UNIVERSITY OF MANITOBA

# GROUP WORK PRACTICE WITH TRAUMATICALLY HEAD-INJURED YOUNG ADULTS

A PRACTICUM SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
IN CANDIDACY FOR THE DEGREE OF
MASTER OF SOCIAL WORK
SCHOOL OF SOCIAL WORK

BY

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WINNIPEG, MANITOBA

MAY, 1988

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GROUP WORK PRACTICE WITH TRAUMATICALLY

HEAD INJURED YOUNG ADULTS

BY

VALERIE ANN STANOWSKI

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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# ABSTRACT

Many traumatically head-injured young adults experience problems in psychosocial functioning due to the residual effects of head injury. A small group experience was offered to head-injured individuals who were willing to participate. The purpose of the group was to provide the participants with opportunities to explore, and possibly develop ways of coping with, problems that they were experiencing in their psychosocial functioning. A number of evaluation instruments were used in order to assess the value of the group experience for the individuals participating in this project. The formation, development, and evaluation of the group experience were described in this detailed report.

The evaluation results indicated that the group did not progress enough in its development for the members to explore, and develop ways of coping with, their psychosocial problems. Instead, the value of the group experience lay in the opportunities it provided for the group members to meet others in similar situations, obtain information about head injuries, and ventilate feelings and frustrations related to their social situations.

It was intended that the findings and recommendations made in this demonstration project would be useful to those conducting future research and practice in the area of group work practice with traumatically head-injured young adults.

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# CHAPTER I

## INTRODUCTION TO THE PRACTICUM

### 1.1 "Traumatically Head-Injured Young Adults" Defined

The brain is a collection of nerve cells forming the part of the central nervous system that is contained within the skull (Restak, 1984, p. 7). The brain controls all facets of human functioning. Various parts of the brain allow human beings to perform the functions of communicating; thinking; remembering; understanding; experiencing and expressing emotions; using the senses; and being physically mobile (Restak, 1984; Walsh, 1978). In short, the brain enables human beings to carry out the functions necessary for living in our complex world. Damage to one or more parts of the brain may have serious, long-term implications for the life of any individual.

"Trauma" is defined as "a morbid condition of the body produced by wound or external violence" (Sykes, 1983, p. 1140). Most head trauma victims experience and survive "closed head injuries." This term refers to the fact that the brain may be severely injured even though the skull has not been penetrated (Walsh, 1978, p. 80). The severity of impairments resulting from head injury depends upon the nature and location of brain damage resulting from a trauma.

In this study, traumatically head-injured (or brain-injured) young adults are regarded as those who have sustained brain damage resulting from closed head injuries. The term "traumatically head-injured" (or "brain-injured") is accepted in neurological medicine as a descriptive diagnosis of a physical condition. The term refers to the nature and

location of an injury and does not carry any negative connotations or implications for outcomes after treatment. For the purposes of this study, traumatically head-injured young adults are those between the ages of 17 and 39 who have been living in non-institutional settings in the community after discharge from hospital.

After severe head injury, the characteristic of the disability is the combination of mental and/or physical deficits and the stress of coping with them. This combination often leads to a greater degree of social disability than would be expected from the mental and/or physical deficits alone (Rosenthal, Griffith, Bond & Miller, 1983, p. 5). The combination of mental and/or physical deficits and the stress of coping with them continues to affect the psychosocial functioning of young head-injured persons long after their discharge from hospital.

## 1.2 The Problem Faced by Traumatically Head-Injured Young Adults in the Community

The initiative for this practicum emerged as a result of the actual experience of a social worker involved with traumatically head-injured young adults. This involvement occurred in the Neurological Rehabilitation Unit which is a component of the Health Sciences Centre, the largest health care facility in Manitoba. The Neuro-Rehab Unit provided a program for the assessment and intensive treatment of head injury. The program was conducted by a team composed of doctors; nurses; physical and occupational therapists; speech and language pathologists; psychologists; and a social worker.

The practitioner's role as the social worker on the Neuro-Rehab team involved following the head-injured patient from the time of

admission to the Unit until he or she became settled in the community. As a result of her experience, the practitioner discovered that many head-injured young people made enough physical and mental recovery to be discharged from the hospital to live in non-institutional settings. The practitioner also discovered that, after discharge from hospital, they returned to a community apparently lacking in resources to help them cope with the psychosocial problems resulting from head injury. The available literature indicated that low self-esteem; depression of a reactive nature; and dependence on significant others were the most salient of the psychosocial problems experienced by traumatically head-injured young adults. These and other problems in psychosocial functioning seemed to interfere with the ability of this client population to function in the community in ways which were satisfying to them.

## 1.3 Objectives of the Practicum

### i) Aims of the Intervention

Group work practice had not been used with traumatically head-injured young adults in Manitoba prior to this practicum. Attempts at group work practice with head-injured persons elsewhere in Canada and in other countries were few in number. The processes and outcomes of such attempts were not carefully documented in the available literature. This practicum was therefore conducted as a demonstration project. The practitioner planned to describe carefully the process involved in, and assess the outcome of, the use of group work practice with young victims of head trauma.

Based on the available literature and her practice knowledge the practitioner expected that some young head-injured persons who experienced problems in their psychosocial functioning in the community would participate in a small group. She further expected that they would use the group to explore, and possibly develop methods of coping with, their psychosocial problems. The aims of using group work practice as an intervention in this practicum were:

1. To describe the formation, development, and evaluation of the small group for traumatically head-injured young adults as a demonstration project.

2. To explore the hypothesis that the use of standardized measurement would indicate that group members experienced one or more of the most salient psychosocial problems evident after head-injury: low self-esteem; depression of a reactive nature; and dependence on significant others.

3. To assess the value of group work practice in this practicum by comparing changes in the magnitude of each group member's ratings of the salient psychosocial problems, and by reporting on each group member's written and videotaped evaluations of the group experience.

The practitioner intended to achieve the aims of the intervention by employing this methodology:

1. Forming and facilitating a time-limited, small group of traumatically head-injured young adults between the ages of 17 and 39. These would be persons who have been living in the community, in non-institutional settings, since discharge from hospital.

2. Producing audio and video tapes of interviews and group

sessions along with a log of the practitioner's observations and impressions of individual and group development.

3. Comparing pre-group, mid-group, and post-group measures of the magnitude of problems in self-esteem, depression, and dependence for each group member.

4. Analyzing findings from group members' mid-group questionnaires and post-group individual interviews with members.

This methodology was intended to yield data which should have enabled the practitioner to explore the hypothesis that the group members experienced psychosocial problems, particularly low self-esteem, reactive depression, and dependence on significant others. The data also should have enabled the practitioner to evaluate the overall development of the group and assess the value of the group experience.

The analysis of audiotapes and videotapes of interviews and group sessions and the practitioner's log was expected to contribute to the practitioner's evaluation of the group's development and the progress of individual members in the group. The analysis of the results of standardized measures was expected to enable the practitioner to explore the hypothesis that the group members experienced problems in the areas of self-esteem, depression, and dependence. The analysis of the members' mid-group questionnaires and the videotapes of post-group interviews was expected to contribute to the evaluation of the progress of the individuals in the group and the progress of the group as a whole. Chapter IV contains a detailed description of the methodology used to conduct this study; evaluate the extent to which the aims of the intervention had been achieved; and assess the value of the use of group

work practice in this demonstration project.

ii) Expected Educational Benefits for the Practitioner as Student

This practicum was designed to enable the student as practitioner to:

1. Make a direct effort to benefit traumatically head-injured young adults who lack services designed specifically to help them cope with their psychosocial problems as they function in the community.

2. Combine the theory and practice of both social work and group work with knowledge about traumatic head injury in the facilitation of a group of traumatically head-injured young adults attempting to cope with their psychosocial problems as they function in the community.

3. Receive consultation from the advisory committee and other interested professionals in the community. This was intended to help the student increase her theoretical knowledge and practice skills in terms of utilizing group work practice with a client sample which had some very special needs in the areas of physical, intellectual, and social functioning.

4. Present this practicum as a "demonstration project" which may prove useful to other professionals working with young victims of head trauma. Following a planned process of description and evaluation was intended to enable the practitioner and the clients involved to assess the results of this project in terms of its benefits, or lack thereof. It also was intended to enable the practitioner to make recommendations which could be utilized by others attempting similar projects.

5. Receive, from the advisory committee, an evaluation indicating whether or not the knowledge and skills required to obtain the M.S.W.

degree had been demonstrated.

## 1.4 The Practicum Report

This report describes the practitioner's activities and experiences as she worked toward accomplishing the practicum objectives. Chapter I introduces the practicum. This chapter includes a description of the client population and the problems they face in the community. It also describes the objectives of the practicum in terms of the aims of the intervention and the expected educational benefits for the practitioner as student.

Chapter II reviews literature describing the nature of traumatic head injury as well as the factors contributing to, and the nature of, the psychosocial problems experienced by traumatically head-injured young adults.

Chapter III reviews the literature describing an ecological systems approach to group work practice and its application to the situation of traumatically head-injured young adults. Selected literature pertaining to the use of group work practice with this client population is also discussed.

Chapter IV provides a detailed description of the components of the intervention (i.e., the formation and facilitation of the small group for young head-injured clients).

Chapter V describes the evaluation method, instruments, and procedures employed in the practicum.

Chapter VI presents the evaluation results of the post-intervention assessment of the practicum experience. This chapter includes a description of the formation and development of the group for

traumatically head-injured young adults. The hypothesis that the group members experienced one or more of the psychosocial problems of low self-esteem, depression, and dependence is also discussed. This chapter concludes with an assessment of the value of group work practice in this practicum.

Chapter VII presents the conclusion of the practicum. This chapter includes a summary of findings, concluding remarks, and a description of the educational benefits of the practicum for the practitioner as student.

# CHAPTER II

# TRAUMATIC HEAD INJURY: REVIEW OF SELECTED LITERATURE

## 2.1 Introduction

The term "psychosocial problems" is used to refer to problems that individuals perceive themselves to have, or that others perceive them to have, in terms of how they function in their social environments. Psychosocial functioning is affected by an individual's thoughts, feelings, and behaviors as he or she relates to him or her self and to others. An individual's psychosocial functioning is also affected by the ways in which others in the social environment relate to him or her.

The psychosocial problems of traumatically head-injured young adults appear to stem from their experience of two stressful situations. First, is the situation of coping with surviving a life-threatening trauma which has resulted in multiple impairments. Second, is the situation of coping with the ways in which others in the social environment relate to head trauma victims who are trying to resume satisfying lifestyles after discharge from hospital. "Stress" is defined as "the tension that arises in a system -- individual, family, group, and so on -- from the perception of an event as involving uncertainty and risk" (Compton & Galaway, 1984, p. 139). The occurrence of traumatic head injury and the resulting long-term sequelae and stressors experienced by its victims affect all spheres of life: physical; psychological; social; educational; and vocational (Brooks, 1984, pp. 109-120; Dornan, 1985, p. 248; Rosenthal et. al., 1983, p. 31).

Working with young head-injured clients in groups is a relatively new approach. The understanding of such a project requires familiarity with knowledge derived from two sources. The literature reviewed in this chapter describes the factors which contribute to the psychosocial problems of young people with head injuries. The literature reviewed in Chapter III will describe group work practice and the implications of its use as an intervention in the case of an actual group formed for traumatically head-injured young adults.

## 2.2 Factors Contributing to the Psychosocial Problems of Traumatically Head-Injured Young Adults

### i) Pre-Morbid Factors

A number of studies support the assertion that most individuals experiencing head injury have in common certain pre-morbid factors. This assertion is based on commonalities found in studies which review the social histories of head injury victims. Literature which refutes this assertion has not been available to date. Therefore, the findings of studies dealing with pre-morbid factors should be read prudently for several reasons. First, head injury is a relatively new area of interest in medicine, nursing, psychology, and social work. As a result, most studies have not been replicated enough times to yield data which substantially supports or refutes the available findings. Second, most studies exploring the relationship of pre-morbid factors to head injury have been conducted by researchers in the area of medical science. These researchers tend to seek "cause-effect" relationships in the explanation of illness. Third, information about pre-morbid factors in the lives of head injury victims is based on the subjective verbal

reports of the victims themselves or their significant others. Such information may be inaccurate due to the passage of time or the fact that all people involved in a single situation may perceive it differently. Fourth, most studies in the area of head injury tend to be done with small samples in the U.S.A., Canada, and Great Britain. There is a lack of information about the incidence and outcomes of head injury in other countries. Some countries, or parts of them, may still lack the technology to keep head trauma victims alive in the acute phase of recovery.

The findings presented in the literature reviewed here are not intended to serve as "personality profiles" of the majority of head injury victims. The presence of certain pre-morbid factors in an individual's social history may make him or her more susceptible to sustaining head trauma but it should not "label" him or her as a potential head trauma victim. Conversely, those who have experienced head trauma should not be "labelled" as particular "types" of people (e.g., alcohol or drug abuser; from the lower socioeconomic strata; sociopathic; etc.) because of their medical diagnosis.

The importance of the findings presented in the literature reviewed here lies in the light that they shed on how pre-morbid factors may influence the psychosocial outcomes of recovery from head trauma. Pre-morbid factors can play a major role in determining how head trauma victims cope with permanent deficits in cognitive, emotional, and physical functioning and with the stress of returning to life in the community with those deficits.

The current literature indicates that head-injured persons do not

represent a random sample of the population (Brooks, 1984, p. 137; Parkinson, Stephenson & Phillips, 1985, p. 70). The majority of head trauma victims appear to share some or all of a set of pre-morbid factors in which personality and social characteristics figure predominately.

Head injury is two or three times more common in males than in females (N.H.I.F., Inc., 1984; Parkinson et. al., 1985, p. 79; Rosenthal et. al., 1983, p. 11). The age range at highest risk for head injury is between 15 and 29 years. Motor vehicle accidents cause at least one-half of all head injuries (N.H.I.F., Inc., 1984; Rehab Brief, 1982; Rosenthal et. al., 1983, p. 13).

Research data indicates that psychiatric disturbances exhibited after head injury are related to the individual's pre-morbid personality (Saskatchewan Co-ordinating Council on Social Planning, 1984, p. 11a). Studies indicate that most head-injured persons exhibit a different pre-morbid "make-up" than those not sustaining head injuries. Dencker (1958) found them to have a greater degree of accident proneness, more antisocial behavior, and a lower social position when compared with twin controls. These persons generally have not completed high school or post-secondary education and are either unemployed or in the lower socioeconomic strata within a specific geographic area (Rosenthal et. al., 1983, p. 12; Tobis, Puri & Sheridan, 1982).

Large numbers of head injury victims have histories of alcohol and drug abuse and are likely to have been drinking heavily at the time of the accident (Rosenthal et. al., 1983, p. 139; Rehab Brief, 1982; Tobis et. al., 1982). Many of the them have backgrounds which include divorce

or separation of parents, poor school records, and poor marital stability (Brooks, 1984, p. 139). Rosenthal et. al. (1983, p. 13) reviewed research suggesting that adults who sustain a single head injury are at high risk of another insult.

This general description of the group at high risk of head injury does not negate the fact that some head-injured individuals are simply victims of "unfortunate" accidents (e.g., the sober, middle-aged driver who loses control of his car on an icy road). It is also necessary to bear in mind that head injuries do not occur only as a result of motor vehicle accidents. They also occur as a result of car-pedestrian injuries, sports injuries, physical violence, and accidents in industrial or home settings.

Regardless of the cause of a head injury, the role of pre-morbid social and personality characteristics may be more important than age in the recovery process. Although a "young" brain may heal more rapidly than an "older" brain, it is the emotional responses of the head-injured person which represent the combination of primary brain damage and reactions to physical, mental, and social recovery at different stages of recovery (Brooks, 1984, p. 170).

Most research in the area of pre-morbid factors has been done by Brooks (1984). There does not appear to be any research available in which others strongly substantiate or refute his findings. Brooks (1984, p. 172) claims that exaggeration of pre-morbid traits after head injury is common. He further claims that, generally, pretraumatic neurotic and sociopathic personality characteristics impair adjustment to the effects of injury and/or cause havoc with interpersonal

relationships (Brooks, 1984, p. 172). Brooks (1984, p. 172-173) does indicate that sometimes exaggerated pre-morbid traits can actually help the head-injured person to achieve a successful lifestyle. For example, traits of orderliness and drive combined with preservation of insight and comprehension can provide the impetus for positive response to difficulties and problem-solving. Persons who were highly organized and strongly driven toward their goals pre-morbidly are likely to be able to set new goals post-injury, work toward them, and feel good about accomplishing them.

The role of pre-morbid social and personality characteristics is important in determining the emotional reactions and behavior of head-injured individuals (Brooks, 1984, p. 174). These characteristics help to mold their feelings and behaviors and, ultimately, their adaptation to a new social role (Brooks, 1984, p. 176). These characteristics greatly influence both the process and outcomes of the recovery of victims of traumatic head injury.

ii) Physical Impairments

The physical impairments of traumatically head-injured young adults comprise those related to cerebral hemisphere functioning and those caused by damage to the brain stem and cranial nerves (Rosenthal et. al., 1983, p. 5). Young head trauma victims may exhibit one or more physical impairments, in varying degrees, which may be motor or sensory in nature (Dornan, 1985, pp. 244-258; N.H.I.F., Inc., 1984; Rosenthal et. al., 1983, pp. 24-26; Torkelson Lynch, 1983, p. 33). They may exhibit deficits in vision; hearing and speech; gross and fine motor skills; sensation of touch and pain; and temperature and position sense.

Some of them experience recurrent seizures.

Depending upon the nature of the damage to the brain and central nervous system, some individuals will be quite independent in their physical functioning in terms of ambulation, eating, dressing, grooming, and hygiene. Others may require aids such as wheelchairs, canes, special utensils, reaching devices, or the help of other persons for physical functioning.

Some head-injured individuals, particularly those involved in vehicular accidents, manifest cosmetic damage in addition to other physical impairments. Cosmetic damage includes permanent scarring of the face and/or body and damage to facial bone structure.

Motor and sensory physical impairments play a major role in determining whether or not head-injured persons will be mobile in the community in terms of being able to drive or use public transportation. Physical impairments, depending upon type and degree of severity, will play some role in determining whether or not these persons will be able to resume their former educational, vocational, social, and recreational activities in the community (Dornan, 1985, p. 257). Physical impairments, particularly those involving cosmesis, profoundly affect self-image and self-worth (Rosenthal et. al., 1983, p. 30). According to Bond and Brooks (1976, p. 127), in general, physical deficits show a marked tendency to improve and, even when they remain, they produce fewer problems for the injured person and his or her family than do disturbances of intellect or emotion.

iii) Cognitive-Intellectual Impairments

The fact that head injury can lead to serious cognitive deficits is well known (Brooks, 1984, p. 44). Measurement of the degree of severity of such deficits is usually derived from the results of neuropsychological interviews and testing conducted with head-injured individuals during the recovery process. Based upon such data, the cognitive-intellectual consequences of traumatic head-injury are described by a number of authors (N.H.I.F., Inc., 1984; Parker & Hawryluk, 1982; Rosenthal et. al., 1983, p. 29).

The available literature reports that head injury victims display varying degrees of impairments in verbal associative processes (e.g., naming and word production), learning ability, and ability to analyze spatial orientation and representations. The literature also indicates that they generally manifest decreased ability in terms of attention span; reaction time; information processing; speed of decision making; and performance on verbal and mathematical intelligence tests. Alteration in cognitive processes is also evident in head injury victims. This is exemplified by an increase in concrete thinking and a decreased appreciation of subtleties. The literature repeatedly reports that cognitive deficits are severe, often persistent, and related broadly to the locations and severity of brain damage. Walsh (1978) presents a detailed explanation of cognitive deficits in the book entitled Neuropsychology: A Clinical Approach.

Eiben, Anderson, Lockman, Matthews, Dryja, Martin, Burril, Gottesman, O'Brien, and Witte (1984) examined functional outcome of closed head injury in children and young adults. According to Eiben et.

al. (1984, p. 169), deficits in cognitive functioning and communication skills contributed proportionately more to disability than did problems in other areas. Within the areas of cognition and communication, memory deficits seemed to contribute most to dependence. Fuld and Fisher (1977, pp. 495-502) indicate that cognitive dysfunction and personality changes are often unrecognized and changes in these areas may lag behind improvements in other functional areas.

The cognitive-intellectual impairments may impinge most severely on other life functions (Rosenthal et. al., 1983, p. 27). These impairments adversely affect the ability of head-injured persons to learn, retain knowledge, solve problems, and make decisions. These functions are essential in order for an individual to participate fully in all facets of family, social, educational, and vocational life.

iv) Personality-Emotional Impairments

According to Levin, Benton, and Grossman (1982, p. 172), personality-emotional impairments, or behavioral sequelae, were recognized in the head-injured as early as the sixteenth century. Levin et. al. (1982, p. 172) state that the American Psychiatric Association specifies in its diagnostic manual, DSM III, the "Organic Personality Syndrome" in which head trauma is among the most common causal factors. They cite the description of Organic Personality Syndrome as:

> ...a marked change in behaviour or personality involving at least one of the following: 1) emotional lability (e.g., temper outbursts, sudden crying); 2) decreased impulse control (e.g., poor social judgment, sexual indiscretions); 3) marked apathy and indifference; and 4) suspiciousness or paranoid ideations.

Various personality-emotional manifestations of head injury are

related to the type and severity of injury and the patient's overall level of consciousness (Levin et. al., 1982, p. 172). Some of these manifestations diminish as recovery progresses while others produce a permanent alteration of behavior (Levin et. al., 1982, p. 172).

Torkelson Lynch (1983) suggests two categories of personality-emotional impairments. The first category is changes of personality (i.e., changes in reactions to events and to people). Changes in personality may be evidenced by lack of foresight, tact and concern; inability to plan ahead or judge consequences of actions; loss of refinement; and lessened vitality (Lishman, 1973; Torkelson Lynch, 1983, p. 33).

The second category of personality-emotional impairments suggested by Torkelson Lynch (1983, p. 33) is changes of temperament. These are likely to be based on specific brain pathology and include fluctuating withdrawal and depression; disinhibition and euphoria; morbid anxiety; obsessional traits; persistent irritability; and a lowered tolerance for frustration and noise (Torkelson Lynch, 1983, p. 33). Lezak (1978a, pp. 9-15) highlights three additional changes in temperament. These are perplexity (i.e., distrust of one's ability and a quest for reassurance); distractability (i.e., inability to screen out unwanted stimulation); and fatigue.

Head-injured persons returning to community life may exhibit some or all of these sequelae in varying degrees. Specific sequelae and the degree to which they are exhibited depend upon the severity and location of the brain insult, the length of time of coma, and the amount of time that has passed since injury.

Due to the multifaceted nature of brain functioning and the diffuse nature of traumatic injury, each individual will have a unique array of functional limitations and residual capacities (Torkelson Lynch, 1983, p. 33). Personality-emotional impairments, depending upon the degree to which they are present in each head-injured person, will influence his or her functioning in all spheres of life and how he or she will ultimately come to terms with the effects of head injury.

v) Secondary Behavioral Manifestations

According to the literature there are several behavioral manifestations that do not have their origins in the structural brain damage resulting from the injury. These manifestations are more of a result of the stress of adapting to the trauma and its devastating effects upon the lifestyle and daily existence of the head-injured individual (Rosenthal et. al., 1983, p. 203; Sisler, 1978, p. 138). Throughout the recovery process the common emotional reactions of anxiety, depression, and irritability may be present at various times representing reactions to losses, frustrations, and varying levels of feelings of insecurity (Brooks, 1974, p. 174).

Emotional reactions tend to be most noticeable whenever the head-injured person encounters an event that makes him or her aware of the effects of injury and whenever physical, emotional, or social setbacks occur. According to Brooks (1984, p. 174), key stages in recovery tending to trigger alterations in emotion include discharge from hospital; the cessation of active rehabilitation at a time when the individual's expectations for recovery have not yet been met; and the point when the individual has to accept that he or she will face

obstacles in pursuing former educational, vocational, and/or social interests.

(a) Denial

Denial is a common occurrence among brain-injured patients (Romano, 1984; Tobis et. al., 1982). An inability to acknowledge the effects of head injury seems to be most marked in the first few months post-injury (Rosenthal et. al., 1983, p. 203). This denial may be an adaptive mechanism, initially, if the patient is avoiding a major emotional disorder through the selective use of denial (Rosenthal et. al., 1983, p. 203). According to Rosenthal et. al. (1983, p. 203), the head-injured person rarely denies the actual injury or the physical sequelae but rather tends to minimize the mental sequelae.

The maladaptive effects of denial are often experienced after the head-injured person returns to the community (Rosenthal et. al., 1983, p. 204). According to Brooks (1984, p. 175), denial is usually operating in most head-injured persons, in varying degrees, one to two years post-injury. This denial tends to promote expectations of recovery which are unrealistic. Coming to terms with disability may therefore be a process in which periods of false hope are alternated with periods of distress (Brooks, 1984, p. 174).

Living with disability in the home environment may, on the one hand, make the head-injured person more aware of the mental deficits and promote a more realistic adaptation to disability. The tendency to block out the reality of the situation may, on the other hand, be reinforced by hopeful, optimistic family and friends and may have adverse consequences in terms of helping the head-injured person to deal

with disability (Rosenthal et. al., 1983, p. 204).

(b) Depression

Depression is a significant secondary behavioral manifestation experienced by head-injured persons. Since head injuries usually affect the young (ages 15 to 30), these persons experience major and lasting changes in their daily lives. They usually experience a sense of loss due to these changes. They often feel less able to perform physically, more dependent socially, and very powerless in their attempts to reconstruct their lives (Rosenthal et. al., 1983, p. 204). Compared to their pre-injury situations, many head trauma victims find that social relationships are less rewarding and often diminish; educational and vocational prospects are dim; and life is less interesting (Rosenthal et. al., 1983, p. 204).

Researchers have not speculated on the reasons for these findings in the available literature. However, social science research has yielded an abundance of knowledge about accomplishing tasks and coping with situational crises in each stage of the life-cycle (Aguilera & Messick, 1982; Coe, 1972). This knowledge makes it reasonable to make certain assumptions about why head injury victims become depressed as a result of their post-injury social situations. Head trauma strikes young people at the ages at which they are beginning to take control of their own lives. At the time that head trauma occurs, young people are most likely to be involved in dating and/or marital and social relationships and educational or vocational pursuits. Head trauma victims who are discharged from hospital do not simply return to their pre-injury activities and relationships. These people often need to

devote most of their emotional energy to coping with the reality of head injury and the realization that they will have to live the rest of their lives with one or more permanent deficits. Mental and physical impairments may also interfere with the ability of head trauma victims to "pick up their lives where they left off" after discharge from hospital.

Diminished mental capacities cause many head-injured persons to become dependent on spouses, parents, or professionals for a host of activities which they used to perform independently. Such activities include money management, decision-making, using transportation, and organizing their time. Other head-injured persons can do these things but do not have enough return of mental capacities to fully resume familial, educational, or vocational activities.

Characteristics of depression are often manifested by head-injured persons in reaction to the ways that they are treated by their significant others in their social environments. These significant others either tend to place unrealistically high expectations on head trauma victims or label them as "disabled" and treat them according to prevalent negative stereotypes. Not all head-injured persons will have exactly the same types and degrees of deficits and problems in functioning in their social environments. Each one needs others to encourage him or her to be as independent as possible. Head-injured persons also need to know that others do not value them less because of the things that they can no longer accomplish.

Due to the realization of diminished competence in a number of aspects of daily living; the realization that others do not recognize

the areas in which they are competent; and the feeling that life will never return to "normal" many head trauma victims verbalize feelings of being "less than a person." Along with this decrease in self-esteem they experience heightened feelings of anxiety, frustration, sadness, and anger which result in a chronic state of depression (Rosenthal et. al., 1983, pp. 204-205).

Suicidal thoughts or acts associated with severe depression are often evident after head-injured persons have been discharged from hospital, especially if they find that the return to community life is not as easy as they imagined (Rosenthal et. al., 1983, p. 205).

The form of depression which they experience is usually a reaction to the situation in which they find themselves post-injury, rather than a depressive illness (Rosenthal et. al., 1983, p. 204). This reactive depression is often inextricably intertwined with the head-injured person's recognition of one or more of a set of impairments and feelings. These include cognitive-intellectual and personality-emotional impairments; the sense of being physically, emotionally, and socially dependent upon others; and the feelings of low self-esteem which result from the sense of losing control over one's own life (Fordyce, Roueche & Prigatano, 1983, p. 620).

(c) Dependence Upon Others

The net effect of the mental and physical sequelae of head injury causes its victims to become more dependent on others emotionally and for assistance with the performance of various functions involved in daily living (Rosenthal et. al., 1983, p. 205). This dependence is manifested in a variety of ways. It may be either temporary or

long-term. It may also have significant effects on the relationships between head trauma victims and their families.

Although Brooks (1984, p. 175) claims that regression is encountered only occasionally after head injury, others claim that it is common (Brooks & McKinlay, 1983; Lezak, 1978b). Families of head injury victims have participated in studies exploring the effects of head injury upon family units and the responses of family members to head injury. The findings of these studies indicate that the families of head trauma victims describe them as manifesting selfish, childish, demanding, and dependent behaviors (McKinlay, Brooks, Bond, Martinage & Marshall, 1981; Oddy, Humphrey & Uttley, 1978; Rosenbaum & Najenson, 1976). Families regard such behavioral manifestations as acceptable when head injury victims are still in hospital getting over the worst of a life-threatening trauma. Families, however, find it difficult to cope with such behaviors when they persist after the patient has returned to the home environment. Spouses of head injury victims often report feeling as if they were caring for another child rather than interacting with an adult marriage partner (Rosenthal et. al., 1983, p. 205). Spouses and other relatives may, however, unknowingly reinforce such behaviors by refusing to enforce behavioral limits or reprimand head injured persons who are regarded as "not being responsible for their behavior" (Rosenthal et. al., 1983, p. 205).

Head trauma victims are usually not able to resume all of their former roles in the family and community for some time after discharge from hospital. This may result from the effects of their various impairments, from the difficulties that they have in coping with the

trauma and its outcomes, or from some combination of both. Most head trauma victims return to the community able to perform independently the basic activities of daily living (i.e., dressing, grooming, eating, and toileting). If head-injured persons have sustained significant damage to short-term memory, impulse control, and reasoning abilities they may be at risk in the community, at least initially, after discharge from hospital. Head trauma victims may therefore require supervision because they may be at risk of wandering and becoming lost; physically injuring themselves or others; or being physically or financially taken advantage of by others.

Families of head-injured persons may need to be overprotective of them initially after discharge from hospital. However, head trauma victims who are improving in the areas of physical, cognitive-intellectual, and personality-emotional functioning find it frustrating when their families do not recognize these improvements and decrease their overprotectiveness. Continued overprotectiveness on the part of families often serves to invoke anger and hostility within head trauma victims. They tend to display projection of angry feelings. The objects of such projection are not only relatives, but also the person or persons responsible for the accident, or medical and allied professionals (Brooks, 1984, p. 175). More often than not, however, it is the family who must deal with the cognitive and emotional fall-out resulting from head injury (Peters, Stambrook & Esses, 1985, p. 3).

According to Lezak (1978b, p. 592), characterological changes in the victims of head injury contribute in a major way to their social and psychological dependence and to family stress. Brooks and McKinlay

(1983); Gust (1981); Lezak (1978b); and Livingston, Brooks, and Bond (1985) have explored this complex area. Most recently, Peters, Stambrook, and Esses (1985) have submitted a proposal to further examine this area by conducting further research with head injury victims and their families in Manitoba. Much more research needs to be done in order to improve education and counselling programs to promote family relationships which are satisfying to head-injured persons and their families.

The secondary behavioral manifestations related to head injury, such as denial, depression, and dependence on others, may occur in different degrees in each head-injured individual. These behavioral manifestations occur as head-injured persons experience the physical, cognitive-intellectual, and personality-emotional impairments caused by head injury and the effects that these impairments have upon return to family and community life. It is important that those living and working with head-injured persons become aware of the behavioral manifestations described here in order to respond appropriately. As head-injured persons work through their rehabilitation and their attempts to resume as normal a life as possible it appears that they and those involved with them require assistance in dealing with these secondary behavioral manifestations. These play a major role in affecting how head-injured persons and those involved with them will come to terms with the changes which head injury causes in all aspects of life.

