

THE USE OF BIBLIOTHERAPY FOR STRESS
REDUCTION IN NONPROFIT HEALTHCARE EXECUTIVES

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THE USE OF BIBLIOTHERAPY FOR STRESS REDUCTION IN
NONPROFIT HEALTHCARE EXECUTIVES

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ABSTRACT

The use of bibliotherapy is becoming more widely accepted by Americans as a first line treatment for self-improvement. Although there has been a drastic increase in the number of bibliotherapy books published over the past ten years, there is little empirical data to prove that it is an effective means of treatment. This study uses a text from the Norcross (2006) bibliotherapy consensus list in an eight-week intervention program to test its effectiveness for stress reduction in nonprofit executives. Results show significant decreases in stress after eight weeks of intervention and ability to further decrease stress at an eight-week intervention/control group follow up.

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CHAPTER ONE

Introduction to the Problem

Human beings are constantly evolving to meet the demands of their environment. Mentally this evolution requires a change in behavior, one that is often difficult to maneuver without help. This change in behavior sometimes occurs through work with a coach or a therapist. Increasingly however, the first step for an individual will be a stop at the local library or bookstore to peruse the shelves labeled “self-help”. In fact, research shows that 75% of people who change their behavior do so on their own (Klingemann et al., 2001). While there is no evidence delineating the quality of self-help books, Salerno (2005) estimates that over 3,500 self-help books were published in 2003 alone, totaling more than \$650 million in revenue. A quick search on Amazon.com for “self-help” finds 128,690 books available for purchase, while a Google search for “self-help” returns about 34,000,000 results. Despite the popularity of self-help, there remains skepticism and controversy around its use by mental health professionals and a growing need for empirical data in specific populations to determine its effectiveness.

Statement of the Problem

Self-help, therapeutically, was originally given the term bibliotherapy by Samuel Crothers in the *Atlantic Monthly* (1916). Dorland’s Illustrated Medical Dictionary first acknowledged the term in 1941, defining bibliotherapy as “the employment of books and

the reading of them in the treatment of nervous diseases” (Rubin, 1978). Webster’s *Third New International Dictionary* (1961) defined bibliotherapy as “the use of selected reading material as therapeutic adjuvant in medicine and psychiatry; and, guidance in the solution of personal problems through directed reading.” The American Library Association officially accepted the term in 1966, defining it as “guidance in the solution of personal problems through directed reading” (Rubin, 1978).

In the 1980’s, biblical or fiction stories were used as a form of bibliotherapy in which readers identify with characters to gain insight into effective behaviors (Schrank & Engels, 1981). Today, bibliotherapy is used in many forms: unassisted bibliotherapy, in which a text will be recommended by a practitioner and may contain a written program, but no additional therapeutic support is given; assisted bibliotherapy, which contains short intervals of therapeutic support or guidance; and, self-help group therapy, which may or may not include a therapist. Through his decades of research, Norcross (2006) found that “self-help versus formal treatment typically show that self-help texts are almost, but not quite, as effective as therapist-assisted interventions” (p.684). He also provided several examples of empirical research and meta-analyses in which self-help programs were proven to be effective when compared to wait-list and no treatment control groups. In his article, he offered psychotherapists sixteen practical suggestions to help in bringing about a change of attitude among his colleagues related to the definition, use, and recommendation of self-help to their patients.

Thousands of Internet sites and bookshelves in popular bookstores are loaded with solutions and suggestions for self-improvement. While the research has shown that there are several effective publications to be used as a means of self-help, it is difficult

for the layperson to select which publications give good advice and which ones do not.

Norcross (2006) stated,

The urgent task, then, is to separate the wheat from the chaff in self-help resources.... an estimated 95% of all self-help books are published without evidence of their efficacy or safety, and 99% of Internet sites are launched without such evidence (p.687).

Rosen et al. (2003) urged clinicians to study specific bibliotherapy texts in the context and populations for which they were intended to determine true effectiveness. However, the sheer volume of 3,500 books and 15,000 websites dedicated to mental health each year is far too many to study with empirical research. To this end, psychologists have gathered the “best available research and collective clinical wisdom...over the past twelve years” (Norcross, 2006, p.687). Eight national studies have been conducted to determine the most useful self-help resources. From this research, Norcross compiled a list of resources based on peer consensus, including self-help books, autobiographies, Internet sites and commercial movies. When referring to the use of this list as an alternative to controlled research on each of the books, Norcross (2006) stated:

peer consensus is just that: majority opinion as opposed to unanimity... Although professional consensus is no guarantee, it is probably superior to random selection, dust-cover jackets, or bestseller lists. We would, of course, prefer to rely on lists of self-help resources that have been subjected to controlled research and found to be demonstrably effective and safe (p. 687).

Purpose of the Study

The purpose of this study is to determine if bibliotherapy is an effective alternative treatment for decreasing stress in the nonprofit healthcare executive population.

Focus Questions

This inquiry is guided by a central research question as follows:

Does bibliotherapy influence stress levels of nonprofit healthcare executives?

To ascertain a workable answer to the focus question, two ancillary questions must be addressed:

1. Is bibliotherapy effective in decreasing perceived stress levels of nonprofit healthcare executives?
2. Will the intervention group maintain any decrease in mean stress scores at an eight-week interval after treatment with bibliotherapy?

Significance of the Study

This study will contribute to an understanding of the effectiveness of psychological self-help outside of formal treatment. Norcross (2006), with contributions from over 3,500 Psychotherapists, compiled a consensus list of the top twenty-five resources in three categories: self-help books, autobiographies, and films that are routinely recommended by therapists to individuals searching for reliable self-help. Because of the volume of published and internet-based self-help materials, it would be impossible to empirically review every resource. Norcross suggests that empirical review begin with the consensus list. The chosen text, *The Relaxation and Stress Reduction Workbook* (Davis et al., 2008) appears as number eleven on the self-help book consensus list, but is the only text directly addressing stress reduction and relaxation. There is no documented empirical data to date on whether or not bibliotherapy can be useful or effective for stress reduction.

Limitations of the Sample

This study seeks to explore the use of bibliotherapy in effectively decreasing stress in nonprofit healthcare executives. The stress level of the nonprofit healthcare executive can be significantly influenced by specific or time-sensitive events during the year that increase workload, such as annual conferences and board meetings. For this reason, the phenomenon of nonprofit healthcare executive stress needs to be studied as it naturally occurs without manipulation or control of variables. In addition to work stress, there are other factors that impact stress levels of the nonprofit healthcare executive. The data gathered in each setting is very dependent on these contexts, which could limit the generalizability of the findings. As a means to gather meaningful information for the study, the follow up surveys attempted to identify any unforeseen changes in events that would cause increased stress, which will be reported in the results if data is skewed or normalcy is affected.

Nonprofit healthcare executive positions can be very challenging and time consuming. The self-help workbook provided to the intervention group required the nonprofit healthcare executive to read, reflect, and apply the principles of treatment to their own situations as they arose. To help standardize the process, the researcher provided a weekly protocol and reflection tools for the study as a measure of fidelity. These added safeguards allowed readers to judge the information and make their own decisions about whether or not the themes that emerged from the research could be transferred to their own situations.

Summary

Chapter One contains the introduction of the study, including the background information, the problem statement, the purpose, the significance of the study, and the limitations of the study. Chapter Two consists of a review of the literature including histories of stress, stress reduction, bibliotherapy for healing purposes, the use of bibliotherapy for stress reduction, and a summary of the limited amount of research available related to stress reduction in the nonprofit healthcare executive. Chapter Three details the research design and methods used in the study. Chapter Four contains a summary of the data and results, along with analyses. Finally, Chapter Five contains the conclusions, implications, and recommendations for further study.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

Chapter two begins with a summary of literature related to the historical perspective of stress, the emergence of workplace stress, methods of stress reduction used throughout history, and the use of various types of bibliotherapy as a means of treatment. This is followed by a synopsis of literature detailing the use of bibliotherapy for stress reduction. Next is a review of the limited amount of literature that has been conducted to specifically address the reduction of stress in the nonprofit healthcare executive population.

A Historical Perspective of Stress

Stress has been examined in human lifestyle for many decades. Noted as one of the most influential scientists on the subject, Lazarus (1966) stated that stress arises in human beings when demands of a situation exceed individual ability and resources. Acclaimed Scientist Selye (1974), often referred to as the ‘Father of Stress,’ states that stress is a result of failure to deal with present situations or danger that face an individual. While he felt that moderate stress levels were motivating and helped to maintain focus on a task, Selye cautioned that high levels of stress could threaten homeostasis and lead to the deterioration of health. He went on to classify stress into four categories: 1) Distress (negative stress); 2) Eustress (positive stress); 3) Overstress (which leads to burnout); and 4) Understress (which leads to idleness and lacking motivation). Researchers during the Second World War became alarmed at the results of what they referred to as “combat stress” among American soldiers.

Grinker and Spiegel (1945) attempted to identify the factors that were causing high numbers of soldiers to suffer emotional breakdowns. These researchers coined the terms “battle

fatigue” and “war neurosis” while advancing the perspective that stress was a psychological manifestation rather than neurological as had been thought when shell-shocked soldiers returned home after World War I three decades earlier.

Lazarus (1966) categorized stressors as being internal or external. He defined internal stressors as those characterized by one’s personality. For instance, individuals who tend to be aggressive, compulsive, perfectionistic, and non-trusting are said to have high levels of internal stress. External stressors are stimuli that threaten us in either visible or invisible ways. For instance, high workloads, emergent situations or tasks, expectations of others, bad news, traffic, pollution, disasters, and war are all examples of external stressors that can affect our ability to cope.

In his historical perspective on the topic, Lumsden (1981) provided a definition of stress as “any hardship or adversity.” Given this simplistic definition researchers have identified incidents of stress relating back to the beginnings of the world as viewed by Judeo-Christians in the Holy Bible, when Eve was coerced by the serpent to eat fruit from the tree of eternal life.

Hinkle (1973) argued that currently accepted definitions of human stress actually grew out of the work of physicist Robert Hooke during the seventeenth century. Hooke’s research dealt with the physics of stress on man-made structures, identifying how these structures could better survive the effects of wind, earthquakes, and other forces of nature. Hinkel notes that Hooke’s work advanced the 20th Century definition of stress as “an external load or demand on a biological, social, or psychological system.” Selye (1974) further expanded this thinking through his explanation of the physiological response to the external load of stress. His work stated that when faced with acute stress, the human body secretes a stress hormone (adrenal gland cortex) to alert and provide energy in the forms of increases in blood sugar and blood

pressure to allow the body to cope with the impending stress. He also categorized this physiological response into three stages of adaptation, calling it the General Adaptation Syndrome (GAS). The three stages include: 1) the stage of alarm reaction, in which the hormone is released and there is an increase in blood sugar and blood pressure; 2) the stage of resistance, where the effects of elevated blood sugar and pressure give extra strength and energy to cope; and 3) the stage of exhaustion, in which the body struggles if required to maintain high levels of stress for an extended amount of time. Excessive time spent in the stage of exhaustion is what leads to a breakdown of health and wellness. The ideal adaptation comes when a person is cognizant of the stress and effectively deals with it in the first stage of adaptation.

The work of researchers such as Grinker, Spiegel, and others during wartime was expanded during the latter 20th Century. Hooke's analyses of stress more than three hundred years earlier continued as the determining factor of whether an incident was or was not conducive to stress, while researchers including Brown and Farber (1951), Lazarus and Eriksen (1952), Maddi and Kobasa (1984), and Rosenbaum (1990) expanded the scope of stressful conditions to include many conditions of ordinary life. These included but were not limited to marriage, school, illness, and workplace issues.

While studies of the stress phenomenon were abundant through the first half of the twentieth century, theories related to coping with stress did not begin to emerge on any widespread basis until later. Initial coping studies, such as Lazarus (1966) and Calhoun and Solomon (1984) advocated removal of stress-causing variables from one's life. It became quickly apparent based upon follow-up studies, however, that this was not always possible. Books and journal articles mostly published since the 1980's have advocated techniques or strategies for coping with stress-inducers that must be a part of one's life. While some of these

publications fit into the realm of pop culture, others are based upon research. Scholars like Harre (1986), Plutchik and Kellerman (1989), and Frijda (1986) have documented positive results based upon increased emotional well-being for stress sufferers.

Workplace Stress

With Americans working longer hours than any point in history since the agrarian age, the phenomenon of workplace stress has grown significantly over the past three decades, to the point where it is often considered a condition unto itself. Kweon et al. (2008) have gleaned from surveys that approximately 40% of American workers regularly deal with workplace stress.

They have identified ways in which workplace stress manifest itself, such as excessive absenteeism, declines in productivity, deterioration of physical health, and aggression against others. These manifestations are costly for organizations in more than human resources. It is estimated that stress-related illnesses cost more than \$4.2 billion year (Benton, 2000).

The significance of workplace stress within the overall landscape of stress in general was documented by Bradley and Sutherland (1994), who stated that 55% of all reported cases of stress arose from the workplace.

Increased incidents of workplace stress have, in recent years, resulted in a separate definition being developed for the phenomenon. One more widely accepted definition was developed by Wright (2007). It defined workplace stress as occurring when “the demands of employment exceed the controls of the individual needed to interact with those demands.”

Kleiner and Ornelas (2003) identified two major types of workplace stress: acute and chronic. Acute stress is identified as being more immediate but usually of shorter duration, such as an argument with a co-worker or files that are lost on a computer. Chronic stress is more long-term, and can include factors like holding a job that one dislikes or working for an unfair supervisor.

Edwards (2009) concluded that stress like that described by Kleiner and Ornelas was widespread in the American workplace and not necessarily limited to certain levels of an organizational chart or certain salary levels.

Stress Reduction

As might be expected, once the concept of personal stress was isolated and categorized attempts to remedy its root causes were explored. Stress reduction is not the sole domain of any one classification of practitioner, but is offered by psychologist, psychiatrists, medical doctors, and less-traditional professions such as massage therapists, holistic healers, and acupuncturists.

The ability to cope with stress is thought by some to be deeply rooted in our belief system. Cohen (1995) states that those who can think critically and observe a situation logically can help to reduce stress. Lazarus (1966) examined one's self-efficacy as a means of dealing with stressors effectively. He determined that those with positive self-efficacy could more easily cope with stressors. However, if that self-efficacy was non-existent or if the stressor was prolonged, stress levels would increase and the ability to cope would decrease, thereby leaving one feeling frustrated, fatigued, and even depressed. These feelings, over time, lead to a deterioration of health.

Over the years a number of stress reduction treatments have evolved and found their place in society. For any treatment to be considered viable it must be supported by extensive evidence. One of the earliest of these treatments, developed by physician Edmund Jacobson in the 1920's, is referred to as Progressive Muscle Relaxation (PMR). Involving the alternate tensing and relaxation of muscles, PMR was based on evidence that stress is typically accompanied by muscle tension, and elimination of the tension will result in a corresponding decrease in personal stress. Much of Jacobson's work is still in evidence today, as practitioners

often start treatment with relaxation exercises that vary little from those developed almost a century ago.

An outgrowth of PMR was developed by Schultz (1950) and labeled Autogenic Training (AT). Essentially, Jacobson's relaxation techniques were moved from the physician's office to the home or workplace of the stress sufferer. A series of commands or exercises are taught to the patient over a period of four to six months, after which they can command their body to relax, reducing heart rate, blood pressure, and breathing to a point where stress is minimized. While success using AT has been documented, initial claims that the practice could help eliminate such significant conditions as heart disease or asthma have since been disproved.

Important findings related to brain function by Harvard University's Herbert Benson in the 1960's led to development of Relaxation Response. Benson's team of researchers discovered that the brain actually possesses a counterbalancing mechanism to stress, and that by stimulating other areas of the brain can reduce stimulation of the hypothalamus, the area of the brain where stress originates. Patients using Relaxation Response can achieve decreased stress levels in just ten to twenty minutes a day, through repetition of a word or sound that has been associated with stimulation of the brain.

Researchers gathered at Santa Monica hotel during the summer of 1969 consolidated a number of research studies and practices into the concept of Biofeedback. According to Moss (1999) instruments are used to measure physiological activity such as breathing, heart rate, brainwaves, and skin temperature. Once compiled, the data is fed back to the patient who, working with a therapist, plans changes in emotions, behavior, and thought that will bring about desired physiological changes which, in this case, would be stress. Over time the practice of biotherapy has evolved to the point where only licensed biofeedback therapists formally practice

in the area. Patients are in treatment for three to six months, after which they should have developed the skills needed to take control of their physiological functions.

The practice of Guided Imagery as a stress reducer owes its origins to Native American tribes that existed long before the European colonization of the New World. Joe (2006) wrote that imagery-related techniques of stress reduction were introduced to the modern world in the 1960's, then grew in prominence after being presented at a 1982 Marquette University Conference called "The Power of Imagination." This form of Guided Imagery still exists today and is usually taught to patients as part of a four to eight-week course. Patients select images that they consistently find pleasing or symbolic to certain positive responses. When the onset of stress is felt the patient is taught to concentrate on those images to achieve a state of relaxation.

One of the more popular stress reduction techniques in use today is diaphragmatic or deep breathing. Common to practitioners of yoga, deep breathing has been acknowledged for centuries as a viable means to arrest high levels of tension or stress. Jerath et al. (2006) define diaphragmatic breathing as "manipulation of breath movement contributing to a physiologic response." Responses can include decreased heart rate and blood pressure accompanied by increased theta wave amplitude in EEG recordings. A trained professional typically teaches patients, though it is acknowledged that many individuals have successfully gleaned the practice through trial and error.

Thanks in no small part to the Beatles and the 1960's hippie and peace movements, Transcendental Meditation (TM) grew in prominence during the latter 1960's. Introduced to the West by Indian scholar Maharishi Mahesh Yogi, TM is practiced for twenty minutes each day by sitting with one's eyes closed and repeating meaningless sequence of sounds called a mantra. Jevning et al. (1992) debunks the common misperception that TM is a religion or cult, noting

that it is a seven-step course taught by instructors who have earned TM certification. Walton et al. (2004) describe “a natural shift of awareness to a wakeful but deeply restful state.”

A final treatment technique, the most recent of those reported, was developed in the 1990's and is referred to as the Emotional Freedom Technique. According to the website, EFT Universe (2012), EFT was developed by therapist Gary Craig based upon his findings and the research of others that emotional trauma contributes significantly to physical pain and stress. Treatment using EFT involves tapping on nine pressure points of the body while repeating a preselected phrase. Patients are initially under the care of a practitioner, but eventually are able to treat themselves.

