Wellness Works: Community Service Health Promotion Groups Led by Occupational Therapy Students

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Key Words: group process • motivation

Objective. In the context of a group process course, occupational therapy students learned health promotion skills through working on personal wellness goals and leading community-based health promotion groups. The groups targeted topics such as smoking cessation, improving diet, reducing stress through yoga, meditation, tai chi chuan, ROM (Range of Motion) Dance, aerobics, and a variety of other activities.

Method. After identifying a personal wellness goal and developing it in a Wellness Awareness Learning Contract, each student used a Goal Attainment Scale (GAS) to predict an expected outcome for achieving the goal and to measure his or her progress toward attaining the goal. Students also used the GAS to measure progress in attaining group leadership skills within the community groups, which they outlined in a separate Group Skills Contract. Students kept weekly logs to foster reflective thinking, and the logs were used for interactive dialogue with the instructor. To further evaluate lifestyle change, students compared pretest and posttest scores on a Self-Assessment Scorecard, which surveyed six areas of health and human potential in body, mind, and spirit.

Results. Students monitored their own change process on both their personal health lifestyle goals and their group leadership skills while developing a richer appreciation of the dynamics of working for change with clients in community and traditional settings. Differences on the Self-Assessment Scorecard indicated improvement on two of the six scales for physical health and choices.

Conclusion. Students experienced firsthand the challenges of developing healthier lifestyles on the basis of their personal goals as well as through fostering group changes. The two GAS learning contracts provided them with concrete evidence of their growth and learning. This experience—embedded in the context of a group process course with a community service learning group practicum—provided most students with a positive initial experience with group leadership as they began to explore roles as agents for lifestyle and health change. Suggestions for expanding health promotion roles in practice in the changing health care environment are also examined.


As a profession, occupational therapy has a long-standing commitment to the philosophy of occupation as a vehicle for health promotion. The vision statement of the American Occupational Therapy Association (AOTA) states that “AOTA advances occupational therapy as the preeminent profession in promoting health, productivity, and quality of life of individuals and society through therapeutic application of occupation.”
The Standards for an Accredited Educational Program for the Occupational Therapist (AOTA, 1999) include the following statements in the section on the basic tenets of occupational therapy: The student will “acknowledge and understand the balance of performance areas to the achievement of health and wellness” and “understand and appreciate the role of occupation in the promotion of health and the prevention of disease and disability for the individual, family, and society” (p. 578). Lastly, Uniform Terminology (AOTA, 1994) acknowledges self-management and health maintenance as parameters of occupational therapy intervention.

In support of initiatives toward health promotion, valuable prototypes are emerging. A model preventive health program using group and individual occupational therapy with multiethnic older adults living in the community documented major improvement on variables of vitality, general health, general mental health, social function, and absence of health-based role limitations (Clark et al., 1997). Healthy People 2000 (U.S. Department of Health and Human Services [DHHS], 1991) and the subsequent document Healthy People 2010 (DHHS, n.d.) present a national public health initiative to promote healthy lifestyles with priorities that include decreasing tobacco use and substance abuse, improving diet, increasing level of physical activity, and focusing on stress-related problems. “Ranking second only to tobacco use in contributing to premature mortality, [are] dietary patterns [eating habits] and the sedentary lifestyle of most Americans” (Lee & Estes, 1997, p. 70).

Healthy People 2000 identifies health promotion goals relevant to persons with disabilities, including use of leisure activities, stress management, education regarding community and self-help resources, and reduction of secondary disabilities associated with head injury and spinal cord injury. A survey in 1994 by the National Center for Health Statistics documented that 59.4 million Americans—about 23% of the population—had functional disabilities (Office of Disease Prevention and Health Promotion, n.d.). According to Baum (1997), managed care entities will seize opportunities to address the health and wellness needs of persons with chronic illness and disability not only to decrease costs, but also to capture new markets.

Concurrent with the major restructuring of health care delivery, the need for viable fieldwork settings has created a demand for developing innovative approaches to fieldwork placements that correspond to needs of clients in the community and that reflect the values and activities that occupational therapists can effectively address in emerging practice areas (Baum & Law, 1998; Brownson, 1998; Drake, 1992; Fleming, Christenson, Franz, & Letourneau, 1996; McColl, 1998). Many educational institutions support a mission of community service, and such an orientation is consistent with the philosophical and ethical base of occupational therapy practice that embraces a holistic approach reflecting the environmental context of the client’s lifestyle.

