which arose were discussed with the experimenter. In almost all cases the same graduate student conducted both the telephone and face-to-face interviews with an individual client.

Graduate students in Counselling Psychology and Social Work and one practicing clinical psychologist from the community served as therapists in the group therapy conditions. All had previous supervised group leadership experience. Before treatment began a series of meetings were held to discuss the purposes of the project, the rationales underlying the chosen therapies, and the specific procedures involved. Meichenbaum's (1974b) treatment manual was used as a guide for two of the conditions and also for the self-help condition; Goldfried and Davison's (1976) book chapter on behavioural rehearsal served as a model for the remaining treatment condition. All sessions were taped and weekly meetings were held individually with therapists to discuss problems and progress.

Conditions

Clients in the treatment conditions met in groups of six to eight
members for a series of six one and one-half hour weekly group sessions followed by a post-treatment assessment session. Over this period, all clients were asked to monitor details of stressful situations.

The control groups were informed that, because of the overwhelming response to our advertisement, all weekly group positions had been filled. They were offered a two hour workshop instead.

**Self-instructional training.** This condition was similar to Meichenbaum's treatment as described in his manual. During the first session group members made statements about the factors which had led them to seek help. Therapists encouraged a situational analysis of the problems presented and fostered a discussion of thoughts and feelings in stressful situations.

The treatment rationale was presented to the group in a statement similar to the following:

Anxiety is to a considerable extent produced not by what happens to you, but by how you think about what happens. Two people may interpret a situation in very different ways. (At this point an example was given.) Since it will be necessary to go through many stressful situations in one's daily life, it is unrealistic to try to avoid them. A much better approach is to change the way you think about them. In a way, thinking is like talking to yourself. When you are in a stressful situation, you may tell yourself things which are realistic and helpful or things which only upset you more. The focus of our treatment is to analyze the negative things which you are currently saying to yourself to produce anxiety, and then come up with coping self-statements which can be substituted in their stead to bring about a reduction in anxiety and tension.

The group then discussed baseline monitoring data which clients had brought with them to the session. At the end of the session it was suggested that group members continue to monitor stressful situations, while paying close attention to stress-provoking stimuli in the environment.
Sessions two through six each began with clients presentations of monitoring data concerning stressful situations. Other group members were encouraged to offer their opinions on what each person was "saying to himself" in monitored situations and to relate this to their own experience. An attempt was made to identify themes in problem situations.

During the second and third sessions the focus of discussion was mainly on the analysis of negative thoughts. Later meetings focused almost entirely on the rehearsal of coping self-instructions. Clients were asked to find positive, but realistic self-statements which they could try out in problem situations. As an aid in this process, they rehearsed new positive self-statements in the group before committing themselves to using them during the coming week.

Awareness. This condition provided an analysis of anxiety in terms of negative self-statements, but did not offer specific training in changing unproductive modes of thought. Session one began with group members descriptions of their problems. As in the first condition, therapists encouraged a situational focus and fostered a discussion of thoughts and feelings in stressful situations. He/she offered the following treatment rationale:

Anxiety is to a considerable extent produced not by what happens to you, but by how you think about what happens to you. Two people may interpret the same situation in entirely different ways. (An example was given.) The major goal of our treatment is for each group member to become aware of the factors which are contributing to his anxiety. As we continue our meetings you will discover just how closely your thoughts are tied to your feelings. Until you understand very clearly what your negative thoughts are, or in other words, what you are saying to yourself, certain situations will continue to upset you. In our group discussions we will spend most of the time
carefully examining the self-statements you are presently using. As you gain insight into exactly what is bothering you, you will gain control over your anxiety.

At this point, monitoring data was discussed. Later, as a homework assignment, clients were asked to continue self-monitoring while paying attention to negative thinking.

Sessions two through six began with each client going over his monitoring data for the week and describing any negative self-statements which he had become aware of. Other group members offered their views about how such self-statements were maintaining anxiety. An attempt was made to find commonalities across the problem situations presented by individual clients.

To assist in clarifying negative thinking, group members were involved in role-playing situations which required that they verbalize negative self-statements. Therapists pointed out connections between these self-statements and failures to cope well in problem situations.

**Skills training.** In this condition, an attempt was made to change overt behaviour in stressful situations. During the first session, clients described the circumstances which had brought them to therapy. Therapists focused attention on the situational determinants of the distress experienced by clients and on the behaviours which had led to an unsatisfactory outcome. They also provided the following treatment rationale:

To a considerable extent, anxiety is a product of the situations in which we find ourselves and of our own behaviour in these situations. Anxiety is usually a signal that we are not behaving effectively. Often we get ourselves into trouble by the way we look at a problem. It is useful to translate statements like "social situations upset me" into "in certain social situations I do not behave effectively." The second statement is better
because it points to a solution — you can change your behaviour. Altering your behaviour can have several beneficial effects: it can reduce anxiety because you know that you've done well, it can lead other people to change their behaviour toward you so that they make you less anxious, and it may allow you to avoid absolutely impossible situations in which no one could cope effectively. The focus of our treatment will be on identifying problem situations and on specifying the causes of distress in each. Then we will try to come up with new ways of dealing with situations which will lead to a feeling of accomplishment rather than anxiety.

Baseline monitoring data was then discussed, with therapists maintaining a behavioural focus. The homework assignment required that clients continue to monitor stressful situations paying particular attention to the stimuli which provoked anxiety.

Sessions two through six commenced with a discussion of monitoring data. During the second and third sessions, discussion centred on the identification of anxiety-producing stimuli. Sessions four through six focused on the development of alternative behaviours to use in stressful situations. Modelling, role-playing and behaviour rehearsal were used to train clients.

Self-help treatment. Clients met in two small groups. The experimenter presented a situation-specific view of stress and described the treatment methods of Meichenbaum and Ellis. The groups then described their problems while the therapist focused attention on the stimuli which triggered anxiety and the thoughts which provoked stress. They were given monitoring instructions and encouraged to record the details of stressful situations as a first step in gaining control over them. They were also instructed to change the nature of their thinking, and especially to try out coping self-statements in problem situations. At the end of
the meeting they were requested to return after six weeks to report on their progress.

An attempt was made throughout to present this condition as therapy. The group leader made an effort to provide what assistance he could within the brief time available, and although clients were aware that they were not receiving the "full" treatment, many expressed gratitude and optimism at the end of the session.

During the second meeting, clients described their experiences using the suggested cognitive techniques. It was clear that some of them had made little attempt to modify their thinking, but several reported that monitoring and the use of coping self-statements had been helpful. The group leader reiterated much of what had been said during the initial session to correct any misconceptions which had arisen and encouraged clients to continue to use what they had learned.