Historical Use of Bibliotherapy for Healing

The use of literature to aid in healing can be traced all the way back to the time of the great philosopher Aristotle (Salup & Salup, 1978). Rudman (1995) states early use of literature as a form of healing was first noted on library epigraphs around 300 BC in Alexandria and Greece, which stated they were created for the purpose of “Medicine for the Mind” and “healing of the soul”. His historical account also describes the first known prescribed use of literature for healing purposes in 1272, when the Koran was used as part of a treatment plan at a hospital in Cairo. The use of literature to help in the healing process continued to be used in correctional, psychiatric and medical facilities throughout the middle ages. McDaniel (1956) reported that books were used as a basis for moral foundation to help correct behavior, and aid in the healing of medical and physical disorders. Weimerskirch (1965) asserted that the prescription of books in Europe in the 18th Century were used primarily in the treatment of the ‘mentally insane’, treating both the moral and physical conditions from which they suffered. He further stated that

by the end of the 18th Century, most European psychiatric hospitals contained libraries due to the popularity of the treatment method.

It was the 19th Century before books were routinely used as a treatment modality in the United States. McDaniel (1956) writes that during that period hospital libraries began to increase their selection of literature to include books for amusement, rather than strictly religious and moral readings in the United States. Dr. Benjamin Rush was the first known physician to prescribe books for healing his medical patients in 1802, and expanded this treatment practice to his mental patients by 1810 (Weimerskirch, 1965). In addition to silent reading, his treatment plans included audible reading, copying text from manuscripts, and committing certain parts of the prescribed literature to memory.

Dr. John Minson Galt II was the first physician to write an article on the use of literature for therapeutic purposes. He strongly believed that reading lists should not be too intellectually demanding and that they should not excite impulsive emotions. He published his most notable work in 1853, titled *On Reading, Recreation and Amusement for the Insane* (cited in Weimerskirch, 1965). Galt identified five main benefits of reading for the treatment of mental patients: 1) reading occupies the mind so that morbid thoughts and delusions can be avoided; 2) reading passes time; 3) reading communicates instruction; 4) reading aloud to the patients allows hospital employees to show a kind disposition toward their patients; and 5) reading aloud to the patients keeps them occupied and therefore makes them easier to manage.

In 1904, the first American-trained librarian, Kathleen Jones, was specifically qualified by the American Library Association (ALA) to assist physicians by directing the patient library at Boston's private psychiatric MacLean Hospital (Tews, 1970). This appointment created notable tension between physicians and librarians that would last for nearly forty years.

The first formal reference to the term bibliotherapy came a few years after the turn of the Century in 1916, when the Reverend Samuel Crothers wrote an article in the *Atlantic Monthly* describing a process in which fiction and non-fiction books were prescribed to adults to treat a variety of conditions, including depression. The process described is very similar to what is now referred to as ‘assisted bibliotherapy’ in which adults returned to discuss the content with their Therapist.

During World War I, Army hospitals began to establish libraries that would aid in diverting adversity or nurturing soldiers to continue their duty to their country (McDaniel, 1956). In 1923, a formal bibliotherapy program was established for the first time in a Veterans Administration hospital, using a specified set of bibliotherapy to aid in increasing self-esteem, develop adequate skills for living in society, knowledge development, and entertainment (Tews, 1970).

The use of bibliotherapy in children began with a recommendation from Bradley and Bosquet (1936) apprising physicians about the use of books for children who had behavior or personality disorders. In their recommendations, they included a specific bibliography and stated four therapeutic function of bibliotherapy for children: 1) overcoming resistance; 2) developing hobbies and special interests, such as sports; 3) informal schooling for those children who were unable to attend public school; and 4) supervised activity between scheduled appointments with their therapist. From this initial work, a wealth of bibliotherapy advocates began to surface, developing bibliographies of children’s literature that could be used to treat personality and behavior disorders.

In 1937, Dr. William Menninger attempted to bridge the gap that had formed between physicians and librarians by creating an operational plan to differentiate responsibilities of both

parties and gain additional support from his physician colleagues to support the use of bibliotherapy as a method of treatment. His recommendations included physician responsibilities of approving all books before their purchase for the hospital library, approving the weekly reading list of his patient after a formal interview, and meeting weekly with the librarian regarding results and communication of any problems that had arisen throughout the week. He further outlined the responsibilities of the librarian to include the purchase, maintenance, and distribution of books, knowledge of which books were loaned to all patients, speaking with patients about their feelings related to the reading, and completion of detailed reports for each physician related to the patient comments about the prescribed book (Menninger, 1937).

After Dr. Menninger's work became published, social scientists began to look at the science of bibliotherapy as a treatment modality. Alice Bryan (1939) noted that although there could be promise in the use of bibliotherapy, there was little evidence present beyond anecdotal remedies. She identified the need to collect a body of experimental data that would conclude beyond scholarly doubt that bibliotherapy was effective. Bryan's skepticism is still echoed today among many health care practitioners, as there continues to be ongoing debate about the efficacy of bibliotherapy as an effective means of healing.

By the 1960's, bibliotherapy was becoming more popular and supported by many professions. In 1964, the American Library Association (ALA) held a consensus workshop, attended by physicians, psychologists, librarians, educators, and chaplains. Workshop attendees developed three major requirements for bibliotherapy to continue to develop as a scientific field: 1) bibliotherapy training courses must be created for multidisciplinary groups to gain required skills in order to use the treatment effectively; 2) there must be outcome research conducted to

fully understand the field; and 3) a standard nomenclature must be created for all practitioners (Tews, 1970).

In 1977, Sharon Spredemann Dreyer published the first known thesis on bibliotherapy, which focused on Children's literature for the needs and problems of youth aged 2-18. In 1994, the book was published in its fifth edition. In 1980, Warner reviewed twenty-eight studies conducted on bibliotherapy from 1969-1980. She reported that ten studies reported no success; in four studies, short term gains were not maintained at follow up; in two studies there was some reported improvement but did not transfer to a change in behavior; four studies found other techniques more successful than bibliotherapy; two studies endorsed bibliotherapy in conjunction with other techniques. Her review of the two studies who had reported unqualified success found that one did not attempt any follow up or transfer to behavior changes, and the other was testing reading ability as it related to bibliotherapy rather than the effectiveness of bibliotherapy as a means of treatment. She concluded that any positive results seen with bibliotherapy "may be short term and may not translate into changes in behavior" (p. 108).

Glasgow and Rosen's work (1979) was a pivotal point in the differentiation of the nomenclature of bibliotherapy. Their work divided bibliotherapy into four types of self-help: 1) the Self-Administered approach, where there is no contact with the therapist and a written treatment program is the only basis of therapy; 2) the Minimal-Contact approach, where clients rely mainly on a written treatment program, but do have some contact with a therapist. An example of this approach would be a weekly phone call in which the therapist answers questions and encourages the client to continue; 3) the Therapist-Administered approach, where the therapist has regular contact with the client, gives frequent instruction, clarifies expectations and discusses the client reactions to the self-help materials at frequent intervals; and 4) Therapist-

Directed approach, where therapy is completely directed by the therapist and self-help materials are only used as an adjunct to regular therapy sessions.

The 1990's brought about a series of studies that would emphasize the increased use and effectiveness of bibliotherapy as a treatment alternative. Grant, Salcedo & Hynan (1995) conducted an outcome study on quality of life therapy for depression using bibliotherapy. The study included 16 participants who were diagnosed as clinically depressed but had no other disorders. The participants also indicated they were interested in bibliotherapy as a means of treatment. The participants "met weekly to discuss a manual on 'Quality of Life Therapy'" (p. 1203). Participants who completed the treatment were "reclassified as non-depressed and showed significant increases in quality of life and self-efficacy at the end of the treatment. All but one subject maintained these improvements at a follow up assessment" (p. 1203). An additional study that year reported by Jamison and Slogen (1995) included eighty depressed community members from Tuscaloosa, Alabama. Each member participated in minimal contact bibliotherapy. Results showed that the intervention bibliotherapy group had statistically significant decreased levels of depression, as well as significant decreases in dysfunctional attitudes and negative thoughts and they maintained their level of improvement at a three month follow up. Marrs (1995) used meta-analysis to examine the effectiveness of bibliotherapy. He analyzed seventy samples (mean estimated effect size $[d] = +0.565$) in which bibliotherapy treatment groups were compared to control groups and therapist-administered treatment groups. Results showed no significant differences between the two treatment groups and no significant loss of effect sizes at follow up. The analysis also highlighted areas in which bibliotherapy might be most effective: anxiety, sexual dysfunction, and assertion training. Bibliotherapy was not felt to be as effective for weight loss, impulse control, and studying problems, as these types of

problems responded better with increased therapist contact. Marrs' meta-analysis encouraged researchers to focus any further bibliotherapy research on specific needs within particular helping professions. Forrest's review of the literature (1998) concluded that bibliotherapy was utilized mostly by psychologists (57%), followed by librarians (20%), nurses (11%), and social workers (10%).

Differentiation of bibliotherapy began in the mid to late 1990's. In 1997, Doll and Doll provided a continuum-based division of bibliotherapy into three categories: Developmental Bibliotherapy, Interactive Bibliotherapy (guided reading), and Clinical Bibliotherapy (Prescribed). The main focus of this study was bibliotherapy for children and adolescents, a topic that has been well documented in literature. Developmental bibliotherapy is the personalization of literature for the purpose of meeting normal ongoing life tasks, emphasizing general personality development. It is often used in school-aged children to explore normal socialization. Interactive bibliotherapy focuses on the process of growth, change and healing around topics such as self-esteem, social skills, responsibility, sharing, honesty, and conflict resolution. The growth, change and healing occur not merely by the reading, but also the guided discussion that occurs after the reading. Clinical bibliotherapy is an intervention used to help persons severely troubled with emotional or behavioral problems that interfere with daily functioning. Topics include eating disorders, anxiety, anger management, and depression. Additionally, it includes follow-up and evaluation by a therapist in order to be effective (Doll & Doll, 1997).

Additional research on bibliotherapy has been the focus of many empirical studies as well as meta-analyses over the past fifteen years. These meta-analyses consistently indicate that bibliotherapy exceeds outcomes of those who have been placed on wait-lists or no-treatment control groups (Norcross, 2006). Topics discussed as promising in 1995 by Marrs continue to be

reviewed and show increasing evidence in favor of bibliotherapy in the areas of depression, anxiety, sexual dysfunction, and alcohol addiction. Additional positive factors include the cost savings of bibliotherapy when compared to therapist-assisted interventions (Norcross, 2006).

Bibliotherapy for Stress Reduction

Quick et.al (1997) described stress as an unconscious utilization of internal resources as a means of adjusting to changes or demands in a person's environment, exhibited through physical, psychological or behavioral means. They also expressed that some stress was useful to allow individuals to obtain and maintain their highest level of achievable health and performance. Lazarus & Folkman (1984) found that individuals would react differently based on their own cognitive appraisal and judgment of the situation and its effect on them personally.

There is limited literature on the effectiveness of bibliotherapy specifically for stress reduction. Some of the earliest research was conducted by Hiebert et.al (1983) and included two groups of participants: one group with therapist-instructed relaxation and one group who self-instructed relaxation and stress reduction using bibliotherapy and home practice sessions. Results showed that there were no significant outcomes between groups, and reliable changes on all self-monitored home practice measures were observed. In 1986, Kiely & McPherson studied the use of self-help specifically for stress-related problems. The authors reported that self-help was significantly superior to a control group ($d = .88$) in terms of scores on the general health questionnaire and change in number of psychological consultations, but not in patient-rated improvement. Review of the study shows a small sample size of twenty-seven and non-blindness of the practitioners, making interpretation difficult. Cohen (1993) used fictional bibliotherapy in a qualitative study with positive treatment outcomes in stress reduction when the participant

could identify specifically with a character or situation. Cotton (2000), after conducting an extensive literature review, stated

It is appealing to think that one can learn to manage stress by reading a book. This has not yet been proven. One would suspect that a relatively intelligent and essentially healthy person could gain some benefit from reading some of the self-help books on stress management which are currently on the market...In the absence of any concrete evidence that any of these books does in fact evoke significant change, one cannot recommend books as a means of therapy by themselves (pp.17-18).

One year later, Bower et al. (2001) conducted a review of all studies from 1966-1999 with select keywords related to self-help bibliotherapy. The author concluded, "Some psychological treatments can be provided in a self-help format which has the potential to reduce the cost of treatment and increase access to specialist help. There is preliminary evidence that these treatments are more clinically effective than general practitioner care" (p. 844). Among the first studies to review internet-based bibliotherapy was Zetterqvist et al. (2003). The study showed significant reductions in perceived stress, anxiety and depression in the treatment group. Jorm et al. (2004) did a thorough review of all literature on complementary and self-help treatments for anxiety disorders, of which acute stress was included. The findings related to bibliotherapy used for stress reduction included a review of several meta-analyses. The results found that "bibliotherapy has been found to be most effective in reducing anxiety when the problem is circumscribed in its nature (e.g. specific phobias), and when the individual is highly motivated to undertake treatment" (p.46). Van Straten et al. (2008) offered a four-week internet-based program targeting reduction of depression, anxiety and stress. The study results showed that the intervention was effective in reducing symptoms of depression and anxiety and in enhancing quality of life.

The most recent studies found related to stress reduction through the use of bibliotherapy included a study done by Riahinia et al. (2010). Their work, conducted in Iran, studied forty postgraduate students who suffered from stress, as diagnosed by a Depression, Anxiety and Stress Scale (DASS) subscale score >20. The students were placed in one of three groups: a bibliotherapy group which included group reading of a biography of a person who had to deal with many problems during his life followed by discussion; a group receiving counseling by a psychologist; and a control group. Measures included pre and post testing using DASS before and after eight sessions of treatment, and participant evaluation of the experience. Results show that there is a significant difference in mean scores of students receiving bibliotherapy or individual counseling when compared to the mean scores of the control group. However, their findings showed that counseling was the most effective means of treatment and offered no follow up to test if results were sustained over time. Kilfedder et al. (2010) studied stress reduction based on three groups receiving face-to-face counseling, telephone counseling, or bibliotherapy. The bibliotherapy workbook provided to the participants was produced specifically for the study and was described as an occupational Stress Management workbook based on the interactional model of occupational stress. The results of the study found that, when considering treatment options and cost, one should use “bibliotherapy as the first line of intervention, followed by telephone and face-to-face counseling as required” (p.242).

As can be gleaned from recent research, primary findings on bibliotherapy for stress reduction have been somewhat positive and parallel findings of bibliotherapy in general. As many experts have noted in their studies, research specific to self-help books or specific topics used in specific populations will increase the reliability of the use of bibliotherapy as a technique

to be supported and recommended by therapists independently or with the assistance of a therapist.

With all of the research that is evolving, the question remained as to whether significant numbers of therapists were actually using bibliotherapy in their practice. In an attempt to answer this question, Ouzts (1991) conducted a survey to determine how many health care practitioners routinely used bibliotherapy. The results of the 487 Portland health care practitioners showed that 88% of psychologists, 59% of psychiatrists, and 86% of internists used bibliotherapy as part of their practice.

Stress Reduction in Nonprofit Healthcare Executives

This research study is focused on stress reduction in nonprofit healthcare executives. A thorough review of the research conducted over the past thirty years indicates very limited research related to nonprofit healthcare executive stressors, or stress reduction for nonprofit healthcare executives. In a study of 500 of its members conducted by the Institute of Directors (1998), forty percent of respondents regarded stress as a major problem in their organization. Worrall & Cooper (1997) conducted a similar study of for-profit and not-for-profit managers and found that sixteen percent had taken time off because of stress within the past twelve months. Only one study, conducted by Herbert (2004), specifically addressed the stress and burnout of nonprofit healthcare executives. Her review of literature concluded that the current publications do not speak specifically to the stress levels of nonprofit healthcare executives and encouraged further research in this population. Eaton (1980) suggests that nonprofit human service professionals are prone to stress because of organizational demands to shoulder personal responsibility for other's significant problems but often lack the power or means of doing much

about them, as well as the likelihood of internalization of these factors by the human service professional.

Weaknesses of Existing Research Base

Although much has been written regarding the history and impact of bibliotherapy as a means of treatment, there continues to be an overwhelming amount of new information published every year, most of which has no empirical data to support its use for effectively meeting the needs of the consumers who are searching for self-improvement. Adding to the confusion, therapists are skeptical about the use of bibliotherapy as an adjunct to or in place of individual or group therapy sessions.

Stress in the nonprofit healthcare executive was identified more than twenty years ago as a very real problem. Very limited research, however, focuses on this population. With the recent recession, the nonprofit sector and therefore the executives that lead the sector are under even more stress. Decreases in private and governmental funding as well as increased reporting requirements have put more demands on nonprofit leadership over the past four years (McLean & Brouwer, 2010). Schwinn & Sommerfield (2002) indicated that the primary reason for turnover in the nonprofit sector was related to stress from the demands of the job. The research gap identified by Herbert in 2004 continues to grow regarding the stress and coping mechanisms of the very important segment of American leadership. More research is needed to help find ways to decrease burnout and increase the wellness of our nonprofit healthcare executives.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

Introduction

Chapter Three details the purpose and methods used in this study. It begins with an overview of the problem and purpose, followed by the research questions to be addressed along with anticipated hypotheses. Participant selection and data collection will also be addressed. The sample of nonprofit healthcare executives is defined and grouped and the data gathering processes and statistical procedures are described.

Problem and Purpose Overview

The purpose of this study is to examine the effectiveness of bibliotherapy for stress reduction in the nonprofit healthcare executive population. The chosen text was selected from the consensus list of top rated self-help books developed by Norcross (2006). Titled *The Relaxation & Stress Reduction Workbook, 6th Edition* (Davis et al., 2008), it was the only title on the list to focus specifically on stress reduction.

Research Questions and Hypotheses

1. Is bibliotherapy effective in decreasing perceived stress levels of nonprofit healthcare executives?

Null Hypothesis: There is no statistically significant difference between the mean stress scores of the intervention group before and after bibliotherapy treatment for stress reduction.

2. Will the intervention group maintain any decrease in mean stress scores at an eight-week interval after treatment with bibliotherapy?