In an effort to respond to the preceding concerns and to provide occupational therapy students with a meaningful exposure to community health and principles of wellness, I initiated Groups in Health Care, a course targeted to juniors in the third semester of a 2.5-year education program. The practicum part of the course was designed to offer initial community exposure before the Level I fieldwork in the next semester. In class and in a variety of community settings, students learned to apply the use of health-promoting occupations to enhance their personal health as well as that of those they worked with through service learning in community and traditional sites.

Course Objectives and Content

The objectives for the 15-week course were to

- provide students with theoretical and practical exposure to group process via didactic and community service experiences,
- enhance skills in the therapeutic use of self and an appreciation of reflective reasoning,
- increase understanding of the phenomenology of the change process
- learn to evaluate outcomes of individual and group goals
- value wellness as part of occupational therapy practice, and
- incorporate health-promoting occupations into their personal and professional repertoire.

Teaching Method and Materials

The course met three times a week, one session for lecture and two for lab experiences. Initial lectures covered content on health promotion reflecting wellness models from Healthy People 2000 (DHHS, 1991) and occupational therapy (Johnson, 1986; Swarbrick, 1997; West, 1968). A videotape entitled Healthy Lifestyle (Whole Person Associates, 1995) introduced students to the examination of their own lifestyles and approaches to wellness in the areas of eating, exercise, stress, relationships, and change. The video also focused on developing goals for planning a personal agenda to enhance wellness. Students completed a Self-Assessment Scorecard developed by Dossey and Keegan (1986) on physical, emotional, mental, relationships, choices, and spiritual dimensions of health.

In preparation for addressing the spiritual dimension of practice, a class exercise required students to review several chapters of Healing Words (Dossey, 1993) and the special issue of The American Journal of Occupational Therapy on spirituality (Peloquin & Christiansen, 1997). This exercise attempted to explore students’ perceptions of the role of spirituality in occupational therapy practice. Material from Siegel’s (1988) Love, Medicine and Miracles concluded the discussion on spirituality.

Instructional materials on lifestyle change and cultural issues in health care included Leininger’s (1990) “Acculturation Health Care Assessment Tool for Cultural Patterns in Traditional and Non-Traditional Lifeways.” Students were intrigued with the Healing and the Mind videotape series by Moyers (1993) and Ornish’s (1992) Avoiding the Surgeon’s Knife, a videotape presenting his approach to healthy lifestyle for cardiac patients using diet, support groups, and yoga. A third videotape, Conducting an HIV Parent Support Group (1990), illustrated Yalom’s (1986) curative factors in group therapy.

The practical, or laboratory, section of the course met two times a week. One meeting was structured as a support group to discuss the students’ individual experiences with their personal wellness goals from their Wellness Awareness Learning Contracts (see Appendix A). The instructor did not attend the support groups because they were conceptualized as a peer-oriented process. The second session involved formulating and refining plans for the community-based health promotion groups. The instructor took an active role in providing resource material and assisting with problem solving for developing the community group protocol to be implemented in the second half of the semester and to facilitate learning group skills in the community setting. During the two lab sessions, students also identified an area of concern for developing group leadership skills via a Goal Attainment Scale (GAS) Group Skills Learning Contract (see Appendix B), to be implemented once the community groups were started in the second half of the semester.

Learning Contracts: Wellness Goal

To promote an experiential perspective to the dynamics of lifestyle change, students were required to formulate a personal wellness goal, which they outlined in a Wellness Awareness Learning Contract (see Appendix A). The use of learning contracts has been an educational staple to promote active, learner-directed goals in both academic and clinical settings (Boyd, 1979; Knowles, 1986; Malkin, 1994; Mazhindu, 1990). To identify an area for wellness focus, students also used a Self-Assessment Scorecard (Dossey & Keegan, 1986). The scorecard lists six areas: physical, emotions, mental, spirit, relationships, and choices. Once the wellness goal was identified, students used behavioral terms to describe their goals in the learning contract.