Pre-treatment measures

Interviewer Assessment Form. Interviewers used this record sheet to note their observations of each client. (Refer to "Subject recruitment and selection" for content areas and to Appendix 2 for a copy of this form.)

State-trait Anxiety Inventory. This questionnaire has been widely used in the assessment of anxiety (manual by Spielberger, Gorsuch and Lushene, 1970). It was originally designed to test Spielberger's theory of situational and general anxiety, and many investigations have supported the relative independence of these two constructs (see Smith and Lay, 1974, for a review). Several studies have reported decreases in state anxiety with psychological treatment (Allen, 1971; Spielberger et al., 1970).
Social Avoidance and Distress Scale. This measure was developed by Watson and Friend (1969) to assess one aspect of social anxiety. The scale consists of 28 true-false items dealing with anxiety responses in social situations.

Fear of Negative Evaluation. Another scale reported by Watson and Friend (1969), this instrument has 30 items which reflect anxiety surrounding actual or imagined criticism from other people. The initial study provides validity data for both of Watson and Friend's scales. Several groups of investigators have employed them in therapy research (Meichenbaum et al., 1971; Bander et al., 1975; Thorpe et al., 1976).

Past Week Tension Thermometer. A simple 1-10 point rating scale similar to Walk's (1956) Fear Thermometer was used to obtain an overall tension rating.

Situational Stress Assessment. This procedure was developed specifically for the present research. Because it was not feasible to use either behavioural observation or role-playing measures due to the diversity of target problems, clients assigned to the first three conditions were asked to rate their own anxiety as they went through a stressful situation in the pre-therapy week. A situation was selected (by the interviewer and client in the assessment interview) which would be moderately difficult and of relatively high frequency of occurrence. Clients recorded their experiences on a form provided for this purpose, and also rated their anxiety on the Subjective Stress Scale (Berkun, Bialek, Kern and Yagi, 1962).

The latter is an equal appearing interval scale of 15 words. Each word has an attached value, ranging from 1 for "wonderful" to 94 for "scared stiff." Berkun et al. provide evidence that the scale is
sensitive to stress provoked by life-threatening situations. More recently a dissertation by Neufeld (1972) found that the scale was sensitive to anxiety caused by slides of homicide victim. In addition, the scale has been used to measure stress in hospital patients (Parisen, Rich and Jackson, 1969).

Post-treatment measures.

All of the questionnaires were readministered at the termination of therapy. In the case of the Situational Stress Assessment, the clients were asked to expose themselves to the same stressor which they had encountered in the pre-assessment. In addition, at this time clients responded to the questionnaires described below.

Relationship Inventory. Clients' perceptions of therapists were assessed by this instrument which was developed within the framework of client-centred therapy by Barrett-Lennard (1962). The questionnaire provides scores for Level of Regard, Unconditionality, Empathy and Congruence. In a review paper, Bergin and Suinn (1975) note that some investigators have found that perceived levels of Rogerian facilitative conditions, as assessed by the Relationship Inventory, are a better predictor of therapeutic outcome than rating scores derived from therapist behaviour.

Programme Evaluation Form. We obtained clients' impressions of clinical improvement by using five rating scales assessing changes in tension level, ability to deal with personal problems, ability to function under pressure, tendency to become upset and duration of "upsets." In addition, individuals indicated how much of their problem had been handled by the treatment and rated therapist competence and group warmth
on a series of rating scales.

In order to assess the internal consistency of the three scales which made up the Programme Evaluation form, item-to-total correlations were calculated for each of them. Correlations for the five Self-rated Change items ranged from .58 to .82. Only four of the five items in the Therapist Competence Scale showed a correlation above .50 with a total score. The low item was accordingly dropped. For the same reason two of the 10 items were dropped from the Group Warmth scale. The analysis of the data used total scores derived from the revised scales (see Appendix for items and correlations).

**Significant Other Questionnaire.** Clients were asked to have a relative or close friend provide his/her impressions of change which had occurred during the six week treatment period on a questionnaire made up of the five scales used in the Self-rated Change form. Again, item-to-total correlations were calculated, all of which exceeded .50 (see Appendix 2 for correlations).

**Follow-up procedure and measures**

One month after the last treatment session, clients were sent several questionnaires which they were asked to complete and return by mail. These included the State-trait Anxiety Inventory, the Fear of Negative Evaluation Scale, the Social Avoidance and Distress Scale, and the Self-rated Change Scale from the Programme Evaluation Form.
CHAPTER SEVEN

Results

Pre-measures

A one-way between groups multivariate analysis of variance (MANOVA) was performed on pre-treatment scores. The obtained Heck value (Heck=0.15, s=3, m=5, n=17.5) was not significant, indicating no differences among experimental conditions. For mean pre-scores by group refer to Table 1.

The group as a whole had a mean score of 6.47 (s.d.=1.39) on the Tension Thermometer. This rating indicates a moderate level of overall tension. Mean scores for A-state and A-trait were 42.4 and 47.4, respectively (s.d.=9.50 and 8.93). The trait score is similar to the average score reported for a group of psychiatric patients with a diagnosis of anxiety reaction cited by Spielberger et al. in the manual for the State-trait Anxiety Inventory. On the other hand, on A-state the present sample is comparable to general medical patients whose scores are also given by Spielberger et al.

Fear of Negative Evaluation and Social Avoidance and Distress mean scores were similar to those reported by Watson and Friend (1969) for normal undergraduate students (X=16.7 and 10.6, s.d.=8.4 and 8.2, respectively). Clients obtained a mean score of 69.5 (s.d.=17.8) on the Subjective Stress Scale. The word associated with this value is "nervous." The average score obtained is comparable to those reported for subjects who underwent simulated, but apparently real, emergency situations in Berkun et al. (1962). Mean scores varied from 69 to 74 for the three life-threatening emergency situations encountered in the latter study.
Table 1
Means and Standard Deviations for Outcome Measures

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a SIT = self-instructional training, AWARE = awareness, ST = skills training and SH = self-help.

b TT = Tension Thermometer, FNE = Fear of Negative Evaluation, SAD = Social Avoidance and Distress, SSS = Subjective Stress Scale, SRC = Self-rated Change, and SOQ = Significant Other Questionnaire.
Treatment outcome

A series of two-way analyses of variance (Conditions X Time) were used to test for changes on all instruments for which repeated measures had been obtained. Significant main effects for Time were found on all outcome measures except Social Avoidance and Distress. None of the Condition main effects or the Conditions X Time interactions were significant. (See Table 2 for a summary of these analyses). Tukey hsd tests for individual comparisons revealed the following differences among means: pre was different from post and follow-up for Tension Thermometer, pre was different from follow-up for Fear of Negative Evaluation, for State Anxiety, pre was different from post and pre was significantly different from post and follow-up for Trait Anxiety, and for the Subjective Stress Scale, pre was different from post. (This last finding should be interpreted with caution because of heterogeneity of variance among conditions on the Subjective Stress Scale.)