Null Hypothesis: There is no statistically significant difference between the mean stress scores of the intervention group after treatment with bibliotherapy and at an eight-week follow-up.

Participant Selection

Power analysis was conducted to determine total group size needed to produce medium effect and adequate power. Results show that twenty-four participants in each group would give sufficient power (see Table 1). The study participants were chosen from within member community forums of The ASAE, a professional nonprofit executive association. Healthcare executive groups were petitioned online to join the study, using the subject line “Seeking Healthcare Executives who feel that stress is beginning to diminish their life happiness and personal effectiveness”. Within two weeks 78 candidates had stated interest in participating. Consent forms (see Appendix Eight) were emailed to each of the candidates. Of the seventy-eight contenders, eight were removed for failure to respond or sign the consent documentation. The remaining seventy were randomly assigned to either the intervention group or the control group. After initiation of the study, four participants were removed for failing to complete the pre-survey before the deadline, one removed herself due to time constraints, and one stated she was attending another course on stress reduction, thereby disqualifying herself from the study. This left the final group size of twenty nine in the intervention group and thirty five in the control group, meeting the power analysis requirements of twenty-four per group.

Data Collection

Online surveys were sent via an online survey tool Constant Contact (www.constantcontact.com) to all of the study participants. Demographic data was collected initially in order to determine if any covariates were present that could significantly affect the

perceived stress levels of nonprofit healthcare executives. Two widely used Stress Scales were selected as the measures for the study:

The Perceived Stress Scale (PSS) (See Appendix Four).

The PSS is a widely used 10-item self-report scale that measures the perceived stress level of the participant. The raw sub-scale score for the PSS-10 ranges from 0-40. In a validation study by Cohen et al. (1983), the PSS scale is described as

a brief and easy to administer measure of the degree to which situations in one's life are appraised as stressful. It has been proven to possess substantial reliability and validity; thus, it provides a potential tool for examining issues about the role of appraised stress levels in the etiology of disease and behavioral disorders (p. 385).

PSS-10 has been found to provide better predictions for psychological symptoms, physical symptoms and utilization of health services than other similar instruments (Cohen & Williamson, 1988). In a cross-sectional study, higher PSS scores were associated with greater vulnerability to stressful life-event-elicited symptoms (Kuiper, Olinger, & Lyons, 1986). Normative data Studies were completed with the PSS in 1983, 2006, and 2009, the latest reported in 2010 (Cohen & Janicki-Deverts), which showed a mean PSS-10 score for those employed full time of 16.23 (SD 7.31).

The Depression, Anxiety, and Stress Scale (DASS) (See Appendix Five).

The DASS is a 42-item self-report instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress (See Appendix Five). The test has reliability and validity testing that proves it can be used to assess pre and post- treatment levels of depression, anxiety and stress. Although all data was collected, only the stress data was extracted for use in this study. The raw sub-scale score on the DASS-42 ranges from zero to forty-two. Crawford et.al (2009) conducted a normative data study of the DASS, among other

tools and reports a mean DASS stress score of 9.27 (SD=8.04). However, the recommended cut-off scores for conventional severity labels (normal, mild, moderate, severe, and extremely severe) related to stress are as follows: 0-14 (Normal); 15-18 (Mild); 19-25 (Moderate); 26-33 (Severe); and, ≥ 37 (Extremely severe).

The two scales were administered at three time points to all participants: pre-treatment, post-treatment (8 weeks) and follow-up (16 weeks). After the pre-treatment survey, the intervention group was mailed the book along with a study protocol which included directions to read the following chapter(s) at the beginning of the week complete any associated exercises and apply the principles learned in the chapter throughout the week in their personal and professional lives, building on each chapter from week to week: Week 1: Chapters 1 and 2; Week 2: Chapter 3; Week 3: Chapter 4; Week 4: Chapter 7; Week 5: Chapter 10; Week 6: Chapter 13; Week 7: Chapter 15; Week 8: Chapter 18.

At the end of each week, intervention group members received an email reflection journal to aid in documentation of what they liked about the chapter and what they did not like. This was done as a measure of integrity to insure that the intervention group was staying on track throughout the study.

Control group members were sent an email at the four-week time point stating the importance of completing additional surveys at the eight-week and sixteen-week time points.

All data were collected via Constant Contact online and were tabulated by hand into an excel spreadsheet for analysis using SPSS-19.

Data Analysis

The following demographic data was collected at the pre-survey measure to determine which, if any, covariates to keep for the model, using the Enter Method Regression

model: Gender, Marital Status, Number of Children <18 years of age in the home, Years as Executive, Annual Income, Size of Board of Directors, Annual Budget of Organization, and Number of Employees.

To address the first Null Hypothesis specifically, pre-survey and post-survey scores from the PSS-10 scale and the DASS Stress scores were tabulated for intervention group participants, excluding cases with missing data. Data analysis included the use of independent t-test, repeated measure ANOVA, and multivariate tests and running descriptive statistics to determine mean scores.

To test the second Null Hypothesis, post-treatment and final stress survey scores from the PSS-10 and the stress results from the DASS were tabulated for the intervention group, excluding cases with missing data. Data analysis included the use of descriptive statistics, Independent t-test Samples, Repeated-Measure ANOVA, and multivariate tests.

Summary

The study ran for a sixteen-week period from February to June 2012. The sample population included volunteer nonprofit healthcare executives who felt that stress was diminishing their life happiness and personal effectiveness. Based all over the nation, tools were offered to keep the participants on track and within the boundaries set up to insure integrity in the study. Data was hand tabulated from two measures at three time points before bibliotherapy treatment, after treatment (8 weeks), and at a follow up (16 weeks). Cases with missing data were excluded from analysis and counted for a large attrition rate in the study.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF DATA

Introduction

This study has examined the effectiveness of bibliotherapy for stress reduction in the nonprofit healthcare executive population. The study was conducted over a sixteen-week time period between February and June of 2012. Commonly, nonprofit leaders experience varying periods of higher stress throughout the fiscal year. These times may include preparation for board meetings and elections, fundraisers, annual conferences, and leadership or board evaluations. The study measures specifically asked leaders to rate their stress within the previous month, recognizing that stress levels would vary according to current workload. Additionally, a weekly protocol was provided to standardize the reading and application rate of exercises throughout the course of the study. The pre-treatment survey included the collection of demographic information for each participant and was the only point at which this data was collected. The post-treatment survey was collected on both the intervention and control groups. Only the intervention group had participated in eight weeks of bibliotherapy following the study protocol, using the stress reduction workbook.

The final survey was collected from both the intervention and control groups after eight weeks of no contact following bibliotherapy, which was completed by the intervention group. Once all surveys had been collected, data was hand tabulated for the three time periods to determine raw scores on the Perceived Stress Scale (PSS) and Stress Scores from the Depression, Anxiety and Stress Scale. This data was uploaded via Excel document into SPSS-19 for data analysis.

Demographic Data

It is safe to assume that there are no two nonprofit organizations or their executives that are exactly alike. There are varying degrees of differentiation within organizations, such as size of the governing board, number of employees, annual budget, and components of the annual strategic plan that affect the performance of the organization. Likewise, there are personal factors of executives leading the organization that affect overall performance of the organization. According to the White House Project (2009), 45% of nonprofit organizations are lead by women in the United States. The breakdown of participants for this study was 78% female and 22% male (see Figure 1). Further demographic analysis shows that the majority of participants completing the study were married (see Figure 2). Another question asked about the number of children less than eighteen years of age living in the home of the nonprofit executive, with one to two children being the most common response (see Figure 3).

In addition to personal demographic data, professional demographic data was analyzed to determine if size of the governing board, number of employees, number of years as an executive, or annual salary resulted in any significant difference in the perceived stress level of executives. Study participants most commonly had >10 years of executive experience (see Figure 4); the annual salary most commonly reported was >\$100,000 (see Figure 5); the number of employees directly reporting to the executive most commonly reported <25 (see Figure 6). The final demographic factor thought to might affect the nonprofit executive's perceived stress was the budget size of the organization. Study participants responded most commonly with budgets of \$1,000,000-\$10,000,000 (see Figure 7).

Statistical Assumptions

Using SPSS-19, the data was evaluated to check for any violation of assumptions of normality (Skewness and Kurtosis scores <2.5 , $p=.01$), homogeneity of variances (Levene's Test, $p=0.90$, $p=.283$), and sphericity (Mauchly's Test, $p=0.550$) for all cases with no missing data ($n=37$). Additional analysis of boxplot diagrams showed no significant outliers.

Testing the Significance of the Demographic Data

Data analysis was conducted to determine if any of the demographic covariates as described above would significantly impact study results. Simple Regression using the Enter method was used to analyze demographic and showed that all combined demographic factors only account for a total of 4% of perceived stress ($r^2=.040$). Results for each of the factors including gender ($p=.274$), number of years as an executive ($p=.976$), income ($p=.716$), size of board ($p=.854$), annual budget ($p=.828$), marital status ($p=.750$), and number of children under 18 years old in the home ($p=.573$) show that ($F=.283$, $p=.97$) there is no statistically significant systematic association between the demographic data collected and the stress levels of nonprofit healthcare executives.

Comparison of Completion Groups

Due to considerable attrition of participants completing the final measure in the study, independent t-test analysis of the pre-treatment measures was conducted to compare the means of those completing all measures ($n=24$) of the study with those who did not complete all measures ($n=40$). Those completing had a mean Pre-treatment PSS Score of 22.21, with a Standard Deviation of 6.065 and Standard Error of 1.238, while those not completing had a mean Pre-treatment PSS Score of 20.33, with a Standard Deviation of 4.801 and a Standard Error of 0.759. Levene's Test was not significant ($p=>.05$), therefore allowing the reader to assume that

the variances are roughly equal and the assumption is tenable. Based on the independent t-test, there was no significant difference between the means of these two groups. In general, the group members completing all portions of the PSS measures had slightly more perceived stress ($M=22.21$, $SE=1.24$) than those not completing ($M=20.33$, $SE=.759$). The difference was not significant ($p>.05$); however, due to the large attrition rate of study participants completing all three time points, the sample represented only a small effect $r=.17$.

Independent t-test analyses of the Pre-treatment scores were also completed in the same manner for the second measure in the study, the DASS, to compare those completing all measures ($n=23$) with those who did not complete all portions ($n=41$). The completing group had a mean Pre-treatment Stress Score from the DASS of 14.04, with a Standard Deviation of 7.486 and Standard Error of 1.561, while the group not completing had a mean Pre-treatment PSS Score of 13.12, with a Standard Deviation of 6.185 and a Standard Error of 0.966. Levene's Test was not significant ($p>.05$), therefore allowing us to assume that the variances are roughly equal and the assumption is tenable. Once again, based on the independent t-test, it was concluded that there was no significant difference between the means of these two groups. In general, group members who completed all portions of the DASS measure had slightly more perceived stress ($M=14.04$, $SE=1.561$) than those not completing all measures ($M=13.12$, $SE=.955$). The difference was not significant ($p>.05$); however, due to the large attrition rate of study participants completing all three time points, the sample size did not meet the standard for a small effect $r=.07$.

Pre-Treatment Participant Levels of Stress Compared to Normative Data

Normative data studies were completed by Cohen and Janicki-Deverts in 2010 and found that the mean score of full time employees was 16.23 (SD 7.31). Analysis of study participants showed that their stress levels were, in general, higher than the average person who is employed full time in the normative data study (see Figure 8). Similar analysis was completed for the Depression, Anxiety and Stress Score measure. Study participants show considerably higher levels of stress (see Figure 9) than the normative studies conducted by Crawford et.al (2009), in which the mean stress score was noted as 9.27 (SD=8.04).

Research Question

The data collection in this study was guided by a central research question:

Does bibliotherapy influence stress levels of nonprofit healthcare executives?

To ascertain a workable answer to the focus question, two ancillary questions were addressed. The first research question that the study data set out to answer was:

1. Is bibliotherapy effective in decreasing perceived stress levels of nonprofit healthcare executives?

To answer this question, one-way repeated measure analysis of variance (ANOVA) was conducted at the Pre-treatment and Post-treatment time points using the differences of means at each time point for all participants, but divided into intervention and control groups. Using all cases with complete data at all three time points, the intervention group (Group 1) had 12 participants and the Control Group (Group 2) had 28 participants. Skewness and Kurtosis were divided by the Standard Error and evaluated to check the assumption of normal distribution of data (<2.5 , $p=.01$). Levene's Test of the Differences in Mean Scores of all completed time points for the PSS and DASS were not significant ($p=.391$, and $p=.184$ respectively), indicating that the variances between groups are approximately equal. Independent t-test analysis shows that Group

1 (the intervention group) had 12 participants and group 2 (the control group) had 28 participants for both PSS and DASS measures.

For the PSS measure, the Intervention group had a mean decrease in the Perceived Stress score of 6.00, with a Standard Deviation of 4.880 and Standard Error of 1.409, while the control group had a mean decrease in the Perceived Stress Score of 2.18 with a Standard Deviation of 4.651 and a Standard Error of .8790. This difference was significant $t(38) = -2.347$, $p < 0.5$ and represented a medium-sized effect $r = .34$.

Analyzing the DASS measure, the Intervention group had a mean decrease in the Stress score of 4.17, with a Standard Deviation of 5.654 and Standard Error of 1.632, while the control group had a mean decrease in the Stress Score of 1.64 with a Standard Deviation of 4.381 and a Standard Error of .8281. This difference was not significant $t(38) = -1.529$, $p > 0.5$ and represented only a small-sized effect $r = .24$.

Repeated-measures ANOVA, with Sphericity Assumed, was conducted to assess whether there were differences between the Pre-treatment and Post-treatment Perceived Stress scores of the two groups of participants. The following assumptions were tested and met: (a) independence of observations, (b) normality, and (c) sphericity. Results indicated that participants in the intervention group did have significantly lower levels of Perceived stress, $F(1,38) = 25.23$, $p < .001$ for the Pre-treatment and Post-treatment PSS Scores. Furthermore, the intervention group had significantly lower Scores than the Control Group, $F(1,38) = 5.51$, $p < .05$. Multivariate analysis using Pillai's trace was significant for the decreased stress scores at the post-treatment time point, $V = .399$, $F(1,38) = 25.234$, $p < .01$. Additionally, Pillai's trace shows that the intervention group had significantly lower Post-treatment stress scores than the Control group, $V = .127$, $F(1, 38) = 5.509$, $p < .05$ (see Figure10). The significance of the

multivariate test gives increase confidence that the differences between stress scores at the Pre-treatment and Post-treatment time periods is significant.

Additional repeated-measures ANOVA, with Sphericity Assumed, was conducted to assess whether there were differences between the Pre-treatment and Post-treatment DASS mean stress scores of the two groups of participants. The following assumptions were tested and met: (a) independence of observations, (b) normality, and (c) sphericity. Results indicated that participants in the intervention group did have significantly lower levels of stress, $F(1, 38) = 12.382, p = .001$ for the Pre-treatment and Post-treatment DASS Scores. However, although the Intervention group had lower scores at the Post-treatment time point, the difference in scores was not significantly lower than the Control Group, $F(1,38) = 2.337, p = >.05$. Multivariate analysis using Pillai's trace was significant for the decreased stress scores at the post-treatment time point, $V = .246, F(1,38) = 12.382, p = .001$. However, Pillai's trace shows that the intervention group did not have significantly lower Post-treatment DASS stress scores than the Control group, $V = .058, F(1, 38) = 2.337, p = >.05$ (see Figure 11).

The second research question to be analyzed is: Will the intervention group maintain any decrease in mean stress scores at an eight-week interval after treatment with bibliotherapy? To test the Null Hypothesis, a repeated-measures ANOVA was conducted to assess whether there were differences between the Pre-treatment, Post-treatment, and Final (8 week follow up) Perceived Stress scores of the intervention group of participants. The following assumptions were tested and met: (a) independence of observations, (b) normality, and (c) sphericity. Results indicated that participants in the intervention group did have significantly lower levels of Perceived stress, $F(2,70) = 16.828, p < .001$ for the Pre-treatment, Post-treatment, and Final PSS Scores. However, the intervention group did not have significantly lower Scores than the

Control Group, $F(2,70) = 2.579$, $p = >.05$. Multivariate analysis using Pillai's trace was significant for the decreased stress scores at the final survey time point, $V = .489$, $F(2,70) = 16.279$, $p = <.01$. However, Pillai's trace shows that the intervention group did not have significantly lower final measure stress scores than the Control group, $V = .148$, $F(2,70) = 2.951$, $p = >.05$. The significance of the multivariate test for the final survey score of the intervention group gives increase confidence that the significant decreases in stress obtained from bibliotherapy were maintained at the eight week follow up in the intervention group (see Figure 12). Therefore, we can reject the Null Hypothesis for research question two.

Additional repeated-measures ANOVA was conducted to assess whether there were differences between the Pre-treatment, Post-treatment, and final survey DASS Stress scores of the two groups of participants. The following assumptions were tested and met: (a) independence of observations, (b) normality, and (c) sphericity. Results indicated that participants in the intervention group did have significantly lower levels of stress, $F(2,70) = 8.035$, $p = <.01$ for the significantly decreased level of stress as reported by the DASS Scores. It is noted that the final DASS score shows a slight increase in the mean of the intervention group but remains significant. Although the Intervention group had lower scores at the final time point, the difference in scores was not significantly lower than the Control Group, $F(2,70) = 1.14$, $p = >.05$. Multivariate analysis using Pillai's trace was significant for the decreased stress scores at the final time point, $V = .304$, $F(2,34) = .304$, $p = <.01$. However, Pillai's trace shows that the intervention group did not have significantly lower Final DASS stress scores than the Control group, $V = .07$, $F(2,34) = 1.275$, $p = >.05$ (see Figure 13).

CHAPTER FIVE

OVERVIEW, FINDINGS, AND RECOMMENDATIONS

It was the intent of this study to expand the limited knowledge base regarding stress reduction in the nonprofit healthcare executive population. The study builds on eight previous studies reported on by Norcross (2006), in which over 3000 therapists worked together to determine the most useful self-help resources. From this research, Norcross compiled a peer reviewed consensus list of self-help books, autobiographies, Internet sites and commercial movies and rated the top twenty-five in each category. His final recommendations were to conduct controlled research on selections from the consensus list in order to have resources available that are effective and safe.