Although students were exposed to material on wellness that framed health in terms of body, mind, and spirit, most selected goals focused on exercise (46%), diet, and improved nutrition (14%). A few students chose to work on a more spiritual plane, with a goal of using occupations to restore a healthier balance of activities in an academically dominated schedule through yoga or relaxation (11%) or resumption of previously valued hobbies like reading or playing an instrument (11%). One student indicated a need to establish a more regular sleeping pattern, another designated better time management, and another sought to develop a more realistic approach to budgeting. Three students focused on selected aspects of academic performance that were stressful for them, such as public speaking (7%), for which they wanted to overcome uncomfortable reactions.

Students coupled their contract with a projected outcome score from the GAS 5-item ranking system (Kiresuk & Sherman, 1968): much less than expected outcome (–2), less than expected outcome (–1), expected outcome (0), more than expected outcome (+1), or much more than expected outcome (+2). These numerical values corresponded to a normal curve with the zero value representing “normal.” A final T score of 50 corresponded to the “expected level of outcome” or the zero point on the scale. Originated for evaluating goal outcomes in community mental health, GAS has been used extensively in a variety of health and educational settings with both populations that are typical and those that have physical or mental disabilities (Ortenbacher & Cusick, 1990, 1993; Scott, 1998; Scott & Haggerty, 1984).

Students specifically projected two GAS outcome scores—one for their objective health promotion behavior and the other for their affective response. With the use of
Bloom’s (1956) taxonomy to categorize learning domains, the behavioral wellness goal was related to cognitive or psychomotor aspects of learning. To address increased awareness of the process of change, the affective domain was also included as a separate GAS. Students could monitor their emotional responses to efforts to improve wellness behaviors on the affective GAS. Once the outcome scores were projected, students used the GAS to monitor their progress in achieving their wellness goals.

At the end of 6 weeks, students repeated the Self-Assessment Scorecard. When pretest and posttest scores were compared using a paired t test, improvements were found in the areas of “physical health” and “choices” (see Table 1). Items included on the physical scale addressed exercise, diet, energy level, and balancing work and personal life. The dimension of choices included time management, commitment to new projects and follow-through, and not taking on more tasks than can be handled.

Students had 6 weeks to achieve their designated wellness goals. They rated their psychomotor or behavioral GAS and the affective GAS and recorded their progress in a weekly log. The log was also used to reflect on their emotional response as measured on the affective aspect of the GAS. The instructor reviewed the logs weekly to offer support and feedback via comments and queries, which provided external validation and informal supervision. Because students could also respond to the instructor’s feedback, this interactive dialogue between instructor and student was useful in promoting self-reflection relevant to their personal efforts to change (Neistadt, 1996; Raymond, 1998; Tryssenaar, 1995).

**Community-Based Groups**

Working in teams of two or three, students spent 15 to 20 hr during the second half of the semester providing service in the community service learning sites once or twice a week for 4 to 6 weeks. The sites included a shelter for women who are homeless and mentally ill, senior programs for well elderly persons and persons with mental illness, an inpatient pediatric sickle cell unit, and a university health club with programs for students and staff members.

The students applied the same format they used to articulate a personal wellness goal to develop a learning contract addressing skills intrinsic to group process work, such as group preparation and management, leadership, and team skills. They first completed a needs assessment using the Group Leadership Skills self-assessment scale. The items for this scale were taken from Moyers’s (1984) Group Leadership Evaluation Form and from Mercy College’s Professional Development Feedback Form (Golisz, 1996). Students then projected a GAS outcome score and developed a Group Skills Learning Contract (see Appendix B) on the basis of their evaluation. Most students chose to focus on the skill of developing comfort in taking a leadership role.

Before starting the health promotion groups, each student team had developed a group protocol for their community health promotion group. Some teams had the advantage of using protocols and needs assessments (Grossman & Bortone, 1993) completed by a previous class. Group protocols are procedural outlines that delineate the goals, focus, method of implementation, and outcome criteria for the group. Student teams then visited the sites to seek input from the agency staff members and clients related to the population’s health promotion needs. This input was needed to refine the group protocols. Feedback was also sought regarding possible outcome measures to evaluate the efficacy of the group process with the community clientele. A weekly outcome assessment assignment assured ongoing focus on the quality and efficacy of the group interventions.