To further evaluate differential treatment effects, one-way between MANOVA's were performed separately on post and follow-up for all measures except the Subjective Stress Scale. The resulting Heck values were not significant (Heck=0.25, s=3, m=1.5, n=15 for post; Heck=0.19, s=2, m=1.5, n=12.5 for follow-up). In combination with the findings from the earlier analyses, this indicates that the treatments offered did not produce different outcomes, either at the termination of treatment or after a period of one month, although significant change did occur for the client group as a whole.

Therapist effects

Another one-way between MANOVA found no significant differences among the three group therapy conditions on clients' perceptions of therapists or group atmosphere (Heck=0.19, s=2, m=1.5, n=12.5). This
### Table 2

#### Analysis of Variance Summary Tables

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*a See notes on Table 1.*
analysis included the four scores from the Relationship Inventory as well as scores for Therapist Competence and Group Warmth. As a further check on possible differences in clients' perceptions, one-way analyses of variance were carried out for small groups (n's varied from 5 to 7). None of the F's obtained were significant indicating no differences among the 8 groups.

Although clients in different conditions apparently did not perceive therapists differently, it is possible that therapists were not equally effective. To test this hypothesis a series of three-way analyses of variance (ConditionsXGroupsXTime) with small groups nested within treatment conditions were performed. These analyses revealed no significant GroupsXTime interactions on any of the outcome measures.

**Relationships between process and outcome measures**

Correlations coefficients (Pearson r's) were calculated to investigate the relationship between clients perceptions of treatment and actual treatment outcomes. Where repeated testing had been done, pre-post d' scores were used as indices of outcome. For the remaining outcome measures (Self-rated Change and Significant Other Questionnaire) correlations were simply calculated between the single scores available and process scores. Level of Regard scores from the Relationship Inventory were positively related to Self-rated Change (r=.34, p<.05). Empathy and Congruence were related to the Subjective Stress Scale (r=.30, p<.05 and r=.35, p<.05). Of the scales constructed for the present research, both therapist Competence and Group Warmth were positively correlated with the Subjective Stress Scale (r=.28, p<.05 and r=.31, p<.05). In addition, there was a significant relationship between Group Warmth ratings and changes in state anxiety (r=.27, p<.05).
Any interpretation of the obtained correlation coefficients must be made with caution since they represent only a small proportion of those calculated. Thus, of 48 coefficients only six were significant beyond the .05 level, and even these were not large in magnitude. However, one interesting pattern which seems to emerge is that clients' perceptions tend to be related to change on measures of specific anxiety (Subjective Stress Scale and State Anxiety) but not to more general measures of specific anxiety (Fear of Negative Evaluation, Social Avoidance and Distress and Trait Anxiety).
CHAPTER EIGHT
Discussion

The results of this study indicate that significant changes occurred on outcome measures for the client sample as a whole, but contrary to expectations, the treatments provided did not have differential effects. Because there were no significant differences between the first three treatment conditions and the self-help condition, it is necessary to consider whether the overall changes actually indicate a reduction in anxiety. It might be argued that they are due to the operation of a Hawthorne effect, or to statistical artifact due to repeated testing.

In the absence of a no-treatment control group it is not possible to rule out these alternative explanations for the results obtained. With limited resources it was possible to include only one "control" condition in the present study. A choice was made in favour of a minimal treatment group for two reasons. First, it is ethically questionable to withhold treatment from people who are in need. If psychologists advertise a treatment programme, they should commit themselves to treating as many of the people who respond as their resources allow. A waiting list control can partly overcome the ethical objection to a no-treatment group, but for practical reasons this alternative was not feasible in the present research.

The second point in favour of a minimal treatment is that such a condition can provide a more adequate baseline against which to compare the effects of a more complex therapy. Unless a particular treatment approach is able to produce better results than minimal treatment, the additional costs of the former are not justified. From a more traditional
experimental control perspective, a minimal treatment group is also able to provide a control for certain "non-specific" factors (e.g., situational demand characteristics, expectations of help and opportunity to share emotional experiences) which are present in any therapy.

Thus, an investigator can feel reasonably confident that a therapy which is superior to a minimal treatment is actually effective. However, when differences do not emerge, there are problems in interpreting experimental results. On the basis of the data obtained in the present study, one might conclude that, for practical purposes, all of the treatments offered were of equal effectiveness. Such a strong conclusion is probably unwarranted. In all therapy research, treatment outcome is due to an interaction of client, therapist and technique variables. Very often client and therapist effects may obscure the operation of specific treatment variables by increasing the variance on outcome measures. Clients in the present study were diverse in terms of age, sex, psychiatric history and specific presenting problems. Although there were no significant differences among treatment conditions, either on these variables or on pre-scores for outcome measures, within-condition variances were generally large. The same was true for within-groups scores on process measures; again an absence of significant differences among groups was accompanied by large score variances.

Analysis of variance (groups nested within condition) did not find significant groups by time interactions. However, this finding does not necessarily indicate that therapist characteristics were unimportant, since ANOVA with small n's may be unreliable. A variety of differences among therapists in background, training and therapy style may have been
related to treatment outcome despite the finding that clients did not view their therapists differently.

Finally, several aspects of the treatments themselves may have decreased the likelihood of differential outcome. First, it should be noted that in some ways the individual treatments were actually rather similar. Although there were differences in treatment rationale and in the specific techniques used in therapy, similarities may have outweighed the differences. All conditions adopted a situational focus, all used self-monitoring, all attempted to create an atmosphere in which change was expected to occur, and all provided the opportunity for sharing upsetting experiences and receiving emotional support. Several authors have argued that non-specific variables may be as important as actual treatment factors (see, e.g., Shapiro, 1971; Mahoney, 1974). In the light of the fact that all conditions shared both non-specific and technique similarities, the absence of significant differences may not be surprising.

Possibly a more protracted therapy is necessary for multi-problem clients. From a common-sense perspective, clients with two or more problems may be more difficult to help than clients with only one problem. This is especially likely when group members do not share a common problem, since relatively little therapist attention can be paid to any one client under these conditions. Under such circumstances, none of the treatments may have been given a fair trial. In addition, it should be noted that the data available from the present study does not indicate exactly what clients were doing in the treatment conditions. Although they reported that they were applying the techniques taught in the group sessions to
extra-therapy situations, we have no way of directly assessing their compliance. In order to investigate this question, future research should more systematically collect information on clients' application of treatment techniques.