The workbook chosen for this study, *The Relaxation & Stress Reduction Workbook, 6th Edition* (Davis et al., 2008) is a 372-page self-help workbook with two foundational chapters which review how the reader reacts to stress and understanding body awareness; and nineteen chapters comprising a psycho-educational and cognitive-behavioral treatment approach. It was the only text on the consensus list that focused on stress reduction and relaxation. The book has sold over one million copies, and is highly recommended by therapists and coaches, but has never had any empirical data to rely on for the safety and efficacy of its use.

My desire to build on the work of Norcross along with my particular interest in stress reduction, and my curiosity about the limited pool of research related to nonprofit healthcare executives guided me to complete this body of work.

This chapter is divided into six sections. The first section discusses the overview and design of the study. The second section briefly reviews results of the study. The third section discusses future considerations for researchers who would like to build on this work, while the

fourth section renders conclusions of this study followed by recommendations. The final section is a summary and conclusion of the study.

Overview and Design of the Study

The purpose of this study was to examine the use of bibliotherapy as an effective treatment for stress reduction in the nonprofit healthcare executive population. Using the workbook from the consensus list created by Norcross (2006), participants were solicited from online forums in a professional nonprofit healthcare executive association. A total of seventy-eight candidates stated their interest, but eight of those were removed prior to the study for failure to sign the consent or complete the pre-treatment measure prior to the start date of the intervention. The remaining seventy participants were randomly assigned to an intervention or control group. The intervention group was mailed the workbook along with a study protocol (See Appendix Two), outlining the eight weeks of assigned reading and exercises. Weekly reflection statements were emailed to each member of the intervention group to allow for journaling and as a method to keep the study participants on track.

Email surveys were created that contained two stress measures: The Perceived Stress Scale (PSS), and the Depression, Anxiety and Stress Scale (DASS). These were administered at three times during the course of the study: pre-treatment, post-treatment (after the eight weeks of bibliotherapy), and at a follow up (eight weeks after the post-treatment survey). Additionally, demographic data was collected at the first time point (See Appendix Three) to assess if any significant covariates should be added to the final study design. The final survey also contained questions to ascertain that participants had not sought other stress reduction interventions or had unexpected stressors that might greatly affect their scores on the measures.

There was significant attrition by the time the follow up survey was collected at eight

weeks after the intervention, ending with only 12 members in the intervention group and 28 in the control group completing all study requirements. However, data collected was analyzed using Regression, Independent t-test, and One-Way Repeated Measure ANOVA methods with SPSS 19.

Study Results

Demographic data was collected during the pre-treatment survey to determine if gender, number of years as an executive, income, size of board, annual budget, marital status, and number of children under eighteen years of age in the home significantly affected the perceived stress level of the nonprofit healthcare executive. Results indicated that all combined predictors only accounted for just 4% of perceived stress, with no individual factor being significant.

The two measures selected for inclusion in the study were used to adequately evaluate stress levels of the study participants. The PSS-10 item scale was created to assess the degree to which situations in life are perceived as stressful (Cohen & Williamson, 1988). Items in the PSS-10 were designed to tap how unpredictable, uncontrollable, and overloading respondents find their lives (Cohen & Janicki-Deverts, 2010). In the most recent study conducted by Cohen & Janicki-Deverts (2010), the mean PSS-10 score for an individual employed full time was 16.23 (SD=7.31). The pre-treatment mean PSS-10 score for the intervention group of nonprofit healthcare executives was 21.58 (SD=3.99) and the control group pre-treatment mean was 20.54 (SD=5.11). The second tool, the DASS, recommends a cut-off score for “normal” stress was 0-14. More specifically, Crawford et. al conducted a normative data study (2009) and reported a mean DASS Stress score of 9.27 (SD=8.04). The pre-treatment mean DASS stress score for the intervention group was 13.09 (SD=6.84) and the control group was 13.31 (SD=6.875).

The first research question asked if bibliotherapy was an effective treatment for stress reduction in the nonprofit healthcare executive population. To answer this question, data was collected from the intervention group at the pre-treatment and post-treatment time points, using both measures. Data analysis was conducted using repeated-measures ANOVA to test the differences between the pre-treatment and post-treatment Perceived Stress mean scores of the intervention group of participants. Results indicated that participants in the intervention group did have significantly lower levels of Perceived stress, $F(1, 38) = 25.23, p < .001$ for the pre-treatment and post-treatment PSS Scores (see Figure 10).

Additional repeated-measures ANOVA were conducted to assess whether there were differences between the pre-treatment and post-treatment DASS Stress scores of the intervention group of participants. Once again, results indicated that participants in the intervention group did have significantly lower levels of stress, $F(1, 38) = 12.382, p = .001$ for the Pre-treatment and Post-treatment DASS stress mean scores (see Figure 11). With this data, we can reject the Null Hypothesis for question one.

The second research question asked whether any significant decrease in stress scores would be maintained for an eight-week follow up period after treatment with bibliotherapy. To test the Null Hypothesis, a repeated-measures ANOVA was conducted to assess the existence of any differences between the Pre-treatment, Post-treatment, and Final (8 week follow up) Perceived Stress scores of the two groups of participants. Results indicated that participants in the intervention group did have significantly lower levels of Perceived stress, $F(2, 70) = 16.828, p < .001$ for the Pre-treatment, Post-treatment, and Final PSS Scores (see Figure 12).

Additional repeated-measures ANOVA was conducted to determine whether there were differences between the pre-treatment, post-treatment, and final survey DASS Stress scores of

the intervention group. Results indicated that participants did have significantly lower levels of stress, $F(2,70) = 8.035, p < .01$ for the significantly decreased level of stress as reported by the DASS Scores. It is noted that the final DASS score shows a slight increase in the mean of the intervention group but remains significant (see Figure 13). With the data presented, we can reject the Null Hypothesis for the second research question.

Comparison of Intervention and Control Groups

While the research questions specifically focus on the results of the intervention group using repeated mean scores from the two measures, data was also analyzed to review the results against a control group during the same 16-week period. When looking at stress reduction PSS mean scores of both groups at the pre-treatment and post-treatment time points, the Intervention group had a mean decrease in the Perceived Stress score of 6.00, with a Standard Deviation of 4.880 and Standard Error of 1.409, while the control group had a mean decrease in the Perceived Stress score of 2.18 with a Standard Deviation of 4.651 and a Standard Error of .8790. This difference was significant - $t(38) = -2.347, p < 0.5$ - and represented a medium-sized effect $r = .34$.

For the DASS measure, the Intervention group had a mean decrease in the Stress score of 4.17, with a Standard Deviation of 5.654 and Standard Error of 1.632, while the control group had a mean decrease in the Stress Score of 1.64 with a Standard Deviation of 4.381 and a Standard Error of .8281. This difference was not significant $t(38) = -1.529, p > 0.5$ and represented only a small-sized effect $r = .24$.

Further analyses were conducted at the final survey time point (16 weeks) on both the intervention and control groups. Results indicated that participants in the intervention group did have significantly lower levels of Perceived stress, $F(2, 70) = 16.828, p < .001$ for the Pre-treatment, Post-treatment, and Final PSS Scores. However, the intervention group did not have

significantly lower Scores than the Control Group, $F(2, 70) = 2.579, p = >.05$. Multivariate analysis using Pillai's trace was significant for the decreased stress scores at the final survey time point, $V = .489, F(2, 70) = 16.279, p < .01$. However, Pillai's trace shows that the intervention group did not have significantly lower final measure stress scores than the Control group, $V = .148, F(2, 70) = 2.951, p = >.05$. Results indicated that participants in the intervention group did have significantly lower levels of stress, $F(2, 70) = 8.035, p < .01$ for the significantly decreased level of stress as reported by the DASS Scores. It is noted that the final DASS score shows a slight increase in the mean of the intervention group but remains significant. Although the Intervention group had lower scores at the final time point, the difference in scores was not significantly lower than the Control Group, $F(2, 70) = 1.14, p = >.05$. Multivariate analysis using Pillai's trace was significant for the decreased stress scores at the final time point, $V = .304, F(2, 34) = .304, p < .01$. However, Pillai's trace shows that the intervention group did not have significantly lower Final DASS stress scores than the Control group, $V = .07, F(2, 34) = 1.275, p = >.05$.

Limitations of the Study

Data in this study was gathered from nonprofit healthcare executive all over the United States, causing all communication to be done online and by email. Like the leaders of most organizations, nonprofit healthcare executives are very busy professionals. It would seem to be very difficult for them to commit to anything for a sixteen-week period, as there are so many changing phenomena that occur on any given day in the life of this population. Although the study showed some very positive outcomes in decreasing stress and maintaining it in the intervention group, the attrition rate was so large that the number of participants completing was far less than the goal of 24 in each group, causing the study to not meet the goal of the power

analysis. A review of the demographic data of those who did not complete all measures of the study and were therefore removed shows no trend in the types of professionals who could not complete all measures. Therefore, the researcher cannot explain the random attrition rate, but speculates that stricter reporting guidelines, pay for performance issues, and the recent economic downturn have stretched nonprofit executives thin trying to provide service to their customers and meet the challenges their jobs. Although some of the results did meet the goal of a medium effect size, other results fall short of this objective. The researcher believes that some of the results that were not significant could have been strictly due to sample size. For this reason, I would suggest the following things for future considerations:

1. Due to the large attrition rate and the difficulty of assuring that all participants were staying on course, I would recommend the researcher to consider conducting the study with nonprofit healthcare executives in a smaller geographical region.
2. Consider meeting in person prior to the study to ascertain that all participants understand the requirements, sign the consent form, complete the pre-treatment measure, and leave with the bibliotherapy text.
3. Consider conducting the three measures in person to further enhance the importance of staying on track. It is important to mention that in order for the study to be considered ‘unassisted bibliotherapy’, it will be very important to not discuss stress reduction or the contents of the text at these sessions.
4. Consider beginning the study with a larger sample size if possible to account for any unexpected attrition rate in this population. As the initial goal of sixty participants was exceeded, the attrition rate was higher than anticipated. A larger sample size in the beginning will help to account for any unusually high attrition rate.

Conclusions

1. The initial mean stress scores in the nonprofit healthcare executive sample tested are relatively higher than the mean stress scores of full time employed Americans.
2. The Demographic factors of gender, number of years as an executive, income, size of board, annual budget, marital status, and number of children under 18 years old in the home did not significantly affect the mean stress scores of the nonprofit healthcare executives in this sample.
3. The bibliotherapy text, taken from the consensus list created by Norcross (2006), *The Relaxation & Stress Reduction Workbook, 6th Edition* (Davis et al., 2008) was significantly useful in decreasing mean stress scores of the nonprofit healthcare executives in the study. The intervention included reading and completing exercises from nine chapters over eight weeks.
4. Significant decreases in mean stress scores gained by nonprofit healthcare executives after eight weeks of bibliotherapy were maintained at significant levels over 16 weeks.
5. Although decreases in repeated-measure mean stress scores were significant in the intervention group, on only one occasion were those decreases also significantly lower than the control group. This could have been an issue related to the large attrition rate of the study.
6. Both groups in the study had a decrease in mean stress scores over the course of 16 weeks.

Recommendations for Further Study

As identified by Herbert in 2004, there is a gap in the research related to nonprofit healthcare executives. Nonprofit organizations play an enormous role in the United States' economy and provide services to individuals, families, and communities every day. With the current economical downturn, downsizing of nonprofit organizations around the country, and increased accountability requirements, Executives are faced with many stressful situations that cause feelings of burnout and helplessness. Further study on the stress levels and ways of decreasing that stress are needed in this very important population.

Bibliotherapy is growing as a means of self-help treatment. Whether stopping by the local bookstore to peer at the shelves for some inspiration, speaking to a professional coach therapist, individuals need guidance to help them steer through the vast number of new publications each year. The consensus list based on eight studies and compiled by Dr. Norcross in 2006 is a great place to begin if trying to conduct further research in the arena of bibliotherapy.

In addition to the above recommendation, I would also like to encourage researchers to conduct similar research on the stress workbook from this study. Repeating this study in different populations would be ways to further prove the effectiveness and efficacy of bibliotherapy for stress reduction.

Summary

Bibliotherapy has been used for over one hundred years in the treatment of various disorders. Although studies show that there are benefits to bibliotherapy, there remains skepticism about its use and effectiveness. Despite that skepticism, thousands of new self-help titles are published every year, most of which have had no controlled research to

determine the safety or effectiveness of recommendations made by the authors. Over the past eighteen years, Dr. Norcross has been focused on identifying the most widely recommended texts, movies and Internet sites for self-help. He has implored researchers to select a title from the consensus list and conduct controlled research in specific populations to better have an understanding of how effective and safe self-help can be. Only when the empirical data shows that bibliotherapy is effective, will those skeptics join in to use it as an adjunct to or in place of individual or group therapies.

Stress reduction is, in my mind, one of the most valuable things that we learn and share with others. In today's world, stress is the norm. Families often consist of single parents or families with two working parents just to make ends meet. The recession over the past three years has added increased pressure, more loss of jobs, and more families at or below the poverty level around the country. It is my hope that this study brings about a new hope that bibliotherapy can be effective at reducing stress levels.

APPENDIX ONE: REQUEST FOR VOLUNTEERS

Submission Subject:

Seeking Executives who feel that stress is beginning to diminish their life happiness and personal effectiveness for an intervention study.

Submission Body:

Seeking nonprofit healthcare executive ASAE members who feel overwhelmed by stress and are motivated to change. The study involves receiving a free copy of a workbook that will focus on how you react to and cope with stress in your life. Study participants will also be asked to fill out questionnaires on stress levels and a brief weekly reflection on the assignment for the week.

The study is completely confidential. To enroll, call or email Robin Wootten at

robin.l.wootten@gmail.com or at 816.305.2797.

APPENDIX TWO: STUDY PROTOCOL

The Relaxation & Stress Reduction Workbook, 6th Ed.

Authors: Martha Davis, Ph.D., Elizabeth Robbins Eshelman, MSW; Matthew McKay, Ph.D.

Congratulations for being accepted into this study. The requirements for the study include:

- Completing a Pre-study survey
- Follow this protocol, completing 9 chapters of the workbook in the time frame provided. Note that completing the chapters indicates reading the chapter at the beginning of the week and applying the exercises for the remainder of the week.
- Provide a weekly, short reflection of the chapters assigned – this will be emailed to you on Friday to be completed by Sunday before beginning the next reading.
- Complete a Post-study survey after the completion of the final chapter and reflection.
- Complete a Follow up survey 8 weeks after completion of the post study survey
- Please do not complete any other treatments for stress during the 16 weeks you are in the study. You will be asked to report any unforeseen circumstances occurred that would greatly affect your stress level during the 16 weeks of the study.

Week 1: Read and complete all exercises in Chapters 1 and 2 of the book; complete the survey reflection that is sent to you by email.

Week 2: Read and complete all exercises in Chapter 3 of the book; complete the survey reflection that is sent to you by email

Week 3: Read and complete all exercises in Chapter 4 of the book; complete the survey reflection that is sent to you by email

Week 4: Read and complete all exercises in Chapter 7 of the book; complete the survey reflection that is sent to you by email

Week 5: Complete Chapter 10 of the book; complete the survey reflection that is sent to you by email

Week 6: Complete Chapter 13 of the book; complete the survey reflection that is sent to you by email

Week 7: Complete Chapter 15 of the book; complete the survey reflection that is sent to you by email

Week 8: Complete Chapter 18 of the book; complete the survey reflection that is sent to you by email; complete the post-test survey

Week 16: Complete Follow up survey that is sent to you by email. If you have completed all steps, your name will be entered into a drawing for an iPod!

Congratulations! Once you reach this step, you have completed the program. Thank you for your participation.

APPENDIX THREE: DEMOGRAPHIC QUESTIONS

1. Gender:
 - a. Male
 - b. Female

2. Years as Executive:
 - a. 1-3
 - b. 4-6
 - c. 7-10
 - d. >10

3. Annual Income:
 - a. <\$40,000
 - b. \$40,000-\$70,000
 - c. \$70,001-\$99,999
 - d. >\$100,000

4. Size of Board of Directors:
 - a. <7
 - b. 8-15
 - c. 16-25
 - d. >25

5. Annual Budget of Organization
 - a. <\$50,000
 - b. \$50,001 - \$500,000
 - c. \$500,001 - \$1,000,000
 - d. \$1,000,001-\$10,000,000
 - e. >\$10,000,000

6. Number of Employees
 - a. 1-10
 - b. 11-50
 - c. 51-100
 - d. >100

APPENDIX FOUR: PSS-10

INSTRUCTIONS:

The questions in this scale ask you about your feelings and thoughts during **THE LAST MONTH**. In each case, please indicate your response by placing an “X” over the circle representing **HOW OFTEN** you felt or thought a certain way.

	Never 0	Almost Never 1	Sometimes 2	Fairly Often 3	Very Often 4
In the last month, how often have you been upset because of something that happened unexpectedly?	○	○	○	○	○
In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○
In the last month, how often have you felt nervous and “stressed”?	○	○	○	○	○
In the last month, how often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○
In the last month, how often have you felt that things were going your way?	○	○	○	○	○
In the last month, how often have you found that you could not cope with all the things that you had to do?	○	○	○	○	○
In the last month, how often have you been able to control irritations in your life?	○	○	○	○	○
In the last month, how often have you felt that you were on top of things?	○	○	○	○	○
In the last month, how often have you been angered because of things that were outside your control?	○	○	○	○	○
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

APPENDIX FIVE: DASS - 42

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (e.g., legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (e.g., lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Reminder of rating scale:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (e.g., in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

APPENDIX SIX: DASS 42 SCORE SHEET

Enter each score from the questionnaire into the first two columns.
 Add up each row and enter the score into the available box (D, A or S)
 Add up each of the D, A and S columns.
 The total for each column is the score for that trait:

D = Depression

A = Anxiety

S = Stress

Use the ratings table below to assess the meaning of each score.

Q	Score	Q	Score	All D scores	All A scores	All S Scores
1		22				
2		23				
3		24				
4		25				
5		26				
6		27				
7		28				
8		29				
9		30				
10		31				
11		32				
12		33				
13		34				
14		35				
15		36				
16		37				
17		38				
18		39				
19		40				
20		41				
21		42				
				Total for D	Total for A	Total for S

Interpretation	Depression (D)	Anxiety (A)	Stress (S)
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	>28	>20	>34

APPENDIX SEVEN: POST-TREATMENT AND FOLLOW UP QUESTIONS

In addition to the 2 surveys that you have already completed, please answer the following questions as accurately and honestly as possible to allow aid in analyzing the study data.