## 2.3 The Psychosocial Problems Experienced by Traumatically Head-Injured Young Adults

Many young head-injured adults become well enough to be discharged from hospital, but this does not mean that they are "cured." The recovery process actually takes years and, along the way, these people must deal not only with both short-term and long-term impairments, but also with a variety of psychosocial problems. These are problems that head-injured young adults perceive themselves to have, or that others perceive them to have, in terms of how they function in their social environments. The term "social environment" includes all aspects of an individual's family, vocational, and social life.

Head injuries usually occur among young adults in the prime of their career development and social independence, according to the available literature (Dennis, Ebert, Wolfe, Mueller, Brintnell & Vargo, 1986, p. 6). Many head-injured young adults who make enough physical and mental recovery to return to community life appear, superficially, quite normal once gross recovery has stabilized (Dennis et. al., 1986, p. 3). Their residual impairments, however, frequently result in global and complex disabilities that may delay or impede a return to former satisfying lifestyles (Griffith, 1983; Long & Webb, 1983). The probability of successful social and vocational adjustment is low for head-injured young adults (Cope, 1982; Wolfe, 1984). Their psychosocial problems become most evident as they attempt to resume former familial, social, and vocational roles.

Physical, cognitive-intellectual, and personality-emotional functioning are important determinants of the extent of psychosocial adjustment achieved by each head-injured individual, however, social and

vocational functioning ultimately indicate how the individual is adapting (Torkelson Lynch, 1983, p. 33). Cognitive and emotional status post-injury is at least as powerful a determinant of personal and socioeconomic adjustment as is physical and neurological status (Jennett & Bond, 1975). Memory impairment and personality disorders are the aspects of mental function primarily responsible for poor social integration in terms of leisure, family, and work (Torkelson Lynch, 1983, p. 33).

Return to work appears to be a frequently used indicator of successful recovery in studies exploring social recovery after head injury (Bond & Brooks, 1986; Bruckner & Randle, 1971; Oddy & Humphrey, 1980; Weddell, Oddy & Jenkins, 1980). This is not surprising since our society still assesses an individual's worth in terms of his or her ability to work and the nature of that work. According to Torkelson Lynch (1983, p. 33), factors having an adverse effect on return to work have been found to be: memory impairment; loss of concentration; impaired initiative, responsibility, intellect, and social sense; emotional lability; dysphasia; hemiplegia; sensory loss; and unrealistic goals. Cognitive limitations and disturbances in social behavior affect final employment results most negatively (Rosenthal et. al., 1983, p. 219; Torkelson Lynch, 1983, p. 33).

Benton (1979), Goldstein (1952), and Lezak (1978b) have reviewed the effects of brain damage on the personality. The "characterological alterations" which are most likely to create adjustment problems for social, family, leisure, and educational and vocational pursuits are summarized, in terms of deficits and psychosocial implications, by

Torkelson Lynch (1983, p. 33):

> ...An impaired capacity for social perceptiveness (deficit) results in self-centered behavior with greatly diminished empathy, self-reflective, and self-critical attitudes (implications). An impaired capacity for self-control and self-regulation (deficit) give rise to impulsivity, random restlessness, and impatience (implications). Stimulus-bound behavior (deficit) is evidenced as social dependency and difficulty in planning and organizing projects (implications). Emotional alterations such as apathy, silliness, lability, irritability, and change in sexual interest (deficit) can seriously impinge on social and interpersonal relationships (implications). Inability to profit from experience (deficit) can compromise the individual's capacity for social learning (implication).

The psychosocial problems of head-injured persons which result from their deficits and the implications thereof become most evident in their efforts to lead their lives in ways which are satisfying to them.

As head-injured individuals attempt to resume their pre-morbid lifestyles, they have difficulty in accepting and adjusting to the sudden and unexpected changes in their status and abilities (Karpman, Wolfe & Vargo, 1986; Weddell, Oddy & Jenkins, 1980). Activities that were once accomplished with ease, such as concentrating on a lecture in a class, remembering a bus route, or driving a car, become frustrating experiences because of impairments in memory, planning skills, and attention span.

Family and friends have difficulty adjusting to the many changes manifested by the head-injured individual (Lezak, 1978b). They often respond to the changes by treating the individual like a child who needs to be continually supervised and protected. Those close to head-injured individuals often emphasize the things that they cannot do, rather than

emphasizing and positively reinforcing their accomplishments.

Head injury victims often report decreased contact with friends. It appears that contact with friends sometimes diminishes because they cannot deal with some of the characterological alterations manifested by head-injured persons. Overtures made by friends are often rebuffed by head-injured people themselves because they fear that friends will see them as "inadequate," "abnormal," or "stupid" as a result of their impairments. For similar reasons, head-injured people report fears about, and disappointments in, attempts to engage in dating relationships with the opposite sex. Those head-injured persons attempting to resume marital relationships often report that their spouses treat them like "children" or "patients."

Problems also occur as a result of unrealistic expectations for recovery commonly held by the victims of head injury, their families, friends, and employers (Bond, 1983). These people often believe that appearing "physically well," as do most closed head injury victims, is an indicator of ability to resume pre-injury roles and activities. These people often refuse to accept the explanations given by Neuro-Rehab professionals about why head-injured persons need to "ease" themselves back into former roles and activities. These explanations involve describing how physical, cognitive-intellectual, and personality-emotional impairments will interfere with the ability of head-injured persons to resume all of their former roles and activities simultaneously. Such explanations are based on formal test results and assessment data. In many cases, head-injured people need to take time to allow for natural recovery to occur. They also need time to

participate in occupational therapy to expand on their potential in the areas of life skills and educational or vocational skills. Too often head-injured persons, either on their own or with urging from significant others, attempt to take on more roles and activities than they can handle. There is often "a cycle of failure" observed in such cases. This cycle begins when head-injured persons prematurely, and usually without sufficient preparation and support, attempt to resume activities and responsibilities in the areas of family, social, educational and/or vocational life (Wolfe, 1984).

For those of the head-injured who attempt to resume competitive employment, return to a regular academic setting, or return to independent living too soon the probability of failure is high (Torkelson Lynch, 1983). Those who do not succeed must face personal discouragement, increased family stress levels, termination of education or employment, and a damaged reputation that may negatively influence future opportunities (Fowler, 1981). Channelling head-injured persons into vocational rehabilitation programs designed for individuals with specific physical or mental disabilities tends to be unsuccessful. This lack of success results from inadequacies within the programs or because the head-injured people regard the work as too menial and themselves as quite different from their co-workers with other disabilities (Bolger, 1983; McNeny, 1983; Torkelson Lynch, 1983). Many head-injured people will often simply refuse to participate in such programs. For those who do return to competitive employment, termination is usually a result of poor attendance, incomplete assignments, and resistance to supervision (Fowler, 1981; Hackler & Tobis, 1983; Rosenthal et. al., 1983, p. 31).

The head-injured persons who return to living in the community, either alone or with family or friends, often have difficulty planning and organizing their time, managing money, finding satisfying leisure-time activities, and dealing with loneliness and the large amounts of time they have for mourning the abilities and lifestyles they had prior to injury. These problems result from the residual impairments of the head-injured people and often contribute to feelings of anger and frustration which they tend to vent on those closest to them -- only to result in damage to relationships with family and friends.

The lack of an appropriate range of resources available to help head injury victims deal with their many problems in psychosocial functioning only creates more problems for them. As they become aware of, and frustrated by, their impairments and the effects of those impairments on their lives, they may present as dependent upon others, become depressed as a reaction to their situation, and experience a loss of self-esteem. These problems in psychosocial functioning usually result from the head-injured persons perceiving themselves as unable to master the stress caused by their situation and as not being "accepted" in the community because of their difficulties in physical, psychological, and/or social functioning.

The economic and social costs associated with the frequent failure of head-injured individuals to adjust to "life after head injury" are enormous (Dennis et. al., 1986). Efforts to promote recovery of head-injured persons to their maximum psychological, social, and educational or vocational potential have been confined mainly to medical

rehabilitation facilities. Such facilities often promote good physical recovery, but have neither staff nor programs available to adequately train and support victims of head injury throughout the psychosocial transition from "patient" to "independently functioning member of the community" (Dennis et. al., 1986, pp. 6-7).

## 2.4 Conclusion

The literature reviewed thus far has described the psychosocial problems of traumatically head-injured young adults which can affect how they function in the community. It has also indicated the existence of a need for a variety of rehabilitative services aimed at helping head-injured persons to maximize their potential for functioning in the community. The provision of some type of group experience for this client population is only one of the wide range of such rehabilitative services.

Group work practice is not a new form of intervention in the area of helping people to deal with the short and long-term effects of illness and injury. Group work practice is a relatively new interventive frontier in terms of working with traumatically head-injured young adults. The past few years have spawned several attempts to use group work practice as a means of helping head-injured persons to understand the nature of their impairments; cope with their psychosocial problems; improve their communication and socialization skills; and give and receive emotional support (Ashby, 1981, p. 56; Dennis et. al., 1986, p. 18; MacDonald & Millard, 1985; MacDougall & Semkow, 1985; MacDougall & Stradiotti, 1985; Rosenthal et. al., 1983, p. 399).

# CHAPTER III

# THE USE OF GROUP WORK PRACTICE WITH TRAUMATICALLY HEAD-INJURED YOUNG ADULTS: REVIEW OF SELECTED LITERATURE

## 3.1 Introduction

Much experience with young head-injured adults, both during their stay in the Neuro-Rehab Unit and after their discharge, led this practitioner to conclude that something was lacking in terms of social work services offered to these clients. In the "one-to-one" counselling situation, each young head-injured individual could talk only about his or her own feelings and problems with a practitioner who did not share the personal experience of being head-injured. The practitioner's numerous interactions with the head-injured clients who returned to visit her after discharge from hospital led her to believe that they wanted to talk about how their head injuries had affected their lives. However, these clients still appeared reluctant to share feelings and release tensions and anxieties with a professional. The practitioner was not sure if these clients were simply uncomfortable about discussing their situations or if they really could not identify their problems and concerns. The practitioner was aware that group work practice could perform several functions which might resolve this dilemma.

Group work has long been regarded as a form of social work practice in which a practitioner brings together a number of unrelated individuals and creates an environment in which each may: release tensions and anxieties through discussion and/or physical activity; achieve some identity with others, and especially with those in a

similar situation to oneself; give and receive emotional support and information; and/or achieve change in his or her self-image, attributes, behavior, and/or personal circumstances outside the group situation (Davies, 1975, pp. 45-46; Martin, 1983, p. 214). The underlying assumption is that other clients, and not just the professional practitioner, may do something to modify an individual's feelings about himself or his attitudes to others (Davies, 1975, p. 47; Martin, 1983, pp. 213-214). The importance of group work practice lies in two factors (Davies, 1975, p. 47). First, this form of practice provides an experience in which clients might not only act together, but also create conditions which ultimately strengthen individuals for action outside of the group. Second, the group experience might promote clients to achieve change, for themselves and in their everyday lives, which the practitioner, acting directly on them or on their behalf, could never achieve.

Group work practice, as a specific form of social work practice, is "based on an optimism that assumes that the human being can be helped to grow and change" (Konopka, 1983, p. 174). The main premises of group work practice, as it is used in social work, are "that social work as a profession is concerned with the enhancement of people's social functioning; there is a significant correlation between social functioning and group experience; and people need help -- sometimes professional help -- to enhance social functioning" (Konopka, 1983, p. 174).

The philosophies of social work and group work practice seemed to complement the basic philosophy of rehabilitation. That philosophy is

concerned with the restoration of patients not only to their fullest physical and mental capabilities, but also to their fullest social capability (Illis, Sedgwick & Glanville, 1982, p. 1). Given the client problems evidenced in the rehabilitation setting and the philosophical bases of the practitioner's profession and work setting, it seemed appropriate to provide a group experience for young head-injured adults who were willing to participate.

Based on her knowledge about group work practice and her conclusions derived from her work with young head-injured adults, this practitioner elected to offer them a specific resource to use at some point after discharge from hospital. The purpose of that resource was to improve the psychosocial functioning of young head-injured adults in their social environments. A group experience, for such clients, might provide at least a "starting point," where they could begin to face and explore their problems. The objective ultimately achieved would be an assessment of the value of this form of intervention in the case of a small group of traumatically head-injured young adults.

Chapter III reviews selected literature dealing with an ecological systems approach to group work practice, its application in the case of traumatically head-injured young adults, and the implications of group work for this client population.

## 3.2 Group Work Practice: An Ecological Systems Approach

Current group work literature emphasizes "an approach to helping with a three-fold, interrelated focus: on individuals as group members; on groups as social units; and on individuals and groups in relation to their social situations" (Balgopal & Vassil, 1983, p. 20; Toseland &

Rivas, 1984, p. iii). This "person-in-situation" perspective is referred to as an "ecological systems" approach (Toseland & Rivas, 1984, p. iv). This approach is grounded in the social work value system which emphasizes human worth and dignity, acceptance of diversity, and collaborative interdependence (Toseland & Rivas, 1984, p. 10). Toseland and Rivas (1984, p. 12), the major proponents of the ecological systems approach, define group work practice as:

> Goal-directed activity with small groups of people aimed at meeting socioemotional needs and accomplishing tasks. This activity is directed to individual members of a group and to the group as a whole within a system of service delivery.

Implicit in this definition is the idea that group work practice is "a method of helping people through group experience -- a form of social helping directed toward giving people a constructive experience of membership in a group so that they are able to develop as persons and be better able to contribute to the life of the community" (Klein, 1972, p. 26).

Toseland and Rivas have not developed a new method of group work practice. They have developed a typology of treatment and task group practice and an interactional model of group leadership which integrates the existing knowledge about group work practice into a coherent whole. The ecological systems approach of Toseland and Rivas bridges the gap between two approaches to group work practice: the group-centered, process-oriented approaches and the individual member, structure-oriented approaches.

Toseland and Rivas (1984, p. iv) describe the ecological systems approach as one which

> ...facilitates a theoretical electicism and a fruitful use of psychodynamic, behavioral, and other orientations and procedures. It emphasizes the principles and procedures of situational interventions with groups. These group/situational interventions are pursued and accomplished in the interests of individual members, as well as for the benefit of their groups, organizations, communities, and welfare service systems.

Group work skills are used by social work practitioners to help members meet their personal needs and to help group accomplish their goals (Toseland & Rivas, 1984, p. 3). According to Toseland and Rivas (1984, p. 4), group work involves:

1. Practice with a wide variety of treatment and task groups.
2. Work in three focal areas, that is, with individual group members, the group as a whole, and the group's environment.
3. Utilization of generic skills for leading all types of treatment and task groups.
4. Integration and utilization of specialized skills from differing approaches to practice for leading specific groups in particular situations.

The ecological systems approach to group work practice promotes an electic and flexible form of practice. This approach derives its knowledge base from a variety of social science theories, the most notable being: psychoanalytic theory; social exchange theory; and systems theory (Toseland & Rivas, 1984, p. 55). Each theory contributes somewhat to an understanding of why the group as a whole can have a powerful influence on individual group members. These theories form the knowledge base used by group work practitioners as they exercise group leadership skills in each phase of group development. According to Hartford (1971), Heap (1985), Northen (1969), Toseland and Rivas (1984),

and Yalom (1985), group work practice can be conceptualized as a series of generic skills performed by the group work practitioner throughout the life of a group. Group work literature is consistent in the view that group work practice is comprised of the phases of planning, beginning, middle, and ending. During each phase groups exhibit certain properties and processes while the group work practitioner applies specific skills and activities (Toseland & Rivas, 1984, p. 10).

### 3.3 Group Work Practice: Application of the Model to the Group for Traumatically Head-Injured Young Adults

The formulation of group work practice presented by Toseland and Rivas (1984) is the model upon which the formation and development of the group of traumatically head-injured young adults was based. According to this model, the group for young head-injured adults was considered to be a treatment group because its main purpose was to meet members' socioemotional needs (Toseland & Rivas, 1984, p. 15). Toseland and Rivas (1984, pp. 20-21) have formulated a typology of treatment groups in which they outline the selected characteristics to be considered when forming a treatment group. These characteristics are: purpose; leadership; focus; bond; composition; and communication.

According to the model of Toseland and Rivas (1984, p. 23), the group for traumatically head-injured young adults was being formed for the purpose of remediation. The purpose of a remedial group is "to help members change their behavior, cope with or ameliorate their personal problems, or rehabilitate themselves after a social or health trauma" (Toseland & Rivas, 1984, p. 23). Members meet for the common purpose of solving their problems in psychosocial functioning. Each member may

have a different problem with different symptoms. The group leader sometimes considers it necessary to have to focus on one member at a time in order to achieve individual goals because members' problems are unique (Toseland & Rivas, 1984, p. 24). Group members are also expected to help each other work on their problems (Toseland & Rivas, 1984, p. 24).

The remedial model is characterized by a leader-centered approach to group work in which the professional leader actively intervenes in the group's process (Toseland & Rivas, 1984, p. 82). Since this model focuses on restoring or rehabilitating individuals, the group leader acts as a change-agent who intervenes in the group to achieve certain specific purposes determined by the group members, the group leader, and society (Toseland & Rivas, 1984, p. 82). The practitioner leading the practicum group expected that she would act as authority figure or facilitator depending upon: the unique characteristics and life experiences brought to the group by each member; the extent to which members participated in the group; and the extent to which members shared in leading the group (Toseland & Rivas, 1984, pp. 21 & 92). One method of leadership is not effective in all situations. The group leader must vary the type of leadership and the leadership skills employed depending on the characteristics of the group members and the amount of autonomy displayed by the group as a whole (Toseland & Rivas, 1984, p. 85).

The focus of the group for young head-injured clients was to be on individual members' problems, concerns, or goals. Examples of these are coping with physical and/or intellectual deficits; establishing a new

friendship circle; coping with stress; or becoming more assertive. Such problems, concerns, or goals were expected to be indicative of problems in the psychosocial functioning of the young head-injured clients. Such problems include depression, low self-esteem, or dependence. The literature reviewed in Chapter II indicates that each group member was expected to experience some impairments in cognitive-intellectual and personality-emotional functioning along with some secondary behavioral manifestations. These characteristics underly the problems in psychosocial functioning of young head-injured adults. It was considered to be possible that these characteristics could decrease, to some extent, the insight of the practicum group's members into their situations. It was also considered to be possible that these characteristics could, to some extent, impede the members' abilities to utilize effectively the practicum group as a setting in which they could actually employ behavior change strategies to work on correction; rehabilitation; coping; and problem-solving in relation to their problems, concerns, or goals. It was therefore expected that the members might be able to use the practicum group only to begin to explore and identify the psychosocial problems which affected their functioning in their social environments.

The bond existing among the members of the group of young head-injured adults was expected to be two-fold. First, a relationship was expected to form between the practitioner and each group member as a result of the pre-group interviews done in the planning phase. Second, a bond among the members was expected to form as a result of belonging to a group in which they shared a common purpose but in which each one

remained free to realize his or her separate goals.

The composition of the group was expected to consist of traumatically head-injured young adults joining the group voluntarily. These clients would have been informed about the purpose and focus of the group in the planning phase. They would have joined the group knowing that it was designed to help them work on their problems in, concerns about, and goals for improving their psychosocial functioning in their social environments.

Toseland and Rivas (1984, pp. 126-127) have reviewed much group work literature dealing with group size. Although they suggest that a group size of seven members is ideal they recognize that group size must be related to: demographic characteristics of members; interaction desired; individual member needs; interaction with the worker; worker comfort; single leader or co-therapy; mortality rate of the group; group dynamics; space and time; and agency policies. Balgopal and Vassil (1983, pp. 152-153) also support the need to consider these factors when forming a group. For the purposes of this practicum the number of individuals which constitutes a group will be three or more, as suggested by Davies (1975, p. 22).

Elements of both homogeneity and heterogeneity are necessary in a group (Toseland & Rivas, 1984, pp. 124-125). In the practicum group some homogeneity was expected to occur naturally. This was expected because the group was designed to attract young adults who shared a desire to explore problems, concerns, and/or goals in relation to the situation of being head-injured. Some homogeneity was to be ensured by opening the group to young adults who met a specified criteria in terms

of age, physical and intellectual capabilities, and willingness to participate in all aspects of the group experience. Heterogeneity was expected to occur naturally in the group because members would display differences in coping skills; life experiences; levels of expertise; and unique responses to potentially diverse outcomes of injury.

Communication in the practicum group was expected to be, ideally, mainly member to member with the leader as facilitator. Communication in the group was expected to be mainly leader to member if the leader assumed the role of authority figure or expert in response to the needs and abilities of the group members.

Self-disclosure among members in the practicum group was expected to be, ideally, moderate to high if members were able to use the group experience as a mode of helping themselves and others by sharing experiences and ideas.

In addition to considering the characteristics of purpose; leadership; focus; bond; composition; and communication when forming and conducting groups the available literature indicates that groups will proceed through predictable phases of development. The literature produced by Balgopal and Vassil (1983), Hartford (1971), Northen (1969), and Shulman (1984) is consistent with that of Toseland and Rivas (1984) in describing the planning, beginning, middle, and ending phases of group development. It was expected that the practicum group would pass through some or all of these phases.

The planning and beginning phases of group development focus on planning, organizing, and convening a group. Due to the many factors that must be considered, the planning phase is one of the most complex

phases in working with any group (Heap, 1985, p. 23; Toseland & Rivas, 1984, p. 136; Shulman, 1984, p. 177). A group moves into the beginning phase once it has been formed and convened. The beginning phase is marked by the emergence of "group feeling" which arises out of the conflict between group members' desire to become a part of the group while maintaining their individual autonomy (Toseland & Rivas, 1984, p. 74).

The conflict found in the beginning phase continues in the middle phase. The conflict, in this phase, revolves around group members' testing and exploring the practitioner's role as the designated leader. Simultaneously, interpersonal relationships deepen and greater group cohesion results. Once this has occurred, differentiation of roles and the development of feedback and evaluation methods come into being. The group then focuses on task performance in a process which is referred to as problem-solving, performance, maintenance, or maturity (Toseland & Rivas, 1984, p. 74).

The ending phase of group development focuses on the completion and evaluation of the group's efforts. Treatment groups begin a separation process in which group feeling and cohesion decline. The ending phase is often marked by summarizing the group's accomplishments and a final celebration (Toseland & Rivas, 1984, p. 74).

During the phases of group development the group work practitioner must attend to the group dynamics. Such dynamics are the patterns of communication and interaction; the attraction of the group for its members; social controls (e.g., norms, roles, and status); and the group's culture. Communication and interaction patterns allow the

properties of the group as a whole to develop and allow the group to accomplish its work (Toseland & Rivas, 1984, p. 75).

According to Fuchs (1984), a "true" group is one in which members see themselves as being collectively bound and experience a degree of cohesion and group identity. The extent to which a collectivity of people becomes a group is determined by the extent to which cohesion and group identity exist. The factors of cohesion and identity provide the group with the strength and motivation to move through the change process.

Theoretically, the principles of group development should be applicable to any group work effort. The available literature does recognize that there may be variations in the process. Some groups may move through the phases rapidly while other groups may become "stuck" in a particular phase. Some groups appear, on the surface, to pass through all of the phases of group development. Careful analysis of group process, content, and dynamics can indicate that a group has not developed by showing that its members have not developed feelings of identity and cohesion to any great extent.

The significance of the literature reviewed thus far in this chapter is that it serves as a means of illustrating what must be considered in order to form and conduct any group in a systematic, methodological manner. These considerations guided the practitioner in her attempt to form and conduct the practicum group for young head-injured adults according to a method which could be replicated by other practitioners. The relevant literature provided this practitioner with: an ecological systems approach to group work practice; a

methodology for forming and conducting a group; and some expectations about how a group might develop. The ecological systems approach to, and method of, group work practice seemed applicable to the case of young adults in the situation of being head-injured. The decision to actually engage in group work practice with traumatically head-injured young adults was based on work previously done in this area. The implications of group work practice for traumatically head-injured young adults are discussed in the literature which describes the outcomes of some previous attempts at this form of intervention and the importance of group work practice to this client population.

### 3.4 Implications of Group Work Practice for the Group for Traumatically Head-Injured Young Adults

There appears to be a paucity of literature describing attempts to work with head-injured persons in group settings. These clients fall into the category of the long-term disabled rather than that of the terminally ill. Most of the available literature dealing with the long-term disabled focuses on group work done with persons with various physical, developmental, and psychiatric disabilities. Due to the limitations inherent in this literature the findings of the studies cited are not always directly applicable to persons with head injuries.

Those head-injured people seeking a group experience often find themselves participating in groups along with others who are stroke victims, mentally retarded, emotionally disturbed, spinal cord injured, or arthritic. Some of the current literature indicates the need for various types of treatment and self-help group efforts for head-injured people. Only recently has work been done in terms of actually creating

various types of group experiences specifically for persons with head injuries. The literature currently available is relevant to this practicum for two reasons. First, it offers suggestions which are useful in terms of forming and conducting groups specifically for head-injured persons. Second, it indicates that there is some value in using group work practice with people with a variety of long-term neurological impairments and deficits in mental functioning.

Delahooke-Democker and Zimpfer (1981, p. 248) synthesized the results of fifteen selected studies describing group approaches to psychosocial intervention in medical care from 1970 to 1977. These authors explored adaptive groups which are similar in focus, purpose, and functioning to remedial groups. The members of these groups experienced disabilities such as hemeplegia and blindness and had to face not only disability but also the re-establishment of supportive relationships with other people.

Delahooke-Democker and Zimpfer (1981, pp. 254-257) identified nine group gains, some or all of which were experienced by group members in varying degrees. These gains were: provision of information, emotional catharsis, peer support, a setting for practice, and models; broadening of perspective; improvement of interpersonal communications; expansion of role; and help in confronting reality. The sources of such gains rely heavily on interaction among group members. These gains represent the unique contributions of group therapy, counselling, and discussion in dealing with chronic illnesses or disabilities. Their research led Delahooke-Democker and Zimpfer (1981, p. 258) to conclude that:

> The experiences of illness are universally shared and have a potential for personal growth. Stress is

> created as a result of specific, predictable aspects of the experience: dependency, loss of control, potential loss of function and self-esteem, uncertainty about behavioral norms, fear and concern over the responses of loved ones. There are general goals that are important for all patients: sound physiological outcome, reintegration into family and community, adequate personal resolution of the experience, and individual growth. Healing in that context is as important as cure. Participation in a group can help the patient attain those outcomes.

Carrasquillo, Ing, Kuhn, Metzger, Schubert, and Silveira (1981, pp. 486-490) established four group counselling experiences for developmentally disabled young adults over a one year period. Clients involved in the project were those experiencing mental retardation, cerebral palsy, epilepsy, and neurological handicaps. Common problems shared by the clients were: an inability to express feelings; an inability to act independently or even view themselves as independent beings; and lack of external support. The group leaders used a basic approach to group work practice and found that their group took more time than expected to move through the phases of group development. Techniques and exercises used to facilitate the group process were role modelling, role playing, and values clarification exercises. These exercises had to be adapted in ways which met the needs and levels of the groups. Carrasquillo et. al. (1981, p. 490) agreed that the use of co-leaders and the commitment of sufficient time for group process were essential.

Carrasquillo et. al. (1981, p. 490) concluded that "group counselling can be an effective therapeutic method of working with persons who are developmentally disabled." This method "can be effective in helping this client population improve their self-concept,

assert their independence, and develop methods of problem solving." The factors inhibiting their clients from participating fully in groups were identified by Carrasquillo et. al. (1981, p. 490) as lack of peer relationships, suppression of feelings, and low self-esteem. Confidentiality, prior relationships with clients, and leaders' personal feelings about handicapped people were identified as factors creating difficulties in the service aspects of group sessions.

Philipp (1981, pp. 434-435) ran twelve group sessions for eight physically disabled people. The purpose of the group was to provide disabled people with an opportunity to share concerns and experiences. Regardless of each member's reason for joining the group, two common concerns were evident. Some participants expressed a desire to meet others in similar situations and gain greater understanding and support from them. Other participants expressed a need to accept their own disabilities more fully while learning more about the disabilities of their co-participants in the group. According to Philipp (1981, p. 437), who did not produce any statistical evaluation of her group's experience, several members reported that the value of the group lay in the emotional support provided to each member. Philipp (1981, p. 437) asserted that support groups represent an important effort to reduce the personal and social isolation which are pervasive problems for physically disabled adults.

Edwards (1967, p. 267) attempted group work with brain damaged patients in a psychiatric setting in an effort to achieve some social rehabilitation. Although this was not a controlled study, Edwards (1967, p. 270) was convinced that "the group experience helped the

patients to develop insight and ability to conceptualize, which is not developed by brain-damaged patients who receive only routine casework and no group services at all."

Ben-Yishay and Diller (1983) and Stuart (1977) state that small groups have proven very useful as therapeutic psychosocial and educational communities in which members can learn about themselves and develop more adaptive behaviors.

Dennis et. al. (1986, p. 18) have proposed a model post-discharge rehabilitation program for head-injured adults. These researchers indicate that an important component of their program is a socialization group which will deal with a variety of problems that interfere with the social and vocational rehabilitation of head-injured persons. Based upon the research of Ben-Yishay and Diller (1983) and Bolger (1983), Dennis et. al. (1986, p. 18) assert that the group environment provides a place where members can safely practice cognitive, personal, and social skills. Simultaneously, group members can gradually become educated about the consequences of their disabilities through the use of resources such as videotape feedback of interpersonal, social, and communication skills.

The experiences of three groups formed specifically for traumatically head-injured adults were described at the Canadian Congress of Rehabilitation in 1985. These groups focused on providing cognitive retraining, social skills, and emotional support (MacDonald & Millard, 1985; MacDougall & Semkow, 1985; MacDougall & Stradiotti, 1985). The groups were part of a program at the G. F. Strong Rehabilitation Hospital in Vancouver, B.C. The practitioners conducting

the groups provided valuable information about the formation of, and procedures for conducting, groups which consider the specific needs of head-injured people. These practitioners described a variety of positive outcomes for members of such groups in terms of improved communication and social skills, ability to express emotions, and ability to deal with feelings. These positive outcomes were based upon the practitioners' observations rather than on methodological evaluation procedures and/or evaluations done by clients participating in the groups.

The Saskatchewan Co-ordinating Council on Social Planning (1984, p. 27) conducted a study of rehabilitation needs and services in Saskatchewan for persons who have experienced brain injury. This Council (1984, p. 27) reported that the need for a support group "was underscored by the responses of several people interviewed who perceived the need for such service." Based upon its report, and upon the fact that local self-help groups and national associations have been formed for people with a variety of chronic problems (e.g., heart attack, stroke, diabetes, cancer, and arthritis) and have proven helpful, the Saskatchewan Co-ordinating Council asserts that similar groups efforts would prove valuable in terms of providing support, education, and advocacy for head-injured persons and their families.

Over the last seven years national head injury organizations have been formed in Canada and the United States. These organizations do provide advocacy and support for the head-injured and their families. A Manitoba Head Injury Association came into existence in January of 1987. This organization sees the formation of support groups for head-injured

persons as a necessary component of its agenda in the future.

### 3.5 Conclusion

The literature reviewed does not deal with group work efforts formulated specifically for head-injured persons. This literature does relate the basic premises of group work practice to the formation of groups for persons with a variety of long-term disabilities. The articles reviewed indicate that group work practice can be adapted to the particular needs and abilities of disabled participants involved in various types of treatment groups.

Although they are unique because of the combinations of physical, cognitive-intellectual, personality-emotional problems, and secondary behavioral manifestations that they experience, head-injured people are similar in many ways to people with other disabilities who have benefitted from group work practice. The value of the literature reviewed, when related to head-injured persons, rests mainly in the information provided about various types of group experiences; methods of forming and conducting groups; program activities to facilitate group process; and outcomes that groups for the disabled could work towards.