Student teams then videotaped a simulated group session on the basis of their group protocol, using a group Session Evaluation Form Protocol (Howe & Schwartzberg, 1995) to critique and refine their leadership activities. For several teams, the videotape feedback was a powerful means of learning. This method permitted them not only to focus on group task issues, but also to expand on a social–emotional approach in their projected group activities and facilitate a more interactive process and leadership style.

The student-led community groups used a variety of traditional and nontraditional activities and incorporated Eastern and Western perspectives to reflect the cultural values and diversity of the group members, an urban inner city population. Activities included ROM Dance with tai chi chuan (Van Deusen & Harlowl, 1987); yoga; meditation; making Native American dream catchers; craft, art, and music activities; aerobics; nutrition education using the food pyramid; assertiveness training; and a smoking cessation program.

One team led an assertiveness training group for women with mental illness who were homeless; the women named the group “Why Can’t We All Just Get Along.” Another team joined the occupational therapy instructor and other faculty members in a campus smoking cessation program, using guidelines (Ask, Advise, Assist, and Ask Again) formulated by the National Cancer Institute and the AHCPR (AHCPR, 1996; Royce, 1998; Swarbrick, 1997). The program used a popular format known as “Quit and Win,” in which a contest was held for those who wanted to stop smoking and was funded through grants.

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**Table 1**

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<th>Pretest and Posttest Scores on the Self-Assessment Scorecard (Dossey &amp; Keegan, 1986)</th>
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*Statistically significant.
obtained by the OT Network on Smoking and Wellness (Williams, Burkhardt, & Royce, 1995). The team co-led support groups to help participants cope with the pressures of nicotine withdrawal and lifestyle change, supplemented with deep breathing techniques and relaxation tapes supplied by the American Lung Association. The team also monitored smoking cessation compliance with a Breathalyzer™ provided by the local chapter of the American Cancer Society.

Several student teams worked in senior programs where goals were tailored to the needs of each population (e.g., stress management, fitness, healthy diet). In one senior setting, where clients were also coping with recovery from mental illness, activities were well received that used music, art, and ROM Dance—a ROM videotape incorporating tai chi chuan and relaxation techniques (Harlowe & Yu, 1993). Another senior program called Nutrition as a Way of Life, was so successful that the student team was invited to conduct the group on a salaried basis at the conclusion of the semester. Two other teams focused on getting busy students and staff members to engage in health promotion activities: Sunrise Aerobics for students and Relaxation Spa for Stressed-Out Staff.

One team conducted a bedside group in which Native American dream catchers were crafted to offer a meaningful activity with creative expression and social support for children hospitalized for sickle cell crisis or other medical conditions. Symbolically, the dream catcher amulet is believed to ward off nightmares and let only the pleasant dreams pass through. Many of the children embraced the curative elements of this symbol, reporting that they had experienced no unpleasant dreams during their hospital stay! The following vignette reported by the student leaders demonstrated how engagement in this activity helped some children and family members feel more empowered to deal with the stress their illness presented.

A mother and son worked side by side, making a typical creative dream catcher. During show-and-tell, the mother explained, “The multicolored feathers in the middle represent my son’s asthma crisis; the lanyard is a bridge to the blue feathers, which represent my son’s good health in the future.” It was apparent that the dream catcher activity carried significant symbolism. “To our surprise, what started out as a simple way of encouraging self-expression turned into something poignant and profound for these children with remarkably threatening and difficult health concerns.” (Scott et al., 1997, p. 4)

During this practicum, weekly seminar sessions with the instructor and fieldwork coordinator focused on integrating the students’ experience with leading groups with theoretical perspectives and making parallels to future Level I fieldwork experiences. Issues that emerged from the dialogue included students’ concerns about working with populations with mental illness and the stigma associated with this population (Lyons & Hayes, 1993); effective techniques to engage group members; how to work in community agencies where the role of the occupational therapist is not known; views on how to integrate wellness into traditional practice; and the value of supervision provided by agency staff who were usually in social services.