One implication to be drawn from the results of the present study is that it is unwise to assume that therapists with rather limited experience and training can necessarily bring about therapeutic change merely by following manuals which describe treatment approaches. While such manuals are admirable in that they standardize treatment procedures in research, it is probably unrealistic to suppose that their use will necessarily produce dramatic success. The changes which were obtained in the present research were of small magnitude. It is of interest to note that when asked at post-assessment about the success of the treatment received, a majority of the clients (76%) responded that at least 75% of their problem remained to be coped with. When one takes into account the reluctance of clients to admit that they have received absolutely no assistance, these reports suggest that treatment was actually of little value to them. Certainly one would expect them to go on to seek further treatment in the future. Since additional therapist training and experience in the self-instructional procedure might have produced a stronger treatment effect for this condition even with the present client population, the results as they stand should only be generalized to other research with relatively inexperienced therapists.

It may be that self-instructional training was not really an appropriate treatment for the present sample. Its effectiveness has been demonstrated mainly with fairly circumscribed fears in normal clients. Although the
screening procedure attempted to exclude individuals who had general or free-floating anxiety, the high trait anxiety scores which clients obtained suggest that the present group may have been more generally anxious than subjects included in earlier studies. In addition, many of our clients had experienced stress-management problems for a long time (60% for more than five years) and 30% had had previous psychiatric treatment at one time in their lives. Probably these factors combined to make beneficial change less likely to occur.

In order to determine whether trait anxiety and problem duration were related to treatment outcome, Pearson's r's were calculated between these measures and outcome scores for the total N. Duration was significantly related to change on the Tension Thermometer (r = .42, p = .01) and Subjective Stress Scale (r = .33, p = .01), while initial trait anxiety scores were significantly correlated only with changes on the Fear of Negative Evaluation (r = .25, p = .05). The direction of these relationships does support the view that clients with high trait anxiety scores and long-standing problems show less improvement with treatment. Most of the self-instructional training research in anxiety to date has been conducted with student clients (e.g. Meichenbaum et al., 1971; Meichenbaum, 1972; Holroyd, 1976; Thorpe et al., 1976). Perhaps the technique requires more intensive application or some kind of modification to maximally benefit more "clinical" groups.

The finding of no differences between the awareness condition and self-instructional training supports the conclusion of Thorpe et al., that the insight component of self-instructional training is more important
than the specific technique. However, in view of the failure of self-instructional training to out-perform minimal treatment it is not possible to draw definite conclusions on the basis of this finding. Because such differences between treatments may have relatively weak effects in comparison to the client and therapist variables discussed above and also in comparison to non-specific effects it seems more appropriate to investigate this question with subjects who are similar to each other and who share a common problem. Probably future research should focus on more homogeneous samples.

Self-instructional training is a promising approach to stress-management because it offers a method of analysis and a technique which can be applied to the problem of anxiety in diverse situations. It is certainly worthwhile to continue to investigate its usefulness with multiproblem clients, but future studies with a community population should pay closer attention to client variables with a view to discovering characteristics which will predict good treatment outcomes. Findings from the present study suggest that problem duration and level of trait anxiety may be important. It also seems likely that the nature of the specific stress-producing stimuli will be related to outcome. Not only might better results be expected when the stressful situation can be specified in detail, but the treatment may bring about greater anxiety reduction with clients who experience stress in particular types of situations. For example, it may be that people who become anxious in work situations are more easily helped than those who find difficulty coping with situations which arise in the context of intimate relationships. In addition to client variables, therapist variables may also partly determine therapeutic effectiveness.
For this reason, future research should provide for an analysis of therapist effects so that this source of variance can be extracted to better assess the effectiveness of treatment.

However, before client and therapist variables are investigated, a more lengthy and intensive treatment programme should be considered for multiproblem clients similar to those who served as subjects in the present research. At this point, the first priority is to develop an effective programme for this population. Later research can then be devoted to a comparison of different treatment approaches in stress-management.
1. See Appendix 3 for typical therapy interactions.

2. The Subjective Stress Scale was not included in this analysis because scores were available for only three groups. A univariate analysis of variance found no difference on pre-treatment measures (see Table 2) but because of heterogeneity of variance among conditions this finding may be unreliable.
REFERENCES


Appendix 1

Interview Guides
TELEPHONE CALL-BACK

Time: 15 minutes maximum

Begin the conversation by asking what sort of problems the respondent has been having. Probably you will get a rather disorganized stream of vague complaints at this point. Try to focus the conversation by asking specific questions. Ask about the duration of the problem ("how long have you been feeling that something was wrong?") , the extent ("how much do your feelings of anxiety or tension" — use the client's words — "interfere with your daily life?", "how often do stressful situations arise?"). Also try to find out whether the anxiety experienced is fairly constant and all pervasive or related to several situations("Are there times when you don't feel anxious or tense?").

Then move on to a description of a particular situation which causes anxiety in the respondent. If he/she has already given examples, use one of these. Ask about where it happens, when it happens (time of day, following some other event), how often it happens, the characteristics of other people in the situation, their responses to the respondent's upset. Then ask the respondent to describe in some detail how he experiences his anxiety. How does he know there's a problem(s) (is he weak and trembly, physically tense, nauseous, panicky, etc.).

If the respondent is still with you, give him a brief description of the treatment programme. Introduce this description with the statement, "I'll give you a short description of our programme so you can decide if it sounds like what you are looking for." Say that the treatment will take place in groups of 6 to 8 people. There will be one group meeting per week lasting about 1½ hours. Most groups will probably meet in the evening. Treatment will last for 7 weeks. It is important that the clients commit themselves to being there for almost all of the sessions.

The group leaders will be graduate students in psychology who have had
experience in therapy and are being supervised by clinical psychology faculty members (professors). Make sure you mention that this is a research project. They will receive free treatment, but in return they will be expected to fill out several questionnaires. If questioned, say that "we believe our approach is a good one, and it has worked for many people. However, we want to carry out research in order to obtain data to support our belief."

Don't answer more specific questions about the content of the therapy sessions. Say that this will be discussed at the initial interview.

Arrange an interview if:

1) the person seems to be in genuine discomfort and is eager for help.

2) his anxiety is tied to specific situations. (He is able to describe anxiety-free periods, he can say what provokes his stress reaction.)

3) he is not psychotic. (You feel that what he says makes sense -- allowing for some confusion because of high anxiety. He does not report hallucinations or delusions.)
ASSESSMENT INTERVIEW GUIDE

Time: 30-45 minutes of interview and 15-30 minutes for questionnaires.

In this interview you will be interested in the same material as you covered in the telephone call-back, but in more detail. As a guide to the interview, please follow the Interviewer Assessment Form. You may fill in the client's responses as you go along, or complete the form after the interview is concluded. Suit your taste. For the rating scales at the end of the Assessment Form, your judgement will be required because you may have only vague intuitions to go on. Follow these if you have no hard data.