The basis for forming, conducting, and evaluating the practicum group results from combining knowledge derived from two sources. These are the literature describing group work done with persons with physical, developmental, and mental disabilities and the literature describing the ecological systems approach to group work practice.

# CHAPTER IV

# INTERVENTION: THE GROUP FOR TRAUMATICALLY HEAD-INJURED YOUNG ADULTS

## 4.1 Introduction

The practitioner developed a proposal for the intervention. This proposal was based on her practice experience and the literature dealing with head injury and the ecological systems approach to group work practice. The proposal was highly structured and detailed for three reasons. First, it allowed the practitioner to take an orderly, methodological approach to forming, conducting, and evaluating the experience of the practicum group. Second, it enabled the practitioner to make clear comparisons between what was expected to occur and what actually did occur in each phase of the group's development. Third, it provided a clear outline of the intervention which could be followed exactly, or modified, by other practitioners attempting group work practice with head-injured clients. The intervention was conducted according to the proposal which the practitioner formulated by carefully considering each component of the intervention and the phases of development of the group for traumatically head-injured young adults.

## 4.2 Clients

The practitioner knew that the population of young head-injured adults in the community contained persons whose impairments ranged from severe to moderate, in varying degrees, in the physical, cognitive-intellectual, and personality-emotional areas. She also knew that each head-injured individual was unique in the degree to which

he/she experienced secondary behavioral manifestations and psychosocial problems as a result of trying to cope with the experience of being head-injured. The practitioner expected that heterogeneity would occur naturally within the group because each participant would bring his/her unique characteristics to the group experience. The practitioner ensured a degree of hemogeneity among the group members by establishing the following criteria:

1. Clients must have a diagnosis of traumatic head injury.

2. The group is open to both sexes.

3. Clients should be between the ages of 17 and 39 and should have been living in the community, in non-institutional settings, since discharge from hospital.

4. Clients will have an intelligence measure of no less than 70, as assessed by neuropsychological testing.

5. Clients should display some insight regarding their situations. They should be able to recognize the aspects of being traumatically head-injured that are problematic for them.

6. Clients should be in charge of their own affairs or be willing to have authorized persons sign contracts and consent forms on their behalf.

7. Clients must be mobile with or without aids, such as canes or wheelchairs, and must be able to arrange their own transportation.

8. Clients must be able to communicate verbally even if speech is impaired.

9. Clients must be able to perform self-care functions (i.e., eating, dressing, grooming, and toileting) independently.

10. Clients should be medically and psychologically stable in terms of their ability to participate in a group. They should not be prone to being physically harmful to themselves or others.

11. Clients should not have had any intensive involvement with the practitioner in the past. They must not be persons who have participated in groups for traumatically head-injured adults run by the practitioner in the past.

12. Clients must join the group of their own volition and must be willing to participate in making the audiotapes and videotapes used to record interviews and group sessions.

## 4.3 Setting

The practicum site was the Health Sciences Centre Hospital complex. The Department of Social Work of the hospital provided space for group meetings and individual interviews as well as secretarial services.

The pre-group client interviews were held in offices belonging to the Department of Social Work. The offices were private, accessible, and located away from hospital ward areas. The group meetings were held in the Department of Social Work Conference Room. This room was located in a building a fair distance away from hospital treatment areas. The building was physically accessible for the group members and close to bus routes and free parking for vehicles. The meeting room provided a lounge atmosphere and videotape equipment. Refreshments such as coffee and pastry, could be easily served in this room.

## 4.4 Personnel

Although the available literature indicates the benefits of co-leadership, the group was formed and facilitated by one practitioner due to several factors. The practicum was not funded, therefore no remuneration could be given to a co-leader. The practitioner was not able to locate a co-leader who was experienced in group work practice and willing to volunteer his or her services for this practicum project. The practitioner was working under a time restriction and could not take the time to wait for an appropriate volunteer co-leader to become available. The practitioner also considered that even if a co-leader was found, the project would have been further delayed while the co-leaders took time to develop a working relationship.

The practitioner was also aware that co-leadership could present potential obstacles to the group's functioning, especially in terms of any conflicts that might arise between co-leaders. Examples of this would be group members attempting to play one co-leader against the other or focusing upon the leaders' conflict to avoid working on difficult issues (Toseland & Rivas, 1984, p. 108). Co-leadership would have also introduced another variable to be analyzed in evaluating both the group process and the effect of the group upon the members.

Audiotapes of interviews and videotapes of group meetings were shared by the practitioner with the practicum advisors for the purpose of providing feedback about her leadership style to the practitioner and evaluating her leadership skills.

## 4.5 Procedures

### i) Procedure for Obtaining Referrals

No less than four and no more than eight clients were required to begin the group (Toseland & Rivas, 1984, p. 126; Carrasquillo et. al., 1981, p. 486). It was expected that having four to eight members in the group should have allowed a single practitioner to provide adequate attention to each member's concerns and problems. A group size of no more than eight should have also promoted intimacy and cohesion among group members.

Referrals were sought from the rehabilitation professionals having the most contact with head-injured young adults in the community who were experiencing problems in psychosocial functioning. These professionals were the psychologist and social worker on the neurological rehabilitation team at the Health Sciences Centre and the vocational rehabilitation counsellor at the Society for Manitobans with Disabilities, Inc. The practitioner met with the referring professionals, described the nature of the practicum, and presented the client criteria. The referring professionals reviewed their caseloads and discussed, with the practitioner, four clients who might be interested in joining the group. The referring professionals contacted these clients, described the nature of the group, and learned that they were indeed interested in participating. The practitioner then sent out letters requesting that the interested clients contact her by telephone if they wished to arrange an initial pre-group interview. The practitioner told the referring professionals that they would be informed whenever a client agreed to join the group. They were also

instructed to contact the practitioner to ensure that space was still available in the group before promising a client that he or she would actually be referred.

Referrals were sought in this manner for two reasons. First, this process ensured that clients joined the group voluntarily. Second, this process eliminated the possibility that more than eight clients might want to join the group. If this were the case, clients who were not accepted into the group might not understand that the group could only accommodate eight people and might feel that they were "rejected" from the group on the basis of some personal deficiencies.

Due to the time restriction under which the practitioner was working she decided to convene the group with a minimum of four participants, three weeks after the initial pre-group interviews had been held. This would have allowed time to interview any potential group members who were late referrals.

As a result of the referral process, one female and three males learned about the group and expressed interest in joining. The three males contacted the practitioner and participated in both the initial and second pre-group interviews. The female reported a number of personal problems which were contributing to her decision to leave the province. She could not commit herself to join the group. In an effort to recruit more members the practitioner approached two males and a female who met the criteria and who had been discharged from the Neurological Rehabilitation Unit. One of the males participated in the pre-group interviews. The other male was interested in the group. However, he had obtained evening employment and thought that this would

interfere with attending meetings. The female was wheelchair-bound and lived outside of the city limits. She did not join because she was not able to obtain transportation to meetings.

Four young head-injured males participated in the pre-group interviews. These men were Andy, Bill, Jim, and Fred. A fifth young man, Len, participated in the pre-group interviews after the group had actually begun to meet. The practitioner has used fictitious names and has altered some of the characteristics of the men's situations to ensure confidentiality.

ii) Procedure for Initial Pre-Group Interviews

During the initial individual pre-group interviews the practitioner described to each client the purpose of the group, how it would serve as a practicum project, and the obligations of the group members and the practitioner. Audiotaping, videotaping, completing questionnaires, and the contract (see Appendix I) were also discussed. Clients were asked to think about the group, decide if they would participate, and contact the practitioner within two days after the initial interview if they decided to join. Clients were told that a second interview would be scheduled for those committed to joining the group. This was necessary to allow the practitioner to obtain social data from the clients and to have them complete questionnaires.

iii) Procedure for Second Pre-Group Interviews

Clients committed to joining the group met individually with the practitioner who structured the interview to obtain social data and discuss the following areas of psychosocial functioning (MacDougall &

Semkow, 1985):

1. Moods - euphoria, depression, anger, hostility, low frustration point, feelings about self.

2. Friendships - is isolation a problem?

3. Family support and constellation.

4. Level of independence:

- where living
- living alone or with others
- means of transportation
- employment
- social life.

5. Problems with concentration or distractability in social settings.

During this interview potential members were asked to establish individual goals in terms of things they would like dealt with in the group. Examples of individual goals discussed were: meeting others with similar problems; how to present oneself socially; how to be comfortable being different; and understanding the source of emotional distress.

During this interview potential group members completed the pre-group questionnaires measuring self-esteem, depression, and dependence (see Appendix II, Measures 5.2, 5.3, and 5.4). At this time the group member-practitioner contract was signed.

iv) Procedure for Conducting the Group

The participants and the practitioner mutually agreed that the group should meet from 7:00 p.m. to 9:00 p.m. on twelve, consecutive Wednesday nights. They also agreed that as many meetings as possible should be videotaped.

The participants agreed with the practitioner that the procedures to promote the development of the group would be comprised of discussion and exercises revolving around theme-oriented or educational material, task-oriented material, and individual work. Some examples of topic areas considered were:

1. Life after discharge from hospital.
2. Relationships with family and friends.
3. Concerns about education, vocation, and recreation.
4. Dealing with anger.
5. Assertiveness.
6. Relaxation.
7. Sexuality.
8. The "thing about head injury" that is most difficult for me.
9. Should there be a self-help group for the head-injured?

Group members were encouraged to participate in planning the agendas for meetings and to consider inviting guests with expertise or personal experience in the topic areas. Group sessions were flexible enough to involve the use of role playing, reviewing videotapes of group meetings, and other exercises to promote interaction among the members.

4.6 Duration

Based on suggestions made in the available literature, and on the wishes of her clients, the practitioner decided to run the group for two hours each week for twelve consecutive weeks (Northen, 1969, p. 227; Philipp, 1981, p. 434). The available literature suggested that this duration and frequency should have been sufficient to accomplish the goals of individual members and the group as a whole. The practitioner informed the participants in the group that she was open to increasing or decreasing the twelve week period based on their needs and opinions.

4.7 Open Versus Closed Group

Since the practitioner was convening the group with the minimum number of four participants, there existed the possibility that the group would not be able to continue if one or more members dropped out. Due to the nature of the group and its time-limited duration, the practitioner initially intended that the group would be closed. This meant that no new members would be accepted after the group's inception. The practitioner was aware that "each new person who comes into a group changes it, alters the interpersonal relations in which the original members are involved, and provides a new stimulus and situation to which members need to adapt" (Northen, 1969, p. 104). It would follow that the loss of a member from a group would result in an alteration in the network of relationships (Northen, 1969, p. 104). The practitioner was prepared for the possibility that at least one member would drop out of the group. She decided that, if and when this occurred, the group members themselves would have the final say as to whether or not new members would be allowed into the group.

## 4.8 Recording

The practitioner recorded data used to evaluate the progress of individuals in the group and the group as a whole.

### i) Implementation of Procedures

Audiotapes of pre-group interviews, videotapes of group sessions, and videotapes of post-group interviews were made. The practitioner also produced a narrative record log in which she recorded her observations and impressions of group sessions. Group members completed three questionnaires measuring self-esteem, depression, and dependence. These were completed before the first group meeting, mid-way through the group's life, and after the termination of the group. Group members also completed a written evaluation on the group mid-way through the group's life and a verbal evaluation after the termination of the group.

### ii) Progress of Clients and the Group as a Whole

The progress of clients and the group as a whole was assessed by means of the practitioner's analysis of all audiotaped, videotaped, and written materials. The videotapes of group sessions were analyzed by the practitioner and the group. All material was available for sharing with members of the advisory committee for consultation purposes.

Upon completion of the practicum all taped material, written material, and completed questionnaires were destroyed to maintain confidentiality.

## 4.9 Conclusion

The practitioner adhered as closely as possible to the interventive plan described in the practicum proposal. The practicum experience and the evaluation of the project will be described and discussed in greater detail in the subsequent chapters.

# CHAPTER V

# EVALUATION

## 5.1 Introduction

The main goal of this practicum was to conduct, and assess the outcomes of, group work practice with a small group of traumatically head-injured young adults. This practicum was a demonstration project which was conducted and assessed in a systematic, methodological manner. The purposes of evaluation with respect to this project were three-fold. First, the practitioner intended to contribute to the little knowledge available about group work practice with head-injured persons and to social work research in this area. Second, the practitioner intended to produce a study which could be replicated and improved upon by other practitioners working in this area. Third, the practitioner intended to contribute to the development of programs in group work practice with head-injured clients. These programs could be conducted in settings such as the Neuro-Rehab Unit, Health Sciences Centre, or community agencies (e.g., Society for Manitobans with Disabilities, Inc. or Health and Community Services).

According to Trecker (1955, p. 217), evaluation is that part of group work practice

> ...in which the worker attempts to measure the quality of a group's experience in relation to the objectives and function of the agency. Evaluations may be centered upon individual growth, program content, or worker performance because all these aspects tend to influence the general achievement of the group. When individuals, groups, and workers are studied in an attempt to ascertain their growth and development, subsequent experiences can be better provided to meet newly recognized needs.

The function of the Neuro-Rehab Unit, Health Sciences Centre, is the restoration of patients to their fullest physical, mental and social capabilities in order to help them lead lives satisfying to them in the community. One of the objectives of social work in the Neuro-Rehab Unit is follow-up of patients discharged to the community. Given these factors, it seemed appropriate for a rehabilitation social worker to conduct and evaluate group work practice with head-injured persons.

Conducting and evaluating research in group work practice with head-injured clients was no small task due to the difficulties inherent in the study of group work practice in general. Trecker (1955, pp. 274-275) has discussed these difficulties in detail but they are briefly described here because they all affected this practicum project to some degree.

First, such studies consume a great deal of practitioner's time and are often regarded, by agencies, as "extras" not included in his/her required duties. These studies do not have high visibility and must be interpreted in order to have any long-term, far-reaching value.

Second, a practitioner must feel quite secure in order to subject his/her own work to self-study and scrutiny by colleagues.

Third, a lack of standard and reliable forms of recording has been a seriously limiting factor and problem in research in group work practice. It is the existence of appropriate and accurate records which makes it possible to construct hypotheses, examine cases, and draw tentative conclusions.

Fourth, it is time-consuming and difficult to select and clearly define one of the many study areas or problems for study evident in

group work practice. Clear problem definition is the foundation upon which data gathering for the evaluation of practice is based.

Fifth, it is difficult to make judgments about the value of given groups in the lives of participants. Most members of groups sponsored by social agencies are often members of other groups making it difficult to screen out the specific contributions of any one group to the development of an individual.

Sixth, there has long been a lack of agreement on uniform criteria of effective group work practice. Such criteria are the prerequisites of a good research program as they provide the standards against which new research can be measured.

Notwithstanding these difficulties, the practitioner was determined to conduct and evaluate group work practice with young head-injured clients. The practitioner was working with a small number of people, in a problem area thus far not explored by the use of more rigorous research designs. She therefore decided to employ the case study design and to monitor and evaluate the project by using a variety of instruments. The relevant literature did not contain any examples of groups run specifically for head-injured persons which were systematically evaluated by any means. The practitioner therefore recognized the importance of carefully describing the evaluation instruments and procedures used in this practicum.

## 5.2 Evaluation Criteria

### i) Criteria for Evaluating Post-Intervention Assessment

In order to evaluate the outcomes of the practicum the practitioner had to illustrate whether or not the aims of the intervention were realized in this practicum. Those aims were:

1. To describe the formation, development, and evaluation of the small group for traumatically head-injured young adults as a demonstration project.

2. To explore the hypothesis that the use of standardized measurement would indicate that group members experienced one or more of the most salient psychosocial problems evident after head injury.

3. To assess the value of group work practice in this practicum by comparing changes in the magnitude of each group member's ratings of the salient psychosocial problems, and by reporting on each group member's written and videotaped evaluations of the group experience.

### ii) Criteria for Evaluating Educational Benefits for the Practitioner as Student

In order to evaluate the educational benefits of this practicum for the student the practitioner had to accomplish the following goals:

1. Complete the practicum which was her direct effort to benefit traumatically head-injured young adults. These clients lacked services designed specifically to help them cope with their psychosocial problems as they functioned in the community.

2. Present a practicum report which illustrated how she combined the theory and practice of social work and group work with knowledge about traumatic head injury. This was accomplished by reporting on the

facilitation of a small group for young head-injured individuals attempting to cope with their psychosocial problems as they functioned in the community.

3. Present a report of this practicum as a demonstration project. The report had to include a description of the intervention; an assessment of the benefits, or lack thereof, for the clients involved; and recommendations which might be utilized by other practitioners attempting similar projects.

4. Receive from the advisory committee, an evaluation indicating that she possessed the knowledge and skills required to obtain the M.S.W. degree.

## 5.3 Evaluation Method: The Case Study Design

The case study design is a model of "simultaneous intervention and observational assessment performed by a helping professional" (Bloom & Fischer, 1982, p. 289). Case studies involve precise descriptions, accurate observations, and detailed analyses of a single example or case. The practitioner recognized that this design had both strengths and limitations and she acquainted herself thoroughly with these.

### i) Strengths of the Case Study Design

The strengths of the case study design have been described by Bloom & Fischer (1982, p. 290), Jehu (1983, pp. 26-27), and Toseland and Rivas (1984, pp. 316-317). This design promotes clinical speculation and innovation because it is easily applied to any intervention.

"Case studies may suggest events or sources of influence in the past that have contributed to the current problem" (Jehu, 1983, p. 26).

They are a source of aetiological hypotheses.

The case study can cast either light or doubt on an assumption or prediction because it yields immediate feedback by testing that idea in practice.

The case study method can promote the development or refinement of technical skills because it clearly connects practice techniques and their evaluation.

Case studies allow rare problems to be investigated without collecting large amounts of data from many persons. Such problems may never occur in sufficient numbers to be evaluated in controlled group designs.

There is heuristic value in case studies. They allow the purposeful collection of subjective information. This may, in turn, suggest the usefulness of a technique or application and stimulate more controlled studies. Subsequent studies may employ more rigorous single system designs resulting in more precise investigations.

ii) Limitations of the Case Study Design

The limitations of the case study design are recognized by Bloom and Fischer (1982, p. 290) and Jehu (1983, pp. 27-28). Case studies are often based upon anecdotal information provided by clients. This information is subject to further filtering and interpretation by the practitioner. This often creates considerable doubt about the accuracy of the data upon which case studies are based.

It is frequently evident that several techniques are being administered simultaneously in any case study. This makes it difficult for the practitioner to separate the active, effective components of the

intervention from the extraneous components in order to benefit the next phase of treatment as well as future case situations.

The case study method allows the practitioner to be casual in both specifying and measuring problems to see if changes occur. This lack of systematization and clear guidelines for measurement, design, and evaluation often promotes a strong bias in favor of interpreting events in terms of how a theory predicts they will occur. "There is little independence in making observations that are the basis of the data" (Bloom & Fischer, 1982, p. 290).

The uncontrolled nature of case studies makes it impossible to eliminate threats to internal validity such as history, maturation, and instrumentation (Jehu, 1983, p. 27). History refers to the fact that changes in clients may result from events in their lives that are unrelated to the intervention rather than from the intervention itself. Maturation refers to the fact that people change in ways that are relatively independent of environmental experiences. Maturation rather than the intervention, might produce some changes in clients. Instrumentation refers to the fact that changes in clients might be attributed to the intervention when in fact the instruments evaluating client progress might be changing and not the clients themselves.

Case studies do not allow for validity or reliability checking. This makes it difficult for others to repeat studies exactly.

The case study method does not easily lend itself to challenging desired outcomes for alternative explanations of the results of studies and the reasons for them.

Case studies lack the power to make causal references and provide

few solid reference points to indicate significant change.

## 5.4 Evaluation Instruments

The case study design allowed the practitioner to employ evaluation instruments which would yield a qualitative description of the formation, functioning, and outcomes of the group for traumatically head-injured young adults. These instruments enabled the practitioner and the group members to evaluate the group experience in order to assess the value of group work practice in the case of the small group of young head-injured persons.

### i) Audiotapes and Videotapes

Audiotapes of pre-group interviews and videotapes of both the group sessions and post-group evaluations by individual members were used as records of the group's formation and development. These were useful to the practitioner in her efforts to describe and evaluate the effect of the group upon its members.

### ii) The Practitioner's Log

The log was used mainly as a record of the practitioner's observations and impressions of each group meeting. It was useful in helping the practitioner to quickly recollect important occurrences in the meetings. The log also served as an additional record of the activities of the group leader and the progress of the group and of individual group members.

iii) The Mid-Group Written Evaluation

This questionnaire (see Appendix II, Measure 5.I) was designed by the practitioner to enable group members to freely, but privately, express their opinions about the group and its functioning. It also enabled group members to make suggestions for changing the way in which the group was being conducted.

iv) The Group Members' Final Evaluations

These evaluations were conducted in the form of private, individual interviews, done by the practitioner, with each group member. The interviews were conducted according to the basic format of the written and mid-group evaluations. The group members were also given opportunities to discuss other aspects of the group experience which they felt were important.

## 5.5 Supplementary Evaluation Instruments

From the range of psychosocial problems experienced by head-injured persons, the practitioner chose to evaluate three of their most salient psychosocial problems discussed in the literature: low self-esteem; depression; and dependence. The supplementary evaluation instruments were not used in such a way as to yield valid and reliable baseline measures of these variables. Rather, the use of these instruments did enable the practitioner to accomplish several things. First, by using these instruments the practitioner could explore her hypothesis that the young head-injured persons in the group experienced some or all of the problems of low self-esteem; depression; and dependence. Second, by using these instruments, the practitioner could gain some experience in

administering and scoring standardized measures. Third, by using the measures the practitioner could gain some insight into how young head-injured individuals might react to responding to standardized measures such as questionnaires. Her understanding and use of the case study design and her use of standardized measurement instruments contributed to the practitioner's efforts to conduct the practicum in as orderly and methodological manner as possible.

i) The Index of Self-Esteem (ISE) and the Generalized Contentment Scale (GCS)

The Index of Self-Esteem (ISE) (see Appendix II, Measure 5.2) measures the degree or magnitude of a problem the client has with his or her self-esteem. The practitioner operationally defined self-esteem as the presence of positive feelings about oneself. The Generalized Contentment Scale (GCS) (see Appendix II, Measure 5.3) measures the degree or magnitude of non-psychotic depression. The practitioner operationally defined depression as a feeling of general discontentment with one's life and surroundings which is experienced as a reaction to the situation of being traumatically head-injured.

The ISE and GCS are part of a package of standardized scales developed by Walter Hudson and his colleagues (Bloom & Fischer, 1983, p. 148). These instruments are designed specifically for single system research. They are designed to monitor and evaluate the magnitude of a client's problems through repeated administration to the client. The ISE and GCS each consist of only 25 items. These scales are easy to administer, interpret, complete, and score. They do not appear to change merely as a result of being repeatedly administered over time.

These scales are a stable and reasonable measure of change when administered weekly, over a period of several weeks (Bloom & Fischer, 1982, p. 161).

According to Hudson and his colleagues (Bloom & Fischer, 1983, p. 151), the higher the score on a scale the greater the magnitude of the problem. A score of 30 on any scale serves as a very rough guide to the existence or absence of problems. When used properly, the scales have a reliability of .90 or greater and possess good face, construct, and discriminant validity (Grinnell, 1981, p. 152).

In order for the ISE and GCS to have any real research value, they should have been administered to participants in the group weekly. This should have been done for several weeks prior to the first group meeting in order to establish a baseline. The scales should also have been administered to the participants in the group throughout the intervention phase and several times post-intervention.

The practitioner was conducting a case study and was not able to use the ISE and GCS as intended. She recognized that the scores on these scales had no statistical significance. The scores on the scales were merely used as "readings" of self-esteem and depression for correlative reasoning.

ii) The Index of Practical and Personal Help (IPPH)

The Index of Practical and Personal Help (IPPH) (see Appendix II, Measure 5.4) measures the degree to which one uses the help of others in accomplishing the activities and dealing with the experiences of everyday living. The practitioner operationally defined dependence as a reliance upon others for instrumental or affective aid. The IPPH simply

records the degree to which one perceives that he or she uses the help of others, be they non-professionals or professionals.

The IPPH is a scale that was developed by the practitioner after an unsuccessful search for a standardized measure which would yield scores on group members' measures of dependence or independence. The practitioner designed the IPPH to appear similar in length and rating method to the ISE and GCS. The IPPH was administered to six non-head-injured persons, in a pre-test, prior to being administered to the group members. This was done to ensure that the items were interpreted easily and consistently. The method of scoring the IPPH was different than that of the ISE and GCS.

The group members scores on the IPPH, like those on the ISE and GCS, had no statistical significance. Rather, the IPPH scores were intended to give the practitioner a "reading" on the group members' perceptions of their dependence.

### 5.6 Evaluation Procedures

All pre-group interviews were audiotaped. Eleven out of twelve group meetings were videotaped. All individual post-group interviews and evaluations were videotaped.

The ISE, the GCS, and the IPPH were completed three times by each group member. The scales were administered in the pre-group phase, midway through the group, and during the post-group individual interviews. The practitioner administered the scales to each group member in the pre-group phase and during the post-group individual interviews. The practitioner simply read each item out loud and marked in the group member's response. Due to time constraints, group members

were asked to complete the scale done midway through the group on their own and return them to the practitioner.

The post-group verbal interviews and evaluations were videotaped and conducted individually with each group member several weeks after the termination of the group. These interviews gave group members an opportunity to express their feelings and opinions about the group experience and to respond verbally to a repetition of some of the questions that had been on the Mid-Group Written Evaluation. During these sessions, group members completed the ISC, and GCS, and the IPPH for the third time and the results of all of their scores on the scales were discussed with them.

### 5.7 Conclusion

The case study was the best design to apply to the group for traumatically head-injured young adults. This type of project had never before been conducted and evaluated systematically. There were no studies available to replicate and no data available to substantiate or refute. The case study was employed in this practicum to develop testable ideas and as a temporary measure to aid in identifying more specific measurement procedures.

The means of collecting subjective data from the group members and the practitioner, who was the group leader, were: audiotapes of individual interviews; the practitioner's log; the mid-group written evaluation; and the videotapes of post-group interviews and verbal evaluations. The videotapes of each meeting provided a permanent record of the group in action. The practitioner later reviewed these tapes to more objectively evaluate her own skills and the group's process and

development. The practitioner found it difficult to evaluate such things while she was actually immersed in the group experience.

The practitioner also employed supplementary evaluation measures (i.e., the ISE, the GCS, and the IPPH). These measures did not yield statistically significant results. The practitioner's use of these measures allowed her to get a "reading" on the magnitude of the problems of low self-esteem, depression and dependence for each group member. It also allowed her to test her assumption that the measures could be completed by head-injured persons intellectually similar to those who participated in the group. The practitioner concluded that the measures were appropriate for use with head-injured clients and could be applied more systematically and rigorously in future studies according to a more controlled A-B research design.

The opportunity to become familiar with the case study design and to explore the application and creation of evaluation instruments was a learning experience for the practitioner. The practitioner's knowledge about the weakness of both the case study design and the evaluation instruments employed promoted her to be as objective and honest as possible in her final evaluation of the project.

# CHAPTER VI

## EVALUATION RESULTS: POST-INTERVENTION ASSESSMENT

### 6.1 Introduction

The details of the plan for the intervention were carefully described in Chapter IV. That plan was formulated on the basis of the practitioner's experience in working with head-injured clients and the available knowledge about head injury and group work practice. In Chapter VI the practitioner will address the objectives which were the aims of the intervention in this practicum. First, she will describe the formation and development of the group based on material derived from audiotapes, videotapes, and the practitioner's log. Second, the practitioner will describe the results of the use of supplementary, standardized evaluation instruments. These results allowed the practitioner to explore the hypothesis that the group members experienced one or more of the salient psychosocial problems evident after head injury. These problems are low self-esteem, depression, and dependence. Third, the practitioner will assess the value of group work practice in this practicum. A comparison of the members' pre, mid, and post-group ratings of the salient psychosocial problems was intended to contribute to this assessment. Material derived from the members' mid-group and final evaluations also contributed to this assessment. The practitioner will also relate the assessment of the value of group work practice in this practicum to her experience with head injury and the available knowledge about head injury and group work practice.

## 6.2 Formation of the Group

The practitioner was aware that the planning phase is one of the most complex in working with any group. Heap (1985, p. 23), Toseland and Rivas (1984, p. 136), and Shulman (1984, p. 177) stressed the need for careful planning in group work and for recognizing the components necessary to establish a group and increase the chances of its success. The practitioner worked within the boundaries of the limitations imposed by the availability of resources to promote and support the development of the group. These resources included: her emotional and physical energy and expertise; time; agency support; and the interest and motivation of young head-injured persons in the community. The practitioner had to consider many variables and exercise control over as many of them as possible. The practitioner was aware that good planning is careful, reflective, and systematic, with a number of requirements. According to Heap (1985, p. 21), planning a group

> ...requires professional knowledge of the members' common problems and as much information as is obtainable concerning the potential group members. (Of course, the availability of such information varies greatly from one situation to another.) It requires the ability to see contexts and connections between wide societal circumstances, cultural influences, group processes, the dynamics of family life and the configurations of individual clients' traits, ways of coping and specific problems. It requires understanding and a preparedness to be wrong and to continue to learn about the particular problem which brings members to a group. It requires the ability both systematically and sensitively to project reasoning and evaluate thinking into an as yet non-existent group situation. It requires empathy.

As a result of careful planning the practitioner produced a highly structured proposal for forming and conducting the group in an effort to

ensure that her clients had as promising a group situation as possible.

As the practitioner reviewed the material collected throughout the group experience she realized that even the most careful planning does not always yield the expected outcomes. This was the case in terms of the number of referrals received and the number of clients who joined the group. The practitioner's contacts with young head-injured clients and various professionals involved with them, along with the relevant literature, suggested that there should exist a fairly large pool of potential group members, most of whom would be male (N.H.I.F., Inc., 1984; Parkinson et. al., 1985, p. 79; Rosenthal et. al., 1983, p. 11). Although the referral process was carefully planned and conducted the practitioner did not get as many referrals as expected. Only four clients were actually referred by professionals working in the Neuro-Rehab Unit and the Society for Manitobans with Disabilities, Inc. (S.M.D.). The practitioner herself approached three more head-injured clients whom she had met in her practice in the hope of increasing the number of potential group members.

The practitioner might have obtained more referrals had she planned the project differently. First, she could have sought referrals from professionals in hospital and community agencies in addition to those in the Neuro-Rehab Unit and the S.M.D. The practitioner did not do this because she believed that most of the head-injured people in Manitoba who needed help to return to living in the community would have been channelled through the Neuro-Rehab Unit and/or the S.M.D., even if they were initially clients of other hospitals or community agencies. Second, the practitioner could have designed a less stringent set of

criteria for entry into the group. The entry criteria were very stringent because the practitioner wanted to ensure some homogeneity among group members in terms of physical and intellectual capabilities; communication skills; and willingness to participate in the group experience. Third, the practitioner could have extended the time frame for accepting referrals. She did not do this because she had a limited amount of time in which to complete the practicum. She also felt that taking the time to wait for more referrals might have caused her to lose the interest of the few clients who were ready to join the group and anxious to begin meeting.

As a result of the pre-group planning process, five young head-injured men actually participated in two pre-group interviews; completed questionnaires measuring problems in the areas of self-esteem, depression, and dependence; and signed the contract committing themselves to a twelve week group experience. The pre-group interviews allowed the practitioner to discuss with the clients the purpose of the group experience and plans for conducting the group. These interviews also allowed the practitioner to obtain some basic information about each group member.

Andrew

Andrew was 31 years old and was injured in 1984 in a motor vehicle accident. He and some friends had been consuming alcohol at a party and were on their way home when the accident occurred. Andrew was a passenger in his own car which he had allowed someone else to drive. At the time of the accident Andrew held a job he really enjoyed. He was a salesman with a nationally known company. Andrew had completed

post-secondary education in business administration. After the accident Andrew received adequate financial support from insurance payments. It would be some time before he would be able to return to any form of gainful employment. Andrew presented with impaired, but intelligible, speech and an abnormal gait (i.e., walking pattern). He was working very hard to improve his speech and physical abilities.