### Monitoring the Change Process

The process of self-monitoring an objective goal on a weekly basis and one’s psychological experience with making lifestyle changes was extremely informative for students, altering their perceptions about the ease with which goals can be reached even by motivated students. One student wrote in her log, “I never realized how difficult it would be to accomplish one small goal. Going through this personal effort on my own will allow me to be more sensitive in the future toward clients who will be trying to achieve personal goals.”

Some students started by making progress toward their goal only to falter, whereas others struggled for several weeks to make small lifestyle changes. The GAS numerical ratings objectively captured whether a student had engaged in the desired activity. Old habits were especially pervasive. Continued inner dialogue and motivational strategies were crucial in sustaining the effort to change a health behavior. Some students enlisted encouragement from classmates or recruited family members and friends to go to the gym, to take health walks, to maintain a more nutritious diet, or to take a stress break from a demanding school schedule.

The log summaries at the end of 6 weeks and at the end of the semester revealed that, for some, the impact of the Wellness Awareness Learning Contract assignment was profound. Students reported feeling uplifted and inspired by the response of group members to the activities they presented. The following are examples:

> I have learned a great deal about wellness as well as myself and the ways I deal with others over the past few weeks. I now truly understand the whole concept of being well and trying to make as many healthy choices for myself as I can. Whether it is the food I eat, the exercise I do or even the decisions I make on a day-to-day basis, like getting enough rest or knowing when enough is enough, I try to keep a healthful attitude and do what is best….I hope to continue to have exercise as part of my weekly routine.

> I learned a lot about leadership and to confront one of my biggest fears, speaking in front of people. I also took on group roles that I hadn’t before, like that of leader and information giver….Had we not addressed these “social–emotional” concerns, I feel I would have missed out on one of the most important constituents of group process. Had we not addressed these concerns, I don’t think we would have been as effective as we were.

Through the group practicum experience I feel that not only have I grown spiritually and mentally, but I have grown professionally. After our last session at the shelter, we had our last seminar with our supervisor. She said that she had noticed a big change in me. She saw my confidence grow and she said, “You have become quite a leader.”

### Conclusion

The Groups in Health Care course provided most students with a positive initial experience with group leadership as they also began to explore roles as lifestyle and health change agents. The two learning contracts provided concrete evidence of students’ growth and learning about promoting...
health on an individual and group level. The experience of running health promotion groups and their Wellness Awareness Learning Contract became both a work in progress and a work in process. The evidence recorded in the summative logs and reflected in the final scores on the GAS contracts suggest that students gained a rich appreciation of the challenges of developing healthier lifestyles on the basis of their personal goals as well as through fostering group changes:

Tryssenaar (1995) contends that although it is not possible to teach every skill for every practice area, teaching skills of reflection can help meet the challenge….Keeping a journal crystallized aspects of the fieldwork experience [that] I would otherwise not have noticed. Usually the gamut of emotions one encounters in new situations are incidental features, but as indicators of growth they can still be useful. (Raymond, 1998, p. 164)

Group process issues that were transformed from abstract theories to real-life concepts included developing skills in therapeutic relationships, group leadership roles, grading health promotion activities, adapting the environment, handling developmental group stages, and termination. Teamwork and the support of peers were crucial because students were primarily in settings without the benefit of occupational therapist role models. Several sites offered focused supervision and guidance, which was invaluable in processing the group experience.

Therapists in traditional practice should likewise explore methods to expand health promotion approaches with persons with disabilities (Patrick, 1997). Brownson (1998) recommended viewing clients as being at “Step 1 of a recovery or rehabilitation process and looking for gaps in the continuum of care and supportive services” (p. 61). Aspects of lifestyle such as diet, smoking cessation, pain, stress and anger management, physical activity and leisure pursuits, health education, lifestyle redesign, and support groups are all viable interventions.