Begin the interview by asking the respondent to describe his problems in more detail, and direct the conversation so that all of the necessary questions are asked, in any order you like. After you have obtained answers to these questions, leave the client, taking the Interviewer Assessment Form with you. Complete the assessment ratings at the bottom of the second page and arrive at a decision about the suitability of the client for the stress management programme.

If the person is judged inappropriate: Tell him/her that he probably wouldn't be happy with the treatment we are offering. If he asks where he should go, suggest that he consult his family doctor.

If the person is judged appropriate: Answer questions he/she may have about the treatment programme. Emphasize that it will deal with specific techniques which can be used to deal with stressful situations. If pressed for details, say that the techniques used will be to some extent dependent on the nature of his problems and that it isn't possible to be very specific about it now.

Make it very clear that the client is expected to attend all treatment sessions, since this is a brief intensive course of therapy and that a lot of hard work is
expected of him. Assign him to a group according to his time preference (refer to a master-list which will be posted somewhere).

Self-Monitoring: Give the client a copy of the Self-Monitoring Instructions. Tell him that an essential aspect of the stress-management programme is that he keep a record of situations which cause anxiety or tension. Provide him with a booklet for this purpose and ask that he begin to use it during the coming week.

Data Deposit: Show the client a copy of the Data Deposit Agreement. Ask him to bring a cheque for $20 payable to a charity of his choice to the first group meeting, at which point he will be expected to sign the form. Explain to him that this procedure has been found necessary to avoid loss of information which we need for the research part of this project.

Situational Stress Task: Give the client a copy of the Situational Stress Sheet. The two of you should select one of the situations which have been discussed during your interview. This situation should cause discomfort but not absolute panic. (Should fall around 7 on the tension-rating scale.) It should be relatively easy to arrange, if it will not occur naturally during the coming week. Stress the importance of carrying out the task.

The Questionnaires: After your interview the client should complete the following questionnaires:

1) Self-evaluation Questionnaire (both sides)
2) Social Avoidance and Distress Scale (SAD)
3) Fear of Negative Evaluation Scale (FNE)
4) Past week tension thermometer.
Before the client leaves make sure that:

1. He has received copies of the Situational Stress Form and Self-Monitoring Instructions.

2. He has been given a self-monitoring booklet.

3. He has been given a time and place for the first group meeting (or an arrangement has been made to do this).

4. He has completed all the necessary questionnaires.
Interviewer Assessment Form

Client's name __________________________________________

Age __________ Marital Status ____________

1. When did you first notice that you had a problem? __________________________

2. What have you done about it? (eg. consulted a doctor, taken pills)

3. Are you currently seeing a psychiatrist? __________________
   (Explain that we cannot take people who are currently receiving other treatments)

4. Are you currently taking medication for your nerves? ______________
   a) When did you obtain the most recent prescription? ______________
   b) What is the brand name of the medication? ______________
   (Explain that the client will be expected to continue to take this medication at his present level during the course of treatment)

5. What aspects of your life do you manage well? (eg. work, marriage, children)

6. Do you often have periods of hours or days during which you experience little anxiety or tension? __________________________

7. What kinds of situations pose a problem for you? (Try to get descriptions of three situations).
   Situation 1: __________________________________________
   a) when? __________________________________________
   b) where? __________________________________________
   c) exactly what do you think is upsetting about the situation?

   Situation 2:
   a) when? __________________________________________
   b) where? __________________________________________
   c) exactly what do you think is upsetting about the situation?

   Situation 3:
   a) when? __________________________________________
   b) where? __________________________________________
   c) exactly what do you think is upsetting about the situation?
8. Have you considered receiving treatment for a drinking problem in the recent past? ____________________________

9. Have you been feeling depressed lately? (e.g. withdrawing, losing interest in life, being very self-critical, having little motivation to do anything) ____________________________
   a) How long do these periods last? ____________________________

Assessment of suitability

Please rate the client using the following dimensions. In each case use a 7 point scale, on which 1 = very little of the characteristic and 7 = a great deal of the characteristic.

_____ 1) Motivation for treatment
_____ 2) Specificity of stress
_____ 3) Present clinical anxiety level
_____ 4) Current level of depression
_____ 5) Likelihood of alcoholism
_____ 6) Likelihood of psychosis

Note: The ideal client will come out high on the first two measures, moderate on anxiety level during the interview, and low on the last three measures.
Appendix 2

Instruments
PAST WEEK TENSION THERMOMETER

Name ___________________________ Date ____________

Think back over the past week. Take each day separately and remember as much as you can of what you did, how the day went, and particularly the level of tension you experienced. Now, use the thermometer below to rate your average level of tension for the past week.

- 10 completely tense (not relaxed at all)
- 9
- 8 very tense (only slightly relaxed)
- 7
- 6 tense
- 5
- 4 relaxed
- 3
- 2 very relaxed
- 1
- 0 completely relaxed (not tense at all)
SITUATIONAL STRESS SHEET

Name ________________________________

During your interview you will have chosen a situation which you will undergo during the coming week. This exercise will help to make you more aware of how you experience anxiety.

Please give a description of the situation as it actually occurred:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Using the monitoring scale of tension (0 to 10) rate how upsetting this experience was for you. In addition, please circle the word or phrase in the list below which best described your feeling:

comfortable: didn't bother me
panicky: scared stiff
unsafe: frightened
wonderful: timid
steady: indifferent
nervous: unsteady
fine: worried
In order to evaluate the effectiveness of our programme we would like to find out if changes are occurring in the daily lives of group members. Since you know one of these people well, we would like you to give us your impressions. Please respond honestly and thoughtfully to the following questions. When you have completed this brief questionnaire, place it in its envelope and mail it to us. Your answers will not be seen by the person you are describing unless you choose to reveal them yourself. The information obtained will be used for research purposes only.

For the items below, please circle the number preceding the response which most accurately describes changes you have observed over the past six weeks.

| 1. General tension level: | 1) much reduced | Item to total r | .69 |
| 2) somewhat reduced | | | |
| 3) no change | | | |
| 4) somewhat higher now | | | |
| 5) much higher now | | | |

| 2. Ability to deal with personal problems: | 1) much improved | .79 |
| 2) somewhat improved | | |
| 3) no change | | |
| 4) somewhat reduced | | |
| 5) much reduced | | |

| 3. Ability to function under pressure: | 1) much improved | .54 |
| 2) somewhat improved | | |
| 3) no change | | |
| 4) somewhat reduced | | |
| 5) much reduced | | |

| 4. Tendency to become upset | 1) much more easily upset now | .68 |
| 2) somewhat more easily upset | | |
| 3) no change | | |
| 4) somewhat less easily upset | | |
| 5) much less easily upset now | | |

| 5. Duration of "upsets" | 1) not nearly so long now | .70 |
| 2) not quite so long | | |
| 3) no change | | |
| 4) somewhat longer now | | |
| 5) much longer now | | |
PROGRAMME EVALUATION FORM

Name __________________________________________ Date ____________

A. Self-rated Change
For the items below, please circle the number which precedes the response which most accurately describes changes you have observed in yourself since you first came to the Tension Management Clinic.