Andrew described himself as a "flexible" person who "kept bad and sad feelings inside." He did not report experiencing any major mood changes since the accident and did not perceive himself as depressed. Andrew said that he did not feel anger often and when he did it was usually in regard to the accident. He expressed some feelings of hostility toward certain people because of the accident and a desire to "get even with them." Andrew reported that he had a lower frustration tolerance than he did pre-morbidly and that he coped with this by "working harder" at whatever was frustrating him at any given time. He did not feel that fatigue was a problem.

Andrew reported that some of his friendships had "droppped off" since the accident but several people had "remained close." He said that throughout his recovery he had "good support" from his family and from one sister in particular.

Since his discharge from hospital Andrew had been living alone. He could not drive but he walked a great deal and took buses. He expressed being dissatisfied with his social life. He was not able to dance and he had enjoyed dancing very much pre-morbidly. He reported being self-conscious about his walking and, because of his poor balance, he had been mistaken as being drunk on several occasions. Andrew reported

that he did not deny his physical problems and found it easy to discuss them with others.

Andrew felt that his ability to concentrate was "pretty good." He said that background noise sometimes bothered him but his "ability to concentrate on television and movies was better." He reported that his short-term memory was sometimes a problem but his long-term memory was intact. He said that "he wrote things down" to aid his short-term memory.

Andrew's goals for joining the group were: to practice speaking skills because he felt that he was repetitious; to practice keeping appointments; and to share problems with others in order to help them and to help himself.

Bill

Bill was 34 years old and was injured in 1984 while parachuting, which was his hobby. At the time of the accident Bill held a job as a mechanic with the railroad. He had completed Grade 12 as well as special courses and an apprenticeship to receive his mechanic's license. After the accident Bill received adequate financial support from disability benefits and his savings. He had also returned to work at the railroad on a part-time basis. Bill presented with no obvious impairments in speech or physical movement. He did tend to verbalize too much and ramble off topic in conversation and he was aware of this problem.

Bill reported that his friends felt that his temper was shorter than it had been pre-morbidly. He felt that his temper became shorter as his fatigue increased. Bill said that although he kept his feelings

of anger inside himself he was willing to discuss these feelings with others. He said that he sometimes experienced feelings of depression (i.e., feeling "low or down") and coped with them by "keeping busy." Bill reported that he had talked about suicide since his accident. He did discuss these feelings with his girlfriend and psychologist. Bill felt that he was not yet "happy" with himself but that he was slowly getting to that point. Bill reported having many worries about his future.

Bill reported that his friendship circle had not changed significantly since the accident. He said that his girlfriend Diane, and his friend, Phil, were "pretty much the mainstays of his existence" before the accident and continued to be so after the accident. Bill wanted to marry Diane but he felt that he had to first sort-out his employment situation. Bill felt that he had "good support from his family throughout his recovery process."

Since his discharge from hospital Bill had been living with his parents. He could not drive but was able to walk and take buses. He seemed happy to have part-time employment and he was receiving help and support from the S.M.D. Bill seemed to be satisfied with his social life and spent most of his time with Diane.

Bill did not report problems in his ability to concentrate or his long-term memory, but he did report problems with his short-term memory.

Bill's goals for joining the group were to make new friends and to help others with problems.

Jim

Jim was 28 years old and was injured in 1984 in a motor vehicle accident. He worked as a cook and at various other jobs before his accident. After the accident finances had become a problem. Jim had received financial support from welfare and a government disability pension. He had also obtained low-paying, full-time employment with a woodworking company. Jim presented with no obvious impairments in speech or physical movement.

Jim reported that he got "mad rather than depressed." He said that he sometimes felt frustrated because he was not able to do the kinds of work that he could do pre-morbidly. He also said that he sometimes got frustrated and angry with his common-law wife's young children but he recognized that they were only youngsters who did not understand the nature of his problems resulting from the head injury.

Jim reported that he had lost contact with a number of his former friends. He felt that the friends who had kept in contact were "kind of leery" about him and "not sure what to expect" from him. Jim's parents were in another province but they kept in touch by telephone and letters. Jim said that his best support after his injury came from his common-law wife, Laurie, and her family.

Since his discharge from hospital Jim had been living in a low-rental housing unit with his common-law wife, Laurie, and her two sons, ages seven and ten. Laurie worked at various temporary jobs. Jim could not drive but he had no problems walking and taking buses. He did not participate in the kind of social life which he had pre-morbidly. This involved mainly consuming alcohol with friends at parties or in

bars after work. Since his accident Jim had adopted a "family style" social life which involved staying at home with Laurie and her sons or participating with them in family activities such as bowling, movies, and outings. Jim also received help and support through his involvement with the S.M.D. He had obtained his job through this agency but he hoped to become a cook again or own a restaurant in the future.

Jim felt that his ability to concentrate depended upon the importance of the activity he was involved in at any given time. He did report that he was "somewhat distractable" and that he did sometimes "lose track and wander" in conversations. Although he reported that he sometimes had problems with short-term memory, Jim said that he generally felt quite confident about his abilities.

Jim's goals for joining the group were: to see how people with the same injury handled themselves and their frustration; to satisfy his curiosity about other head-injured people's reactions to their different situations; and to talk to people with similar injuries. He also felt that the group might be used to help people who have not experienced head injury to understand it better.

Fred

Fred was 31 years old and was injured in 1978 in a motor vehicle accident. At the time of the accident he held a job as a laborer with the railroad. He had not completed high school. After the accident Fred received financial support from Autopac benefits and a government disability pension. He had not returned to any form of employment but was involved with special education teachers in the Rehabilitation Centre in an effort to complete his high school courses. Fred hoped to

eventually get into university. Fred presented with no obvious physical or speech impairments. He spoke slowly, answered questions thoughtfully, and gave specific examples of his experiences.

Fred reported that he had sometimes lost control of his temper and had actually "hit" others when angry. He felt that he was learning to cope with frustration and that his frustration tolerance was actually increasing since his injury. Fred did not want to use his head injury as an excuse for his actions. He reported that he had experienced depression since his injury and that he had become "withdrawn." He expressed the feeling that "withdrawing was a form of surrendering to depression," and that he was moving beyond this to a point where he "did not often feel depressed." Fred reported feeling satisfied with himself for the most part but dissatisfied about not achieving his goals. He said that he felt most positive about his willingness to "keep slugging it out" in terms of continuing to work toward his goals.

Fred reported that he felt more socially isolated than he did pre-morbidly but that this was by his own choice. He said that he felt comfortable about this because he chose not to be a "party animal" who hung around bars drinking alcohol and spending time with people who "caused problems" for him. Fred had made some new friends through the Rehabilitation Centre's schoolroom. Fred said that he and his girlfriend broke-up after his accident because she felt that "he had changed." He did report having "good support" from his family since his accident.

Since his discharge from hospital Fred had been living with his parents. He had been able to get his license back and could drive a car

and a motorcycle. He got around by walking and sometimes took buses. Fred reported that he managed to keep himself fairly busy and that he took long walks to alleviate boredom.

Fred's goals for joining the group were: to explore the common problems faced by the group members; to learn how the group members have dealt with those problems; and to bring personal struggles to the group in order to get some answers.

Len

Len was 25 years old and was injured in 1984 in a motor vehicle accident. Len and an older cousin who employed him were in a truck which was hit by another truck. Len was very close to his cousin who was killed in the accident. Since the accident occurred during working time, the Workers Compensation Board provided Len with financial support and opportunities for vocational rehabilitation. Since the accident Len had held at least two jobs. He presented with no physical or speech impairments.

Len described himself as having experienced a variety of moods -- depression, anger, frustration, and euphoria -- which he felt he did not express or show outwardly. He reported that he was capable of managing his moods and controlling his temper and attitudes. Len said that he did not want to "sit and cry about spilt milk" (i.e., the past). He reported feeling more confident about himself than he did pre-morbidly.

Len reported feeling bitterness toward most members of his family because they seemed to "look down" on him "as if something was missing." He seemed to believe that his family felt that he was less capable of

being independent since his injury and that they did not support him in his efforts to be independent. He said that he had decided to handle this by "having as little to do with family as possible because it was really none of their business what he did." Len also said that he did not want "sympathy or charity." He reported feeling uncomfortable with friends who seemed sympathetic after the accident because "they weren't that way before."

Since his discharge from hospital Len had been living in an apartment with his mother. He was able to walk, drive, and take buses. He expressed that he was satisfied with his social life and that he enjoyed "going out with friends and having a good time."

Len felt that his short-term memory sometimes presented problems but that this did not prevent him from carrying out activities socially or at work. He reported that his concentration was quite good and that he was not easily distractable.

Len's goals for joining the group were to gain more information about head injury and to meet others with head injuries.

The young men recruited for the group were fairly high functioning both physically and intellectually. The observer having no experience with head injuries would not see anything outwardly "wrong" with these young men. They all spoke quite well; appeared to be quite physically attractive; displayed a sense of humor; and behaved in socially appropriate ways. The young men each had distinctly different personalities but they were similar in other ways. They were all Canadian-born and raised in upper working class types of families. They had completed all or most of their high school educations and had been

working at jobs with which they were satisfied. The experience of head injury had affected all of their lives in significant ways. They all had hopes and plans for their futures.

During the pre-group interviews none of the young men spoke at length about any specific problems in psychosocial functioning. Each man was, however, most willing to participate in a group which was being formed for the purpose of exploring, and developing ways of coping with, problems in psychosocial functioning after head injury. The practitioner concluded that these men must have had some problems that they wanted to explore in the group. This was evidenced not only by their willingness to join the group, but also by their willingness to join a group which was the subject of a practicum report and which involved them in a lengthy process of being interviewed, completing questionnaires, and signing a formal contract. The practitioner had also learned from the pre-group interviews that none of these young men had experienced opportunities to meet and talk with other young head-injured adults. She also considered the possibility that a desire to meet others "in the same boat" was a strong factor in motivating these young men to join the group.

The formation of the group for young head-injured adults actually progressed according to the plan for the intervention described in Chapter IV. The practitioner had established the group's purpose and obtained sponsorship from the Neuro-Rehab Unit and Health Sciences Centre, Department of Social Work. Potential group members had been sought and found. The pre-group interviews gave the practitioner an opportunity to meet the potential group members and to orientate them to

the plans for conducting the group. The young men who wanted to join the group seemed to like the idea of approaching selected topic areas in each group meeting but they were made aware that the format for meetings was flexible. The potential group members seemed to take the group seriously. This was reinforced by having them complete the questionnaires on self-esteem, depression, and dependence and by having them sign a formal contract committing themselves to a twelve week group experience. The group's environment, a lounge style room belonging to the Health Sciences Centre, Department of Social Work, was booked for a twelve week period and provided with necessary equipment. The group members understood that the group was not funded and that the practitioner was conducting it as a practicum for the purpose of obtaining her M.S.W. degree.

As a result of careful planning, all of the activities necessary to form the group had been carried out. The group was ready to begin meeting and developing the group experience.

## 6.3 Development of the Group

Based on the work of Balgopal and Vassil (1983), Heap (1985), and Toseland and Rivas (1984), the practitioner saw the importance of taking a planned, systematic approach to conducting the group. The practitioner felt that this was especially important for two reasons. First, the group was time-limited to twelve sessions. There was much work to be done in a short period of time. Second, the practitioner had not been able to find any relevant literature describing how head-injured persons actually functioned in a group setting. She was not sure if or how the group members' cognitive-intellectual and

personality-emotional impairments and secondary behavioral manifestations (i.e., denial, depression, and dependence) would interfere with their active participation in the group's development.

The practitioner established a pattern of setting goals and formulating agendas for each meeting. After the first meeting, the goals and the agenda for each meeting were to be based on the outcomes of the preceding meeting. Although the practitioner was taking a leader-centered approach to conducting the group, she expected that the group members would become actively involved in shaping the goals and the agendas, content, and process of all group meetings after the first. Although the group members appeared to be fairly high-functioning intellectually, emotionally, and socially, the practitioner was very conscious of not wanting them to feel "forced" to accept full responsibility for the group's development. If she did this she feared that she might cause the group members to "feel threatened" and "shy away" from the group experience. The practitioner hoped that by indicating to the group members that she was flexible in her approach they would naturally come to play active roles in the group's development.

The practitioner expected that the group would pass through the beginning, middle, and ending phases of group development, as described in the literature. In order to illustrate how the group for young head-injured clients actually progressed through its development, the practitioner elected to provide a narrative, descriptive report of what actually occurred in each group meeting. This was based on the audiotapes and videotapes and supplemented with an analysis based on the

practitioner's log. Since this was a demonstration project it would be the first time that a practitioner had documented what actually occurred in the development of a group conducted specifically for traumatically head-injured young adults. A brief synopsis and analysis of each group meeting is contained in Appendix IV.

i) Practitioner's Assessment of the Phases of the Group's Development

As the group for traumatically head-injured young adults progressed from its inception to its termination the practitioner attempted to assess the group's development in terms of the phases through which the group passed and the functioning of the group as a whole.

The practitioner expected that the group would pass through the phases of planning, beginning, middle, and ending. These were the phases delineated in the model of group work practice proposed by Toseland and Rivas (1984, pp. 72-73). This model was discussed in Chapter III. Other proponents of group work practice models have named the phases of development differently (Toseland & Rivas, 1984, pp. 72-73). Regardless of the names assigned to the phases of group development, there has been consistent agreement in the literature that groups exhibit specific characteristics in each phase and that the phases are not constant across different groups (Toseland & Rivas, 1984, p. 73). Factors affecting the phases of a group's development include: the needs of the members; the goals of the group; the setting in which the group meets; and the orientation of the leader (Toseland & Rivas, 1984, p. 73). In assessing the functioning of the group as a whole the practitioner attended to four areas of group dynamics. These were the

group's communication and interaction patterns; attraction; social controls; and culture (Toseland & Rivas, 1984, p. 174). The practitioner used the recorded contents of each meeting and her analysis of the interaction among the members in each group meeting as the basis for her assessment of the development of the group and the functioning of the group as a whole.

The planning phase of the group for traumatically head-injured young adults was thoroughly discussed in Chapter IV and in the section of Chapter VI which described the formation of the group. In the planning phase, the practitioner considered the factors which would affect the group's development. Each member verbalized the need to meet others with similar injuries and to learn about their problems. The goals of the group were to give the members the opportunity to meet others with similar injuries in order that they might explore, and possibly develop methods of coping with, their psychosocial problems. The setting in which the group met was not imposing any demands of expectations on the group. The Health Sciences Centre Department of Social Work provided space in which the group would meet and supported the group as a demonstration project. The orientation of the practitioner who was the group's leader was the combined result of her interest in, and knowledge about, group work practice and head injury. The practitioner employed a flexible, eclectic orientation to group work practice (i.e., the ecological systems approach of Toseland and Rivas).

The practitioner's knowledge about, and experiences with, head-injured persons made her aware that the group members might have some post-injury impairments which could interfere with their

participation in a group experience. She paid particular attention to the problems that group members might have in the areas of cognitive-intellectual and personality-emotional functioning and secondary behavioral manifestations. These were discussed in detail in Chapter II. The practitioner expected that problems in these areas might influence how the members would function in the group. For example, impairments in short-term memory, concentration, and problem-solving abilities might cause the members to have difficulty in following the content of group meetings and in using the group to explore, and develop methods of coping with, their psychosocial problems. Secondary behavioral manifestations, such as depression and denial, might cause the members to find the meetings threatening if they were pressured to verbalize their feelings about their problems--especially if they were not ready to recognize their problems and to explore ways of coping with them. In the pre-group interviews the group members appeared to be superficially quite normal, but the practitioner was not able to ascertain if or how their residual impairments affected their functioning in the community (Dennis et. al., 1986, p. 3; Griffith, 1983; Long & Webb, 1983). She had access only to the subjective reports of the members which consisted entirely of the information that the members wished to disclose.

Since the practitioner had no previous knowledge about how head-injured persons actually functioned in group settings, she planned to take a highly structured, directive approach in conducting the group initially. She was prepared, however, to be flexible in terms of offering the members opportunities to shape and guide the group if

and/or when they felt comfortable about doing this. The practitioner did not plan for the fact that there would be a change in membership during the life of the group. The group began with Andrew, Bill, Jim, and Fred. Len, a new member, joined the third session, and there were five members until the sixth session when Andrew left the group.

The first meeting of the group of young head-injured men initiated the beginning phase of the group's development. The members seemed to approach the group with caution and tentativeness. The approach-avoidance conflict characteristic of the beginning phase was evident in this meeting (Toseland & Rivas, 1984, p. 142). The members seemed to want to connect with each other but were very cautious about sharing too much personal information for fear of the vulnerability that too much intimacy implies (Toseland & Rivas, 1984, p. 142). This was well exemplified by the way in which the members introduced themselves in the first meeting. Each one shared the same basic information about the nature of his accident, the treatment received, and the kind of work or educational pursuits in which he had been involved since the accident. During the first meeting the practitioner had the members focused on introductions, orientation to the group, and the goals of individual members and the group. Except for Jim, who had attended Alcoholics Anonymous, none of the members had participated in a similar type of group experience. In the first meeting, Bill displayed his tendency toward verbal rambling while Andrew mainly listened, taking a wait-and-see stance toward the other members. Fred and Jim quickly established themselves as the members most willing to share and seek information. In spite of the newness of the group situation the members

immersed themselves in conversation during the break and seemed to feel comfortable with each other -- so much so that they planned to meet for coffee before the next meeting.

The topic of the second meeting, "life after discharge from hospital," was introduced by the practitioner exposing the members to exerpts from the literature about head injury. Most of this meeting consisted of the members' sharing of relevant but safe information about activities in which they were involved. Jim risked sharing his feelings about anger, suicide, and the pity that others felt for him after his accident. He asked Bill and Andrew how they felt about these things but Bill tended to divert the discussion to his concerns rather than his feelings while Andrew remained interested but detached. Jim was absent. If he had been present he likely would have followed Fred's lead in the discussion.

All members including Len, the new member, were present for the third and fourth meetings. Since a guest speaker was the focus of the third meeting there were really no opportunities for significant interaction among the members. The fourth meeting had no set agenda. The presence of Len, the new member, seemed to set the group back in terms of re-initiating the beginning phase. The practitioner was aware that the addition of a new member would change the group by altering interpersonal relations among the original members and by providing a new stimulus and situation to which members needed to adapt (Northen, 1969, p. 104). Len dominated the discussion for most of the meeting. He was energetic and entertaining. He seemed able to focus the group on his personal interests and concerns. The other members allowed him to

do this as they seemed to be "checking him out." Jim seemed to attempt to take the group's focus away from Len by sharing his feelings about his "rotten day." The practitioner sensed that Jim felt that his position as one of the more vocal group members was challenged by Len's presence. The members verbalized their feelings about needing structure and opted to return to the agenda format for future meetings.

At the fifth meeting, Andrew told the group that he would be leaving the province next week. Bill, Jim, and Fred expressed interest in his future plan and expressed regret at his departure. They expressed a desire to correspond with Andrew who also felt that this was a good idea. The group began to discuss the topic of "family and friends." Although each member spoke to the group as a whole it appeared that each was most interested in speaking about himself. Only Fred tried to elicit feedback from the others by asking them to respond to his comments. Andrew remained quiet, probably because it was his last meeting. Len dominated the discussion with his description of how his family and friends treated him. Bill tended to ramble off topic and Jim had to be drawn into the discussion by the practitioner who found it increasingly difficult to keep the group on track. The practitioner recognized that the group was still in the beginning phase of development.

The sixth meeting began with the members focusing on Len's absence rather than on the previously agreed upon topic of "work." The group members had gone off track in this meeting and the practitioner, not realizing what was happening, had gone right along with them. The practitioner learned some things about the group's functioning from this

meeting. She learned that the members' behavior in the group was very much influenced by her own concerns about the rules for conducting the group and the terms of the contract signed by the members. The members saw the practitioner as the "boss" in the group although they verbalized that they felt that any one of them could take the lead in the group whenever they felt like doing so. During this meeting it was Bill who tried to bring harmony to the meeting as he defended Len, the absent member.

It was not until the seventh meeting that the practitioner sensed that the members were actually becoming involved in the group. Communication among the members was stimulated by having them do an exercise which they enjoyed. Fred and Len did a lot of sharing of feelings about their situations with regard to "work." Len talked about the impact that his cousin's death had on him and about his behavior as a "bad boy" while he was growing up. Len seemed to be "exploring" to see how the others would react to the information he shared while Bill and Fred seemed to be "silent critics as supporters" in response (Balgopal & Vassil, 1983, p. 201). Jim was not present. Bill, Fred, and Len seemed relaxed at the end of this meeting and eager to continue this discussion at the next meeting with Jim present. During the eighth meeting the members actually seemed to be communicating with each other and responding to what others were saying. Jim was able to curtail Bill's rambling in a firm but inoffensive way. The beginning of some conflict between Jim and Len was evident when Jim misinterpreted something Len said. Jim seemed to be attacking Len verbally and the practitioner mediated by clarifying for Jim what Len had said.

Afterward, she felt that she should not have intervened but she was not sure how Jim and Len would have handled the disagreement. She was concerned that neither she nor the other members could handle a flare of violent tempers in the group. The members began to express a lot of angry feelings about their situations at the end of this meeting. The group members agreed to discuss "anger" at the next meeting if the guest speaker they wanted was not available. The practitioner reminded the members that the group had only four meetings left but no one expressed any concerns about work that had not been done in the group or about ending the group.

Discussions about "anger" and the members' angry feelings premeated the ninth, tenth, and eleventh meetings. Anger with regard to health care professionals, family and friends, and work situations was the primary focus of these meetings. The members were so involved in discussing anger that the guest could not complete her presentation on relaxation in the ninth session. Jim asked the others if they were a hostile group and Fred wondered how long it would take the members to rid themselves of angry feelings. During the tenth meeting Jim discussed his personal problems around his home and financial situations with the group. The others listened supportively but the discussion soon focused on ways of expressing and releasing anger. The members talked about their recoveries and about their pre-morbid personalities in response to Jim's question, "why are we so angry?" The practitioner sensed that the group was finally beginning to move into the middle phase of development. The members communicated more openly with each other and began to explore why they were the way they were. It appeared

that they were really beginning to explore their anger as a problem and the ways that they had handled it in the past and could cope with it in the future. The members finally seemed secure enough with each other to begin actually working on a problem in an atmosphere of mutual support.

In the eleventh meeting, Jim, Fred, and Len listened supportively to Bill as he spoke about losing his job. They even offered their suggestions as to how he might contest his employer's decision or seek other employment. The discussion soon returned to the topic of "anger." Jim again took the lead in trying to get the others to talk about the reasons for their anger. He encouraged them to explore their pre-morbid as well as their present personalities. The practitioner sensed that Jim was becoming the leader of the group in terms of encouraging members to work on the task of exploring, and possibly developing ways of coping with their problems. Although the members were still "scratching the surface" in terms of their problems, the practitioner sensed that they had developed ways of relating to each other which were the bases of deepening interpersonal relationships which would lead to greater cohesion among them. Clearly, the members were finally reaching a point where they were ready to work on the concerns, issues, and problems confronting them. According to the model of Toseland and Rivas (1984, p. 74), the group of head-injured young men was manifesting the characteristics indicative of entering the middle phase of group development.

If the group had been of longer duration, it might have progressed further into the middle phase of development. According to Balgopal and Vassil (1983, p. 202), the members might have used a variety of skill

sets and assumed various roles in response to the decisions and choices they faced in terms of conflicting issues within the group. Such issues include: "foresight or spontaneity; dependability or uncertainty; peace or conflict; dependence or interdependence; and me (the member) or them (the group)" (Balgopal & Vassil, 1983, p. 202). The skill sets used and the roles assumed depend upon the capacities of the individual members. As the middle phase progressed, the members might have come to realize that these ever-present conflicts are resolved through struggle and intelligent choices. The members might also have come to realize that they were in charge of their own lives and that they could seek the type of help and guidance that they needed from each other, rather than from the practitioner who was the group's leader (Balgopal & Vassil, 1983, pp. 202-203). The middle phase of group development is characterized by a high exchange between and among members in terms of thoughts, feelings, ideas, and skills (i.e., mutual aid) (Balgopal & Vassil, 1983, p. 203). Had this occurred in the practicum group, the members might have developed a flexible group system in which members were respectful, assertive, supportive, and interdependent as they experienced both conflict and cohesion while they explored their problems and possibly developed ways of coping with them (Balgopal & Vassil, 1983, pp. 205-206).

The practitioner also considered that the group of young head-injured men might have continued indefinitely and still never have developed further. This might have occurred for several reasons. First, further development might not have been necessary in order for the group to achieve its purpose (Douglas, 1978, p. 39). The group

members might have felt that meeting with others with similar problems and discussing concerns of mutual interest were the only requirements necessary for the achievement of the group's purpose. Second, the group might not have had the potential to develop further (Douglas, 1978, p. 39). The members' head injuries might have caused them to experience problems in one or more of the areas of cognitive-intellectual functioning; personality-emotional functioning; and secondary behavioral manifestations. Problems in one or more of these areas might have prevented each member from participating fully in the group experience. The practitioner's approach to conducting the group might have also contributed to the group's inability to develop further. Either one or both of these factors could have severely limited the group's potential to develop further. Third, the group might not have developed more completely because some areas of group behavior develop more quickly and soundly than others (Douglas, 1978, p. 39). It is likely that the young head-injured group members quickly developed a sense of being "in the same boat." Although this might have generated some emotional warmth among the members, it is possible that they never really understood each other as people. When the group began to explore issues which were highly personal and sensitive, some or all of the members might have become uncomfortable. They might have felt unable to cope with the pressure or stress created by disclosing their innermost feelings to others who were virtually strangers. It was therefore safer to skirt issues such as "why are we so angry?" or "what kind of people were we before our accidents?" Skirting stressful issues, diverting the discussion away from stressful issues, or repeating particular

individual concerns were methods that members could use to avoid sharing their innermost feelings with others. By not sharing these feelings the members did not have to risk facing the unknown, and possibly unpleasant, reactions of others. The members could, however, still use the group as an outlet for the expression of their frustrations with their situations. This could have caused the practicum group to remain a gathering of individuals which did not progress into a cohesive, working unit.

Since the group did not continue beyond twelve weeks, the practitioner could never know whether or not it would have progressed further into the middle phase of development. The group had been "stuck" in the beginning phase for a long time. It seemed to be making some progress in its development when the ending phase occurred. The ending of the group was no surprise to the members. It had been built into the contract between the members and the practitioner. The practitioner had also begun to prepare the group for its ending mid-way through the group's life. The members were also reminded that they could contract with the practitioner to extend the duration of the group if they wished to continue the group's work. During the twelfth meeting the members reviewed and discussed exerpts from the videotapes of the past meetings. They talked about the value of the group in terms of allowing them to meet each other and discover that they had similar injuries, experiences, and feelings. Except for Bill, who suggested that the group continue to meet once per month, no one opted to continue the group. The members did not seem to experience denial, ambivalence, or feelings of loss and mourning as the group moved toward its ending,

although these are themes which are often evident in the ending phase of groups (Balgopal & Vassil, 1983, pp. 209-210). Instead, the members approached the ending of the group with a review of positive experiences and planning of a final dinner party which would be a memorialization, or symbolic ending, of the group (Balgopal & Vassil, 1983, pp. 210-211).

#### ii) Practitioner's Assessment of the Dynamics of the Group's Functioning

The practitioner completed her assessment of the development of the group for young head-injured persons by making some observations about the dynamics of the group's functioning. The four types of group dynamics examined were: communications and interaction patterns; the attraction of the group for its members; social controls such as norms, roles, and status; and the group's culture (Toseland & Rivas, 1984, p. 75). The practitioner's observations were based on her review of the group's videotapes and her own log.

"Communication and interaction patterns are basic to the formation of all groups. Through communication and interaction, properties of the group as a whole develop and the work of the group is accomplished" (Toseland & Rivas, 1984, p. 75). During the first few meetings, each member seemed to direct his communications to the practitioner. As the group progressed, the members seemed to be communicating more with each other on both the verbal and non-verbal levels. The members, however, seemed to have difficulty in using verbal communication as a means of exploring, and possibly developing ways of coping with, their problems. It often seemed that although all members were communicating in the group they really were not hearing and responding to what each other was

saying. As the practitioner reviewed the group's videotapes, she noticed that neither she nor the members had developed a system of providing feedback about communications within the group. "Feedback is a way of checking to ensure that the meanings of the messages that are communicated are understood correctly" (Toseland & Rivas, 1984, p. 59). Instead of developing a feedback system, the group seemed to be concentrating on simply giving members opportunities to express their individual feelings and concerns. The group might have developed into a more cohesive, working unit had feedback techniques been attended to early in the group's life.

The interaction pattern in the group appeared to change from a round-robin pattern to a free-floating pattern as the group continued to meet. This meant that rather than each member taking a turn at talking, all members were taking some responsibility for what was being said or not said in the group (Toseland & Rivas, 1984, pp. 59-60). A group-centered interaction pattern (i.e., free-floating) had some positive effects in terms of increasing social interaction and morale within the group. This type of interaction pattern was not always efficient in the practicum group because the communications of some members, especially Bill and Len, were often superfluous or extraneous to the group's tasks (Toseland & Rivas, 1984, p. 60). The group might have better sorted out useful communications had the practitioner promoted more use of leader-centered interaction patterns (Toseland & Rivas, 1984, p. 60).

The available literature suggested that the practitioner might have changed the group's interaction pattern by being more aware of, and

modifying, such factors as cues and reinforcers; emotional bonds; subgroups; size and physical arrangement of the group; and power and status (Toseland & Rivas, 1984, pp. 60-64). As the practitioner reviewed the group's videotapes, she saw that she had not taken advantage of opportunities to control some of these factors in order to improve communication and interaction within the group. She also realized that she had no control over some of these factors because of the group's type and size. The practitioner and the members did not mutually decide how the group could use verbal and non-verbal behaviors to facilitate modifications in established interaction patterns (Toseland & Rivas, 1984, p. 60). The practitioner did not encourage the members to explore the positive and negative emotional bonds among them that could increase or decrease interpersonal attraction in the group (Toseland & Rivas, 1984, p. 60). It appeared that the main positive emotional bond among all of the group members was based on the similarity of their circumstances resulting from head injury.

The presence of subgroups was not clearly evident in the practicum group. Had the size of the group been larger the possibilities for potential relationships among the members likely would have increased dramatically (Toseland & Rivas, 1984, p. 62). The practitioner did try to encourage communication and interaction among the group members by means of the circular physical arrangement of seating. This is the arrangement most often used in treatment groups and most often enjoyed by the members of such groups (Toseland & Rivas, 1984, p. 62). Had the practitioner realized that the circular physical arrangement often contributed to a group becoming leaderless, unorganized, and erratic she

might have imposed a more leader-centered physical arrangement in the group (Toseland & Rivas, 1984, p. 62). The members' relative power and status also affect communication and interaction patterns within a group (Toseland & Rivas, 1984, p. 64). Fred and Jim seemed to obtain the most power and status in the practicum group because they worked the hardest in terms of trying to facilitate the group to accomplish its purpose. Fred, especially, actively tried to facilitate communication among the group members by sharing and seeking opinions, ideas, and feelings. Jim was doing more of this in the group's last few meetings. He repeatedly asked the other members why they were so angry and implored them to find answers to this question by exploring their pre-morbid personalities. It is likely that the other members might have begun to direct their communications more to Fred and/or Jim had the group continued to meet and develop (Toseland & Rivas, 1984, p. 64).