Growing numbers of community hospitals are offering health education and health promotion, fitness centers, and occupational health services for employees and patients (“In Focus,” 1988). Areas such as independent living, assistive living, naturally occurring retirement communities, workplace ergonomics, wellness programs across the lifespan, outreach to schools, welfare-to-work programs, and compliance with the Americans With Disabilities Act of 1990 (Public Law 101–336), all offer rich opportunities for new markets. Anticipating a growing interest in health promotion and preventive models, the CARF…Commission on Accreditation of Rehabilitation Facilities recently developed a new certification for Health Enhancement Programs that includes “health and health promotion, nutrition, rehabilitation, disease/injury prevention and management, prevention of secondary conditions, lifestyle management and enhancement, wellness and fitness and quality of life” (C. Solochek, CARF, personal communication, April 1, 1999). To effectively negotiate the transition to more proactive health and consumer-oriented paradigms, occupational therapists need to take stock of their professional inventory, reframe their services, and refine their skills in marketing beyond the medical model (Kornblau, 1999; Walens et al., 1998). We can fulfill our professional legacy by providing holistic services to meet the needs and challenges of society, building bridges to health through occupation in the 21st century.

Acknowledgments

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Appendix A

Wellness Awareness Learning Contract

Log 1 and Preliminary Learning Contract

Week 1

Log 1 (2 to 4 pages typed)
1. Wellness Awareness Assessment (1 to 2 pages)
   The first log focuses on the area you selected for your wellness contract. Briefly discuss your reactions to the Healthy Lifestyle Film/Lecture, wellness readings and the Dossey (1986) Self-Assessment Scorecard. Attach the completed wellness survey. Summarize your strengths and weaknesses in the areas of physical, mental, emotions, choices, spirit, social/relationships, and environment.
2. Wellness Awareness Learning Contract (1 to 2 pages)
   Identify the area (Behavior) you have selected for your wellness contract and why you chose it. Discuss your current baseline. If you have worked on this area before, what was your experience? Discuss your feelings about working on this area (Affective). What strategies/resources will be helpful to you in this process. What obstacles or difficulties might you encounter?
3. Complete and attach Setting a Goal Worksheet.
4. Complete and attach GAS Wellness Awareness Learning Contract and GAS Behavior and Affective Scales. Include Progress Data Chart with your initial baseline ratings for Behavior and Affective GAS.

Week 2

Log 2 (1 to 2 pages typed)
Include all previous material from Log 1 and:
1. Response to Feedback/Comments
   When Log 1 is returned, you will read instructor’s feedback/comments and respond at the beginning of this log.
2. Discuss your efforts to work on your contract (Behavior). Comment on your feelings (Affective) related to how you are doing, strategies you are using to change/grow. Discuss what is helping or getting in the way. What are you learning about yourself and the process of trying to change?
3. Include your Progress Data Chart.

Week 3

Log 3 (1 to 2 pages typed)
Include all previous material from Logs 1–2 and:
Appendix B

Sample Group Skills Learning Contract

Name: O. T. Student

Goal: To be able to skillfully and comfortably discourage any inappropriate behavior that may arise with the children during the group session.

Purpose: To be able to run a group session that is beneficial to the group members so that I can give optimal care to my clients.

Definition of Terms

Skillfully: To be able to terminate any inappropriate behavior quickly and effectively

Comfortably: To be able to terminate any inappropriate behavior with a low level of anxiety

Inappropriate Behavior: Any behavior that is disruptive to group members and that does not allow group goals to be met

Outcomes

Psychomotor/Cognitive (Behavior) Scale

– 2 Not addressing any inappropriate behavior.
– 1 Addressing inappropriate behavior without actually stating which behavior has to end (e.g., distracting the person so the behavior stops).
0 Addressing inappropriate behavior while explaining to the group member that this behavior needs to stop.
+1 Addressing inappropriate behavior with a minimal level of anxiety.
+2 Addressing inappropriate behavior without any anxiety.

Affective (Comfort) Scale

– 2 I am feeling very anxious about confronting someone about his or her behavior.
– 1 My anxiety level over offending an individual does not allow me to explicitly explain which behavior needs to end.
0 I am still anxious about offending the individual but have enough confidence to explain which behavior needs to end.
+1 I address the disruptive behavior in the same manner as above, but I am more comfortable with the process.
+2 I address the disruptive behavior in the same manner as above, but I am totally at ease with the role I play.

Method

I will rate myself after each group session according to my own and my partner’s perception of this skill.

Progress Data Chart

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References