<table>
<thead>
<tr>
<th>Item</th>
<th>Response Options</th>
<th>Item-to-total r</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>General tension level:</td>
<td>1) much reduced 2) somewhat reduced 3) no change 4) somewhat higher now 5) much higher now</td>
</tr>
<tr>
<td>2.</td>
<td>Ability to deal with personal problems:</td>
<td>1) much improved 2) somewhat improved 3) no change 4) somewhat reduced 5) much reduced</td>
</tr>
<tr>
<td>3.</td>
<td>Ability to function under pressure:</td>
<td>1) much improved 2) somewhat improved 3) no change 4) somewhat reduced 5) much reduced</td>
</tr>
<tr>
<td>4.</td>
<td>Tendency to become upset:</td>
<td>1) much more easily upset now 2) somewhat more easily upset 3) no change 4) somewhat less easily upset 5) much more easily upset now</td>
</tr>
<tr>
<td>5.</td>
<td>Duration of &quot;upsets&quot;:</td>
<td>1) nor nearly as long now 2) not quite as long 3) no change 4) somewhat longer now 5) much longer now</td>
</tr>
<tr>
<td>6.</td>
<td>What percentage of your problems remain to be coped with?</td>
<td>1) 0% 2) 25% 3) 50% 4) 75% 5) 100%</td>
</tr>
</tbody>
</table>
B. Therapist rating
Please indicate your feelings about your group leader by responding to the items below using the following rating scale:

1 = strongly agree
2 = agree
3 = mixed feelings
4 = disagree
5 = strongly disagree

NOTE: Group leaders will not be reading this form; the results will be used for research purposes only.

<table>
<thead>
<tr>
<th>Item</th>
<th>Item-to-total r</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. S/he seems to be sure of what s/he is doing.</td>
<td>.58</td>
</tr>
<tr>
<td>2. I find his/her explanations of my behaviour confusing.</td>
<td>.35</td>
</tr>
<tr>
<td>3. An older therapist would have been better for me.</td>
<td>.80</td>
</tr>
<tr>
<td>4. Any suggestions s/he made were well thought out and clearly presented.</td>
<td>.59</td>
</tr>
<tr>
<td>5. S/he would be a better therapist if s/he had more experience.</td>
<td>.65</td>
</tr>
</tbody>
</table>

C. Group atmosphere
Using the same rating scale, indicate your feelings about the other members of your group.

<table>
<thead>
<tr>
<th>Item</th>
<th>Item-to-total r</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt close to most of the members of my group.</td>
<td>.61</td>
</tr>
<tr>
<td>2. There were many aspects of my life which I did not feel I could discuss in this group.</td>
<td>.45</td>
</tr>
<tr>
<td>3. I looked forward to group meetings.</td>
<td>.51</td>
</tr>
<tr>
<td>4. I felt very uncomfortable in my group.</td>
<td>.76</td>
</tr>
<tr>
<td>5. I sometimes felt like an outsider.</td>
<td>.54</td>
</tr>
<tr>
<td>6. I felt safe to express my deepest feelings in this group.</td>
<td>.61</td>
</tr>
<tr>
<td>7. I felt that other group members really cared about me as a person.</td>
<td>.68</td>
</tr>
<tr>
<td>8. Sometimes it seemed to me that everyone was only our to help himself.</td>
<td>.37</td>
</tr>
<tr>
<td>9. I felt that some of the people in the group disapproved of me.</td>
<td>.58</td>
</tr>
<tr>
<td>10. There was an atmosphere of warmth and support in the group.</td>
<td>.51</td>
</tr>
</tbody>
</table>
Appendix 3

Problem situations and

typical therapy interactions
Stressful Situations Reported by Clients

Incidence of problem of problem

1. Social Situations
   a. groups of any kind.............................. 7
   b. parties........................................... 6
   c. meeting new people.............................. 5
   d. entertaining guests.............................. 5
   e. public speaking................................ 3
   f. making requests of others.................... 2
   g. using telephone................................. 1
   h. eating in front of others..................... 1

2. Work Situations
   (41)
   a. dealing with unreasonable supervisors......... 5
   b. interruptions in on-going activities........... 5
   c. starting new projects......................... 3
   d. unreasonable requests from co-workers......... 2
   e. meeting deadlines................................ 6
   f. supervising others................................ 5
   g. work piling up.................................. 3
   h. dealing with conflicts among co-workers........ 5
   i. making presentations............................ 4
   j. using the telephone............................ 2
   k. dealing with tenants............................ 1

3. School Situations
   (4)
   a. writing exams.................................. 2
   b. giving seminars................................ 1
   c. writing thesis................................ 1

4. Situations Involving Significant Others
   (19)
   a. dealing with spouse's disapproval.............. 4
   b. disciplining children........................... 4
   c. handling unreasonable demands from spouse...... 3
   d. dealing with domineering relatives............. 3
   e. responding to criticism from others............ 3
   f. handling unreasonable requests from parents.... 2

5. Other Situations
   (12)
   a. driving in heavy traffic....................... 3
   b. visiting doctors................................ 2
   c. being in enclosed spaces....................... 2
   d. being alone..................................... 1
   e. being in high places............................ 1
   f. walking near heavy traffic.................... 1
   g. shopping......................................... 1
   h. meeting a stranger while walking alone......... 1

a This column indicates the number of clients who reported anxiety in each of the problem situations.
Stressful Situations for Individual Clients