Thank you for your assistance.

1. Since beginning this study, have there been any unforeseen stressful events in your life that might affect your stress level? (Examples could be, but are not limited to: Marital problems, family crisis event, work crisis event, weather crisis event, etc.). If the answer is yes, please list these events below:

2. Since you began participating in this study, have you undergone additional therapy for stress reduction or relaxation exercises other than what you have initiated as part of the workbook? If yes, please list below:

3. Any other information you feel would be important in the data analysis:

APPENDIX EIGHT: CONSENT FORM

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Self-Help Workbook for Stress Reduction and Relaxation

You are invited to participate in a research study examining your reactions to reading a self-help book for stress reduction and relaxation. Before you agree to take part, please read this carefully and make sure you understand what is involved in participating in the study.

Nature and Purpose of Study

The main purpose of this study is to examine the efficacy of a self-help workbook for decreasing stress, coping with stressful events, and improving abilities to respond to stressful situations when they arise.

Previous studies have indicated that between 40% of nonprofit healthcare executives regarded stress as a major problem in their organization and that 16% of all executives have taken time off because of stress in the past 12 months. Many executives do not seek help for their concerns, although they feel overwhelmed and less productive in their professional and personal lives. This study seeks to examine the effectiveness of a self-help intervention for stress reduction using a workbook that contains information and suggestions for reducing and coping with stressful events.

You are being asked to take part in this study because you have indicated interest in doing so previously.

Participant Responsibilities

First, you will be asked to create a unique identifier for use in this study. You will then fill out several questionnaires on your demographic characteristics and your perceived stress, anxiety and depression levels. You will then provide your mailing address and email address, as well as the unique identifier you created earlier. Next, you will receive a copy of the self-help workbook in the mail or a letter indicating you will receive a book in sixteen weeks. (Which group you are in will be chosen randomly). You will not be informed of the name of the book until you receive it in the mail.

If you are in the group that receives a book immediately you will receive a study protocol and be asked to follow the instructions exactly, completing 1-2 chapters of reading and exercises in an eight-week period of time. While reading your book, we ask that you please complete any exercises suggested in the book. After receiving your book in the mail, you will also receive the following additional communications from us:

1. Each Sunday, you will begin a new chapter of the workbook. Not all chapters of the book will be covered in the course of the study. We encourage you to stick to the assigned chapters during the study period, but the book will be yours to keep and reference after the study has been completed.
2. Each Friday of the study period, you will be asked to complete a brief, web-based reflection of the assignment for the week. This will be due on Saturday evening before you begin the next chapter of the book on Sunday.
3. Eight weeks after you receive the book, you will receive an email with a link to the same questionnaires regarding your stress, anxiety and depression levels. You will also be asked a few questions related to unforeseen stressors during the study period.
4. Eight weeks after you have completed your book and have responded to the second set of questionnaires, you will again receive an email with a link to questions regarding your stress, anxiety and depression levels. You will also be asked a few questions related to unforeseen stressors during the follow up period. This is to examine the long-term effectiveness of the self-help strategy that you have received. You will also be asked to complete a few repeat demographic questions.

If you are in the group that receives a book in sixteen weeks, in addition to the letter informing you that you are in this group, you will receive three additional communications from us:

1. Four weeks after we inform you by letter that you are in the group that will receive the book in sixteen weeks, we will send you an email reminding you that a survey will come to you in four weeks and a book will be coming in an additional eight weeks.
2. Four weeks later, we will send you an email with a link to questions regarding your stress, anxiety and depression levels. You will also be asked a few questions related to unforeseen stressors during the study period as well as anything else you have done to address your stress levels while waiting for the book.
3. Eight weeks later, we will send you an email with a link to questions regarding your stress, anxiety and depression levels, as well as anything else you have done to address your stress while waiting for the book. After filling out this questionnaire, you will then receive a complimentary copy of the self-help workbook for stress reduction and relaxation.

Participants in both groups will be asked to complete any surveys sent within five days. If you do not, we will send you up to three email reminders (each five days apart) requesting that you please complete the surveys.

Expected Benefits

By taking part in the study, you will be helping to test the effectiveness of a self-help book for stress reduction, a very common problem among nonprofit healthcare executives. Little research has been done in this area, and you would be helping to contribute to the search for effective interventions.

Another benefit is that you will receive a free copy of a workbook for stress reduction and relaxation. The book that you receive is yours to keep.

Possible Risks

The overall expected risk is minimal. You may be uncomfortable answering questions about stress, anxiety or symptoms of depression. As a result of reading this book, you also face two additional possible risks. One of these risks is that through reading this book you may become aware that your stress levels may be due to more serious concerns (e.g., possible health risks associated with stress). Another risk is that homework exercises suggested by the book will require you to spend time on your own needs that you may not be used to dedicating to your personal development. If you experience any problems as a direct result of being in the study or have questions about research participants' rights, please contact the MU Campus Institutional Review Board at (573) 882-9585.

Right to Refuse or Withdraw

Participation is purely voluntary. If you are an MU employee or student, participation in this research is in no way connected to academic or personnel requirements. You have the right to refuse to take part in this study or to withdraw from the study (i.e., stop reading the book; stop responding to the email surveys) at any time.

Confidentiality

You will be asked to create a unique identifier for this study. You will also be asked for contact information (email and mailing address) to mail you the book and email you the surveys. A list linking your contact information with your unique identifier will be kept in a locked filing cabinet, accessible only to authorized research personnel. The list linking your unique identifier with your contact information will be used only to contact you with reminder emails if you do not reply to the surveys. The actual data you provide via completing the online surveys will not be associated with your identity in any way. Your responses will be used for research purposes only. Study findings will be based on aggregate group data only. You will not be identifiable in any publication or presentation, which may arise from this research. The researchers will never reveal the identity of anyone who participated in this study. At the close of the study, your contact information and its association to your unique identifier will be destroyed.

By entering the study, you are indicating that you have read the above information and that you agree to take part in the study as described. If you would like to receive a copy of this consent form, please contact Robin Wootten at robin.l.wootten@gmail.com.

APPENDIX NINE: SAMPLE WEEKLY REFLECTION

Week 1 Weekly Reflection (will be different each week based on the assigned chapter):

This week, you were to complete chapters 1 and 2 of the workbook. Please use this journal to provide feedback about the chapters and your reaction to the exercises in the assigned reading.

Chapter 1: How you react to Stress

Based on your completion of the Schedule of Recent Experience Exercise, the Symptoms Checklist and the Tactics for coping with stress inventory, please answer the following:

1. The things I felt were helpful in this chapter include:

2. The things I felt were not helpful in this chapter are:

3. Did you utilize any of the further reading found on page 16? If yes, which resource?

Chapter 2: Body Awareness

Based on your completion of the stress awareness diary and record of general tension, please answer the following:

1. The things I felt were helpful in this chapter include:

2. The things I felt were not helpful in this chapter are:

3. Did you utilize any of the further reading found on page 25? If yes, which resource?

You are now ready to advance to week 2 of the protocol.

APPENDIX TEN: REFLECTION FEEDBACK FROM PARTICIPANTS

Chapter 1: How you react to Stress

Based on your completion of the Schedule of Recent Experience Exercise, the Symptoms Checklist and the Tactics for coping with stress inventory, please answer the following:

The things I felt were helpful in this chapter include:

- Not much at all, actually.
- I was shocked at how high my score was. Dang I might be dead! :)I loved the idea of relaxation response. This is a process and you have to peaks and valleys. It is always good to reflect on the changes that have occurred in the last year. It's no wonder why I am stressed! I do often say to other be gentle with yourself but don't do that for myself. If I could ever let go of the control I need my stress would decrease rapidly. I guess you have to know the trigger before you can deal with them.
- The tactics for coping w stress inventory had the most impact for me. Just identifying the coping tactics was useful.
- A reminder that Hans Selye was the first major stress researcher.
- It was interesting to note the different weightings applied to various stress events.
- Although I know about the relationship between chronic disease/illness and stress, the stats on Page 6 are alarming. Those statistics are a helpful incentive to managing stress better.
- The prevention tips are helpful and there seems to be 2 primary themes: take your time, and treat yourself compassionately.
- The symptoms checklist is interesting in may be helpful in pointing out trends (though I'm not quite sure what to do with the information yet).
- The inventories are good for general awareness; reminder that there are other methods to cope with stress than those I habitually use.
- My level of stress and the various reasons for them. Also the part about learnig to be aware of the surroundings such as I am aware that I am typing and I am aware that there is noise in the background from my dryer.
- Learning to be aware of the stress.
- Completed the checklist, brought home that not all stress is bad. I was feeling confident with all the zeros, but having multiple instances in 12 of 42 areas, quickly put me in the high-risk category. Didn't get mean value column origination, was it based on others answers? Reaffirmed importance health wise of getting handle on my reaction to stressful situations.
- I found the schedule of recent experience to be a very good exercise. It made me think about the various types of stressors that impact my life and the number of times that these things occur. I was dismayed to learn that my score was off

the chart.

- I thought that the symptoms checklist was useful as it helped to pinpoint the areas of discomfort that exist in my life. I was able to sit back and think about the things that cause me stress as well as the level of discomfort that they cause me.
- The symptom-relief effectiveness chart was beneficial as it provided me with some tools that I could use in the coming weeks to help reduce the stress in my life.
- The exercise to notice sounds and feeling external to me, vs. those that were internal. The assessment of different kinds of stress. I don't think the stress of raising young children on top of everything else was validated enough. I realized that stressful interactions with my kids could really affect my day.
- Identification of stressful events and the tactics I currently use for coping with stress. Even though I know what I'm doing subconsciously it's there in black and white.
- I appreciated the explanations of social stressors and psychological stressors. I did do realize that financial stress was considered a social stress.
- I liked the schedule, but did not feel that the scale was clear. Some tasks did not seem to fit within the scale, and I did not know if 0 was to be used. I used it anyway. Shading the last fields on the bottom row, except for the total field, would make it clearer for visual learners.
- The symptoms checklist may have been help with more description - for example, what is the difference between worry and non-specific anxiety?
- I've heard "Type A" bandied about, but not know what it was. Yeah... I'm a "Type A". :-)
- Identifying those stressors that cause me distress.
- Becoming mindful of what distresses me most and my reactions to various situations.
- The checklist concerning how to cope with various stressors was interesting.
- Reminder of the sometimes imperceptible negative health impacts that stress causes.
- I am hoping that I can habitually apply what I am learning and understanding. I that that's going to be a significant challenge for me.
- Symptoms checklist
- Tactics inventory
- I found the inventory and the numeric interpretation of my stress level interesting. I didn't check many things and still found myself over 250. That was a surprise, especially the odds of illness.
- Schedule of Recent Experience Exercise: Knowing the point values associated with each stress event; Knowing how I personally rate in terms of total points and my potential for stress-related symptoms or illnesses; Knowing that "vacation" are stressful events for others, too (my vacations are stressful!).
- Symptoms Checklist: Realizing that competing priorities and anxiety with spouse are what I am most uncomfortable with.

- Tactics for Coping with Stress Inventory: I felt thankful that I don't rely on smoking or alcohol; I realized how poor my diet tends to be (on top of no time to exercise).
- Found it interesting that "fight or flight" was not studied in women and that "tend and befriend" has been proposed for women.
- Realized how much I withdraw from others when stressed.
- I realized I am too prone to becoming very irritable and not realizing I take it out on others. Especially if I feel I have lost "control" of a situation.
- Over the past several years, I have not taken time to eat nutritionally sound and I have not exercised as much. I have joined a health club and am attempting to commit to at least a 3 day each week routine.
- Overall, thinking about making healthy lifestyle changes such as eating better, going to bed at a specific time and not falling asleep in a chair, more exercise.
- The chapter was an easy read, which I appreciate (I'm not a "reader"). The vast majority of the theory presented in the chapter I was already rather familiar with. None-the-less, it was a good baseline to begin with. I did find the Schedule of Recent Experience an interesting exercise. Given the number of 0s that I scored on the individual line items, I was a little surprised my overall score was as high as it was...way over the 300 mark that was referenced.
- Because of a lot of major life events in my personal life (i.e. separation from spouse) and stress in a job I love but just have too many things on my priority list, I liked the checklists and inventories that I could complete.
- I realized that I had to make a serious effort to reduce my stress and the chapter made me want to get on to the other chapters. I found from the tactics for coping, that I use both the negative and positive methods listed, but more positive than negative. I make a conscious effort to avoid the negative ways, but they slip in from time to time.
- The symptom-relief effectiveness chart pinpointed the techniques I should focus on.
- Did not realize how stressed my life was last year
- Learned that a vacation is also considered "stress" but he good kind.
- Most helpful was the awareness
- Everything seemed helpful actually. Even if it was more common sense, it was all good reminders.

The Things I thought were NOT helpful in this chapter include:

- I found the Schedule of Recent Experience to be largely non-useful. I don't record events like they ask for to know the frequency, let alone the actual existence, of some of these events. Of course, major life events, such as a death or divorce are readily recalled, but not many of the other things. Based upon this tool, I appear to have a low stress level.
- The symptoms checklist needs guidance as to what is slight, moderate, extreme. Yes, I know researchers advocate that self-assessment is adequate to determine

those levels, but I don't agree and thus, I resist giving much credence to these tools when self-administered. In fact, they could be dangerous if a person judges himself to be in extreme discomfort.

- Wasn't a real fan of the checklist. I know what makes me worry and stress. Why I don't always know is why, the cause or how to stop it. Plus I am not sure even how honest I am with myself about my levels of discomfort. After you have dealt with crazy for so long, it becomes normal.
- I did like doing the inventory list. But I used an ABCD systems, instead of checks. A was for tactics I use often D have used but not often. It made me feel very good to see It also gave me ideas for more things to do!
- I believe I was already aware of the recent experiences that might be related to stress.
- A lot of it seemed to be common sense.
- I was surprised not to see "bruxism" or teeth grinding or TMJ listed.
- I'm reserving judgment about the "Tactics for Coping with Stress Inventory" for the time being although it doesn't seem particularly helpful at the outset. If the methods for reducing stress don't vary based upon the stress reaction, how much do the inventories really mean beyond the general value of self-knowledge (maybe that's reason enough.)
- The charts, they were almost too much to think about.
- Extremely helpful to match techniques to symptoms. Not all techniques were intuitive, might be useful to have a brief description up front although they are covered I depth in future chapters. I liked direction to just focus on 1 or 2 instead of all my areas of opportunities.
- Some of the information was basic (flight or fight response) but overall I found everything helpful.
- I actually feel everything in this chapter has merit, if it doesn't fit my profile; it will probably fit some one else. I will say, though, it was almost too much to confront and not be overwhelmed.
- The length or layout of the Symptom-Relief Chart was not very helpful. There should be a better way to present this info...
- It's too early to determine whether there are any.
- It all fit together well. I didn't recognize any useless information.
- I felt this was just too much information. If I have to do all those different tactics it in itself could increase my stress level because the many tactics means more time out of my day. I also found myself frustrated by the "we will get to that in later chapters" attitude of the authors.
- Before starting this project with you I was going to work through the book Mindfulness: an eight-week program. I will still do that when we are done. I just wonder if an approach with just one focus instead of so many would work better for me. I will be interested to see how I am doing at the end of this series of weekly exercises.
- "Symptom-Relief Effectiveness Chart" was kind of difficult to read because it spanned 3 pages (should be presented in smaller font in landscape view,

maybe?). Also, an explanation of the symptoms should appear next to them (it's not entirely clear what "autogenics" is, for instance).

- I was interested in the "Type D" paragraph, but I didn't find that paragraph to be very clear. How is Type D different from Type A?
- I found it all helpful. Much I have heard before, but I needed to hear it again and reflect on it.
- The Symptoms Checklist and the Tactics Inventory didn't particularly help me identify anything new about myself. I'm hoping that it may come back into play later on in the study.
- I thought completing the schedule of recent experience was a little confusing, but I still found it useful.
- Symptoms checklist was a little confusing as far as purpose and rating scale.

Chapter 2: Body Awareness

Based on your completion of the stress awareness diary and record of general tension, please answer the following:

The things I felt were helpful in this chapter include:

- Not much. I'm aware there are probably physiological connections with stressful events.
- I was surprised how stressed I am before I even get to work. There were so many little stress hiccups in the day. I just did this for 3 days and didn't get I was supposed to be using tactics to de-stress when I wrote things down --- DUH! Once I started to write down the "big" chunks and did stop breath and put it (mentally down) and those 5 second made a difference.
- Interesting. Again, awareness and identification were beneficial.
- Differentiation of internal and external stressors.
- I'm familiar with the basic practices related to the "Body Inventory" section and even though I know they work, I'm lousy at practicing them. So, the stress-awareness diary and the record of general tension are helpful prompts and can probably be easily adapted or simply incorporated into a personal or individualized format.
- I find internal and external scanning a very simple and helpful practice. Again, I don't practice it as often as would benefit me. I need to put a sticky note on my computer that just says, "SCAN."
- Being aware of the stress and when it occurs and why with the journaling.
- Connection between chronic tension/pain and beliefs and attitudes. Suppressing anger and neck pain so describes me.
- Loved the internal external excessive, can do it anywhere... Found it very difficult to let go of my body initially but did get better at it over the past week.
- I think the stress-awareness diary is a good way to note some of the times that

may cause more stress in my life than others.