The group dynamic of attraction or cohesion is the result of all forces acting on members to remain in a group. Groups that are attractive generally satisfy the needs which promoted members to join the group and provide incentives for group membership (Toseland & Rivas, 1984, p. 65). The attraction that the practicum group held for its members seemed to result from three factors. First, the members all had similar experiences with head injury and recovery. Second, the members had all joined the group primarily to meet others in similar situations in order to help each other and themselves. Third, the members saw the group as a beneficial experience and, possibly, as a means of meeting potential friends. The fact that the members were attracted to the group for these reasons seemed to contribute to the members relating to

each other on a personal level and often engaging in conversations not focused on the group's tasks and purpose (Toseland & Rivas, 1984, p. 65). The group did display some attraction or cohesion as evidenced by several factors. The members attended most of the meetings in spite of miserable winter weather. The members persevered in their efforts to benefit from the group and did not leave the group even though each meeting's discussion seemed to be a repetition of the preceding one. The existence of some group attraction or cohesion was further evidenced by the members' willingness to meet for coffee before most group meetings and to share transportation and companionship on the way home from the group. Much of the group's attraction for the members might have resulted from the fact that, except for Jim, none of them had experience with other groups to which they could compare this group (Toseland & Rivas, 1984, p. 65).

The group dynamic of social control involves "the processes by which the group as a whole gains sufficient compliance and conformity from its members to enable it to function in an orderly manner" (Toseland & Rivas, 1984, p. 67). Social control is exerted through the norms, roles, and status that develop in a group. Norms are shared expectations resulting from what is valued, preferred, and accepted behavior in a group (Toseland & Rivas, 1984, p. 67). As the practicum group progressed, all members shared in the development of its norms. The norms also seemed to be influenced by the practitioner's plan for conducting the group and the contract that each member had made with the practitioner. Over time the group established some norms which promoted the group's development. Such norms included attending meetings on

time, attending as many meetings as possible, and members respecting each other's right to express himself. The group also developed some norms which impeded the group's development by hindering effective communication and interaction in the group. Members tended not to interrupt others who were diverting the discussion either intentionally or not intentionally. Both the practitioner and the members avoided giving each other feedback about communications within the group. The group tended to divert discussions away from issues that might be painful or sensitive. As the group progressed, Fred and Jim seemed to try actively to intervene to alter these norms and improve the group's communication and interaction patterns. For the major part of the group's life, the members adhered to the norm of regarding the practitioner as the ultimate authority in the group and as the person responsible for the group's development and functioning. This seemed to impede the occurrence of natural conflicts in the group which could have promoted it to develop fully and accomplish its purpose. The members' reluctance or inability to effectively assume some of the practitioner's leadership functions contributed to her feeling of being overwhelmed by trying to simultaneously observe the group, assess its development and functioning, and guide it in its work.

A second means of exerting social control in groups is the development of roles. These are shared expectations about the functions of individuals in the group (Toseland & Rivas, 1984, p. 68). The practitioner observed that members assumed various roles in the group throughout its life. She assessed these roles in terms of the task, group building and maintenance, and individual functions described by

Dimock (1970, pp. 28-30). All of the members performed the task functions of seeking information and giving opinions. Bill and Len mainly gave opinions. All of the members performed the group building and maintenance function of following the movement of the group (i.e., accepting the ideas of others and serving as an audience). Bill seemed to be the member who performed a mediating-harmonizing function in the group in terms of his efforts to keep the group on a pleasant note when conflict seemed evident. Bill might have done this out of concern for individual members and/or the group as a whole. He also might have done this because of his own feelings of discomfort with, and fears about, conflict in the group. Fred and Jim performed the orienting-facilitating and co-ordinating functions more than any other group members. It did not appear that any members generally performed the supporting-encouraging function in the group in terms of reacting to the ideas and suggestions of others with approval, praise, or warmth and responsiveness. The other members did offer some emotional support when Jim and Bill shared their personal problems in the group. Bill often performed the individual functions of being out of field (i.e., withdrawing from the discussion by tuning out) or digressing (i.e., getting away from the discussion topic by rambling verbally). Len also performed the individual functions of digressing and seeking recognition. The performance of these individual functions often hindered the development of the group by impeding effective comunication and interaction.

Social controls are also exerted through members' status in a group. Status "refers to an evaluation and ranking of each member's

position in the group relative to all other members" (Toseland & Rivas, 1984,p. 68). The method used to rank status varies from group to group. The practitioner elected to rank the status of each member in the practicum group in terms of how status affected social control. That is, status was determined by how a person acted once he or she became a member of a group (Toseland & Rivas, 1984, p. 68). According to this method of determining status, Len appeared to be the low-status member who conformed least to group norms since he had little to lose by deviating. Bill seemed to be the medium-status member who conformed to group norms possibly in the hope of gaining a higher status. Fred and Jim, respectively, appeared to be the high-status members who conformed to group norms and performed, as best they could, valued services for the group in terms of facilitating communication and trying to get the group to accomplish its purpose.

Culture is the group dynamic that develops as a group evolves. A group's culture "is derived from the environment in which it functions as well as from the beliefs, customs, and values shared by its members" (Toseland & Rivas, 1984, p. 75). Due to the problems with the communication and interaction patterns within the practicum group the members never really seized opportunities to share and understand each other's value systems. In the practitioner's assessment, the practicum group exhibited what Balgopal and Vassil (1983, p. 189) referred to as a dependent culture. As she reviewed the group's videotapes, she observed the characteristics of this dependent culture. Several of these characteristics were very obvious in the practicum group. The group members' decisions never appeared to be final until the practitioner

approved them. When members disagreed, the practitioner intervened to settle the argument. The members seemed to prefer to abide by the practitioner's rules rather than to questions them. This type of group culture appeared to interfere with the development of the group and its ability to accomplish its purpose. Had the group continued to meet, it is possible that the practitioner and the members might have seen that this culture was impeding the group's development and ability to work and they might have actively tried to promote a culture that facilitated the achievement of group and individual goals.

The practitioner had expected that the practicum group would not pass through a middle phase of development because of the group members' impairments in cognitive-intellectual and personality-emotional functioning and their secondary behavioral manifestations. She was of the opinion that the members' problems in these areas, which resulted from head injury, would adversely affect the group's dynamics and hence, its functioning and development. As a result of her assessment she concluded that this may not have been the case. Had the practitioner not planned the group's work so rigidly and had she had more time and energy, as well as a co-leader, she might have been able to discuss the group's dynamics with the members. Doing this might have promoted the members' use of the group's dynamics as a means to develop the group into a cohesive unit in which individual member's goals and the group's purpose were achieved. Since interventions which could alter the group's functioning and development were never utilized in the group, the practitioner could only speculate about what caused the group's incomplete development and problems in functioning. The fact that the

group never seemed to get into its work in a meaningful way might have resulted from the residual effects of head injury which impeded the members' abilities to participate fully in the group; the members' lack of knowledge about group dynamics and how to use them; the members' expectations of the group experience; or a combination of some or all of these factors.

The practicum group did not progress completely through all of the phases of group development for a number of possible reasons which have been discussed. This does not mean that the group for young head-injured adults accomplished nothing during its life, nor does it mean that group work practice is of no value to traumatically head-injured young adults in the community. In order to truly assess the value of this form of intervention it is necessary to examine the outcomes of the group in terms of the results yielded by the evaluation instruments used in addition to the group's audiotapes and videotapes and the practitioner's log. This will be done in the remainder of this chapter.

## 6.4 Outcomes of the Group Experience

In order to examine the outcomes of the group experience, and achieve the objectives of this practicum, the practitioner used several evaluation instruments in addition to the group's audiotapes and videotapes and her own log. These instruments were: three standardized supplementary measures (i.e., the ISE, the GCS, and the IPPH); the group members' written mid-group evaluations; and the group members' final verbal evaluations.

i) Supplementary Evaluation Instruments

The practitioner included in this practicum an exploration of the hypothesis that the group members experienced one or more of the salient psychosocial problems ascribed to head-injured individuals in the relevant literature. These problems occurred in the areas of self-esteem, depression, and dependence. The practitioner also wanted to gain some experience with the ways that head-injured persons would respond to the use of standardized evaluation instruments. The supplementary evaluation instruments, and their administration, were discussed in detail in Chapter V. The practitioner knew that the ways in which she used these instruments would cause the resulting data to be unreliable and invalid. She hoped, however, that the resulting data would give some indication of the magnitude of the group members' problems in the three areas.

The practitioner had intended to administer the questionnaires to each group member before the group began, mid-way through the group's life, and several weeks after the group ended. Since Andrew left the group in the middle of its duration, he completed only two sets of questionnaires. Since Len actually decided to join the group almost in the middle of its duration, he also completed only two sets of questionnaires. Jim was issued two sets of mid-group questionnaires, both of which he lost. Jim, therefore, completed only two sets of questionnaires. Only Bill and Fred completed all three sets of questionnaires. The ISE and the GCS questionnaires were scored and the results were summarized in table format to allow for quick and clear comparison. The IPPH was not really a standardized measure but rather a

measure formulated by the practitioner. The members' response ratings on the IPPH were "eyeballed" and yielded results which could be stated in the form of comments rather than numerical scores.

| | Pre-Group ISE | Mid-Group ISE | Post-Group ISE |
|---|---|---|---|
| Andrew | 32 | 17 | 0 |
| Bill | 31 | 29 | 27 |
| Jim | 26 | 0 | 21 |
| Fred | 14 | 22 | 16 |
| Len | 0 | 18 | 17 |

Table 6.1

| | Pre-Group GCS | Mid-Group GCS | Post-Group GCS |
|---|---|---|---|
| Andrew | 14 | 12 | 0 |
| Bill | 23 | 25 | 39 |
| Jim | 21 | 0 | 19 |
| Fred | 33 | 35 | 22 |
| Len | 0 | 26 | 30 |

Table 6.2

As the practitioner reviewed the group members' scores on the ISE and the GCS she reflected on some of the information that the members had disclosed about themselves as individuals. The practitioner had not administered the ISE and the GCS in such a way as to obtain data which

would indicate the possibility that the group experience, as an intervention, affected the magnitude of the members' problems in the areas of self-esteem and depression. She was, however, able to make some conjectures about how the changes in the members' ISE and GCS scores may have related to some changes in events in their personal lives which were disclosed in the group.

The "clinical cutting score" for the ISE and the GCS was 30 (Bloom & Fischer, 1982, p. 151). Scores over 30 were regarded as probably deserving of intervention in order to reduce the megnitude of problems in the areas of self-esteem and depression (Bloom & Fischer, 1982, p. 151). The group members' scores on the ISE are depicted in Table 6.1. The scores on the ISE indicated that Andrew and Bill might have experienced some problems with self-esteem which might have decreased as a result of their involvement in the group and/or changes in their personal lives. Andrew's pre-group ISE score was 32 while his mid-group score was 17. It is possible that his ISE score decreased mid-way through the group because he was feeling good about leaving Manitoba to return to British Columbia where he felt that he would have more and better opportunities for further rehabilitation. Bill scored 31 on the pre-group ISE, 29 on the mid-group ISE, and 27 on the post-group ISE. It is possible that the magnitude of his problems with self-esteem decreased because of his participation in the group and/or because of the strength of his supports in the community. Throughout the group's life, Bill had concerns about keeping his job which he eventually lost. In spite of this, he reported having excellent support from his girlfriend, his family, his psychologist, and his vocational

rehabilitation counsellor while he was going through his difficult experience. It actually appeared that the support he got from people outside of the group was stronger than that which he got from his fellow group members. The pre-group, mid-group, and post-group scores on the ISE obtained by Jim, Fred, and Len indicated the absence of serious problems in the area of self-esteem.

Table 6.2 depicts the group members' scores on the pre-group, mid-group, and post-group GCS. The GCS scores of Andrew and Jim indicated the absence of serious problems in the area of depression that is a reaction to a situation. It was interesting to see that Bill's scores on the GCS moved from 23 (pre-group) to 25 (mid-group) to 39 (post-group). Bill had lost his job between the times of the administration of the mid-group and post-group GCS and he had not found other gainful employment. His comments in the group meetings clearly indicated that having a job and doing it well were extremely important to his satisfaction with his life. Bill's involvement in the group could not help him to get his job back or to get any other job. It is therefore likely that his experience in the group could not decrease the magnitude of his problems with depression. Fred's GCS scores also indicated problems in the area of depression. His GCS scores were 33 (pre-group), 35 (mid-group), and 22 (post-group). The changes in Fred's scores over time might have been related to the difficulties he reported experiencing with his attempts to return to his former job or to succeed in high school courses which could get him into university. By the time he took the post-group GCS he expressed less dissatisfaction with his inability to get his job back and with his memory problems which

interfered with his studies. Fred actually reported that he would be participating in a vocational assessment through the S.M.D. and this seemed to make him more optimistic about his future. In Fred's case problems with depression seemed to be related to vocational and educational problems which could not be affected by his participation in the practicum group. Len's scores on the GCS were also indicative of some problems in the area of depression. His mid-group GCS score was 26 and his post-group GCS score was 30. Len had also reported problems in his job situation. Between the administration of the mid-group and post-group GCS his reports of problems in his job and with the Workers Compensation Board (W.C.B.) were increasing. Len reported that he had gotten into trouble at work and lost his job some time between the administration of the mid-group and post-group GCS. He also reported that the loss of his job was the reason that the W.C.B. was giving him a "hard time" and not wanting to pay his benefits. Again, he had problems in the area of vocation which might have contributed to some depression which could not be alleviated by his participation in the practicum group.

Although they were interesting possibilities, the practitioner's conjectures about the reasons for changes in some of the group members' ISE and GCS scores were still her own opinions which were not supported by meaningful data. The practitioner was forced to conclude that the group members' scores on the ISE and the GCS were really of no value for two reasons. First, she did not administer the measures according to the recommendations made by the creators of the measures. Second, she was not sure if the group members had problems in cognitive-intellectual

functioning which might have interfered with their interpretation of the items on the ISE and the GCS. The data resulting from these measures was, therefore, neither reliable nor valid and did not yield even correlative indications that the group experience, as a form of intervention, in any way influenced these scores.

The practitioner did gain some knowledge from administering the ISE and the GCS to the members of the practicum group. The young head-injured men were able to complete the questionnaires and expressed no complaints about doing them. It is likely that, had there been sufficient time, the practitioner could have repeatedly administered the questionnaires to the members. This might have yielded a baseline and enough scores to indicate if the group experience had any causative or correlative relationship to changes in the members ISE and GCS scores. The practitioner did find that the members' had some problems interpreting several of the questionnaire items. For example, all of the members had difficulty with the meaning of the word "downtrodden" in item seventeen of the GCS. They also needed clarification of item twenty, "I feel that I don't deserve to have a good time," on the GCS. All of the members found items one and seventeen on the ISE confusing. Item one was "I feel that people would not like me if they really knew me well." Item seventeen was "I feel that if I could be more like other people I would have it made." Although no valid or reliable conclusions could be drawn from the ISE and the GCS as used in the practicum it appears that these are evaluation instruments which could be used with young head-injured people who are intellectually similar to the members of this practicum group.

Measures 6.1, 6.2, 6.3, 6.4 and 6.5 (see Appendix III) depict the group members ratings on the IPPH. The IPPH presented problems in interpretation because it was a "home-made" measure. The practitioner could only "eyeball" the group members' numerical ratings on the IPPH. This visual comparison of the members' pre-group, mid-group, and post-group IPPH ratings led the practitioner to conclude that all of the group members saw themselves as not being highly dependent on other people. The members' IPPH ratings were subjective and indicated that these men did not depend highly on other people to assist them with activities of daily living; provide opportunities for socialization; and assist them in dealing with personal problems and feelings, such as anger. The practitioner also recognized the possibility that the group members rated themselves as they did because they were trying to impress the practitioner and/or deny the existence of dependence in their lives.

The practitioner also had no way of knowing how the members' friends, relatives, co-workers, or professional counsellors and therapists would have rated the men on these same items. The practitioner concluded that her measure yielded only information about the members' perceptions of their levels of dependence but no information about the perceptions of others involved with the members. The practitioner therefore concluded that the IPPH did not add another dimension of information to the practicum. This type of measure may provide more meaningful information if responded to by both subjects and observers involved with them.

The use of the supplementary evaluation instruments indicated that only some of the members of the practicum group manifested possible

problems in the areas of self-esteem and depression and that none of the members manifested problems in the area of dependence. The evaluation instruments were not the source of valid and reliable data. The practitioner therefore concluded that the results of the supplementary measures neither supported nor refuted the hypothesis that the members of the practicum group would experience one or more of the salient psychosocial problems of head-injured persons (i.e., problems with self-esteem, depression, and dependence) discussed in the current literature. She also concluded that these supplementary evaluation instruments could be administered to head-injured persons with an intelligence measure of no less than 70. She further concluded that, if used properly, such standardized evaluation instruments might shed more light on the effects of individual or group interventions designed to help this client population to explore, and possibly develop methods of coping with, their psychosocial problems.

ii) Members' Written Mid-Group Evaluations

Mid-way through the group experience the practitioner asked the members to evaluate the group experience. She devised an evaluation which gave the members opportunities to respond to "yes/no" questions and to make comments about how the group experience could be improved. Andrew did not return his evaluation. Jim lost his first evaluation and completed a second one which he also lost. Fred, Bill, and Len completed their evaluations and returned them to the practitioner. Their responses are summarized, for the purpose of comparison, in Measure 6.6 (see Appendix III).

The three group members who completed the mid-group evaluation did

make some comments that the practitioner found valuable. The members' comments seemed to fall in line with the way that each young man presented himself in the group. Fred seemed to be generally satisfied with the group. He did make a good suggestion about having the members write a list of possible agenda topics.

Bill wrote a comment in response to each item on the evaluation. His written comments, like many of his verbalizations, tended to ramble. Although Bill did not express himself well in writing, he did get his points across. He apparently was torn between liking and disliking what he heard in the group (i.e., expressions of the feelings of the other members). Bill felt that the practitioner should have guided the discussion into areas that the members were not discussing. Bill did not feel that the members were giving support to each other because some members were concentrating on expressing negative thoughts without waiting for more information about the matters being discussed.

Len's comments on the evaluation indicated that he seemed generally satisfied in the group. He did note that the group often got off topic. Len felt that the group members gave support to each other only in certain specific instances. He also made a good point about the group not having any female members, as this factor likely influenced the group's functioning.

The results of the written mid-group evaluation indicated to the practitioner that the members knew that the major problem in the group was that the discussion often went off topic. During meetings, however, only Jim and Fred made any active efforts to correct this problem. After reviewing these results, the practitioner came to feel that the

group might have functioned more effectively if the group members had been asked to make the agendas for the meetings rather than to work with the pre-planned agenda topics she provided. The practitioner sensed that had this been done, the members might have brought more personal problems and issues to the group and that this might have resulted in more meaningful, productive discussions and interactions among them. Instead the members seemed to be grappling with the discussion of topics which were too abstract and global. Nevertheless, the three members who completed the evaluations seemed to be generally satisfied with the group experience.

iii) Members' Final Verbal Evaluations

Several weeks after the group's ending the practitioner met with each member individually. At that time, each member was given an opportunity to respond again to items from the mid-group evaluations and to share personal feelings, ideas, and opinions about the group. The practitioner reviewed the videotapes of these evaluations and summarized the comments of each group member (see Appendix V).

This evaluation seemed to be the most useful in terms of describing the outcomes of the group experience for each member. It appeared that the members mainly enjoyed the group because it provided opportunities to meet and speak with others "in the same boat" (i.e., sharing the experience of being head-injured). All of the members expressed recognition of the group's difficulty in sticking to topics and that some topics were "over-discussed." All of the group members expressed that they could have asserted themselves more in terms of taking control and guiding the discussions. Members indicated that they did not do

this for various reasons, especially for reasons such as "it was rude to interrupt" or "the group was not the place to put people 'on the spot'." All of the members seemed to recognize that they had the freedom to have control over the topics discussed in the group and that they chose not to take too much advantage of this. All of the members felt that the group did offer some support to those who brought their personal problems to the group but that this did not happen often. Bill, Jim, and Len all described Fred as the group member with whom they would like to continue a friendly relationship. No ongoing friendships among the members did result from the group experience. The group members agreed that some closeness or emotional bond existed among them during the group's life and that the bond created was sufficient for this type of group.

The members expressed that there were many things that could have been discussed in the group that were not discussed. All of the members agreed that the group experience might have been more productive if the group had been larger; if there had been some female members; and if the practitioner had been assisted by a co-leader. The members also liked the use of guest speakers. All of the members felt that they were ready to end the group in the twelfth week but that they would participate in a similar type of group experience if it was available in the future. There seemed to be a feeling among the members that, if this group had continued, it might have developed into a more cohesive, working unit and accomplished more in terms of meeting their needs.

The members were able to provide realistic, honest evaluations of the outcomes of the group for them. These evaluations were most useful

in contributing to the assessment of the value of group work practice in this practicum.

## 6.5 Assessment of the Value of Group Work Practice in this Practicum

Based on her knowledge about head injury and group work practice the practitioner carefully planned a group experience for a small group of traumatically head-injured young adults. She expected that her careful planning and systematic evaluation methods would lead her to conclude that group work practice would serve a remedial type of treatment function in terms of helping the group members to explore, and possibly develop methods of coping with, their psychosocial problems. The practitioner used her own analytical skills and a variety of evaluation instruments in her efforts to assess the value of group work practice in the case of her small group.

The practitioner's use of standardized, supplementary evaluation instruments (i.e., ISE, GCS, and IPPH) did not contribute meaningful data to the assessment of the value of group work practice in the case of the practicum group. The evaluation instruments which contributed the most valuable information to this assessment were the videotapes of the group's meetings; the members' written mid-group evaluations; and the members' final verbal evaluations. The information obtained from the use of these instruments indicated that the value of group work practice in this practicum did not lie in the outcome of the group members exploring, and developing methods of coping with, their psychosocial problems. Rather, the value of group work practice did lie in the opportunities it gave to head-injured individuals in a small group to meet others "in the same boat;" learn about their similarities

and differences; obtain some information about head injury; express their feelings and ideas; and release their frustrations with their situations. These outcomes were in line with those described in the literature dealing with past attempts at group work practice (Delahooke-Democker & Zimpfer, 1981, pp. 254-257; Philipp, 1981, p. 437; Ben-Yishay & Diller, 1983).

Although the practitioner had expected that the practicum group would perform some remedial type of treatment functions in terms of helping the members to explore their psychosocial problems, and possibly develop methods of coping with them, the group never developed to the point where it could accomplish this. Nevertheless, the group experience was not wasted. In addition to yielding some outcomes which were of value to the members, the group experience was of value as a demonstration project. In that it was a demonstration project, the use of group work practice with the small group of head-injured men yielded another outcome in the form of the questions it raised. First, was the fact that the group did not develop into a cohesive, working unit due to the problems experienced by the members in cognitive-intellectual and personality-emotional functioning and the presence of secondary behavioral disturbances? It is possible that the group did not develop fully because of the group members' problems and/or because the members did not have enough previous experiences with groups, or guidance from the practitioner, to know what was expected from them in the practicum group. Second, was the fact that the group did not develop into a cohesive working unit due to a shortage in the number of members and/or a lack of heterogeneity in the group resulting from these being no

female members? Third, was the fact that the group did not develop into a cohesive working unit due to the practitioner's inactivity in terms of using appropriate interventions to facilitate better communication and interaction patterns in the group; short duration of the group; or some combination of both factors? These questions could only be answered by further research in this area.

The value of group work practice in this practicum was therefore evident in the opportunities it afforded to the members to meet and interact with others "in the same boat;" to give and receive information and support; and to experience emotional catharsis through expression of ideas, feelings, and frustrations. The value of group work practice in this practicum was further evident in its value as a demonstration project which raised questions to stimulate further research in this area.

# CHAPTER VII

# CONCLUSION OF THE PRACTICUM

## 7.1 Summary of Findings

The practitioner found that some young head-injured adults living in the community were willing to participate in a small group experience. This group experience was designed to give this client population an opportunity to explore, and possibly develop ways in coping with, their psychosocial problems. Five young head-injured men committed themselves to participate in the practicum group. These men all had intelligence measures of 70 or greater, as assessed by neuropsychological testing, and they were all physically independent. With the co-operation of these young men the practitioner was able to employ this methodology:

1. Forming and facilitating a small group of traumatically head-injured young adults between the ages of 17 and 39 for a duration of twelve weeks.

2. Producing audio and video tapes of group sessions along with a log of the practitioner's observations and impressions of individual and group development.

3. Comparing pre-group, mid-group, and post-group measures of the megnitude of problems in self-esteem, depression, and dependence for each group member.

4. Analyzing findings from group members' mid-group and post-group evaluations.

The data resulting from this methodology enabled the practitioner to

conclude whether or not she had achieved the aims of using group work practice as an intervention in this practicum.

### i) First Aim of the Intervention

The practitioner had been able to achieve the aim of describing the formation, development, and evaluation of the small group for traumatically head-injured young adults as a demonstration project. The formation and evaluation of the group were conducted systematically and methodologically, according to the practitioner's plans. The group, however, did not pass through all of the phases of development as described by Toseland and Rivas (1984). The group passed through the planning phase and into the beginning phase, in which it seemed "stuck" for most of its duration. The group appeared to be only moving into the middle phase of development when it was nearing its ending.

#### (a) The Group's Incomplete Development: Speculations and Conclusions

Based on the knowledge about head injury and group work practice discussed in Chapters II and III the practitioner was able to speculate about the possible causes for the group's incomplete development. It was possible that problems that the members may have had in the areas of cognitive-intellectual functioning; personality-emotional functioning; and secondary behavioral manifestations (i.e., denial, depression, and dependence) may have impeded their abilities to develop strategies to improve communication and interaction within the group.

Interestingly enough, the results of the mid-group and final evaluations indicated that the members had also been able to speculate about the factors which caused the group's incomplete development. The

members expressed recognition of the group's inability to to keep on track in discussions. The members expressed unwillingness to create conflict in the group. The occurrence of conflict could have either destroyed or strengthened the group. The members also expressed unwillingness to assume too much responsibility for performing leadership roles in the group because they saw leadership as the practitioner's role. Their speculations about the factors that impeded the group's development and their recognition of the group's avoidance of dealing with these factors indicated to the practitioner that the members simply may not have been ready to take the risks necessary for the group to become a cohesive, working unit.

As the practitioner reviewed the data collected during the group experience she recognized many things that could have been done differently in the practicum group in order to promote its development. If the group had been planned and conducted differently the group experience might have been of more value in terms of helping the members to explore, and possibly develop ways of coping with, their psychosocial problems. The practitioner was working within the limitations imposed by her own resources, the resources of the group members, and time restraints. Nevertheless, the available literature and her practice experience led her to come to some conclusions about how she might have promoted the practicum group to develop into a more cohesive, working unit.

The practicum group may have needed more heterogeneity of member coping skills, life experience, and expertise in order to develop more fully (Toseland & Rivas, 1984, p. 124). The practitioner might have

obtained a more heterogeneous group had she used less stringent criteria for entry into the group. Having a mix of male and female members might also have promoted a more interesting and productive group experience.

The group size of four members may have been too small for effective communication and interaction to have occurred (Yalom, 1985, p. 283). A group size of five to seven members could have provided more opportunities for the practicum group to develop communication and interaction patterns and dynamics of functioning which promoted problem-solving; accomplishment of tasks; achievement of members' goals; and achievement of the group's purpose (Toseland & Rivas, 1984, p. 126; Yalom, 1985, pp. 284-285).

Most of the available literature suggested that a duration of two hours per week for twelve weeks should have been sufficient to accomplish the goals of individual members and the group as a whole (Northen, 1969, p. 227; Philipp, 1981, p. 434). However, it was possible that a group consisting of people with neurological disabilities needed more time than expected to move through the phases of group development (Carrasquillo et. al., 1981, pp. 486-490). A duration of two hours per week, for eighteen weeks or more, might have been more appropriate for the practicum group. A longer duration might have benefitted the group in terms of giving the members adequate time to develop communication and interaction patterns and group dynamics which promoted group cohesion and the ability of the group to accomplish its work.

Group cohesion and development also might have been fostered in the practicum group by the use of closed membership, especially since the

group was time-limited. The practitioner found that having a new member enter and an original member leave midway through the group experience changed the group; altered the interpersonal relations of the original members; and provided a new stimulus and situation to which members needed to adapt (Northen, 1969, p. 104). It was therefore likely that the change in membership contributed somewhat to retarding the development of the practicum group. Groups which remain closed after they begin seem to benefit from higher group morale; more predictability of role behaviors; and an increased sense of co-operation among the members (Toseland & Rivas, 1984, p. 129).

Careful planning is an important component of a group experience (Heap, 1985; Toseland & Rivas, 1984). In the practicum group, too much planning on the part of the practitioner may have hindered the development of the individuals in the group and the group as a whole. The members in the practicum group seemed to see the group as "belonging to the practitioner" because she had carefully planned every aspect of forming, conducting, and evaluating the group. Although they were invited to suggest changes in the ways that things were done in the group, the members did not do this. The members of the practicum group might have assumed more responsibility for the work and development of their group if they had been actively encouraged to plan what they would work on, and which methods they would use to accomplish their work, before they heard the plans of the practitioner.

The experience of the practitioner in this practicum indicated that the use of only one professional group leader could have contributed to the incomplete development of the group. The practitioner realized that

she had experienced a great deal of anxiety about conducting the group as a demonstration project and for the purpose of obtaining the M.S.W. degree. This was compounded by her anxiety about being the only female in a group of male head injury victims -- some of whom might not have been able to control their tempers if conflicts or sensitive issues were being dealt with in the group.

The practitioner also realized that she was so focused on her anxieties and so intent upon making the group "work" that she did not make the best use of her social work practice skills in the group. During the life of the group, the practitioner did not make the best possible use of the leadership interventions of confrontation; exploration; cognitive restructuring; role playing; program activities; sequencing; timing; and clarification (Balgopal & Vassil, 1983, pp. 235-272). The practitioner should have used especially her practice skills and appropriate leadership interventions to draw out the group members' feelings about their individual problems and/or about why the group was not developing into a cohesive unit.

Working without a co-leader caused the practitioner to feel overwhelmed by trying to attend to her plans for the group, her own anxieties, and the dynamics occurring in the group. Co-leadership might have benefitted the practitioner by: providing a source of support, feedback, and learning; increasing objectivity; providing assistance during therapeutic interventions; and aiding in setting limits and structuring the group experience. Co-leadership might also have benefitted the group members by providing them with models for appropriate communication, interaction, and resolution of disputes

(Toseland & Rivas, 1984, p. 108).

Videotaping also could have contributed to the group's development if it had been used as a tool to provide ongoing feedback to members about their behavior; their patterns of communication and interaction; and the dynamics of their group's functioning (Yalom, 1985, pp. 433-436).

ii) Second Aim of the Intervention

The practitioner was not able to achieve the aim of exploring the hypothesis that the use of standardized measurement would indicate that the group members experienced one or more of the most salient psychosocial problems evident after head injury (i.e., low self-esteem, depression, and dependence). No conclusive statements could be made about the exploration of this hypothesis because the ISE and the GCS were not used as they were intended to be used; the IPPH was not a standardized measure; and the practitioner had no objective data from outside observers to which to compare the group members' responses on the measures. The attempt to use standardized measurement in this practicum was, however, of some value. The practitioner was able to gain experience in developing and administering a measurement package to head-injured clients. The practitioner learned that head-injured clients with an intelligence level of 70 or greater could comply with the requirements of such measurement procedures and would do so willingly.

iii) Third Aim of the Intervention

The practitioner was able to accomplish the aim of assessing the value of group work practice in this practicum. A comparison of changes in the magnitude of each group members' ratings of the salient psychosocial problems did not contribute to this assessment because of the inconclusive nature of these ratings. The practitioner was, however, able to assess the value of group work practice in this practicum by reporting on each group member's written and videotaped evaluations of the group experience. According to these evaluations, the members did use the group experience to explore some of their problems in psychosocial functioning, particularly anger. The members did not, however, attribute the value of group work practice to the opportunities it provided for them to explore, and develop ways of coping with, their psychosocial problems. Instead, the members attributed the value of group work practice to the opportunities it provided for them to meet and communicate with others in similar situations; learn about head injury; and express ideas, feelings, and frustrations. This finding was similar to the findings of Delahooke-Democker & Zimpfer (1981, pp. 254-257), Philipp (1981, pp. 434-435), and Dennis et. al. (1986, p. 18).