C1: dealing with supervisors, supervising others.
C2: attending group meetings, teaching in classroom.
C3: having definite time commitments, criticism from friends.
C4: upsets in work routine, co-ordinating co-workers.
C5: talking to strangers, groups.
C6: conflicts among co-workers, meeting new people.
C7: speaking to large groups, enclosed spaces.
C8: interruptions in on-going activities, confrontations with others.
C9: entertaining guests, being alone.
C10: disciplining children, having suggestions ignored at work.
C11: parties, first meetings, housework piling up.
C12: small social gatherings, dealing with people on the telephone at work.
C13: starting new projects, eating in front of others, meeting deadlines.
C14: dealing with tenants, disapproval of spouse.
C15: driving in heavy traffic, interference from parents.
C16: going to doctors, meeting a stranger while alone on street, driving.
C17: dealing with supervisors, conflict among co-workers, spouse's disapproval.
C18: meeting deadlines, preparing for guests, responding to unreasonable requests from co-workers.
C19: parties, shopping, starting new projects.
C20: work deadlines, social groups.
C21: work piling up, upsets in normal routine.
C22: dealing with unreasonable requests from spouse, group situations.
C23: work deadlines, interference from parents, giving seminars.
C24: deadlines at work, unreasonable demands from parents.
C25: conflicts among co-workers, dealing with supervisor.
C26: examinations, making requests of others.
C27: public speaking, confronting co-workers, dealing with domineering relatives.
C28: dealing with supervisor, supervising others, entertaining guests.
C29: conflict among co-workers, making presentations at work, dealing with spouse's disapproval.
C30: social gatherings, disciplining children.
C31: public speaking, dealing with unreasonable requests from co-workers.
C32: disciplining children, starting new projects.
C33: dealing with domineering relatives, meeting new people.
C34: upsets in routine, dealing with spouse's unreasonable demands, supervision of others.
C35: entertaining guests, using the telephone, large groups of people.
C36: making presentations, driving, working on thesis.
C37: dealing with unreasonable demands of spouse, entertaining guests, making presentations.
C38: parties, using the telephone at work, meeting new people, supervising others.
C39: interruptions in routine, dealing with unreasonable requests from co-workers.
C40: disciplining children, work piling up.
C41: meeting deadlines, examinations, visiting doctor.
C42: bridges and other high places, walking near traffic.
Typical Therapy Interactions

Condition 1:

Interaction 1:

Client: I get very upset when somebody's sick.

Therapist: Just anyone, or did something happen last week?

C: No, all the time. I live with my aunt who has asthma, and she gets attacks sometimes and she doesn't need me really, they pass on their own, but when I hear her coughing I feel nervous.

T: Can you give a specific situation? It will work better if you can give details.

C: Two nights ago. Tuesday maybe. (Pause) I'd just gone to bed and I heard her coughing in her room and I felt so tense, knots in my stomach and tight in back, you know?

T: What did you thing when you heard her coughing?

C: I thought she'd suffocate or something. Then after I couldn't go to sleep, for hours. That's the way it is when I get tense.

T: Was your aunt all right?

C: She always is. The doctor says there's nothing to worry about but what good does that do. I guess I'm too nervous or something.

T: As I see this situation you're saying tension-producing things to yourself. Correct me if I'm wrong, but aren't you thinking things like, "Oh my God, she's coughing again, it sounds awful, I wonder if I should go to her, my stomach is getting knotted up, I'll never get to sleep now", and so on? What effect do you think that has?

C: I don't know if I think anything. What I feel is tense.

T: Why don't you try paying attention to what you're saying to yourself
next time this happens?

Another C: Seems to me that its enough that her aunt is sick, I know that would make me tense. I remember when my mother was sick, It upset me so much to see her, I felt tense all the time.

T: But are you always upset by people being sick?

Other C: Not really.

T: Then it isn't just the situation, not just what's out there that's bothering you. It's how you see it isn't it?
Interaction 2:

Client: I was walking back to my own office and my boyfriend has an office near there and I was going to stop in and pick up a book. And I walked in the office and this secretary is sitting there, you know, with all these engineers and people. It's dead quiet in there, they're all working. I walked in and said "Hi" to her, and told the secretary what I wanted, and my friend was on the phone in this office. I felt really uncomfortable, everything's so quiet and I'm just sort of left standing there. Didn't know if I should wave to him or just stand there and somehow make myself inconspicuous. The sort of feeling was that somehow I was not the same as those people. I feel that maybe they look down on me and I feel on the spot, people looking at me. My stomach started to hurt, and finally after ten minutes he was still on the phone and I left without anything.

Every time I go to that office if I'm near him or his friends, I feel like that. I feel like a little country bumpkin or something.

Therapist: Can we go back to the beginning. First you walked into the office. When did you begin to feel uncomfortable?

C: It was dead quiet and I felt like I didn't want to take another step. I felt far too loud and cheery.

T: OK, so you were saying to yourself, "I'm too loud; too cheery".

C: I was just sort of disturbing everybody.

T: OK, kind of explore, what else were you saying to yourself?

C: I was feeling, somebody please be friendly, somebody say something, don't just leave me standing there.

T: Mmmmm. So you were saying, "nobody is noticing me". I heard you say
something earlier that somehow they're more sophisticated than you are.
C: I feel I'm not on equal footing.
T: Seems to me like the thought, "I'm not as sophisticated as they are
may be upsetting you. Seems like you're also saying to yourself,"
they're all noticing me, I'm in the way, I wonder how I look".
C: Well, I sort of thought, they're just sitting there, and it was so
quiet and I wondered what they thought.
T: What effect do you think those thoughts had on you?
C: I'm not sure.
T: Did it matter what those people thought.
C: I suppose not, they probably didn't care much one way or the other.
T: That's right. So what if you had changed what you said to yourself?
Instead of upsetting yourself like you did, you could have thought, "I
have a right to be here, they aren't noticing me anyway, I know I look
all right".
C: It would be hard because I always feel odd when I go to that office.
T: You don't think you could change. Let's try it here.
(They go on to rehearse coping self-statements which the client can use
in this situation).
Condition 2:

Interaction 1:

Client: I brought my sister and her really young baby and the whole
time I was on the freeway I was really tense because I was sort of thinking
unconsciously maybe, what if I had an accident with them in the car as
well. And it was extra-bad going over the bridge.

Therapist: When did you start to notice the tension?

C: Well I notice it a little as soon as I get onto the freeway. It's
not enough to really bother me.

T: Where do you feel it?

C: In my neck, my legs, my whole body really.

T: Does it get worse as time goes on?

C: It gets worse. Sometimes it gets better, but usually it gets worse.

T: Do you know what you're saying to yourself before you get tense?

C: I guess when I first got on the freeway I was thinking, "Oh Heavens,
what a terrible long trip I have ahead of me, all the way across Vancouver".
And I think I started to tense up then thinking about all the time it
was going to take.

T: Was there noise in the car?

C: I don't think so. Well, we were talking and the baby was crying some
of the time but not very much. My sister talks a lot, you know sort of
steady conversation, I think that made me a bit tenser.

T: How did it work out?

C: When I got to the bridge it got really bad, a feeling of fear,
stiffening up all over. I guess that's the first sign of stress I have.
And then I start to think about it. And now when I go over the bridge
I think about how I've talked about it here (in the group).

T: What were you saying to yourself when you were crossing the bridge and became aware that you weren't doing as well as you had hoped?

C: I thought maybe it was just a feeling I had had of overconfidence because of thinking I'd gotten something out of this. I don't really feel bad about myself - it's a bit of a letdown.