- As I said before, just doing that awareness exercise several times this week was calming.
- As a drama major in college we learned techniques, which helped with both external body awareness and body scanning which after reading this chapter, I realized I'd forgotten. The stress awareness diary has been printed off and sits on my desk. It will be interesting to see exactly what I write in the next two weeks.
- The diary example was interesting hopefully my diary doesn't look like that and I can keep the stressful events to a minimum.
- I studied a lot to these techniques in theatre classes in college. It was a nice refresher - the tighten/release awareness exercise in particular.
- I hate using diaries. I keep a mental tally but dislike diaries. The sample was good, because it showed that you don't have to record a lot.
- Now that I have tracked my weekly activities and issues that affect me I now have a better awareness of what frustrates me the most. Primarily it is two work issues. Frustration with staff not meeting deadlines and also frustration from not being able to start and complete new and innovative programs because of lawsuits distracting my energy, time and focus. I used to love what I do so it wasn't work- it was a fabulous opportunity. That has changed in the last two years due to internal conflicts within the organization's membership.
- I am usually aware of external matters but I am not aware of internal body matters.
- With the exercise I was able to become aware but that will take practice for me.
- Body inventory
- The daily record was really interesting. I became much more aware of what I get stressed or anxious about and could really see how significant or insignificant those things are in the greater scheme of things. I also learned about the timing of my worry. If it starts in the morning it is difficult for me to get it under control.
- Importance of increasing my awareness of what I do physically when I am stressed.
- Identify physical symptoms of stress; especially neck tension and when irritated my heart rate increases.
- I like the idea of the stress awareness diary, but I admittedly find it difficult to incorporate that type of habit into my regular routine. I've never been one for "journaling" as trying to discipline myself to actually do it frankly just causes more stress for me. Nonetheless, I do appreciate the various suggestions made under the Body Inventory section of the chapter. Those will come in handy!
- I realized I actually have a lot of physical symptoms of stress and need to work on them. I will work the "letting go of body" as an aid.
- Identifying what really stresses me and at what times. I imitating found the diary interesting the first few days but then it became tedious and inconvenient (adding a little stress!)
- Most helpful was the awareness and the "letting go" and "body scanning" exercises.

The things I thought were NOT helpful include:

- While I was aware of stress like events, I did not attribute any physical response to these. How does one separate a pre-existing physical condition to a new event. For instance, I worry frequently and my sleep patterns are poor. They were present prior to the diary.
- My inability to read thoroughly caused me confusion!
- While I understand the advantage of keeping a journal to identify specific times and events, it is just not something that I will do at this point.
- I really didn't like the charts again. I would have preferred a simple list to read from and also felt as though the chapter was almost too short believe it or not! I could have used just a little more.
- Having the further readings at the end of each chapter was a little odd, but then I'm only on chapter 2. Not realistic that I will get books beyond this book before I even finish this one. Maybe consolidate suggested readings at end....
- Having said that about the stress awareness diary, I'm not sure how realistic it will be for me to track my responses - it may turn out to be just another form of stress. I'm also not sure about my ability to do the general tension exercises, particularly when I am at work or at home. I may try to modify them somewhat to best meet my lifestyle. Overall, I didn't find this chapter to be as helpful as the first chapter since I'm always busy (but perhaps that is the point - I need to learn to slow down).
- Keeping a journal. To me that felt like I added work and not something I would sustain in the long term anyways. Just raising my awareness and making a conscious intention to notice throughout the week seemed helpful to me. The act of writing down felt more of a burden.
- Again, most everything had merit so I didn't find anything, which I feel, would not be helpful at one point or another.
- The Record does not show much variation for me.
- There was not anything that I can present.
- I found the body awareness exercise really frustrating. I could feel where the stress is in my body, but felt unable to reduce it. In fact it felt like when I focused on those parts of my body the tension increased rather than decreased.
- Book says that the "Internal vs. External Awareness" activity, when practiced, "allows you to separate and appreciate the real difference between your inner and outer worlds. Why?"

Chapter 3: Breathing

Based on your completion of the breathing techniques for different stimuli, please answer the following:

The things I felt were helpful in this chapter include:

- Learning the different breathing techniques and how each one works with our system.
- Reminders about the benefits of diaphragmatic and nose breathing.
- Breathing out first
- Some of the exercises provided some good alternatives to the methods I was already familiar with. I particularly appreciate ideas for simple things you can do though out the day in a more "real time" sort of flow...understanding it is not often practical to lay down and focus on breathing for 10-20 minutes.
- The whole awareness of breathing so it wasn't second nature. Using the exercises particularly in car/traffic has been helpful in slowing down and regaining center.
- The techniques designed to increase awareness of and connection to breath.
- Practicing the different breathing techniques. I was surprised that one was much more effective than the others for me.
- This was a very helpful chapter. I found the strategy for relieving pain (one hand on abdomen, one hand on painful location) really helpful. Additionally, the counting strategy while breathing is helpful.
- The suggested exercise of counting to 4 during the 'inhalation and exhalation'. Plus, just the reminder to breathe and to use it to calm myself. I think it is easy to go through the day with shallow breathing. Take enough deep breaths and you can feel the calming effect (even if its only brief!). I also found myself reflecting on last week's reminder that if I believe I have the ability to cope with my stress, then I don't feel so overwhelmed.
- As a refresher on breathing exercises I'd learned many years ago, this was great. It also helped me focus more on my breathing. As a singer I was taught at an early age breathing diaphragmatically, but now am much more conscious of how I am breathing. Alternate breathing was interesting and I look forward to giving it a try with the next headache.
- Learning how breathing can impact your stress level and the importance of breathing slowly. Sometimes it is not easy to remember that - the breathing exercises should help.
- I had done some yoga before and got the abdominal breathing. However, I rarely use it. I used this every night and bedtime-it definitely helped be relax. I was truly surprised how quickly things could disappear. I like implementing breathing and counting to get deeper breathing.
- Like the idea of yawning to relax. It makes me realize how much tension is in my jaws.
- Breathing for tension release has helped me to locate points of tension in my body. I tend to focus tension in my neck and shoulders...very tight.
- Remaining mindful of how I am breathing during the day. When I am mindful of how I am breathing I am sometimes able to positively react to a situation that I might otherwise blow up about. Allows me to take time to think about and focus my response.
- Information about diaphragmatic breathing vs. abdominal breathing. Self talk,

- counting
- Breathing techniques and instructions

The Things I thought were NOT helpful in this chapter include:

- Though helpful to tell me to try to do something for at least a specific amount of time and days, I laughed at that because if speaking to an ex, full time mom and wife with 2 jobs it's hard to find that time.
- Explanation of biological details - but that is only because I have a biological background. It probably is helpful for many other readers.
- Much of this I was already familiar with and were therefore exercises I already use from time to time, although I'm sure that if I made it more of a priority it would make a difference.
- Varying degrees of benefit for me. This chapter was much more helpful than the previous two.
- Probably what I found, if anything, not helpful, or perhaps just off-putting, were the medical/technical descriptions of how things work, like diaphragmatic breathing. I really don't care how it works; I just want to know that it does.
- I may also not have needed that because of a few years of voice lessons many years ago. Breathing from the diaphragm is normal for me. I also run a few times a week and am regularly reminded of the benefit of deep breathing, whether or not I actually practice.
- While none of the information was new, not even the exercises...again it was an excellent reminder to use the skills I already have in times when I am stressed at work.
- Some of the suggestions would probably not work in my particular situation, but I did appreciate learning about them. I do think that it is important to keep an open mind, however, when reading this chapter and that is also not always easy to do. Setting aside a specific time to do the exercises is also not completely realistic in today's very busy world.
- I did not like alternative breathing ... felt very weird!
- I seem to sigh a lot - doesn't really help with tension!
- Breathing while lying down. If done when I go to bed I can't sleep. If I do it during the day, I go to sleep. Go figure.
- Alternate breathing
- 20 minutes is a long time in the middle of a busy day
- I completed the daily exercises at the end of the day
- Antony diagram was not helpful

Chapter 4: Progressive Relaxation

Based on your completion of the Relaxation Exercises, please answer the following:

The things I felt were helpful in this chapter include:

- Instead of just saying relax it would be nice to have actual techniques that I can put try out. Creating awareness of body groups through tense and relax techniques outlined in the book has in this short time had a big impact on my pain levels. Over the years, certain body groups seemed "live" in a constant state of tension. While I'm not there (pain free, with more practice and commitment I these tips should yield fruit. Already in a week using them, I feel less pain in some areas. My neck and shoulders, which are the areas with the most tension are proving harder to crack, but am seeing small improvements in pain levels and will continue relaxation exercises and breathing.
- Step by step explanation of the techniques.
- Again, for me, the key is reminding me to do what I sort of know will be relaxing. Building on diaphragmatic breathing with muscle relaxation is a great idea. I've "read ahead" to Chap 7, because of upcoming travel, and see that this will be transitioned to other relaxation methods.
- The reminder of this exercise. I've been doing this exercise on and off for years (less so now). I know it is a helpful exercise. I think it comes down to time and sometimes getting alone time.
- The way to learn to relax and the various body parts in which to concentrate on.
- I liked the suggestion to tense your muscles and then relax them - I've tried this when I have trouble falling asleep and it helps me to relax and go to sleep.
- Basic relaxation. I didn't have a way to record the process, so I had to memorize it. It was like an exercise I did many years ago, so it was familiar. I just forgot how helpful the muscle relaxation could be.
- So far, the active tensing is the practice I find most helpful in this chapter.
- Awareness about muscles and tension
- I liked the very specific instructions. They made it simple to actually to "it." I read it while audio recording to my iPhone so that I could just listen to the instructions. It may take a while until I can just do it automatically. I also tended, just as the book mentioned, to have to "remember to relax tension instantly".
- Defining the three basic levels of tensing and helping me to recognize the type of tensing with which I can be the most comfortable. As I mentioned before this particular technique was taught while I was in an acting class in college, and this chapter, especially, helped me focus on what I had previously learned
- Active tensing exercise
- The effectiveness of correct breathing techniques and the exercises.
- Breathing to release tension.
- How most of us don't breath properly and the benefits of learning how to do this, automatically.
- When you are faced with a tense situation it is difficult to think about breathing exercises as a technique to reduce anxiety or distress.
- I would like to see a video about this chapter.
- All was relevant.

The things I felt were NOT find helpful in this chapter include:

- I feel like I need tapes... It was difficult to read the guided relaxation of different body groupings and apply and remember to hit all. Having an audio that I could download would have been helpful.
- The language in telling me that if I do this for a particular amount of time for so long it will help, I get tense when I read that and laugh because I don't know where to find the time to do that.
- I thought all of the suggestions were helpful but I wish they had provided even more information and suggestions.
- I needed something to focus on after the exercise. The exercise was relaxing, but the minute I concluded, my brain went back into overdrive.
- I didn't find anything unhelpful, but do find threshold and passive tensing much more difficult. I have to admit that I wasn't really ready to move on to this chapter and have still been focusing on the breathing chapter. With a few exceptions, singling out muscle groups for these practices, without tensing other groups, is a practice that's difficult for me.
- Thinking about the lengthy process...
- Basic procedure was difficult to read/follow
- More recommendations about developing correct breathing techniques, as a habit, would be helpful. I am thinking that a daily routine is essential and other reminders, especially when matters are distressing.
- I will need to "find the time" to complete more research about causing habitual breathing actions.

Chapter 7: Applied Relaxation Training

Based on your completion of the Applied Relaxation Exercises, please answer the following:

The things I felt were helpful in this chapter include:

- I liked the way variations of the same relaxation theme were given - so a person can use whichever version fits with lifestyle and results.
- Finding a cue to look at and marking it. Changing it up to keep it fresh. That is easily applied.
- I like this chapter better than the last. Although a bit more of a commitment to make the suggestions work for applied relaxation, I liked that in the end I could create a much quicker experiences for calming down when anxious or stressed. This may sound bad, but when I am extremely stressed, the thought of doing 30 relaxation exercises actually stresses me more. In those instances, I am looking for more instant relief.
- The idea if relaxing tension with my mind.
- I found it interesting.

- I like the simplicity of the exercises in this Chapter. Using these exercises to address episodes of acute stress or anxiety quickly is very helpful. Although more training leading into these exercises is encouraged in the Chapter, I think they have some value even without the earlier practice.
- Interestingly enough by the time I read this chapter I realized I had been doing the first two stages (progressive muscle relaxation and release-only relation) already. Learning about cue-controlled and rapid relation has really helped me focus and give myself some time (which I was beginning to feel I didn't have, especially during the day) to practice. I'm not to the recommended number of quick relaxations per day though. I do have tinnitus and have been working on overcoming that at night through relation as it presents a problem when going to sleep (I used to use a white noise machine) I haven't had much success but do have hope that maybe this will help. I will also be sharing all of this with a friend who has very severe chemotherapy related nausea.
- I was very interested to learn that there are different methods for using tensing. Passive tensing presents the greatest difficulty for me.
- I am almost totally unaware that my muscles are tense. I have become so accustomed to it that I fail to recognize that state.
- I liked the shorthand methods. Where can I obtain an electronic copy of the shorthand procedures?
- I would benefit if a video were available.
- Simply the awareness of having a plan or a safety net to fall back on. Breathing and muscle relaxation is effective.
- Laying out what I think are essentially the steps of a natural progression as you practice relaxation.

The things I felt were NOT helpful in this chapter include:

- These chapters read as if it will take a lot of time to accomplish and that scares me off but I always find at least one item to focus on and the rest will come into place.
- Just don't know if I can commit to 6-8 weeks of daily practice. I get that it will pay off in the end, but it still seems hard. I probably am able to do the exercises about 40% of the week.
- Maybe I need more practice, but could not seem to relax the really tense areas. Will keep practicing.
- I found that since I am not completely comfortable with the progressive relaxation in Chap 4, this chapter was too advanced for me right now.
- The techniques in this Chapter seem to run together, which probably doesn't matter. Many of the exercises can probably be summarized as: "Breathe.... relax". This simplicity doesn't diminish the results however, although it does seem difficult to make the distinctions in the exercises in practice.
- This Chapter incorporates self-hypnosis, which isn't actually introduced until the next Chapter. Seems a little out of order, but probably doesn't matter.

- OK, now this is stress inducing. I have yet to find anything in this workbook that was not helpful. I believe everything is beneficial to if not me, someone else. I will admit I learn better listening and wished the recording at the end of this chapter were included in the workbook. I spend 45 minutes a day driving to and from work, and this would be something to have in my car.
- I think that I previously stated that I would like to learn techniques that will help me recall these techniques not only day-to-day but especially when stress becomes distress.
- I didn't make an audio
- Cue-controlled relaxation. This didn't seem to fit well with the other steps described. Why suddenly add an external focus?

Chapter 10: Brief Combination Techniques

Based on your completion of the Combination Relaxation Exercises, please answer the following:

The things I felt were helpful in this chapter include:

- I loved the fact that it was simply stated that these ideas in chapter 10 could be accomplished quickly during a stressful day. So much of what I've heard before talks about how long it will take and it was nice to find short ways to fix stress. I especially loved the "I am Grateful" part!
- I really like the different combinations of the components and until now did not think about trying to combine more than one relaxation technique. Depending on the circumstances, time and place, I will try to incorporate several into my daily routine in the future. The Autogenic breathing has been helpful in getting to sleep and putting my mind at rest. Interestingly enough in the past several weeks I have not awakened in the middle of the night with my mind racing and not able to get back to sleep. I don't know if it is because of everything I've worked on, just greater awareness on my part, or actually less stress. Either one, it has been nice to get a full night of sleep, which I also think must help lessen stress.
- Nice to revisit concepts from other chapters and dig a littler deeper into breathing with quick exercises.
- I found the autogenic breathing most helpful among the exercises, as well as the deep affirmation. Most of the exercises were helpful.
- I loved the suggested exercises and look forward to trying them in the future.
- The insight that the techniques could be combined and could be more beneficial to, in a sense, layers them for maximum effectiveness.
- Stretch is good idea. I use it now.
- Visualization is also a good idea. I use it for dentist and d0ctor offices.
- I hadn't thought of combining exercises...otherwise, can't say i learned much that was extremely helpful.

- I liked the I Am Grateful exercise, especially the permission to focus on small blessings.
- All was good, especially like the targeted summaries of concepts described earlier in the book and brevity of chapter as a whole.

The things I felt were NOT helpful in this chapter include:

- Having to place all the ideas together from past chapters. It's a bit overwhelming and remembering all the details on relaxation that I find myself having a hard time remembering them all so the idea to put them all together is a hard one. I see how they can work so well hand in hand though.
- Almost too many options to remember.
- I wouldn't say the tension cutter exercise is "unhelpful," I just don't feel like it's an exercise for me.
- Some of the suggestions may not be feasible depending on the time and location. If I'm feeling stressful at work I may just need to suck it up and soldier on.
- I like all the combination examples, but will definitely create my own combination.
- Not sure stomach goes out upon exhale; seems unnatural and opposite of diaphragmatic breathing which expands stomach.
- I didn't experience an increase in relieving stress
- I have a hard time with affirmation and visualization exercises.

Chapter 13: Facing Worry and Anxiety

Based on your completion of the Anxious Episode Record, Risk Assessment, Imagery Exposure, and Alternatives to Worry Behavior, the Alternative Behavior Practice Log Forms, and the problem solving worksheet, please answer the following:

The things I felt were helpful in this chapter include:

- Good to visualize time beyond event, which is most always better than the worry scenario.
- Good to enumerate alternatives to worry behavior.
- Specific dates are good idea for brainstormed solutions.
- Overall great tips for inward reflection.
- Information on imagery exposure - I have tried it to help me deal with my sudden anxiety attacks, particularly when I am in enclosed, dark places. I envision myself being underground and try to practice deep breathing techniques to avoid distress.
- I also am working on worry behavior and ways to develop alternative behavior. I have two children and constantly am worried that something bad will happen to

them. I am learning to take a deep breath and try to imagine the best-case scenario instead of the worst as it applies to various situations with my children.

- The part about the facing your worst fears and how if we continue to face it eventually it will subside a little over time.
- I found this entire chapter helpful. For me, almost any of these exercises (even if I just do them in my head sometimes) diminishes worry and puts unreasonable fear into perspective. Writing it down is even more helpful, although it doesn't always seem practical. The exercises I prefer in this chapter are the risk assessment and alternative behavior practice logs.
- An awareness of how anxiety can really worsen feelings of stress.... almost artificially. While I am not experiencing this level of anxiety right now, it reminded me of times in my life when I know I was going overboard with my doomsday thinking. These exercises are noted as something to come back to if I notice I am doing that again.
- I'm not typically a worrier or particularly anxious. I didn't get much out of this chapter. However, I do subscribe to positive imagery and goal setting.
- I like the steps in the instructions that would allow people to skip around to the most relevant parts previously presented in the book. I like to read cover-to-cover and reiterating that this book was not meant to be used that way is helpful.
- I like the Risk Assessment Form as a tool to assist with recognizing when your anxiety is warranted.
- Liked the Owen samples.