If the practicum group had been of a longer duration, and if the practitioner and the members had been willing to take the risks necessary to improve communication and interaction patterns (i.e., discussing personal problems rather than global issues; working through conflicts rather than avoiding them; and assuming more responsibility for the leadership and development of the group), other outcomes might

have ensued. Such outcomes for the group members might have included: improved interpersonal communications; help in confronting reality; improved ability to problem-solve; provision of emotional support; improved insight; and greater ability to deal with feelings. These outcomes were discussed in the work of Delahooke-Democker & Zimpfer (1981, pp. 254-257), Carrasquillo et. al. (1981, pp. 486-490), Philipp (1981, pp. 434-435), Edwards (1967, p. 270), and MacDougall & Semkow (1985). Although the practicum group ended before it achieved these outcomes, the members seemed satisfied with the outcomes that had been achieved. In the final evaluations, each member expressed that he had enjoyed the group and that he would participate in a similar experience if it were available. Almost one year after the practicum group ended, Bill, Jim, and Fred joined the Manitoba Head Injury Association. This self-help organization offers a variety of group experiences in which head-injured people may participate.

## 7.2 Concluding Remarks

The practitioner was able to achieve only two of the three aims of using group work practice as an intervention in this practicum. However, the practitioner has achieved her goals of offering a group experience to the young head-injured persons in the community; systematically and methodologically planning, conducting and evaluating this experience; describing the experience as a case study; and presenting her findings. This practicum is of value as a demonstration project and it should serve as a starting-point for those who wish to offer similar services or conduct similar research in the future.

During the course of this practicum, the practitioner also

concluded that much work needs to be done in terms of helping young head-injured adults and those involved with them to better cope with head injury and its many residual effects. This work lies in several areas. First, is the need for improved post-injury counselling for head-injured people, and their families, friends, employers, and educators. Second, is the need for improved understanding of the experiences of grief and mourning that accompany the stressful experience of coping with "life after head injury." Third, is the need for both in-hospital and post-discharge programs devoted specifically to helping head-injured persons to find a quality of life satisfying to them psychologically; socially; intellectually; educationally; and vocationally. Group work practice may play a significant role in the creation of services and resources to meet these needs.

### 7.3 Educational Benefits to the Student

The experience of planning, conducting, and evaluating the use of group work practice with traumatically head-injured young adults benefitted the practitioner in a number of ways. She was able to formulate and complete a practicum in an area in which she worked on a daily basis. This experience allowed the practitioner to learn first-hand about the problems inherent in practicing group work with the head-injured. Reviewing and analyzing the group's videotapes gave the practitioner the opportunity to assess her own performance as the group's leader. This part of the practicum experience was sometimes painful and disappointing, but it enhanced the practitioner's abilities to learn and to grow as an individual and as a social worker.

The group did not accomplish all that the practitioner hoped it

would, but the members enjoyed, and saw value in, their first experience in participating in a group designed specifically for head-injured persons. The practitioner accomplished what she had intended in terms of planning, conducting, and evaluating the group experience. Looking back at this experience, the practitioner realized that she attempted to accomplish a great deal in too short a time. She also recognized many things that she could have done differently. Nevertheless, the practitioner attempted to achieve all of her objectives and presented a detailed report of her findings in the hope that others would expand on her research in the future.

The practitioner, benefitted from the practicum experience in terms of her social work education because she was able to:

1. Make a direct effort to benefit traumatically head-injured young adults who lack services designed specifically to help them cope with their psychosocial problems as they function in the community.

2. Combine the theory and practice of both social work and group work with knowledge about traumatic head injury in the facilitation of a group of traumatically head-injured young adults attempting to cope with their psychosocial problems as they function in the community.

3. Receive consultation from the advisory committee and other interested professionals in the community. This helped the student to increase her theoretical knowledge and practice skills in terms of utilizing group work practice with a client sample which has some very special needs in the areas of physical, intellectual, and social functioning.

4. Present this practicum as a "demonstration project" which

should prove useful to other professionals working with traumatically head-injured young adults. A planned process of description and evaluation allowed the practitioner to assess the results of this project in terms of its benefits for the clients involved and to make recommendations which might be utilized by other practitioners attempting similar projects.

# APPENDIX I

## THE CONTRACT

I, , agree to participate in the group for traumatically head-injured young adults, being conducted by Ms. Val Stanowski, under the auspices of the University of Manitoba School of Social Work and the Department of Social Work, Health Sciences Centre. I have discussed the points below with Ms. Stanowski and I understand that:

1. The purpose of the group is to bring together traumatically head-injured young adults to discuss feelings, share concerns, provide mutual support and obtain information about our common problems and methods of dealing with those problems.

2. The group will run for 12 weeks, for two hours per week. I shall inform Ms. Stanowski if I must miss any meetings.

3. Ms. Stanowski is running the group as a project for her M.S.W. degree program. My involvement in the group, and any written or taped material relevant to that involvement, will be discussed only with her practicum advisors, in strictest confidence. All notes and tapes will be destroyed upon completion of the practicum.

4. For the purposes of Ms. Stanowski's final practicum report, real names and identifying situational characteristics will be changed in order that group members may remain anonymous.

5. I shall complete the required questionnaires and participate in exercises, role plays, demonstrations and other simulations conducted during group meetings.

6. I shall refrain from repeating personal matters discussed by group members during our sessions to anyone outside of group meetings.

7. Should my participation in the group adversely affect me in any way, in Ms. Stanowski's professional judgment, she must inform my case manager about the nature of the problem.

8. I am free to withdraw from the group at any time and I shall share my reasons for doing so with the other group members.

9. I consent to being audiotaped and videotaped during interviews and group meetings.

10. I agree to allow Ms. Stanowski to have access to material written about me which is on file in the Health Sciences Centre or in the agency referring me to her group. I understand that she may review this material to better understand my situation or to help her determine why the group may or may not have been of benefit to me.

11. I understand that Ms. Stanowski may maintain contact with the professional referring me to the group to keep him/her informed of my progress in the group.

I, Val Stanowski, have discussed all of the above points with the group member. I shall uphold all of my responsibilities and obligations to the members in the matters discussed above. The member (and/or his/her legal guardian) understand the terms of our contract.

Signed this day of , 1985;

Val Stanowski, B.S.W.

Group Member

Legal Guardian (where applicable)

## APPENDIX II

## SAMPLES OF MEASURES

"HEADS UP" MID-GROUP EVALUATION MEASURE 5.1

This evaluation will help us decide if we should make any changes in the group and what those changes might be. This should help to make the group the best possible experience for all. Please answer the questions below. You do not have to put your name on the sheet.

1. LIST IN POINT FORM THE THINGS THAT YOU LIKE BEST ABOUT THE GROUP:

2. LIST IN POINT FORM THE THINGS THAT YOU LIKE LEAST ABOUT THE GROUP:

3. DO YOU FEEL THAT YOU ARE GETTING ENOUGH OPPORTUNITY TO EXPRESS YOUR IDEAS AND FEELINGS IN THE GROUP? YES ___ NO ___ COMMENTS:

4. ONCE A TOPIC IS DECIDED UPON I WOULD LIKE TO SEE THE GROUP MEMBERS TAKE MORE RESPONSIBILITY FOR GUIDING THE DISCUSSION:
   YES ___ NO ___ COMMENTS:

5. I FEEL THAT THE GROUP IS ACCOMPLISHING ITS PURPOSE IN TERMS OF: GIVING US THE OPPORTUNITY TO MEET AND DISCUSS PROBLEMS AND CONCERNS AROUND HEAD INJURY AND COMMUNITY LIFE: YES ___ NO ___

   GIVING US THE OPPORTUNITY TO GET AND SHARE INFORMATION:
   YES ___ NO ___

   GIVING US THE OPPORTUNITY TO OFFER SUPPORT TO EACH OTHER:
   YES ___ NO ___

6. BRIEFLY DESCRIBE ANY IDEAS THAT YOU FEEL WOULD HELP TO MAKE THE GROUP A BETTER EXPERIENCE FOR EVERYONE:

INDEX OF SELF ESTEEM (ISE) MEASURE 5.2

NAME ______________________ TODAY'S DATE ______________

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

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

Please begin:

1. I feel that people would not like me if they really knew me well. ____
2. I feel that others get along much better than I do. ____
3. I feel that I am a beautiful person. ____
4. When I am with other people I feel they are glad I am with them. ____
5. I feel that people really like to talk with me. ____
6. I feel that I am a very competent person. ____
7. I think I make a good impression on others. ____
8. I feel that I need more self-confidence. ____
9. When I am with strangers I am very nervous. ____
10. I think that I am a dull person. ____
11. I feel ugly. ____
12. I feel that others have more fun than I do. ____
13. I feel that I bore people. ____
14. I think my friends find me interesting. ____

15. I think I have a good sense of humor. ____

16. I feel very self-conscious when I am with strangers. ____

17. I feel that if I could be more like other people I would have it made. ____

18. I feel that people have a good time when they are with me. ____

19. I feel like a wallflower when I go out. ____

20. I feel I get pushed around more than others. ____

21. I think I am a rather nice person. ____

22. I feel that people really like me very much. ____

23. I feel that I am a likeable person. ____

24. I am afraid I will appear foolish to others. ____

25. My friends think very highly of me. ____

Reproduced from Bloom and Fischer, Evaluating Practice: Guidelines for the Accountable Professional, 153.

GENERALIZED CONTENTMENT SCALE (GCS) MEASURE 5.3

NAME ______________________ TODAY'S DATE ________________

This questionnaire is designed to measure the degree of contentment that you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

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

Please begin:

1. I feel powerless to do anything about my life. ____
2. I feel blue. ____
3. I am restless and can't keep still. ____
4. I have crying spells. ____
5. It is easy for me to relax. ____
6. I have a hard time getting started on things that I need to do. ____
7. I do not sleep well at night. ____
8. When things get tough, I feel there is always someone I can turn to. ____
9. I feel that the future looks bright for me. ____
10. I feel downhearted. ____
11. I feel that I am needed. ____
12. I feel that I am appreciated by others. ____
13. I enjoy being active and busy. ____
14. I feel that others would be better off without me. ____

15. I enjoy being with other people. _____
16. I feel it is easy for me to make decisions. _____
17. I feel downtrodden. _____
18. I am irritable. _____
19. I get upset easily. _____
20. I feel that I don't deserve to have a good time. _____
21. I have a full life. _____
22. I feel that people really care about me. _____
23. I have a great deal of fun. _____
24. I feel great in the morning. _____
25. I feel that my situation is hopeless. _____

Reproduced from Bloom and Fischer, Evaluating Practice: Guidelines for the Accountable Professional, 152.

INDEX OF PRACTICAL AND PERSONAL HELP (IPPH) MEASURE 5.4

NAME ______________________________ TODAY'S DATE ____________________

This questionnaire is designed to measure the degree to which you use the help of other people in order to get along in the community. These people are your relatives, friends and helping professionals (i.e., doctors, psychologists, social workers, occupational therapists, etc.). This is not a test so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

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

Please begin:

1. Someone helps me to do my shopping. _____
2. Someone helps me to get around the city. _____
3. Someone helps me to do my cleaning. _____
4. Other people help me to make appointments. _____
5. Someone accompanies me to appointments for the first visit. _____
6. Someone helps me to cook my meals. _____
7. I require other people to help me plan my days. _____
8. Someone helps me to manage my money. _____
9. I try to make friends on my own. _____
10. I wait for people to ask me out socially. _____
11. When I am in a bad mood I get out of it by myself. _____
12. I make decisions by myself. _____
13. When I need practical help I ask my relatives. _____

14. When I need practical help I ask my friends. _____

15. When I need practical help I ask professionals. _____

16. I discuss personal problems with my relatives. _____

17. I discuss personal problems with my friends. _____

18. I discuss personal problems with professionals. _____

19. I go out socially with my relatives. _____

20. I go out socially with my friends. _____

21. I express my anger in front of my relatives. _____

22. I express my anger in front of my friends. _____

23. I express my anger in front of professionals. _____

APPENDIX III

RESULTS OF MEASURES

INDEX OF PRACTICAL AND PERSONAL HELP (IPPH) MEASURE 6.1

NAME Andrew TODAY'S DATE ____________

This questionnaire is designed to measure the degree to which you use the help of other people in order to get along in the community. These people are your relatives, friends and helping professionals (i.e., doctors, psychologists, social workers, occupational therapists, etc.). This is not a test so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

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

Please begin:

| | | Pre-Grp. | Mid-Grp. | Post-Grp. |
|---|---|---|---|---|
| 1. | Someone helps me to do my shopping. | 5 | 5 | |
| 2. | Someone helps me to get around the city. | 1 | 1 | |
| 3. | Someone helps me to do my cleaning. | 1 | 2 | |
| 4. | Other people help me to make appointments. | 2 | 1 | |
| 5. | Someone accompanies me to appointments for the first visit. | 1 | 1 | |
| 6. | Someone helps me to cook my meals. | 1 | 4 | |
| 7. | I require other people to help me plan my days. | 1 | 1 | |
| 8. | Someone helps me to manage my money. | 1 | 3 | |
| 9. | I try to make friends on my own. | 5 | 5 | |

| | | | |
|---|---|---|---|
| 10. | I wait for people to ask me out socially. | 3 | 4 |
| 11. | When I am in a bad mood I get out of it by myself. | 5 | 4 |
| 12. | I make decisions by myself. | 5 | 4 |
| 13. | When I need practical help I ask my relatives. | 2 | NIL |
| 14. | When I need practical help I ask my friends. | 1 | NIL |
| 15. | When I need practical help I ask professionals. | 1 | NIL |
| 16. | I discuss personal problems with my relatives. | 1 | 1 |
| 17. | I discuss personal problems with my friends. | 1 | 1 |
| 18. | I discuss personal problems with professionals. | 1 | 1 |
| 19. | I go out socially with my relatives. | 2 | 3 |
| 20. | I go out socially with my friends. | 2 | 3 |
| 21. | I express my anger in front of my relatives. | 1 | 1 |
| 22. | I express my anger in front of my friends. | 1 | 1 |
| 23. | I express my anger in front of professionals. | 1 | 1 |

INDEX OF PRACTICAL AND PERSONAL HELP (IPPH) MEASURE 6.2

NAME Bill TODAY'S DATE ________

This questionnaire is designed to measure the degree to which you use the help of other people in order to get along in the community. These people are your relatives, friends and helping professionals (i.e., doctors, psychologists, social workers, occupational therapists, etc.). This is not a test so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

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

Please begin:

| | Pre-Grp. | Mid-Grp. | Post-Grp. |
|---|---|---|---|
| 1. Someone helps me to do my shopping. | 3 | 3 | 1 |
| 2. Someone helps me to get around the city. | 1 | 3 | 2 |
| 3. Someone helps me to do my cleaning. | 2 | 3 | 1 |
| 4. Other people help me to make appointments. | 3 | 3 | 1 |
| 5. Someone accompanies me to appointments for the first visit. | 1 | 1 | 1 |
| 6. Someone helps me to cook my meals. | 4 | 4 | 4 |
| 7. I require other people to help me plan my days. | 3 | 3 | 1 |
| 8. Someone helps me to manage my money. | 1 | 1 | 1 |
| 9. I try to make friends on my own. | 3 | 4 | 4 |
| 10. I wait for people to ask me out socially. | 3 | 3 | 3 |

| | | | | |
|---|---|---|---|---|
| 11. | When I am in a bad mood I get out of it by myself. | 2 | 4 | 3 |
| 12. | I make decisions by myself. | 3 | 4 | 3 |
| 13. | When I need practical help I ask my relatives. | 4 | 4 | 1 |
| 14. | When I need practical help I ask my friends. | 5 | 4 | 1 |
| 15. | When I need practical help I ask professionals. | 3 | 5 | 3 |
| 16. | I discuss personal problems with my relatives. | 1 | 3 | 1 |
| 17. | I discuss personal problems with my friends. | 4 | 4 | 3 |
| 18. | I discuss personal problems with professionals. | 2 | 5 | 4 |
| 19. | I go out socially with my relatives. | 2 | 3 | 1 |
| 20. | I go out socially with my friends. | 2 | 2 | 3 |
| 21. | I express my anger in front of my relatives. | 1 | 1 | 1 |
| 22. | I express my anger in front of my friends. | 3 | 3 | 3 |
| 23. | I express my anger in front of professionals. | 4 | 5 | 4 |

INDEX OF PRACTICAL AND PERSONAL HELP (IPPH) MEASURE 6.3

NAME Jim TODAY'S DATE ______

This questionnaire is designed to measure the degree to which you use the help of other people in order to get along in the community. These people are your relatives, friends and helping professionals (i.e., doctors, psychologists, social workers, occupational therapists, etc.). This is not a test so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

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

| Please begin: | Pre-Grp. | Mid-Grp. | Post-Grp. |
|---|---|---|---|
| 1. Someone helps me to do my shopping. | 2 | | 3 |
| 2. Someone helps me to get around the city. | 2 | | 3 |
| 3. Someone helps me to do my cleaning. | 5 | | 3 |
| 4. Other people help me to make appointments. | 3 | | 3 |
| 5. Someone accompanies me to appointments for the first visit. | 1 | | 1 |
| 6. Someone helps me to cook my meals. | 4 | | 1 |
| 7. I require other people to help me plan my days. | 3 | | 1 |
| 8. Someone helps me to manage my money. | 4 | | 3 |
| 9. I try to make friends on my own. | 5 | | 5 |
| 10. I wait for people to ask me out socially. | 3 | | 4 |

| | | | |
|---|---|---|---|
| 11. | When I am in a bad mood I get out of it by myself. | 2 | 3 |
| 12. | I make decisions by myself. | 4 | 5 |
| 13. | When I need practical help I ask my relatives. | 5 | 1 |
| 14. | When I need practical help I ask my friends. | 1 | 3 |
| 15. | When I need practical help I ask professionals. | 3 | 3 |
| 16. | I discuss personal problems with my relatives. | 5 | 4 |
| 17. | I discuss personal problems with my friends. | 1 | 2 |
| 18. | I discuss personal problems with professionals. | 4 | 4 |
| 19. | I go out socially with my relatives. | 4 | 2 |
| 20. | I go out socially with my friends. | 3 | 4 |
| 21. | I express my anger in front of my relatives. | 3 | 5 |
| 22. | I express my anger in front of my friends. | 3 | 5 |
| 23. | I express my anger in front of professionals. | 5 | 1 |

INDEX OF PRACTICAL AND PERSONAL HELP (IPPH) MEASURE 6.4

NAME Fred TODAY'S DATE

This questionnaire is designed to measure the degree to which you use the help of other people in order to get along in the community. These people are your relatives, friends and helping professionals (i.e., doctors, psychologists, social workers, occupational therapists, etc.). This is not a test so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

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

| Please begin: | Pre-Grp. | Mid-Grp. | Post-Grp. |
|---|---|---|---|
| 1. Someone helps me to do my shopping. | 1 | 1 | 1 |
| 2. Someone helps me to get around the city. | 1 | 1 | 1 |
| 3. Someone helps me to do my cleaning. | 1 | 1 | 1 |
| 4. Other people help me to make appointments. | 1 | 3 | 1 |
| 5. Someone accompanies me to appointments for the first visit. | 1 | 1 | 1 |
| 6. Someone helps me to cook my meals. | 1 | 1 | 1 |
| 7. I require other people to help me plan my days. | 1 | 1 | 1 |
| 8. Someone helps me to manage my money. | 1 | 1 | 1 |
| 9. I try to make friends on my own. | 5 | 4 | 1 |
| 10. I wait for people to ask me out socially. | 3 | 1 | 1 |

| | | | | |
|---|---|---|---|---|
| 11. | When I am in a bad mood I get out of it by myself. | 1 | 5 | 1 |
| 12. | I make decisions by myself. | 4 | 5 | 5 |
| 13. | When I need practical help I ask my relatives. | 3 | 1 | 1 |
| 14. | When I need practical help I ask my friends. | 2 | 3 | 3 |
| 15. | When I need practical help I ask professionals. | 3 | 3 | 3 |
| 16. | I discuss personal problems with my relatives. | 1 | 1 | 1 |
| 17. | I discuss personal problems with my friends. | 3 | 3 | 2 |
| 18. | I discuss personal problems with professionals. | 1 | 1 | 1 |
| 19. | I go out socially with my relatives. | 2 | 3 | 2 |
| 20. | I go out socially with my friends. | 3 | 3 | 2 |
| 21. | I express my anger in front of my relatives. | 2 | 3 | 3 |
| 22. | I express my anger in front of my friends. | 3 | 2 | 3 |
| 23. | I express my anger in front of professionals. | 3 | 3 | 2 |

INDEX OF PRACTICAL AND PERSONAL HELP (IPPH) MEASURE 6.5

NAME Len TODAY'S DATE ____________

This questionnaire is designed to measure the degree to which you use the help of other people in order to get along in the community. These people are your relatives, friends and helping professionals (i.e., doctors, psychologists, social workers, occupational therapists, etc.). This is not a test so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

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

Please begin:

| | | Pre-Grp. | Mid-Grp. | Post-Grp. |
|---|---|---|---|---|
| 1. | Someone helps me to do my shopping. | | 1 | 1 |
| 2. | Someone helps me to get around the city. | | 2 | 1 |
| 3. | Someone helps me to do my cleaning. | | 1 | 1 |
| 4. | Other people help me to make appointments. | | 1 | 3 |
| 5. | Someone accompanies me to appointments for the first visit. | | 1 | 1 |
| 6. | Someone helps me to cook my meals. | | 1 | 1 |
| 7. | I require other people to help me plan my days. | | 1 | 1 |
| 8. | Someone helps me to manage my money. | | 1 | 1 |
| 9. | I try to make friends on my own. | | 1 | 3 |
| 10. | I wait for people to ask me out socially. | | 1 | 1 |

| | | | |
|---|---|---|---|
| 11. | When I am in a bad mood I get out of it by myself. | 1 | 5 |
| 12. | I make decisions by myself. | 1 | 5 |
| 13. | When I need practical help I ask my relatives. | 1 | 1 |
| 14. | When I need practical help I ask my friends. | 3 | 1 |
| 15. | When I need practical help I ask professionals. | 3 | 3 |
| 16. | I discuss personal problems with my relatives. | 1 | 1 |
| 17. | I discuss personal problems with my friends. | 2 | 3 |
| 18. | I discuss personal problems with professionals. | 2 | 3 |
| 19. | I go out socially with my relatives. | 1 | 1 |
| 20. | I go out socially with my friends. | 5 | 5 |
| 21. | I express my anger in front of my relatives. | 1 | 5 |
| 22. | I express my anger in front of my friends. | 1 | 3 |
| 23. | I express my anger in front of professionals. | 1 | 3 |

"HEADS UP" MID-GROUP EVALUATION MEASURE 6.6

This questionnaire will help us decide if we should make any changes in the group and what those changes might be. This should help to make the group the best possible experience for all. Please answer the questions below. You do not have to put your name on the sheet.

1. LIST IN POINT FORM THE THINGS THAT YOU LIKE BEST ABOUT THE GROUP:

Fred - Discussing similar problems (e.g., memory) and things of interest.

Bill - Refreshments and hearing the feelings of people who went through the same things I did.

Len - No response.

2. LIST IN POINT FORM THE THINGS THAT YOU LIKE LEAST ABOUT THE GROUP:

Fred - Running out of time.

Bill - Feelings of other people who went through the same thing I did and variations of comments about certain subjects.

Len - We don't seem to stick to one issue and there are no female victims.

3. DO YOU FEEL THAT YOU ARE GETTING ENOUGH OPPORTUNITY TO EXPRESS YOUR IDEAS AND FEELINGS IN THE GROUP? YES ___ NO ___ COMMENTS:

Fred - Yes.

Bill - Yes: some people express more than others and they seem to be more lopsided.

Len - Yes.

4. ONCE A TOPIC IS DECIDED UPON I WOULD LIKE TO SEE THE GROUP MEMBERS TAKE MORE RESPONSIBILITY FOR GUIDING THE DISCUSSION:
YES ___ NO ___ COMMENTS:

Fred - Yes: and staying on the same topic.

Bill - Yes: I think Val is more used to discussions about a certain topic and should guide the discussion in areas that some people might not think of.

Len - Yes.

5. I FEEL THAT THE GROUP IS ACCOMPLISHING ITS PURPOSE IN TERMS OF: GIVING US THE OPPORTUNITY TO MEET AND DISCUSS PROBLEMS AND CONCERNS AROUND HEAD INJURY AND COMMUNITY LIFE: YES ___ NO ___

Fred - Yes.

Bill - Yes.

Len - Yes.

GIVING US THE OPPORTUNITY TO GET AND SHARE INFORMATION:
YES ___ NO ___

Fred - Yes.

Bill - Yes.

Len - Yes.

GIVING US THE OPPORTUNITY TO OFFER SUPPORT TO EACH OTHER:
YES ___ NO ___

Fred - Yes.

Bill - No: because of negative thoughts towards something without waiting for more information on a certain matter.

Len - Yes.

6. BRIEFLY DESCRIBE ANY IDEAS THAT YOU FEEL WOULD HELP TO MAKE THE GROUP A BETTER EXPERIENCE FOR EVERYONE:

Fred - Have members put in a list for topics of discussion and more professionals in to discuss topics of concern.

Bill - I would like to see Michael Stambrook again about the brain.

Len - No response.

APPENDIX IV

## SYNOPSIS AND PRACTITIONER'S ANALYSIS OF EACH GROUP MEETING

### FIRST MEETING

#### Agenda

I. Introduction

(a) Practitioner as leader introduces herself to the group.

(b) Each member introduces himself to the group.

II. Orientation of group program

(a) Leader describes purpose of group.

(b) Leader describes her role in the group.

(c) Leader describes sponsorship of the group and the group experience as a practicum and demonstration project.

III. Discussion about the norms for the group's functioning.

IV. Naming of the group.

V. Planning the meeting.

#### Brief Synopsis of First Meeting

The first meeting convened at 7:00 p.m. on Wednesday, September 25th, 1985. The practitioner and members (i.e., Jim, Bill, Andrew, and Fred) sat in a circle around a coffee table. The practitioner elected to have the members introduce themselves in "round robin" fashion. The practitioner introduced herself first. She described how her practice experience led her to want to form this group. She also described her involvement with three other group experiences. Fred, Andrew, Bill, and Jim, in turn, talked about when their accidents had occurred and

described some of the physical, cognitive-intellectual, and personality-emotional problems resulting from their head injuries. All four men mentioned having problems with short-term memory. Fred, Bill, and Andrew reported having no prior involvement in similar group experiences. Jim reported that he had been a member of Alcoholics Anonymous. All four men expressed that they had joined this group to share information and experiences and to learn from the information and experiences shared by others.

During the coffee break, the group members chatted and joked informally. After the coffee break, the practitioner discussed her role as the group's facilitator, and the nature of the group as a demonstration project conducted as a practicum in the M.S.W. program. The practitioner led the group in a discussion about initial norms for the group's functioning. Smoking would be allowed during meetings. The group members did not want to be responsible for freshments and the practitioner offered to provide coffee and pastry. The group discussed the importance of honesty and openness of expression and that confidentiality about the group would be maintained outside of the meetings. The members' contracts were reviewed. The handling of anger among group members by means of discussion and the idea of "treating others as you would like to be treated" were agreed upon. The group members agreed to meet for two hours each week for twelve weeks. They understood that the twelve week duration was open to negotiation. It was agreed that members would contact the practitioner if they were to be absent from a meeting. The group members decided that taking in any new members would be dealt with by the original members if and when

necessary. Andrew's suggestion that the group be named "Heads Up" was accepted by the other members.

The members discussed possible agenda items. They decided not to invite family and friends to the meetings but they were in favor of inviting guests such as psychologists, doctors, or experts in the areas of relaxation and assertiveness. The members decided that "life after discharge from hospital" would be the discussion topic for the next meeting.

Practitioner's Analysis

The members appeared to be comfortable with each other, considering that they were strangers. They appeared somewhat cautious about the nature of the information they shared. Throughout the meeting, the members seemed to share information, rather than feelings, about their accidents, deficits, and problems. Although the members sat in a circle, each one appeared to be speaking to the practitioner rather than to each other or to the group as a whole. Their movements and postures tended to alternate between leaning forward and sitting back. Having a group of four seemed to give all members ample time to express themselves. Jim and Bill spoke quickly but tended to go on at length. Bill, especially, rambled off topic when it was his turn to speak. Andrew and Fred spoke slowly, as if they were carefully choosing their words. The members all seemed to appreciate and express humor. They appeared especially amused when Andrew suggested that the name of the group be "Heads Up" and "Lights Out." The members apparently established some rapport with each other. During the break, Jim and Fred discussed some of their deficits while Andrew and Bill struck-up a

conversation. At the end of the meeting the members were arranging to have coffee together in the Rehab cafeteria before next week's meeting.

The practitioner took a directive approach in this meeting. She attempted to make the members feel comfortable about participating in the group. She also gave them some idea about how the group's "work" would be structured. The practitioner gave the members a starting-point for interaction by introducing herself and by having them introduce themselves. She openly invited the members to participate in making decisions about how the group would function and planning the agendas for future meetings. The members were able to agree on the discussion topic for the next meeting.

## SECOND MEETING

### Agenda

I. Help members to relax and warm-up for discussion by taking a "temperature reading."

II. Review what occurred in the first meeting.

III. Introduce the topic for discussion by commenting on exerpts from literature dealing with "life after discharge from hospital" in the case of head-injured persons.

IV. Plan the next meeting.

### Brief Synopsis of Second Meeting

Fred, Bill, and Andrew were present. They discussed Jim's absence before the meeting began. The practitioner told them that Jim said he enjoyed the group and would come next week. The practitioner opened the meeting with a "temperature reading" to get an idea of how each member

was feeling and to initiate interaction. The practitioner went first, modeling the exercise for the group. She talked about feeling "very warm" because she was simultaneously "excited, scared, and happy" about returning to her full-time job after one's year's absence and being involved in this group. Fred, Bill, and Andrew, in turn, talked about various events that had put them in a good mood and about feeling happy about participating in the group. Andrew had brought with him some literature about head injury that he had received from a Vancouver hospital. He also said that he had written to an association in the U.S.A. to obtain more information.

The practitioner opened discussion about the topic "life after discharge from hospital" and distributed copies of an article written by a psychologist who had experienced head injury. In order to promote discussion, the practitioner read aloud a section of an article on the psychosocial aspects of head injury which dealt mainly with changes in memory and personality. Andrew said that he did not feel that the topic of the meeting applied to him because he was still attending outpatient therapies at the Neuro-Rehab Unit and was not "totally" discharged from the hospital. The practitioner clarified the topic for him. Andrew then expressed that his social life was "somewhat lacking" but that he presently preferred to concentrate on his recovery anyway. Bill talked about his social outings with his girlfriend and other friends and about being involved in a curling team and a health spa. He said that he sometimes felt that his life was "too full." Fred felt that he was less physically active than he was pre-morbidly and that he did not enjoy his favorite social activities as much as he had pre-morbidly. Fred also

mentioned how frustrated he had become from comparing his "pre-injury self" with his "post-injury self."

As the discussion progressed, Fred brought up his feelings of anger, his thoughts about suicide, and a visit he had made to a psychiatrist. The practitioner read a section of an article in an effort to get Fred to expand on his ideas. Fred compared his situation to that of the man in the article. He talked about how he wept about his situation and asked Bill and Andrew to contribute to the discussion. Bill shared his experiences with suicidal ideas and talked about his visits to a psychologist.

As the discussion continued, Bill said that he "enjoyed talking" and that his friends have been pointing out to him that he "tends to natter." Bill continued to wander off topic and Andrew directly told him that he was "nattering," which resulted in general laughter. Bill got back to the topic by talking about his plans to marry and buy a house. He seemed proud of having definite goals and again wandered off topic as he described how he met his girlfriend.