T: How?

C: It makes me really mad.

T: I'm not sure what you're angry at.

C: I'm angry at myself because I let myself get tense. I feel I can't control it.

T: So when you're coming across the bridge you're just starting to get onto the freeway and I think your thoughts go something like, "I don't think I can make it across the bridge, I hope at least I'm successful in getting across, I hope I'm not in an accident, I'm getting tight, if I got in an accident now I could hurt myself, my sister and her baby, it looks like I'm not going to make it across the bridge, I'm really tense, I can't even do this, I'm out of control with it."

C: Yes, that's really the way I think.

T: Did anyone see anything irrational in that sequence?

Another Client: A lot of it was irrational. I noticed that you got to the point where you couldn't cross the bridge and made a jump to being out of control.

A Third Client: I had the feeling that fear of something had taken control of her and overwhelmed her to the point where she couldn't reason.

T: One thing you can do is keep track of exactly how you feel each time you cross the bridge on a five point scale. That way you can get an idea of how you're doing. Without that kind of thing you don't know.
Interaction 2:

C: I was called in by an architect at the last minute to finish a job after someone else was fired.

T: How did you feel?

C: I was distraught. I was very tense all over.

T: Did you shake?

C: I didn't have the shakes when I went down to meet the man but prior to it I was very upset.

T: Do you know what would have made it easier for you?

C: The best would be I'd say not to take it too seriously. Perhaps I did take it a little too seriously.

T: Is that situation likely to happen again because of the profession you're in?

C: Oh probably, probably. Anyway, when I went to meet the owner he showed me some rough plans, layouts and so on.

T: I was wondering if it would have helped if you'd had more information about the man who was fired.

C: Well the other man was, I don't know why he was fired.

T: Would that have made you feel more comfortable?

C: Yeah, I guess so. I don't like treading on people's toes. Anyway, the owner started to make unreasonable demands on me, quoting prices too low. He asked me to do a "take-off" on these drawings in two days. I couldn't do that.

T: Can you tell me what you were saying to yourself. How were you feeling?

C: Well prior to the meeting I didn't feel uptight. It was the moral objection, about taking over for the other builder.

T: Just before the meeting?

C: Well I could feel tension building up, because the other guy got fired.
Anyway at the meeting I told him I just couldn't have things ready as soon as he wanted -- that it wasn't humanly possible. He seemed annoyed, but in the end I got more time to do it in.

T: I wonder what you were telling yourself before you met with him?

C: Well put in those terms, I probably said, "I wonder if this will work out, because the other guy got fired, and I need this job". Maybe I also thought I'd not do it very well.

T: So maybe you were making it hard for yourself?

C: Yes, I suppose I was really. When I think about it now, I didn't really need the job and all that hassle, did I?
Condition3:

Interaction 1:

Therapist: At the end of last week it seemed that you had some specific situation or some incident that was going to be happening soon.

Client: Well, today, I was very busy with dictating and the manageress came down before ten o'clock. Well, the dictaphones are on over night and they take orders and we have to clear them, and we have an eleven o'clock cut-off time when we're supposed to be completely finished. All the work is written up and everything done. People who call back for mistakes are supposed to call before that.

T: Yes.

C: And this morning the manageress came barelling down before ten o'clock and said in a very nasty tone, "I want all these women at the board, we're very busy and they're supposed to take in-coming calls'. And you'll have to finish this up." She drops a pile of orders on my desk.

T: What were you doing then?

C: I was working on my machine.

T: As you're describing it why don't we set up the situation? Move your chair. Set up for role-playing. Want to pick someone to work with you? If she's going to play you, she has to know what you did. (First they go through what was actually done. The client has responded that she can't possibly do the work before the cutoff time. Manageress says she doesn't care. Client feels very upset because she knows she can't do it alone.' The group discusses alternative solutions. It is decided that the best approach to take is for the client to suggest that she wants to do the best job she can and that she is worried that she won't be able to do it under the present circumstances.)
T: Why don't you try it here?

A Second Client: (role playing) I'm going to have to take the women to the board and you will have to finish these tapes.

C: I'm sorry but we're actually really swamped. Is there any possible way that I can have somebody give me a hand?

C2: No, you're going to have to finish them all.

C: I'm afraid I won't be able to before deadline.

C2: I'm sure you'll be able to.

T: Maybe you shouldn't start out in the beginning by saying that the situation is impossible. Say that you're very willing but it isn't possible. Indicate you're willing first. She can't argue if you agree with her. (The client agrees to try this out.)
Interaction 2:

C: I have something that happened. I don't feel good about it, makes me tense to think of it even now. (laughs)

T: Could you tell us about it?

C: I supervise people who work as docents, at the gallery. Sometimes I have to speak to them about poor performance and I had to talk to a woman last week.

T: Could you be more specific?

C: Well one of the docents has a poor attitude toward other members of her teaching team and they complained to me so I had to talk to her and it made me feel nervous for the whole day. But it's part of my job.

T: What did you do?

C: I called her into my office and told her that she should change her attitude. I was frank with her. I thought I should be.

T: But you didn't feel good about it? Could you say more about bothered you?

C: Not really, it seems that other people always make me feel I don't have the right to do what I do.

T: What did you say to her?

C: I said maybe she should try to change her attitude. Then she said she didn't know what I meant at all and anyway she wasn't being paid for what she did.

Second Client: Wasn't she paid?

C: No, docents are volunteers.

T: Can anyone suggest how M--- could have behaved differently?

Another Client: Seems like you were too timid. Sometimes that seems to
be an invitation.

T: What else could M--- have done?
C: I suppose I: set myself up for it.

T: Perhaps if you went over what you were going to say before you did it
it would help. Now what else might you have said?
C: I could have been more definite.
T: How?
C: Well, I could have said that it was part of her job to make things run
smoothly so it was necessary for me to speak to her. I would have explained
myself better, but why should I, she knows I'm in charge. I don't see
why I can't just say what I think and not feel so upset.

Other Client: It's like our next door neighbour. They leave their yard
in such a mess. So I tell them and they get mad.

T: Since what you tried before hasn't made you comfortable, it seems to
me that maybe you should listen to suggestions from others in the group.
Another Client: Like she said before, she should be more definite, let
the woman know where she stands.

T: How could she do that?
C2: She could explain herself.

T: Yes, she could rehearse a little speech in which she tells the woman
in a straightforward way how she feels and what is required. I think she
could say something like "I have heard that there is some kind of conflict
between you and the other docents. Would you like to tell me what your
point of view is? Let's try role-playing it in the group. (They
proceed to role-play the scene and afterward M--- agrees to try out the
new approach the next time a similar situation arises.)