The things I felt were NOT helpful in this chapter include:

- Disagree that imagining image more will lessen its distressing effect. Is this not the opposite of going to a "happy place?"
- Nice practice examples.
- Although the forms are nice to have, I don't follow them exactly as I just don't like to have that structured of an approach in dealing with stress.
- Imagery Exposure. I didn't care for this area and didn't feel that I would learn much from it. I can see how figuring out how you would handle a situation and confront it before it happens is helpful though felt the chapter was a bit too long and lost my attention.
- I find the imagery exposure exercise difficult and problematic for exactly the reasons cited in the chapter: those practices seem to compound every day worrying.
- Really hard to "do" this chapter (and most of the chapters) adequately in a week. I think I'll be glad to spend more time in the future really focusing on some of the practices I prefer or feel like I need to spend more time with. Just don't feel like there's enough time to really absorb each chapter.
- The thought of trying to do this chapter in one week on top of everything else. This chapter really derailed me from following the schedule of reading assignments. I got stuck thinking I couldn't move to the next chapter until I had

finished this one. But I had no time to actually do all the worksheets, nor did I feel that it was applicable to me at this time. I did not do the exercises and I realized I needed to let that go in order to keep reading.

- Just challenging to keep up and engaged in this chapter.
- This is a BIG chapter. It takes a lot of work and time to actually go through all of the exercises presented. I read them, but did not actually do them. I don't feel I have a current need, but it's nice to know these tools are here.

Chapter 15: Anger Inoculation

Based on your completion of the Coping Thoughts Worksheet, the Hierarchy of Anger Scenes, and the Anger Coping Plan worksheet, please answer the following:

The things I felt were helpful in this chapter include:

- The lists of anger distortions and coping thoughts were awesome. Thinking through these as I encountered "anger" throughout my week was very help to put situations in perspective. I still got angry when for example someone cut me offs, but was able to quickly get back to mild in the hierarchy. Example I was driving to a meeting in dc, entered one of the dreaded circles and another car cut across me and almost caused in accident. I did hit my horn and loose it, but with some deep breathing and putting the situation in perspective I was able to get back to neutral in a few minutes as opposed to it ruining my day.
- I found the anger distortions list very helpful, as this is an area where I could definitely use some help. I'm going to try to develop more coping thoughts to help me as well as continue to view things from the other person's perspective. I do believe, however, that sometimes anger is justified and there is a fine line between standing up for yourself versus accepting things the way they are and learning how to deal effectively with the situation.
- Realize I use blaming, global labels, overgeneralization; best to avoid extreme language or thoughts.
- Good rationalization statements for coping.
- Others don't agree with my rules of conduct.
- Like most of the chapters so far, I feel like I need to use the practices longer in order to really evaluate, but I continue to find the practices generally helpful. Of course, it's just like getting to Carnegie Hall...the trick is to practice, practice, practice. Developing these habits is the real challenge.
- I found the process of identifying anger distortions enlightening, though not entirely surprising. Definite themes emerge. The strategies for coping (self-talk/thoughts) are readily apparent, but still, the trick is to commit to using them. Developing good habits/practices is clearly essential. Why is it so difficult to permit ourselves the time? (Surely, it's not just me ;->)
- I really was in touch with the anger distortions as I think I do most of those and my husband tries to show me that I'm doing them. I plan to re-read this chapter

a few times to get a sense of how to handle this. I liked the examples of the thoughts to liken it to how I current react. I think I do this sometimes in work situations as well.

- Easy transition with the information from the other chapters. I liked the examples/situations.
- Good step by step hints for those who experience a lot of anger.
- Calming down, cool off, and then deal with it.
- I thought the description of the different types of anger distortions was very helpful. Pieces that I have noticed in my staff, peers, family and it gave me some added language on how to coach others and myself around those distortions.
- I think it was good overall advice. I rarely get really angry, that is one thing that I can good with. I stay pretty calm. But I did still pick up some good pointers.

The things I felt were NOT helpful in this chapter include:

- The anger plan and coping worksheets were not very helpful and anger scenes.
- Although I find the worksheets beneficial, I just don't have time to sit down and complete them all in detail. I also think it would be beneficial to find out how gender impacts anger inoculation as I suspect there is a great deal of difference between how a man handles various situations compared with a woman.
- Still not sure, although it is a useful practice, that it is useful to repeatedly visualize anger scenarios. It seems to me that use of the practice would reinforce the negative and it would be better visualize positive images. I understand "ballooning" as a process also, but that usually has a positive outcome as the extreme negative has a low probability of occurrence.
- One question that lingers for me, but isn't answered is: "Is 'why' important?" (Why do I persist in patterns that I know are unhelpful, even destructive?) Maybe the answer doesn't matter, but it can be a hang-up. Does understanding the roots of our behavior matter? (The older I get, the more I suspect it may not matter.) Curious...a little chicken and egg.
- I found the anger exercises pretty repetitive (which doesn't necessarily mean unhelpful), probably because my own distortions are repetitive. Hard to imagine doing them more than a couple of times because the answers seem to be the same. I guess that simplifies things in some ways because the coping thoughts stay relatively consistent.
- As I read there is constant talk about 'mastering' techniques. I'd like to read a book where they tell me what will work best but I feel in reading that word make me tense that it won't work if i don't master. Then I laugh b/c this is all about relaxation and dealing with stress but these words seems to trigger me and add to my stress!
- Six distortions, glossary...
- I feel that I rarely experience true anger. This chapter does not seem applicable for me.

- I like the worksheet, but at this point in the study I am tired of the self-directed exercises. I will, however, earmark this section to help me prepare in the future when I anticipate having anger triggering conversations during our annual meeting!
- As with the other chapters, I think everything is useful. There may be parts that are more applicable than others.

Chapter 18: Work-Stress Management

Based on your completion of the Work Stressors, the Problematic Responses, The self-contract and exercises, and the balance worksheet, please answer the following:

The things I felt were helpful in this chapter include:

- A listing of the factors in what causes work burnout was kind of an eye-opener. My response to specific work stressors is that I become anxious with deadlines. Although, I am one who needs deadlines (goals) to motivate me to complete certain tasks. My supervisor is one who needs the recommendations to coincide with their ideas.
- I do use self-talk, but I didn't use the self-contract.
- I liked the inclusion of the work-stress underload. Pace and Balance also seemed particularly relevant to me. I am telecommuting full time now, and this is especially important.
- Role playing conversations
- Perspective is everything, even in my mind.
- Good to point out lack of control causes stress.
- Agree that lack of stressors can lead to problems.
- Good exercise for self-contract and listing of responses to work stressors.
- Good to address realistic outcome of not doing something vs. blowing it out of proportion.
- Good to negotiate with another over stressful situation.
- Determining what the actual work stressors are in my position as well as thinking about ways to overcome them.
- Identification of the stressors and the responses is really helpful (and a little alarming). Patterns emerge and being conscious of the patterns is helpful for sure.
- The chart about the stressors and how they are handled. The examples were very useful as well. I am going to try these things and the contract with oneself was a fantastic idea. If this chapter had been longer I would have been happy!
- Interesting reading, I did not find as useful because I don't experience many of the issues mentioned.

The things I felt were NOT helpful in this chapter include:

- Would be helpful on P 291 when discussing acquiring additional information, to also suggest having a colleague or friend or family member help guide one through the process. Sometimes it is helpful to have a trusted advisor ask the questions for self-introspection and assessment.
- All of the forms that you needed to complete in order to determine the problem - this format is too structured for me (I do better in a group discussion format).
- I haven't done the self-contract, just something I'm resisting because it just feels forced. I may come around later however, but the other exercises are helpful and I do appreciate the importance of acknowledging a commitment to change.
- I thought this entire chapter was helpful for me!
- My stress at work is mostly due to more work than I can reasonably manage, however, a lot of it is self-induced. I am not sure that I would develop a contract for myself.

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TABLE 1*Advanced Repeated ANOVA Power Analysis***Results for Factor B (Levels =2)**

Test	Power	N	N	Multiply Means By	SD of Effects (Small)	Standard Deviation (Sigma)	Effect Size	Alpha	Beta
GGF	0.99664	24	48	1.00	0.25	0.45	0.56	0.0500	0.0336
Wilks	0.99664	24	48	1.00	0.25	0.45	0.56	0.0500	0.0336

Results for Factor W (Levels =3)

Test	Power	N	N	Multiply Means By	SD of Effects (Small)	Standard Deviation (Sigma)	Effect Size	Alpha	Beta
GGF	1.000	24	48	1.00	0.20	0.16	1.29	0.0500	0.000
Wilks	1.000	24	48	1.00	0.20	0.16	1.29	0.0500	0.000

Results for Term BW

Test	Power	N	N	Multiply Means By	SD of Effects (Small)	Standard Deviation (Sigma)	Effect Size	Alpha	Beta
GGF	0.99664	24	48	1.00	0.25	0.45	0.56	0.0500	0.0336
Wilks	0.99664	24	48	1.00	0.25	0.45	0.56	0.0500	0.0336

FIGURE CAPTIONS

Figure 1. Gender breakdown of study participants includes more females than males and does not reflect the mean breakdown of females in nonprofit leadership roles in the United States.

Figure 2. Marital status demographic data of study participants shows that most are married, followed by divorced, single, and then widowed.

Figure 3. Number of children under 18 years of age living in the home of study participants includes mostly homes with 1-2 children, followed by 0 children, 3-4 children, and then 5 or more children.

Figure 4. Number of years of executive experience of participants, with >10 years being the most common response, followed by 7-10 years, 4-6 years, and then 1-3 years.

Figure 5. Annual salary of study participants shows that most make >\$100,0000 annually, followed by \$71,000-\$99,9999, and <10% making \$40,000-\$70,999.

Figure 6. Most study participants have <25 employees who report directly to them.

Figure 7. Annual budgets of study participants show that nearly have of all participants manage budgets >\$10,000,000.

Figure 8. Nonprofit Executive study participants show relatively higher levels of pre-treatment stress as compared to the normative mean for those employed full time on the Perceived Stress Scale measure.

Figure 9. Nonprofit Executive study participant show relatively higher levels of pre-treatment stress as compared to the normative mean on the Isolated Stress Scores of the Depression, Anxiety and Stress Scale measure.

Figure 10. Study results show the significantly lower levels of stress of the intervention group from the pre-treatment to the post-treatment measure using the Perceived Stress Scale measure.

Figure 11. Study results show the significantly lower levels of stress of the intervention group from the pre-treatment to the post-treatment measure using the stress scores from the Depression, Anxiety and Stress Scale measure.

Figure 12. Study results show that participants in the intervention group were able to maintain significantly lower levels of stress at an eight-week follow up after treatment with bibliotherapy using the Perceived Stress Scale measure.

Figure 13. Study results show that participants in the intervention group were able to maintain significantly lower levels of stress at an eight-week follow up after treatment with bibliotherapy using the stress scores from the Depression, Anxiety, and Stress Scale measure.

FIGURE 1

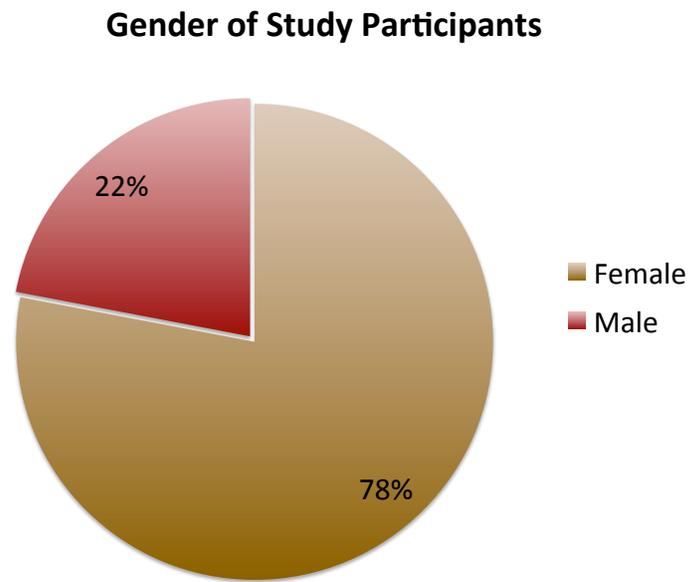


FIGURE 2

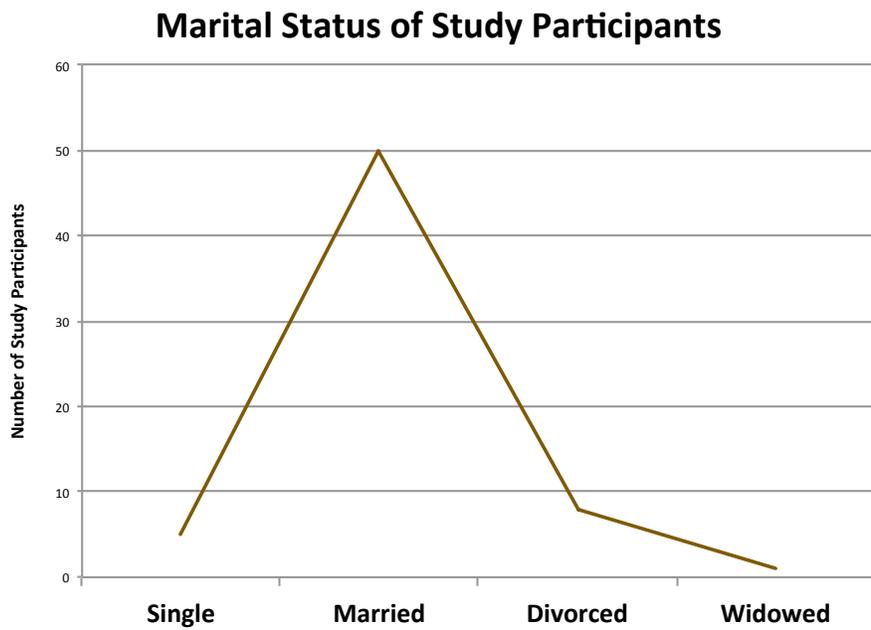


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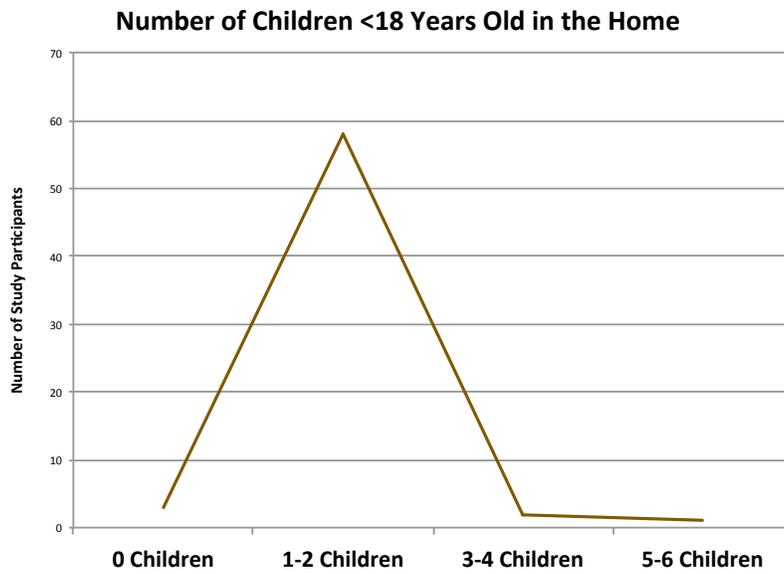


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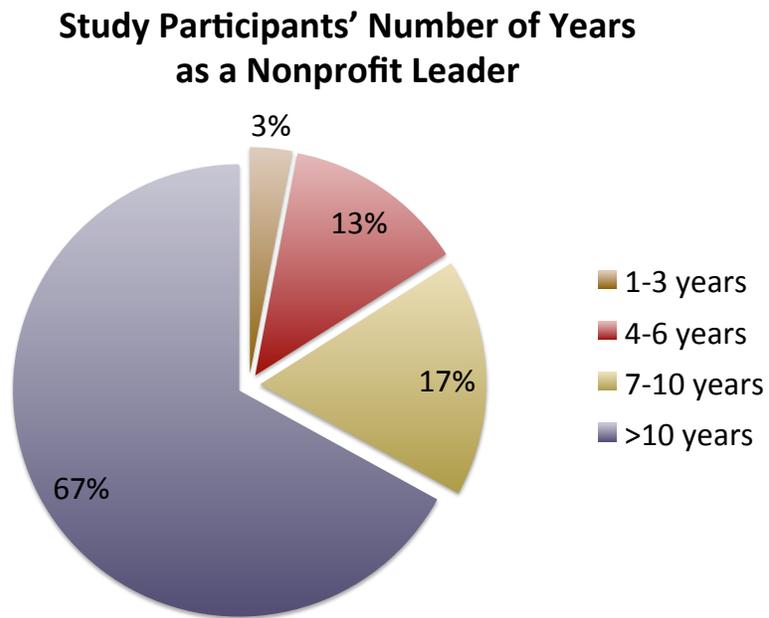


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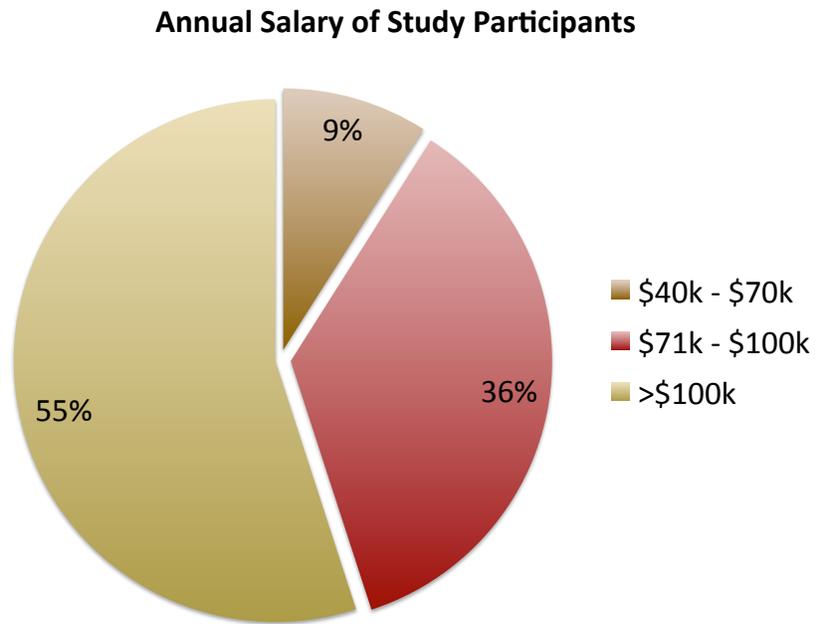