The practitioner got the group back on track by promoting a discussion about goals. Fred saw goals as "a means to keep one out of a depressive state." Andrew agreed that goals were important and sometimes necessary. The practitioner mentioned Fred's goal of attending university and he talked about his current studies and the problems his memory caused in this area. The practitioner confronted Fred with the reality that he may not be able to handle university and asked him if he was prepared for this. Fred said that no matter what, he just wanted to "experience university." Bill and Andrew made some

humorous remarks and the discussion continued.

Fred began talking about the pity that others have felt for him since his accident. Andrew said that pity came mainly from family and friends. Bill mentioned how his memory problems embarrassed him. Fred took the discussion into the area of how people related to him while he was in hospital and since he had been discharged. The practitioner introduced some ideas about the patient role; individual differences among head-injured patients; and the fear of reality of head injury on the part of the patient's family and friends. Fred talked about how his mother was over-protective toward him and how he handled this. Bill said that he felt that his family was not over-protective.

The practitioner and group members began to talk about other persons who had been in accidents and who had to deal with more serious physical deficits. As the end of the meeting drew closer the practitioner encouraged the members to decide on the topic for the next session. Fred suggested that the psychologist from the Neuro-Rehab Unit be invited to answer the group members' questions about the effects of head injury on the brain and how this caused a variety of problems in the functioning of head-injured persons. Bill and Andrew agreed with the suggestion and the practitioner offered to invite the psychologist. Fred discussed some of the questions he wanted answered in the next session. The members ended the meeting by discussing, among themselves, some of the physical problems they experienced after head injury. The practitioner suggested that they might plan an open meeting in which they could discuss some of these issues.

Practitioner's Analysis

Before the meeting actually began, Fred, Bill, and Andrew expressed genuine concern about Jim's absence. They discussed this for a while, even though the practitioner told them that he had telephoned her earlier to say that he had enjoyed the last meeting and would attend next week. Beginning the meeting with the "temperature reading" promoted interaction. All members contributed to the discussion about "life after discharge from hospital." Their discussion seemed to be stimulated by the practitioner's efforts to share information from relevant literature. Fred was the member most responsible for sharing ideas and opinions. He also encouraged Andrew and Bill to contribute to the discussion. Bill was able to share personal experiences and feelings. He did tend to wander off topic and had to be pulled back on track by the practitioner. Andrew appeared to follow the discussion with interest while remaining somewhat detached. He did express the feeling that the topic did not apply to him because he was still an out-patient. The members' postures indicated their comfort in the group and their interest in the discussion. They relaxed in their seats, leaned forward when they were particularly interested, and made humorous remarks when it seemed appropriate. When they spoke, the members seemed to be directing their communication to the group as a whole. The members did not seem to want the meeting to end even though it ran overtime. They continued to talk among themselves after the meeting had actually ended. The practitioner did employ a rather didactic approach in this meeting. She introduced the members to exerpts from the literature on head injury. The practitioner saw value in this because

the members asked so many questions about head injury that were best answered in the literature. The practitioner also used references to the literature as a means of focusing the discussion on the topic chosen by the members. Since the members did tend to wander off topic, the practitioner found herself doing a lot of clarifying of their statements and directing the discussion. She did so much of this that she felt mentally exhausted by the end of the meeting. The practitioner could not encourage the members to end the meeting on time. This meeting ran almost an hour longer than planned. During the meeting, the members were able to agree on the agenda for the next meeting.

THIRD MEETING

Agenda

I. Introduce a potential group member, Len, to the rest of the group.

II. Introduce Dr. Michael Stambrook, the psychologist invited to be the guest speaker at this meeting.

III. Plan the next meeting.

Brief Synopsis of Third Meeting

Andrew, Fred, Jim, Bill, and Len a potential group member, arrived for the meeting. The guest speaker, Dr. Michael Stambrook, was introduced. Dr. Stambrook was the psychologist in the Neuro-Rehab Unit and he had met all of the group members while they were patients in the Unit at the Health Sciences Centre. Dr. Stambrook gave an interesting presentation on the anatomy of the brain. He used an overhead projector to show diagrams of the parts of the brain. He discussed the nature of head injury and the deficits that resulted when various parts of the

brain were injured. The group members appeared to be most interested in the presentation. They seemed to enjoy Dr. Stambrook's "down-to-earth" style of presentation. All of the group members asked questions which were most appropriate. At times, some members, especially Fred, asked specific questions pertaining to their own cases. Dr. Stambrook wanted to only discuss general information about head injury in his presentation. He did encourage group members with questions about their particular cases to make individual appointments with him at the Rehab Centre to deal with their questions. At the end of the presentation Dr. Stambrook asked the group members how they felt about the information presented and if it had upset them in any way. The members expressed that they were pleased with the presentation. None of the members felt that the information presented was shocking or upsetting. One of the members mentioned that we might want to discuss this session at the next meeting. As the meeting ended the practitioner asked the members if they wanted to have an open meeting next week. The members agreed to this plan.

Practitioner's Analysis

The day before the third meeting Len visited the practitioner at the Rehab Centre to inquire about the progress of the group. He had intended to join the group when it was being formed but he could not attend the meetings because he had obtained evening employment. Since his job had been terminated he wanted to enter the group. The practitioner explained to Len that the group had already met twice and that a psychologist was to be the guest at our third meeting. When Len asked if he could attend the practitioner told him that she would have

to check with Andrew, Bill, Jim, and Fred before inviting him. She also told him that if he wanted to become a permanent group member he would have to participate in the two pre-group interviews and complete the questionnaires as the other young men had done. Prior to the third meeting, the practitioner telephoned the original group members to ask if Len could attend. All members agreed that this was alright.

During the meeting the other members were polite and friendly toward Len. He did not verbalize as much as the other members and he sat on the fringe of the circle. The practitioner noted how attentive all members were to the guest. Dr. Stambrook told the group that he was most impressed by their interest and by the questions they asked.

The practitioner noted some events that led her to believe that the group members were developing some sense of "belonging" to the group and some consideration for each other. Prior to the meeting the practitioner encountered Fred at the Rehab Centre. He told her that he had "bumped into" Jim earlier that day and that Jim was not sure how to get to the meeting room. Fred said that he had offered to meet Jim in the Rehab cafeteria before the meeting, have coffee with him, and accompany him to the meeting. Jim and Fred actually arrived at the meeting room early and assisted the practitioner in setting up the overhead projector and the chairs. Just prior to the beginning of the meeting, Jim told the other members that he had become tired because he had been attending follow-up assessments at the Rehab Centre since 8:00 a.m. Since transportation was a problem he had stayed at the Rehab until the meeting. He asked if the other members would be offended if he left promptly at 9:00 p.m. Other members made a few jokes about his

tiredness but agreed that he should leave at 9:00 p.m. At the end of the meeting, Fred, Andrew, and Bill took it upon themselves to tidy-up the meeting room. This was the first meeting at which the members actually helped the practitioner to set-up and tidy the meeting room. The practitioner sensed that the members were beginning to feel that this was actually "their group" and that they should assume some responsibility for it. The members' commitment to the group was further evidenced because all members came to the group on a night when the winter weather was at its worst even though they had to walk or take buses to get to the meeting.

## FOURTH MEETING

### Agenda

I. Inquire as to whether or not Len has decided to join the group.

II. Introduce this meeting as an open meeting.

III. Review the third meeting to deal with questions and concerns and as a lead to promote open discussion.

IV. Plan the next meeting.

### Brief Synopsis of Fourth Meeting

Jim, Bill, Len, Fred, and Andrew were present. The practitioner reminded the members that this would be an open meeting but expressed that she wanted to deal with some general business at the outset. She asked Len if he had decided to commit himself to joining the group. He said that he just started another job which might involve some evening work but he would like to join the group. The practitioner then asked if anyone had questions about the third meeting. Len had some questions

about coma which Jim and Fred tried to answer.

Len introduced the topic of being in hospital. Jim and Fred contributed their feelings about, and attitudes toward, hospitalization. The practitioner focused on how hospital patients "lose control" over their situations. Jim talked about his hospital experience using humor and, especially, jokes about himself. The practitioner then provided the group with some knowledge about the Neuro-Rehab Unit in response to the members' questions.

Len seemed to have many questions about his hospitalization and he asked how he might obtain his hospital chart. Len tended to focus the group on his personal concerns and problems. The practitioner tried to include other members in the discussion. She did this by redirecting the questions which Len asked her to the other group members. As the discussion about hospital progressed, the practitioner found that the members benefitted from concrete examples to answer questions about things such as referrals and consults. As Len talked about hospitalization his words made him sound suspicious of the professionals and paraprofessionals who worked with him. Len made a point of telling the others that it was his style to "ask a lot of questions." During this part of the discussion Jim had been flexing his hands and wriggling in his seat as if something was bothering him. He finally shared with the group his feelings about having a "rotten day" at work which upset him so much that he had accidentally dropped his steak supper on the floor at home, which upset him even more. When the practitioner asked him if he felt alright about being in the group Jim said that he could "handle it in spite of his rotten day."

The group moved into a discussion about being at the Rehab Centre. The discussion revolved around the treatment received there, visitors who came to hospital, and their reason for visiting. Fred expressed his feeling that most of his visitors came to see a "horror show." Jim said that he felt that most visitors were coming out of concern. Andrew and Bill made rather neutral comments. The practitioner sensed that Len had something to say and made an opening for him. Len expressed negative feelings about his relatives. He could not seem to understand why they cared about him after his accident when they never cared about him before. Jim tried to explain to Len that his family might have been concerned because they really took his accident seriously. Bill seemed to want to smooth over what appeared to be a conflict between Jim and Len. Bill did this by interjecting that he did not remember what his relatives had done for him early in his recovery but that he had to trust that they were telling him the truth about their visits and the things they had done for him. Len talked about the bitterness he felt toward his family, especially when they made jokes about some of the things he had done early in his recovery. Fred related bitterness toward people who used "stunts" to get in to visit him early in his recovery. He was upset because acquaintances had lied to hospital staff, saying that they were relatives, in order to visit. Fred felt that these people "just wanted to look at someone who might be dying." Jim said that several people had done the same things to get in to see him in hospital but that he did not take these things as seriously as did Fred.

Len then moved the discussion toward his experiences at the

Employment Preparation Centre (E.P.C.) which provides work assessment and training for the disabled. All of the group members seemed to know about the E.P.C., but Len seemed to feel the most negative about it. The practitioner tried to clarify the purpose and limitations of the E.P.C. Bill related his experiences with work, exercise, and fatigue but his conversation wandered off topic. Jim mentioned his experience at the E.P.C. Len made another angry comment about the E.P.C. and Jim was instrumental in getting Len to express what specifically made him so angry. Len said that the supervisor there made him "feel like a dummy" even when he did a task correctly. Jim related how he had the same experience at his current job and how he had learned to deal with it. Andrew made a comment about Jim being a cook. Andrew had forgotten that Jim was employed in woodworking. This was handled with humor by Jim and the laughter seemed to release the tension in the meeting.

Len wanted to talk about the issue of "emotional break-down." Bill, Fred, and Jim talked about problems with stress and fatigue. Fred talked about the importance of relaxation. Len moved into an unrelated topic which did not connect with what the others were discussing.

After a coffee and "stretch" break the practitioner called the meeting back to order. Jim took some time to clear up his feelings about his "rotten day." As the meeting drew to a close the practitioner asked the group if they preferred open meetings or meetings with set agendas. Jim said that although there was value in open meetings, agendas provided necessary structure in meetings. Bill expressed preference for meetings with agendas. Jim questioned the value of "surprise agendas" and asked how the others felt about the open meeting.

Fred said that his most pressing questions had been addressed. Jim wanted to explore the issues of agitation and anxiety. The practitioner summarized what had been done in the first three sessions. The members decided that the topic for next week would be "family and friends."

Practitioner's Analysis

Jim, Andrew, Bill, and Fred seemed comfortable with Len in the group. During this meeting the practitioner noticed that there was a significant amount of tension in the atmosphere. She sensed that this might be due to the performance of Len in the group. Both Len's communication and body language exuded high levels of energy. His tone of voice was very assertive, his communication was injected with the frequent and emphatic use of swear-words, and when he spoke he usually leaned forward, gesturing emphatically with his arms while his fists were clenched. Len appeared to be highly verbal and very humorous. He appeared to enjoy "centre stage" and seemed to be competing with the other members, especially Jim, for attention. He seemed most interested in venting his own feelings and did not ask others how they felt about the topics being discussed. Jim seemed to be the member most responsible for facilitating the discussion and for keeping the group on track. He also seemed to be member who tried to seek the opinions of others. Jim, like Len, appeared to be containing great amounts of energy. Jim spoke emphatically on issues of personal concern to him and his body language clearly indicated when he was becoming anxious. Jim also felt confident enough to expose his personal feelings to the group. He seemed to trust that the group would understand his feelings about his "rotten day." By sharing these feelings with the group he further

promoted an atmosphere of openness and honesty. Bill seemed uncomfortable with the tension in the atmosphere. He tried to "smooth things over," or mediate, when he sensed conflict building between Jim and Len. Fred remained the calming, stable influence in the group. He addressed the topics under discussion in his usual sensitive, thoughtful style. Andrew remained the interested but detached member. He made mostly neutral comments during the meeting.

The practitioner felt that the group members had managed to discuss some meaningful issues in this meeting. They seemed to be trying to sort-out their experiences post-head injury in an effort to make some sense out of them. It appeared that the members had many unanswered questions about the rehabilitation process and they seemed receptive to the practitioner's efforts to explain to them various aspects of the hospital system.

The group members did seem to crave structure as evidenced by their decision to return to meetings with set agendas. The open meeting format seemed to allow too much latitude for the more verbal members to take over the group in order to discuss primarily their own individual concerns. The practitioner left this meeting feeling emotionally and physically exhausted. She very much felt the tension in the atmosphere and she had a difficult time attending to the non-verbal communication in a group of five; providing information; keeping the group on track; and drawing the quiet members into the discussion. The practitioner noted that in spite of her efforts to end the group at 9:00 p.m., it ran almost an hour overtime. Bill and Fred stayed to help the practitioner clean up the room.

## FIFTH MEETING

### Agenda

I. Review contents of the last meeting.

II. Help members to relax and warm-up for discussion by taking a "temperature reading."

III. Initiate discussion of the topic "family and friends."

IV. Plan the next meeting.

### Brief Synopsis of Fifth Meeting

The practitioner opened the meeting by relating information that Andrew gave her just prior to the meeting. She told the group that Andrew was moving to British Columbia. The practitioner thanked him for his participation in the group and Jim, Fred, and Bill said their "goodbyes" and expressed a desire to correspond with Andrew. The practitioner began the "temperature reading." Jim and Bill reported that they were in good moods. Bill tended to ramble and add information that was not relevant to his mood. Len talked about his work but gave no indication of his mood. Fred said that he was still nervous after writing a physics test. Andrew said that he was having an "okay day." The practitioner spoke last, saying that she was in a pretty good mood. She expressed positive feelings about the group and sadness about Andrew leaving. Bill moved into some discussion about his tendency toward verbal rambling. Len began to talk about his use of sarcasm in conversation.

The practitioner reviewed the last meeting and introduced the discussion about "family and friends." Fred talked about how he felt

that his family and friends were overprotective of him. He also talked about needing to trust these people. Fred asked the other members how they felt. Andrew said that his friends and family were very good to him during his stay at the Rehab Centre. Len asked why rehabilitation centres were different from other hospitals. The practitioner responded to his question. Bill commented on some of his experiences with the Neuro-Rehab Unit and began to ramble off topic. The practitioner clearly indicated that the discussion was going way off track. She encouraged the members to concentrate on the topic of "family and friends."

Len related, at length, his personal experiences with his family after discharge from hospital. Fred spoke about how medical people and relatives encouraged patients' independence. Bill talked about how a friend had treated him after his head injury. The practitioner drew Jim into the discussion. He spoke about how his common-law wife overprotected him. He said that he felt a need to be protected after he left hospital. Jim and Bill shared their perceptions of why their lives were the way they were after discharge from hospital. Len spoke again, at length, about how his family and friends related to him after he left hospital. He said that they treated him like a "crazy person" and that he retaliated with an "arrogant attitude." Len focused much of the discussion on the "role" he plays when he is with his family and friends.

The discussion moved into the area of suicide and depression. The members talked about when they had contemplated suicide and how they had moved beyond this.

The group ended with the members deciding to explore the topic of "work" in the next meeting. Final "goodbyes" were said to Andrew.

Practitioner's Analysis

During this meeting, the practitioner had to work actively to keep Bill and Len on track. Bill tended to ramble verbally. Len tended to ask a lot of questions. His questions were not directly relevant to the topic but they were relevant to the subject of head injury. The practitioner often found herself answering Len's questions, and taking the discussion even further off track, before she realized what was happening. Len's style of communicating was very entertaining and energetic, which made it easy for him to monopolize the discussion. The practitioner recognized that Len was a good contributor to the discussion when he stayed on topic. She was, however, concerned that the other members were not able to seize opportunities to express themselves. Jim, who was usually a leader in discussion, appeared extremely quiet during this meeting. Len seemed to take the role that was usually Jim's.

The practitioner sensed a tension in the atmosphere during this meeting. She was concerned that it might emanate from the performance of Len in the group. She wondered how Bill, Jim, and Fred felt about the new member's functioning in the group and if they were comfortable with him. The practitioner herself felt somewhat uncomfortable around Len but she was not sure exactly why she felt this way.

Although it had already become a norm that the meeting ran overtime, this meeting ended promptly at 9:00 p.m. The group members did not display their usual eagerness to keep the discussion going.

## SIXTH MEETING

### Agenda

I. Review contents of last meeting.

II. Help members to relax and warm-up for discussion by taking a "temperature reading."

III. Introduce discussion of the topic "work."

IV. Plan the next meeting.

### Brief Synopsis of Sixth Meeting

Jim, Fred, and Bill were present. Len had not contacted the practitioner to inform her that he would be away. When the group formed the members had agreed that they should contact the practitioner if they were to be absent. Bill, Jim, and Fred discussed possible reasons for Len's absence. Bill said that he hoped that Len was "okay." Jim posed the possibilities that Len "did not like the meetings," that he found the group "boring," or that the other members were "not good enough for him." The practitioner did not adhere to the agenda because she thought that the members might want to share their feelings about Andrew leaving the group and Len coming into the group. The members kept discussing how Len's absence should be handled. Bill kept saying that we should not "jump to conclusions" until we knew why Len was absent. Jim said that he attended last week in spite of a "family crisis" at home.

The practitioner wanted to learn how the group members would deal with this matter which seemed to be so important to them. She therefore suggested that the group do a role play about this matter. She played

the missing member, Len. The members role played their methods of dealing with Len's absence. After the role play the practitioner asked the members how they felt about taking in a new member after the group had already formed. Bill said that he felt comfortable about this. The others said nothing. The practitioner told the group how she felt the members had treated her (as Len) in the role play. She expressed that Bill seemed the most tolerant, Jim seemed to be the "hardest" on the missing member, and Fred seemed to be somewhere between these two extremes.

As the discussion progressed, the practitioner talked about her overprotective feelings toward the group and her feelings of nervousness which centered on Len. Fred expressed how he felt about the importance of the group. Fred, Jim, and Bill made some humorous remarks to relieve the tense atmosphere. Bill suggested that the practitioner should have talked about her concerns before. Fred suggested that if she had she might have instilled fears in the other group members. Fred and Jim discussed with the practitioner more ideas about how fears and concerns could be expressed. Bill said that he felt that the group was "putting Len down" and that Jim seemed to have negative feelings about Len. Jim mentioned that he felt that he had "pressured" Len in past meetings and that he wondered if Len had become embarrassed or felt displeased by this.

The practitioner suggested to the group members that they let her do too much of the talking. Fred responded by saying to her "you're the boss." The practitioner asked the group members if they felt comfortable about taking the lead in discussions. The members said that

they knew that they could take the lead whenever they felt comfortable about doing it. Jim told the practitioner that she was "chicken" about expressing her feelings.

Somehow the discussion moved back to Len's absence. The practitioner then began to discuss the rules of the group and the ideas of obligation, commitment, and consequences. The members agreed that if Len contacted the practitioner about his absence she should suggest that he discuss it with the members at the next meeting.

The discussion moved into several areas which really were not relevant to what was happening in this meeting. The practitioner seemed unsure about how to end this meeting. She handed out the mid-group evaluations and questionnaires. The group did not seem to be able to end this meeting in a comfortable way. The group members decided to discuss the topic of "work" at the next meeting.

Practitioner's Analysis

The group members seemed to focus on Len's unexplained absence because he had broken the "rule" regarding contacting the practitioner re: absence. None of the members mentioned that we were supposed to be discussing "work." The members appeared to want to discuss Len more than his unexplained absence. They seemed to be trying to sort out their feelings about him. Bill, Jim, and Fred were most animated and energetic in this meeting. Bill seemed to be the member who tried to mediate and harmonize. He did not seem to want "bad feelings" among the members or toward any particular member. Jim shared some definite feelings about how he felt Len perceived the group. Jim also expressed how his negative feelings about Len might have affected him. Jim seemed

to feel badly about this. Fred remained quite neutral during this discussion. During the discussion, each member directed his comments toward the group as a whole. The members seemed supportive of the practitioner when she expressed how Len made her feel uncomfortable. The members did allow the practitioner to do a great deal of talking during this meeting. Bill, Jim, and Fred did not discuss their feelings about the way the group was functioning or the "rules" by which the group was conducted. Only Fred gave the practitioner an idea of how much control she exerted when he told her "you're the boss." As the meeting drew to a close the members seemed quiet and thoughtful. There was a feeling of discomfort in the atmosphere.

The practitioner felt uncomfortable by the end of this meeting. She had wanted the original group members to share their feelings about having a new member, but she had not wanted it to take an entire session. The practitioner recognized that the members had gone way off track and had taken her with them. This meeting led the practitioner to draw some conclusions about the group and her role as leader. She felt that she had began the group with too much emphasis on the contract and on the "rules" for conduct established at the first meeting. The practitioner sensed that this had caused the members to regard her as the undisputed leader. The practitioner considered that her directive approach in the earlier meetings might have caused the members to feel limited in the amount of responsibility they could assume in developing the group. Perhaps none of the members felt comfortable enough to accept responsibility for encouraging the group to stick to its original agenda or perhaps they did not want to discuss "work." The members were

able to discuss the practitioner's concerns with her. The practitioner could have asked the members to express their feelings about what had occurred in this meeting. Instead, her own discomfort caused her to support the members' efforts to divert the discussion toward irrelevant but "safe" topics.

The practitioner allowed the meeting to end without having the members discuss what, if anything, they would tell Len about this meeting. She decided to trust the group members to deal with this as they saw fit. She also decided to try being less directive and to do more listening and keeping the members on track in future meetings.

The practitioner sensed that Bill, Jim, and Fred were eager for this session to end. The practitioner and the members seemed unable to draw the meeting to a proper closing. The meeting ended on time and the members were very quiet as they helped the practitioner to clean up the room.

## SEVENTH MEETING

### Agenda

I. Review last week's meeting.

II. Introduce the topic of "work" with an exercise involving descriptive adjectives.

III. Plan the next meeting.

### Brief Synopsis of Seventh Meeting

Bill, Len, and Fred were actively conversing before the group began. The practitioner opened the group with a message from Jim. He telephoned to say that his job had taken him out of town this evening.

The practitioner also mentioned that Len had visited her at work last Friday to explain that he had missed the meeting he was moving a refrigerator for his mother. Bill also mentioned that he had telephoned the practitioner last week to find out if Len was "okay."

The practitioner stated that the group was to have discussed "work" last week but that Len's absence and other matters had triggered a discussion about various aspects of the group. There were a few jokes and some laughter from Bill and Fred. Len mentioned his involvement with a plastic surgeon because he wanted to have some of his facial scars repaired. This triggered some discussion about the relationship between facial scars and feelings about oneself. Fred said that he felt that having surgery on facial scars was not that important.

The practitioner introduced the topic of "work." She asked the members to participate in an exercise to encourage the expression of their thoughts on the topic. The members were instructed to state which animal name described them at work and at play or leisure. The members were to provide adjectives to describe each animal. The practitioner went first, modeling the exercise. The results of the exercise were summarized by the practitioner.

| Name | Animal at Work and Adjectives | Animal at Play and Adjectives |
|---|---|---|
| Val (Practitioner) | RABBIT<br>- tense<br>- hyper<br>- soft<br>- warm<br>- in a hurry<br>- eager to please | GERMAN SHEPHERD<br>- physically powerful<br>- dominant<br>- emotionally strong |
| Fred | GOAT<br>- strong, but not in the muscular sense<br>- stubborn<br>- able to take care of myself<br>- companionship is important but not absolute<br>- roamer | RABBIT<br>- jumping from one thing to another...until I find something that I enjoy or want |
| Len | FOX<br>- perceptive<br>- moves fast<br>- playing "two ends to the middle"<br>- reliable | PIG<br>- lazy<br>- likes to eat<br>- fearless<br>- bold<br>- carefree<br>- laid back<br>- under no pressure<br>- expresses self openly<br>- doesn't take life seriously |
| Bill | HOUSECAT<br>- neat<br>- meticulous<br>- clean<br>- fast<br>- sometimes very relaxed<br>- roaming<br>- poking nose in<br>- helpful<br>- finicky<br>- fussy | HORSE<br>- competitive<br>- helpful<br>- does a lot of work<br>- physical<br>- clean<br>- neat |

The group members discussed how they could see such "animal" characteristics, as described in the exercise, in themselves and in others. Len introduced the topic of the Workers Compensation Board's work placement program. He felt that this agency told potential employers all about his flaws. Fred talked about using problems with memory as an excuse for not doing things. The practitioner noted how memory problems were repeatedly mentioned in this group and that this characteristic was not mentioned in the exercise. Len and Fred said that they felt that the characteristic of memory problems was irrelevant to the exercise.

Fred focused the discussion on Canada Pension and Workers Compensation benefits for those who could not work. He wanted to know what Bill and Len thought of these. Len talked about how he saw his involvement with the Workers Compensation Board as a "game" which he was trying to win. Fred voiced his dissatisfaction with the "systems" set up to deal with clients such as himself. He named the Rehab Centre as one of these systems. The practitioner asked what could be the ideal rehabilitation system to help people like the group members after discharge from hospital. Fred talked about the problems he had as he tried to return to his job at the railroad after he left hospital. This is the same railroad to which Bill was trying to return as a full-time employee.

Len explained about his situation after discharge from hospital. He talked about his family's involvement, the cousin who was with Len in the accident and who died, and about his pre-morbid personality. Fred commented on the descriptive words Len used when he talked about his

situation and how Len used "a lot of body language." Len then focused on the way he behaved as a "bad boy" when he was growing up and on how important an influence in his life his deceased cousin had been. The practitioner tried to connect Len's discussion to some things that Fred had said about having to deal with all that he experienced when he left hospital and tried to return to the work force. Fred said that now he was willing to do "just about anything" in terms of work. Len suggested to Fred that he should go after jobs on his own, without being channelled through any agencies. Fred and Bill discussed further their experiences in trying to return to work at the railroad. Len talked more about his involvement with the Workers Compensation Board.

As the meeting drew to a close, the members commented that they had enjoyed doing the exercise. They agreed that they wanted to refer to it at the next meeting and that they wanted Jim to do it. The members decided that at the next meeting they would discuss the exercise again and relate it to the topics of "work" and "how family and friends perceive them."

Practitioner's Analysis

The atmosphere during this meeting seemed more comfortable than it had in the past two weeks. Bill and Fred did not make many references to last week's meeting except for a few jokes. The members sat in close proximity to each other. They seemed to enjoy the exercise which promoted discussion. Len, Bill, and Fred shared many ideas and feelings about the systems and agencies with which they were involved. During the meeting, the members were directing their communication toward each other. They did a lot of leaning forwards, indicating their interest in

the discussion. A feeling of camaraderie seemed to be developing among the members. Throughout the meeting they had more physical contact (i.e., touching, poking, and backslapping) than ever before as they talked and joked. Len did begin the meeting by discussing his concerns about plastic surgery but he was able to stick to the topic for most of the meeting. Throughout the meeting the members were able to stay on track. Fred took the most active role in keeping the discussion focused. Len and Fred did most of the talking and sharing of feelings. The members were able to decide on the agenda for the next meeting.

The practitioner was less directive than usual in this meeting. She concentrated on listening and watching the interaction among the members. The practitioner did not have to do much in terms of pulling members on track because Fred was facilitating the discussion. The practitioner again found it difficult to end the group on time and it ran for almost an extra hour. As the members and the practitioner cleaned up, Len asked if there would be a Christmas party. Bill and Fred thought that this was a good idea. The members lelt apparently in good moods even though most of the group's discussion had focused on a topic that evoked feelings of frustration.

## EIGHTH MEETING

### Agenda

I. Obtain some "reading" of the group members' moods.

II. Ask that the other group members inform Jim about what happened last week.

III. Use the exercise that the group members had done last week to

promote a discussion about the members' personality characteristics at "work" and in relation to "family and friends," as decided last week.

IV. Prepare the group for pending termination.

V. Plan the next meeting.

Brief Synopsis of Eighth Meeting

Jim, Fred, Bill, and Len were present. They began chatting and joking before the meeting began. Bill opened the meeting by emphatically stating that "we were talking about work and we'll discuss the first part of this meeting on work." The practitioner asked the members to inform Jim about the last meeting. There was much joking as Bill, Len, and Fred explained the nature of last week's exercise to Jim. The practitioner asked what kind of moods the members were experiencing. Everyone seemed to feel "pretty good," including Jim, who had a terrible cold. The practitioner showed Jim how last week's exercise was done. As the other members joked about the exercise, Jim described himself as a "eagle" at work and a "racoon" at play. His "eagle" characteristics were: "sharp; good eyes; fast; swift; and very conscientious." Jim's "racoon" characteristics were: "hyper; relaxed; frustrated; angry; fast; and very sly."

Jim and Len got Fred and Bill involved in a discussion about whether or not people present personalities at work that are different from those they present outside of work. Jim shared an experience he had at work with a co-worker who did not like Jim. Jim talked about how he confronted the co-worker about this issue. Bill shared his feelings about being "on display" at work. Len shared his feelings about being

confused by the "messages" he got from other people with whom he worked. He felt that they were sometimes "looking down on him" while at other times they seemed to "trust and value" him. Bill wanted to interject while Jim was talking and Jim told Bill to "wait until he finished talking." The members continued to discuss their feelings about how they were treated at work and about confronting co-workers and superiors whom they felt were not treating them fairly. Bill picked up on Len's statements about getting to work late. Bill told Len that he should "get to work on time." Len expressed that he could come to work late because his wages were so low. Len talked about the importance of good wages. Jim interpreted Len's comment as an expression of a desire to stay on Workers Compensation benefits forever and he confronted Len with this. The practitioner clarified, for Jim, what Len had actually said. Jim then expressed his feelings about the low wages he received for doing a job that he did not like. Fred talked about how even doing a job that one did not like still gave that person "something to do."

Fred discussed how he has been fighting for years to get back his job with the railroad. Jim, Len, and Fred talked about how dissatisfied they were with the things that they were doing but how helpless they felt about changing their situations. Fred and Jim discussed Fred's "angry" feelings about his situation. Len talked about the value of the group as "a place to ask questions." He seemed to feel that through discussion the group members might solve some of the problems they experienced in their situations.

Bill shared his concerns about his job stability. He said that these concerns stemmed from some things that Fred had said about the

railroad in the past meetings and from some things that his vocational-rehabilitation counsellor had been saying. Bill asked Fred some questions about his attempts to get back his job at the railroad.

Len talked about knowing when to "break ties" and "let go." He talked about this in relation to "letting go" of his ties with the Neuro-Rehab Unit. Jim and Fred talked about their few remaining ties with the Unit. Fred then told the group that he would one day like to leave Winnipeg forever. He asked the members where he should go. Len asked Fred where he would like to go. Fred said that he would like to go to Vancouver. He said that he wanted to get away because he had a lot of "bad feelings about Winnipeg" as a result of his accident. Len, then brought up the topic of the group's Christmas party. The practitioner said that the party would be discussed soon, and that discussing it now was getting away from the focus of the meeting.