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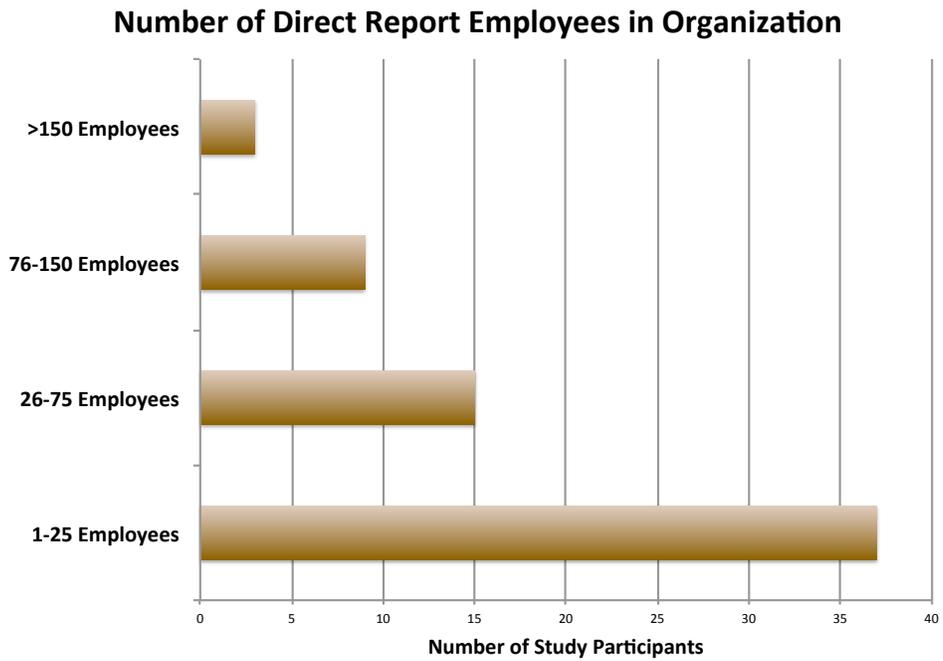


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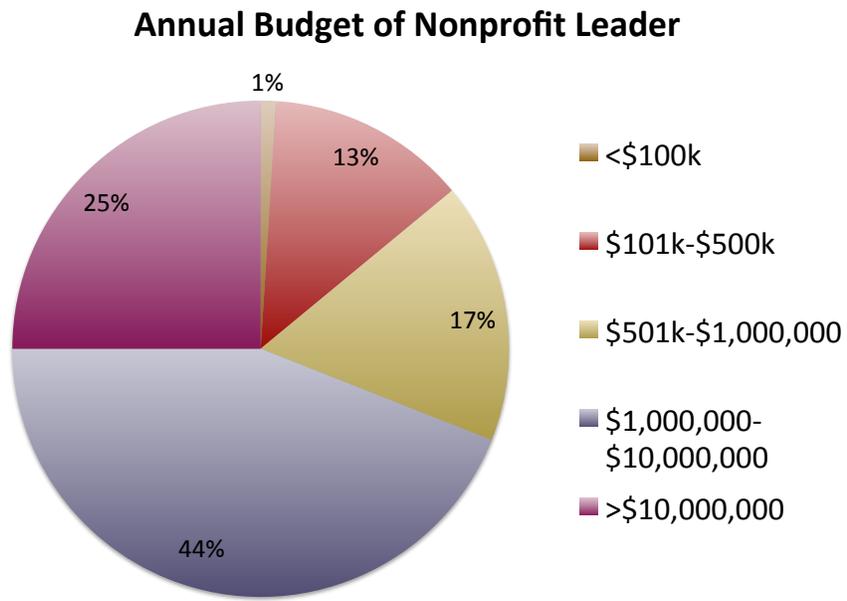


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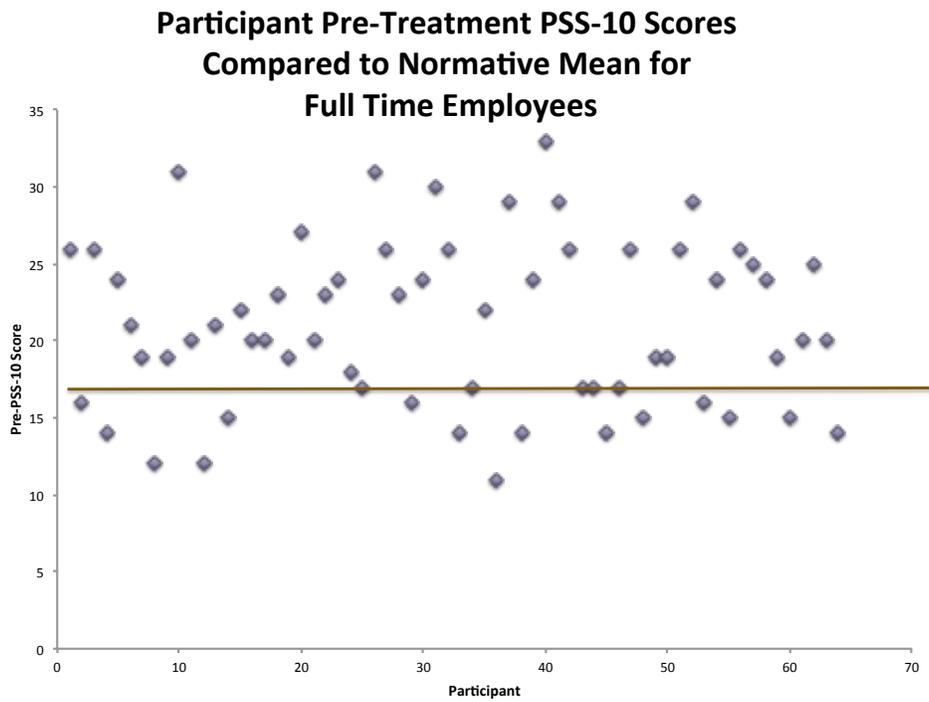


FIGURE 9

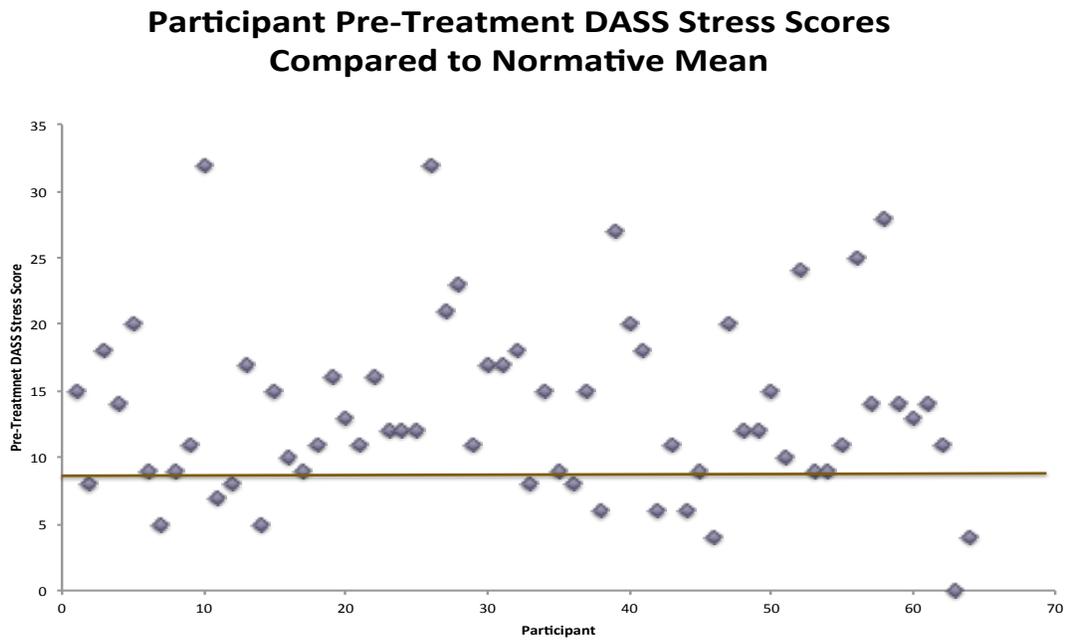


FIGURE 10

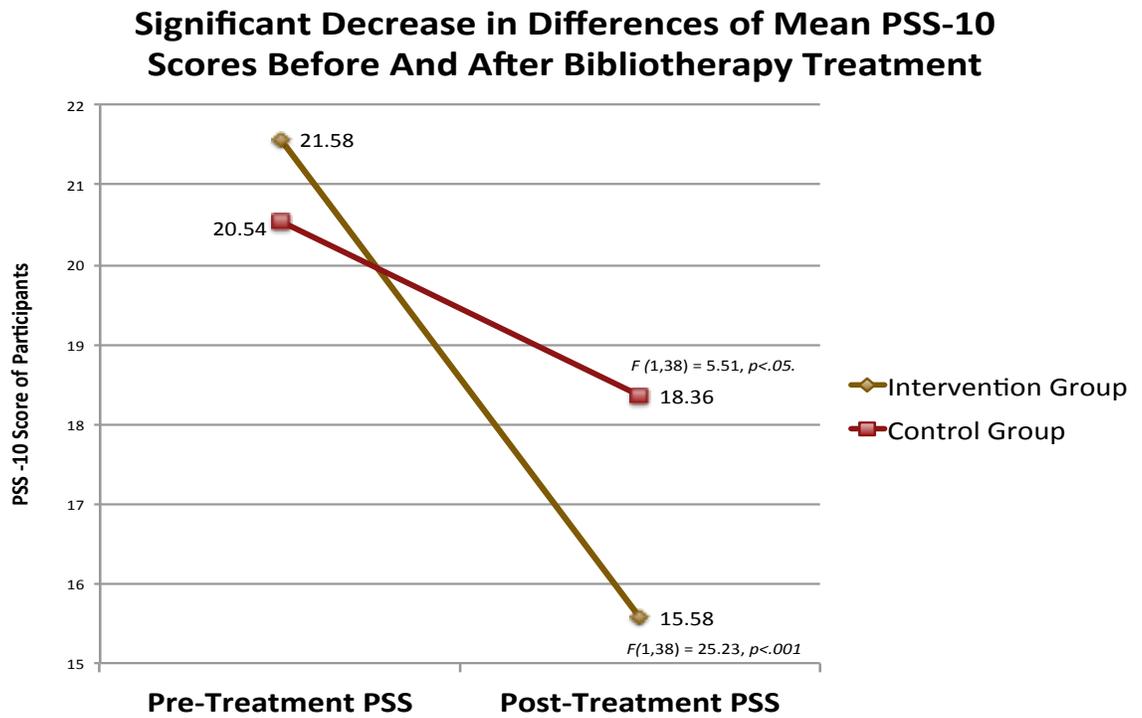


FIGURE 11

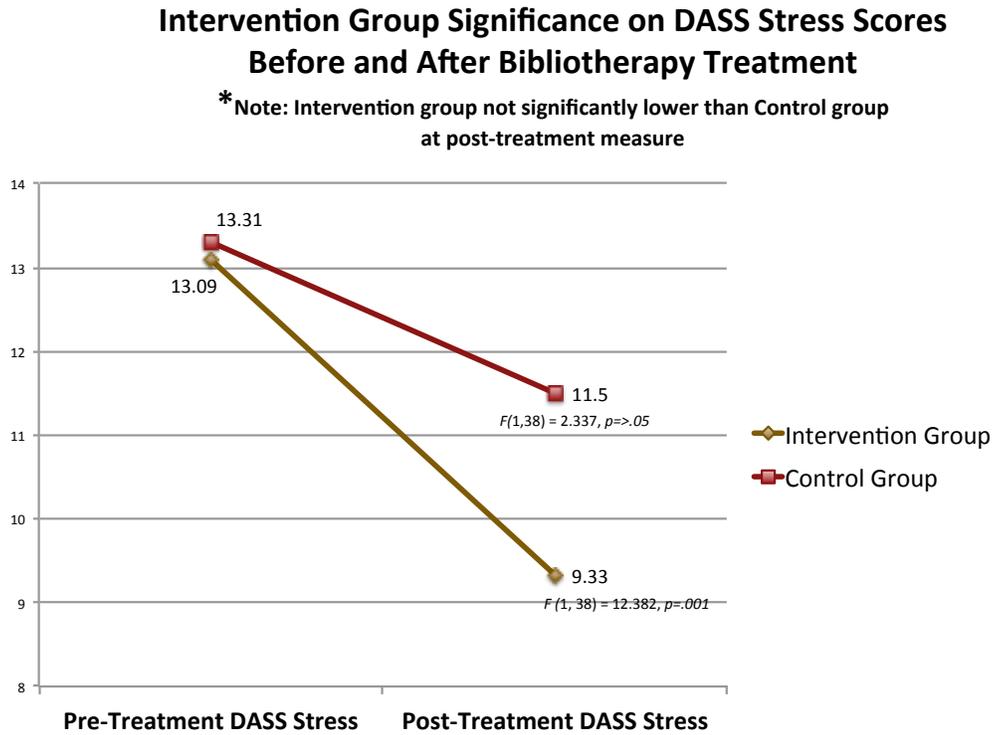


FIGURE 12

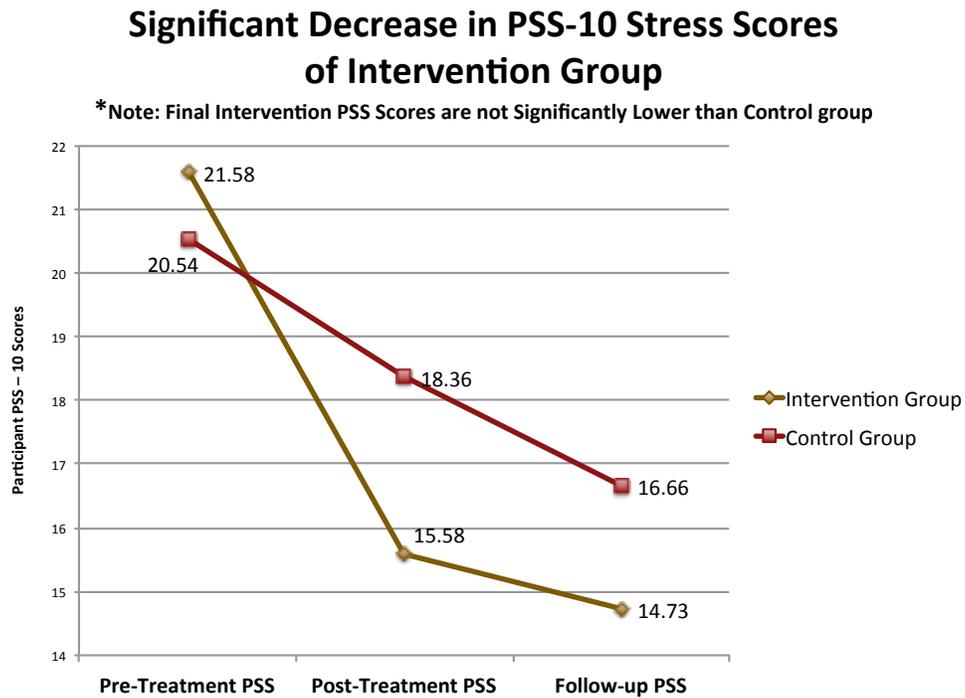
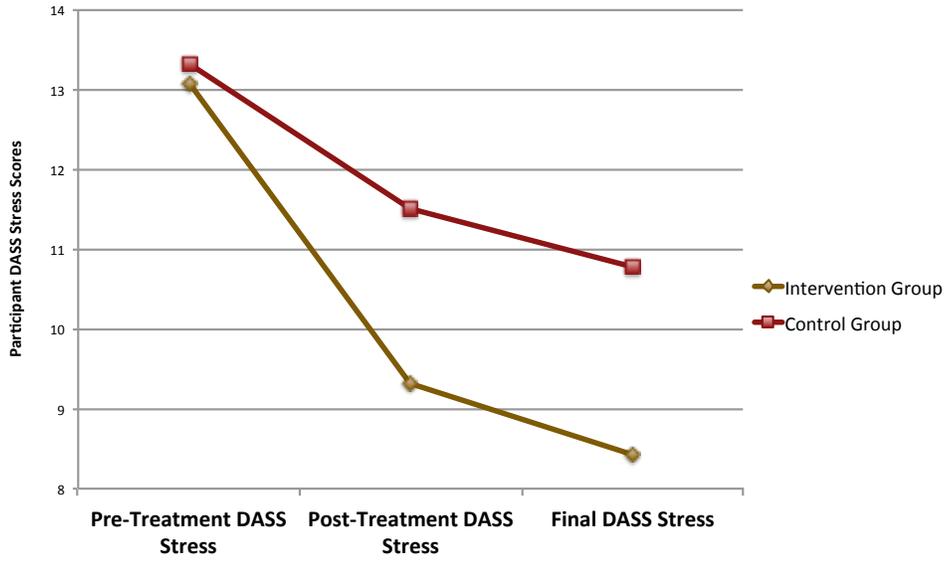


FIGURE 13

Significant Decrease in DASS Stress Scores in Intervention Group

*Note: Final Intervention PSS Scores are not Significantly Lower than Control group



VITA

Robin Wootten is a nurse with over 25 years of experience in various healthcare settings. She has been a staff nurse of Labor and Delivery, Postpartum, Nursery, Neonatal Intensive Care Nursery, Surgery, and the Recovery Room. She also has been the Director of several Maternal / Child and Surgical Units and a Service Line Director of Women's Health, Perinatal Services, and Pediatrics.

Robin originated the Healthcare Simulation Program at the University of Missouri Medical School in 2006 and served as Inaugural Director when the program expanded to the 10,000 square foot Russell D. and Mary B. Sheldon Clinical Simulation Center. She was elected to the Board of Directors of the International Society for Simulation in Healthcare and was recruited after a year on the Board to become the Executive Director of the Society. During her tenure as CEO, the Society membership and annual meeting attendance grew by more than 50%. Robin was instrumental in establishing the first staff of the Society as well as the organizational infrastructure. In her role, she also published articles and traveled around the world as the spokesperson for the Society.

Robin returned to the Kansas City area in 2011 and her love of Perinatal Nursing as the Director of Perinatal Services at Truman Medical Center, the largest Safety Net Hospital in the area.

Robin is passionate about Women's Health and safe, family-centered patient care for all people, regardless of their ability to pay.