The practitioner gave the floor back to Fred. He talked about being "stabbed in the back" by a lot of people. Jim, Fred, and Bill began to discuss how they had felt "mistreated" by others. Bill rambled off topic. The practitioner and the other group members tried to get him back on track. Len was finally able to bring the discussion back to how he felt mistreated by friends and family. Len talked about how he felt that his problems revolved around his accident and how he, like Fred, wanted to leave Winnipeg. Fred and Jim described more personal situations with other people and how these situations had made them feel "angry."

The practitioner asked the members about ways that they could handle anger. Jim talked about being "antagonistic." Len talked about

"just walking away." Bill talked about "putting his head down and keeping to himself." Fred talked about reading the book Look Back in Anger. He said that he admired a character in the book who handled people who upset him by "pretending that they were not there." Fred then discussed how he used to exhibit quite a violent temper when he was angry.

As the meeting was drawing to a close, the practitioner asked the members if they wanted to discuss "handling anger" in greater depth. Fred and Len began to discuss again feelings about how others relate to them. As the session wound down, Jim mentioned that his birthday was next Thursday. Some jokes were made about having a party. Fred then asked if any of the practitioner's practicum advisors would be coming to the meetings and if they had seen the videotapes. The practitioner said that one advisor who had seen the tapes was interested in how the group made transitions from one topic to another. Fred said that the members simply focused on things that they wanted to discuss. Len asked if this type of group had been done before. The practitioner told him about a similar group which existed in a Vancouver hospital.

The practitioner reminded the group that this was the eighth session. She asked them to think about what the group had accomplished and what still needed to be done. The members did not comment on the fact that only four meetings remained. Instead they agreed that the practitioner should invite a guest to speak about "relaxation" at the ninth meeting. If a guest could not be found the members agreed to discuss "anger."

Practitioner's Analysis

There was a comfortable, close feeling evident among the members. They sat in close proximity to each other. Bill, Fred, and Len were able to explain what the group had done last week. They also gave Jim an opportunity to complete last week's exercise. Bill introduced the topic of "work" rather emphatically. The members took, and gave to each other, opportunities to communicate about their angry feelings. They were also able to help each other to explore various ways of handling those feelings. Jim, Fred, and Len shared the responsibility for keeping Bill on track during most of the meeting. They used body language, rather than words, to indicate their impatience with Bill's verbal rambling. Len tried to divert the discussion away from a sensitive issue only once. He did not resist the practitioner's effort to put the discussion back on track.

Jim and Len displayed the most energy, verbally and physically, during the meeting. They tended to raise their voices when they were trying to make their points to the group. There was not much use of humor by the members during the discussion. Jim, Fred, and Len took the most active roles in facilitating the discussion while Bill tended to do more following. Bill did facilitate the group to work on tasks by opening this meeting and by suggesting the agenda for the next one. Although many angry feelings were expressed, the members were able to end the meeting on a pleasant note. They wound the discussion down by focusing on Jim's birthday, the group's progress as a practicum, and questions about similar groups. Bill suggested the agenda for the next meeting and the others agreed.

The practitioner did not feel emotionally exhausted during this meeting because the members had conducted the meeting on their own. She had been free to concentrate on hearing and seeing what was going on in the group. The practitioner encouraged the members to think about termination but she did not prod them to discuss it in depth. She felt that her responsibility was to remind the members that termination was pending and to let them deal with it in their own way. The practitioner found that, again, the members could not end the group on time. They had so much to say that the group ran almost an hour overtime.

## NINTH MEETING

### Agenda

I. Introduce Ms. Shirley Grosser and her presentation on "relaxation."

### Brief Synopsis of Ninth Meeting

Bill, Jim, Fred, and Len were present. Ms. Grosser was introduced to the group. She led the members in a discussion about how relaxation worked for them. The relaxing effects of physical activity, mind altering substances, and music were discussed. Ms. Grosser led the group in the first of two relaxation exercises. After the exercise, the group took a break and continued to discuss relaxation. Jim began to talk about experiencing his head injury more as a "problem" than as a "sickness." Jim discussed how his girlfriend (i.e., common-law wife) had helped his recovery more than his doctor. Bill mentioned how the same doctor had "upset" him. As he spoke he appeared to be getting angry.

Ms. Grosser said that she was "hearing" the agenda which the group

would have discussed if she had not come (i.e., "anger"). Jim and Bill discussed how their girlfriends had been the major supports in their recoveries. Fred and Len seemed to be involved in their own discussion on the side. Bill tried to get the group back on the topic of relaxation. Ms. Grosser expressed her feeling that the topic of "anger" was important and that the group should continue with it. She asked if the group wanted her to remain present and they agreed that she should. Bill tried once more to get the group back on topic of "relaxation." Fred, Jim, and Len discussed their angry feelings toward the doctor and the hospital with which thay had all been involved during their treatment. They also discussed their feelings of anger toward other people who upset them in their personal lives. At this point, Bill seemed to "tune out," with his eyes shut and his head lowered.

As the discussion progressed, Jim asked "are we a hostile group?" Len and Fred talked more about handling angry feelings after head injury. Bill seemed to "wake up" and "tune in" as the others discussed venting anger by means of physical violence and their feelings about their accidents. Fred pondered how long it would take the group members to "get rid" of these angry feelings. Jim indicated that head injury was becoming more noticed as television stations were showing commercials about it. Bill interjected, mentioning that he had been "drifting off and doing the relaxation exercise" during most of this discussion. Fred and Len returned to discussing their angry feelings, post-head injury, which were directed toward family and friends. They seemed especially upset by peers who were "pressuring" them to return to heavy alcohol consumption.

As the group ended, the members focused on the importance of talking about their feelings with others who were "in the same boat." The group thanked Ms. Grosser for attending and the meeting ended.

Practitioner's Analysis

The group members really seemed to enjoy having Ms. Grosser attend. The relaxation exercise seemed to set a calm, relaxed tone for the evening. This tone prevailed even though the group members were discussing some highly emotionally charged issues.

The members seemed to be communicating more with each other. They asked questions of each other and made more empathetic comments than in previous meetings. No one "singled out" Bill for "tuning out" for most of the discussion. Perhaps he was afraid to open-up about his angry feelings. The few times he did contribute to the discussion he appeared to be "containing" his feelings. Fred, Len, and Jim really appeared interested in what each other had to say. At some point during the meeting, each member had taken some responsibility for the direction of the discussion. Jim seemed to be the member who took most responsibility for seeking information and facilitating the discussion. Fred and Len, along with Jim, shared much information about their feelings. Bill was the only member who appeared to be disappointed because the group was not able to stay with the agenda topic of "relaxation." Len appeared to be more thoughtful and more willing to share his feelings than he had been in previous meetings. Fred was able to share his feelings and both seek and give opinions about the issues being discussed. The group members appeared to be more physically relaxed in this meeting than in previous meetings. Perhaps the

relaxation exercise was the reason for this. Even Len and Jim made less tense body movements and exuded loss energy in their body language than they had during previous meetings.

The practitioner actually spoke very little during this meeting. She made use of listening skills and silences. The practitioner's comments involved reflecting and clarifying what group members were saying. The group members were actually responsible for discussing "anger" and related issues in a way that seemed comfortable to them. They did make some use of humor during the meeting. The practitioner felt very relaxed at the end of the meeting. She attributed this to two factors. First, the relaxation exercise had calmed her a great deal. Second, she had not invested a great deal of emotional energy in directing the meeting. The group members were able to do this while the practitioner sat back, listened to the discussion, and attended to the group process. It appeared that the members had done most of the "work" during this session. They talked about being head-injured and explored feelings of anger and frustration about their situations more openly and honestly than in previous meetings.

In spite of the serious nature of the discussion, the members left the meeting on a positive note. They wished Jim a "Happy Birthday" and left the room chatting and joking.

## TENTH MEETING

### Agenda

I. Allow the group to continue exploring the topic of "anger" as planned previously.

II. Prepare the group for pending termination.

III. Plan the next meeting.

Brief Synopsis of Tenth Meeting

Bill, Fred, and Jim were present. No one mentioned Len's absence. The meeting began with Bill and Jim expressing much dissatisfaction about their job situations. The practitioner led the group into a discussion about "anger" and about separating it into thoughts, feelings, and behaviors. Bill talked about his angry feelings toward a friend of his. Bill said that he had actually felt like "getting a gun and shooting his friend." Jim expressed that he felt that he was under a lot of pressure both at work and at home. He seemed particularly upset by his financial problems and by his frustrations around living with Laurie and her two children. Jim told the group that he had spoken to Laurie about his feelings and about leaving her to return to "single life."

The group discussed angry feelings, changing their ways of responding to anger, and ways of releasing anger. Jim and Bill began discussing their anger toward the people with whom they worked. The discussion returned to ways of expressing and releasing anger. Bill began to ramble off topic, as he discussed the anger he felt toward a once close friend. The practitioner tried to get Bill back on topic as Fred and Jim were fidgeting impatiently and making jokes on the side.

Jim finally spoke up and said "why are we so angry?" He expressed the feeling that "every time we come here we talk about anger." He asked Bill and Fred "why are we so angry when we're recovering?" Jim added that "lots of other people don't recover." Bill and Jim

verbalized that they felt "lucky to be making good recoveries." Bill said that his anger had driven him to the point of wanting to "kill" himself and he had seen a psychologist about this. He talked about being afraid that he would lose his job.

Jim asked the group "where all this anger was coming from." He asked "were we naturally angry before our accidents?" Jim talked about how he used to like to "drink and fight" and how he felt that anger was a "direct result of the past." Fred said that he "did not feel angry in the group" and that he felt it was "helpful to listen to other people talk about how they conquer problems." Fred said that participating in the meetings did not release anger.

Jim said that the group members had to "learn how not to get mad" but that no one can tell others how to accomplish this. Bill said that the worst part was "keeping anger inside" himself. Jim spoke again about his angry feelings about his financial situation and his life with Laurie and her children. He said that he felt sorry because he was "so hard on Laurie." Jim felt that he should leave her but that leaving was a "cop-out." Jim said that he was aware that he often "spoke without thinking" and that he was "thinking a lot about himself." The group members continued to discuss communication and ways that they had handled anger in various situations.

As the meeting drew to a close, the practitioner reminded the members that this was the tenth meeting. She asked them to think about what they had accomplished thus far. Jim talked about the possibility of the group conducting "rap sessions" for head-injured in-patients at the Rehab Centre. He wanted to give these people some inspiration and

talk to them about the anger and frustration that they might experience post-head injury. Jim said that it was many months after discharge from hospital before he could talk about "being sick and having problems." Fred and Jim discussed how a "rap group" such as the one Jim proposed might "scare" new head-injured patients. Jim and Fred talked about their memory problems, helping others, and about how they had been "curious about other head-injured people."

The practitioner asked the members to think about what they wanted from this group and what they felt the group needed to accomplish. Jim said that he came to the group to "let out frustrations to someone who'll listen and understand." Jim said that this was "what the group was all about." Fred expressed that when he left hospital he thought that his problems were "very big" and that now they were "smaller." He added that he still wanted more information about the future. Bill mentioned problems with his vision and Fred mentioned problems with his memory. Jim talked about the value of seeing a psychiatrist.

The practitioner asked the group if a twelve week period was enough to accomplish what the group members wanted from the group. Jim suggested that we review our videotapes at the last meeting and decide at that time whether or not to continue the group. Bill suggested that the practitioner should select exerpts from the videotapes of each meeting for the group to watch. As the meeting ended, the members agreed that the next meeting would be devoted to viewing the videotapes, deciding the future of the group, and planning the Christmas party.

## Practitioner's Analysis

The group members seemed to have set the tone for the meeting even

before it began. Bill's feelings about his job situation and Jim's feelings about his job, financial, and common-law situations led the group into the discussion about anger. It appeared that Jim had brought his own agenda to the meeting and that he was seeking opinions from the others about whether or not he should leave Laurie. Bill and Fred listened to him and seemed empathetic but neither of them tried to convince Jim to either stay with Laurie or leave her. During this meeting, Bill expressed, for the first time, the depths of his anger toward other people. He had talked about suicide before but this was the first time that he had actually talked about physically hurting another person who made him angry. Later in the meeting he did try to "smooth this over" by saying that he actually was feeling more kindly toward the friend who was the object of his anger. Jim and Fred shared many personal feelings around the issue of anger.

Communication seemed to be mainly member to member. Jim really made an effort to facilitate the group process with the questions about anger that he posed to Bill and Fred. Bill did tend to ramble off topic in this meeting. When he did this neither Fred nor Jim would ask him to stop. They seemed to deal with this by fidgeting impatiently and talking between themselves until either Bill stopped rambling or the practitioner got the discussion back on track. Jim was very open about sharing his feelings. Fred was somewhat open, yet guarded. Bill appeared to be the member who was most uncomfortable about discussing issues that were unpleasant or painful. When the practitioner reminded the members that the group would be terminating soon and asked the members about what they had accomplished and what needed to be done, Jim

focused the discussion on how the group could help others. Although this was a thought-provoking idea, the practitioner wondered if the group was discussing it in order to avoid dealing with the group's termination. When the practitioner was able to get the group to discuss the pending termination, each member had some good ideas about the work to be done at the twelfth meeting. Although the atmosphere created by the group was generally comfortable, Bill appeared to be the member who was most uncomfortable. He sat apart from the others, separated by an empty chair on either side. He sat upright for the entire meeting rarely moving his arms or legs. Fred and Jim appeared quite relaxed during the meeting, alternating between leaning forward and sitting back in their chairs. Fred and Jim only appeared to be impatient when Bill rambled off the topic.

During this meeting, the practitioner felt comfortable about using listening skills and silences. She offered direction only when the members seemed to be moving away from the topic. For the most part she allowed the members to be responsible for the direction of the discussion. The members seemed to be establishing their roles in the group. Jim seemed to be the task leader and Fred seemed most active in terms of group building and maintenance. Bill often seemed to be the member who performed mediating-harmonizing, supporting-encouraging, and following roles in the group process. Bill did sometimes seem to be performing non-functional roles in terms of his digressing from the discussion topic or seeking recognition. This seemed apparent when he would physically and verbally detach himself from the group and "tune out," or when he would verbally ramble far away from the topic. The

other group members appeared to have developed their own ways of coping with this and were able to return the group to its "work" when they were ready. During this meeting little humor was evident in the discussion. The members seemed to have accomplished a good deal of "work" during this session in terms of sharing and exploring feelings and using each other as "sounding boards." The practitioner had to be quite directive in terms of getting the members to think about what the group had accomplished, what needed to be done, and what activities would be employed in terminating the group. The group members did not seem to be able to plan an agenda for the eleventh meeting. Since the meeting had run longer than it was supposed to the agenda for next week was left open.

ELEVENTH MEETING

Agenda

I. Allow the members to choose the discussion topic.

II. Prepare the group for pending termination.

III. Plan the next meeting.

Brief Synopsis of Eleventh Meeting

Jim, Bill, and Fred were present. No one mentioned Len's absence. Before the meeting actually began, Bill told Jim and Fred that he had lost his job at the railroad. Fred and Jim talked to him about this for a few minutes. Fred announced that it was 7:10 p.m. and said "let's begin." The practitioner asked for a "mood reading." Fred said that he was in a "pretty good" mood. Jim expressed that he felt "the shits." He said that his biggest problem was a lack of money which was

depressing him, ruining his attitude toward work, and causing him to argue with Laurie. Jim said that he saw "no future" in where he worked. Fred appeared empathetic and made supportive comments while Jim spoke. Bill was obviously in a "down" mood. He rambled on about his problems at work, the bottom line being that he had been told that he was "not capable of working." Fred and Jim listened to him but their facial expressions indicated their frustration with his verbal rambling. As Bill continued to ramble, Jim and Fred fidgeted in their seats but would not stop him.

The practitioner summarized what Bill had said. She asked him to tell Jim and Fred how he felt and what he did when he learned that he had lost his job. Bill said that he "felt useless" and "wanted to jump off a building." His girlfriend took him to the hospital where he talked to a medical doctor who "calmed him down." Bill said that he waited several hours to see a psychiatrist but left the hospital because he and his girlfriend could not wait any longer. Bill felt that he had calmed down a lot since the visit to the hospital. Bill talked about his mental anguish. Jim broke the tension by singing "tis the season to be jolly-fa la la la la." Fred talked about his efforts to get back his job at the railroad. Jim talked about his fears that his "current attitude" might get him fired from his job.

The members talked about their "down" feelings and about how they felt that employers "watched" them more carefully than others because of their head injuries. Jim and Fred talked to Bill about the steps he could take to get back his job. Jim and Fred said that they were not optimistic about this because the railroad was a "big corporation." The

men discussed taking a "calm" versus a "hostile" approach to dealing with their problems. There was a lot of "interrupting" among the members, in a good-natured way, during this segment.

Jim said that they had to talk about how they were before their accidents--hostile, angry. Jim said that they had to have been that way because so much anger came out at the meetings. The members discussed how they all felt "labelled" as somewhat incapable because of their head injuries. The members talked about getting revenge on those who made them angry in their work situations. They also talked about how feelings of "anger" might really be feelings of "hurt" and about how they could become "strong."

Jim finally asked "how can we feel good about ourselves when we're always angry?" He said that he came to this meeting, after a "shitty week," hoping to hear "some good things" or "some cheery stuff" and to "talk about Christmas." He went on, saying that he "should've known better" because the group always discusses anger and frustration. He concluded by saying that "thinking about anger made him angrier." The group discussed handling anger by "thinking before speaking." They also talked about communicating anger not only with words, but also with looks and body postures. Jim talked about how "wild" he was before and how he had "changed for the better" since his accident. The members agreed that "God must have kept them on earth for a reason." As the discussion progressed, Jim and Fred tried to encourage Bill in his efforts to find another job. Bill mentioned that he was trying to do this and that he was "feeling better."

As the meeting drew to a close, the practitioner reminded the group

that next week would be the last meeting. They decided to review the videotapes and discuss the Christmas party.

Practitioner's Analysis

The tone for this meeting appeared to be set by the "down" moods of Bill and Jim. This week, it was Fred who got the group to begin it's work. Jim and Fred appeared to feel badly about Bill losing his job. Both Jim and Fred seemed to identify with Bill's problems at work and with the resulting anger, frustration, and sadness. During the meeting, the communication was clearly member-to-member. There was a lot of leaning forward and turning to face each other as they spoke. Jim and Fred were generally very patient when Bill rambled off topic but their aside comments and fidgeting indicated when they became frustrated. The members seemed comfortable about interjecting when they had something to contribute to the discussion. When Jim and Fred did interrupt Bill's lengthy verbalizations they did this in a good natured way, usually accompanied by a joke.

Jim did the most facilitating of the group's process. He asked questions of Bill and Fred in order to get them to share and explore opinions and feelings. The members confronted each other about their opinions and feelings. This was done in an inquisitive, non-threatening manner. Voices were often raised during this meeting when members felt a great deal of conviction about what they were saying. Jim often used humor to lighten the "down" tone of this meeting and to relieve the tension in the atmosphere. Fred seemed to be following the discussion and offering supportive comments and information. The members ended the meeting rather quietly. They had already planned the agenda for the

next week and were prepared to carry it out.

The practitioner did not have to exert a lot of energy to keep the discussion moving. Jim was taking the most active role in terms of facilitating the group to keep on track. The practitioner was able to concentrate on watching the group and on listening to the content of the discussion. Len's absence gave Jim, Bill, and Fred more opportunities to express themselves. Again, the content of the discussion focused on the members' angry feelings. The members could not seem to move beyond this and to focus on what they could do to alleviate these feelings and get on with their lives. Jim and Fred did end the meeting by supporting Bill in his efforts to seek other work. The members began cleaning up the room promptly at 9:00 p.m. as they did not seem to want to talk anymore.

## TWELFTH MEETING AND CHRISTMAS PARTY

### Agenda

I. Review and discuss the contents of the group's videotapes.

II. Allow the members to decide if the group is to terminate with this meeting. If so, arrange for individual post-group evaluations.

III. Finalize plans for the Christmas party.

### Brief Synopsis of Twelfth Meeting

Fred, Jim, Bill, and Len were present. The practitioner began the process of reviewing segments of each videotape and asking for the members' comments. Bill pointed out how the members seemed "protective" about what they said at the initial meeting. Fred noted that by the

second meeting the members seemed more relaxed. As the tapes were reviewed the members discussed a number of issues. Fred and Len talked about the value of meeting with people with similar injuries, experiences, and feelings. Len said that participating in the group had given him the confidence to be as independent as possible. Bill tended to ramble off the topic at one point and Len brought him back to the track. Len said that some sense of trust had developed among the members and the others agreed with him. Len and Fred questioned if female head-injury victims had experiences and feelings similar to those of the group members. This issue promoted the members to discuss again their feelings about family and friends.

Fred brought up a personal matter after the eighth tape was reviewed. He shared with the others concerns about the results of tests assessing his memory and I.Q. and how these decreased his chances of getting back his job at the railroad. Bill, Jim, and Len offered supportive comments and ideas about how Fred should handle this. Jim said that he had to share an experience in which his common-law wife viewed his independence. The practitioner asked the group to return to the review of the videotapes. When this was done, the members voiced their positive feelings about the group.

The members expressed agreement that this should be the final meeting. Bill suggested that the group should meet once a month but none of the others agreed with this. The members said that the practitioner had "done a good job." They agreed to meet with her to do individual evaluations of the group and complete a final set of questionnaires. Plans were made to meet at a restaurant for the

Christmas party next week.

Fred, Bill, Jim, and the practitioner attended the Christmas party. Jim and Bill brought their girlfriends. The other members wondered why Len did not come since he was the one who was most interested in the Christmas party. The evening was purely social and very enjoyable. It ended the group on a happy note. The day after the party Len phoned the practitioner to say he was sorry that he could not attend but that he had fallen asleep at home and had not awoke in time to get to the restaurant.

Practitioner's Analysis

During this final meeting, the group members appeared to be in good humor. They did a lot of joking and talking to each other during the meeting. The members seemed to have some difficulty keeping on topic. Each one seemed to have something to contribute to the discussion. Fred had his own agenda for the meeting. Midway through the viewing of the videotapes he discussed his disappointment with the results of his neuro-psychological tests. He appeared to be more hurt than angry as he talked about his disappointment with various professionals who were supposed to be helping him. None of the other members tried to get Fred to focus on the original agenda. They seemed to be more interested in offering their support than in staying with the agenda. The communication was mainly member-to-member during this meeting. The members were able to find viewing the videotapes and to decide that the group should terminate by the end of the meeting. The meeting ended promptly at 9:00 p.m. because Jim had to leave. The members helped to clean up the room while discussing plans for the Christmas party.

The practitioner did have to keep the members focused on the purpose of the meeting. Although all of the members were contributing equally, none of them took the lead in facilitating the group. The practitioner noted that none of the members expressed feelings of either pleasure or displeasure with the termination of the group. They all seemed accepting of termination, as if it was the natural thing to do. Only Bill expressed a desire to try to continue the group on a monthly basis. The practitioner noted that each member was able to identify what he had gotten out of the group. She was concerned that the group members congratulated her, rather than the group as a whole, for doing a good job. She felt that the members still regarded the group as "the practitioner's group" rather than as "their group."

# APPENDIX V

## SUMMARIES OF GROUP MEMBERS' FINAL EVALUATIONS OF THE GROUP EXPERIENCE

Bill

- I liked talking with others like myself (with brain injuries) about how we overcame depression and other problems we had.

- I felt relaxed.

- The contract ensured confidentiality.

- I saw the group as a means for me to help the practitioner to help other people.

- The questionnaires were not hard.

- I was disappointed because the presentation on relaxation was not completed.

- I was often more of a listener than a speaker. When I talk too much maybe I'm trying to impress others.

- I can't remember the topics discussed by the group.

- I can't remember enough to comment on if the group members were able to take responsibility for guiding the discussion.

- I can't comment on if the group accomplished its purpose.

- I found the group interesting.

- I had a sense of not finishing things. Maybe the group should have been longer.

- Everybody was expressing feelings on certain subjects.

- When I lost my job the group gave me support by giving suggestions on how I could solve my problem.

- It seemed like people were paying attention when others were talking.

- There was a mixture of seriousness and humor.

- We got off topics.

- If I was in another group like this I would assert myself more.

- In a small group everybody gets to voice opinions.

- I would have liked to have some girls in the group.

- The other members talked about dope and drugs. This talk bothered me a little and made me feel uncomfortable because I don't use drugs--they're illegal.

- There's no one in the group that I would really want to keep in contact with except for Fred.

- I might participate in a similar group or in a self-help group for the head-injured in the future.

- I don't think that I have changed as a result of being in the group.

Jim

- I felt comfortable about being with a group of people who have the same problems but I still felt like I was coming to the hospital.

- I came for conversation with other guys--to find out how they felt about their situations and how they were handling them.

- I didn't like how everybody in the group talked about seeing doctors, psychologists, and other professionals for everything--it irritated me.

- I liked the group because we were all different and had different thoughts.

- I didn't get enough opportunities to discuss my ideas and feelings in the group. I wanted the group to last longer because I would have liked to say more. Often, I didn't say what I wanted to because it was rude to interrupt.

- I and the other members held back a lot about what they wanted to say in terms of feelings--anger. I think people always say that they handle things better when in front of others.

- We never talked about love and feeling happiness.

- Len talked about his relatives a lot. He got me angry a few times--the way he said his relatives never helped him at all. I did try to confront him about this but he stuck to his negative attitude.

- I felt that the other group members could relate to my problems with money.

- We talked mainly about ourselves and our problems.

- The group members could not guide the discussion on topics--we always reverted to anger or frustration.

- Prior to meetings, I prepared myself for hearing a lot of angry feelings.

- I didn't take control because I felt that the others would not like it. I was sick too. Who was I to be leader? That's what the professional was for.

- The practitioner should have intervened more to get the group on topic. I didn't want to take control of the group because I wanted to be one of the group.

- It was best that we talked the way we did. People jumped in when they had something to say.

- I thought that discussing anger made the members more angry.

- I did not like the use of literature. Discussion was best.

- I think people did give each other ideas about how to survive in community life after head injury.

- The information discussed among the members was good. The meetings were helpful. I got to see others and how they were experiencing their problems so I could compare them to me.

- Even after a while, I still felt we were very shy of each other although we were sort of friends and buddies.

- Nothing really personal came out. A lot of things were not said that should have been said. This would have happened if the group had gone longer than twelve weeks.

- I came to the group to get support and attention, especially because I had a lot of problems around work. The group was not as supportive as it could have been. They just agreed with me. I didn't want this. I wanted some "kick back"--someone to confront me. If someone had done this, I would've thought twice about what I was feeling and saying.

- I tried to support Bill when he lost his job but his attitude did not allow this to happen. He built a barrier around himself. He thought he was very intelligent. This used to "rile me up."

- There was some feeling of closeness in the group.

- It ended too fast. I didn't want it to end. I think that the members were tired by the twelfth week. It was hard for me to come once a week because of my work. Once every two weeks might have been okay.

- I think that the group members liked coming to the meetings.

- I liked having four members. It was comfortable. Six might have been good too. We could have managed with ten--but could the practitioner have managed?

- Two leaders (i.e., practitioners) might have been better but could have caused confusion and mix-ups. One was enough.

- Two hours was about as much of a meeting as I could take.

- I felt closest to Fred. I gave him my phone number so we could keep in touch. Bill was a strange individual--not in a bad way. He was just not my kind of individual.

- I think that no personal friendships were established among the members because each had his own work and family.

- I would have liked to talk about happiness, love, togetherness, good things--instead of anger, frustration.

- The topics chosen in the group were the ones that promoted anger. Every meeting came to focus on anger. The psychologist's presentation was okay. The one on anger was not for me.

- I miss the group. I enjoyed going--even though we talked about anger.

- I liked the group because the guys were similar and we could talk about our injuries and our problems.

- I would have liked the group to be mixed--both males and females.

- I felt comfortable with a female practitioner as leader. Females have more feelings than men. As a social worker, you had a heart and understanding because you were female.

- I would participate in another group like this but I could not help form it because I get confused.

- The group members did not talk about near as much as we should have--me included. All we talked about was anger. I couldn't get away from anger for more than ten or fifteen minutes.

Fred

- I liked best the conversations which answered questions about my own feelings and ideas and which gave me a chance to compare my feelings and ideas to the other members.

- I learned that there were different types of illnesses as a result of head injury and that some people were better off than others.

- I felt comfortable in the group, except with Bill. I liked him but he would talk on and on--whether or not he was enhancing the topic. I think the rest of the group felt the same way. The practitioner could have limited the length of time that Bill spoke when it was his turn.

- I wanted to discuss a number of things in the group. Once I got the answers I wanted to hear I'd sit back and listen. If I felt that the discussion wasn't going anywhere I'd ask a question.

- We had a lot of freedom to express our ideas in the group and to have some control over the topics.

- I tried to stop others from going off topic by asking questions about the topic.

- I did not like it when topics were overdone.

- I was most nervous on the first night--evaluating the other members.

- I had as much freedom as I wanted.

- Any problems in the group were relatively little--for example, a couple of people didn't know when to stop talking.

- A couple of us really got things going and the ones that were slow starters jumped in to agree or disagree.

- A couple of us were not afraid to take chances.

- The group had a comfortable atmosphere.

- The group started off a little slow because everyone wanted to discuss certain topics. I hoped that the group would go farther. I wanted to hear the thoughts of the other members.

- I felt comfortable with the discussion topics because they were on my mind and I had joined the group to hear how others dealt with these things. I couldn't think of any more topics for the group to explore.

- I felt that each member's concern was what the group could do for him. I really came to the group to get my concerns and problems addressed.

- The members conversed openly and joked. Most of them just wanted to discuss ideas they had around what was happening after the accident.

- The most personal discussion was the one about Bill losing his job.

- We got emotional support on what we went through after our injuries, not on our day-to-day problems.

- I felt close to Jim because I liked him--he was similar to me in many ways. I agreed to keep in touch with him.

- I felt no discomfort with the practitioner's role in the group.

- The group would be a valuable service for other head-injured people. They could meet and evaluate themselves and each other. I'd like to see this become a permanent program.

- Twelve weeks went by fast. If the group lasted longer there would have been cohesiveness among a few members and likely a little more anger--for example, anger directed at Bill because he wouldn't shut-up.

- We had a limited amount of time. It was important to the group's work that everyone arrive at meetings on time and get to work.

- I felt that for the group to operate properly all of the members should have been present for each meeting.

- I was sad to see it end but if it had gone on maybe the interest would have decreased.

- I would have liked more guest speakers.

- At least two females in the group might have given it a different perspective--might have formed another type of group experience.

- The group could have been used to help each member discuss his future plans and get suggestions from other members.

- The practitioner gave members a lot of freedom but not so much that the group would get out of hand.

<u>Len</u>

- I wanted to see what the lives of other people with serious head injuries were like--how they felt about their families and friends.

- I was put at ease because we were similar.

- I got to share my ideas and hear other people's.

- One thing I didn't like--we could never stay on topic.

- We covered a lot.

- I didn't guide the group because I thought that since we were dealing with people who had head injuries I had to watch what I said.

- I "carry on" but I get my point across--I felt that I shouldn't put others "on the spot."

- I didn't know if the members really said what was on their minds. Someone would throw out a line and we'd start discussing that.

- The onus was on the practitioner to keep group members on track.

- Everything got answered in a round about way.

- I enjoyed the group. I got to express my thoughts and feelings. I found out about the different effects of head injury in the group.

- Everybody had the opportunity to express feelings and thoughts and if they didn't it was their own fault. If you put people "on the spot" they could "shy away," feel embarrassed, or resent it.

- We might have benefitted more if we stuck to the agendas.

- Some of the topics we had--we could go on and on and there would still be a lot of unanswered questions.

- Mostly I was curious about people in situations similar to mine.

- I liked the speaker to a point. I liked the presentations on head injury and relaxation. Now I think that we should have given people like doctors and family members opportunities to come to the group.

- I felt that the group gave emotional support--especially one or two of the members I discussed things with on the side--not in front of the group.

- I didn't bring my day-to-day personal problems to the group. I just stuck with the bigger issues being discussed in the group.

- The group offered a degree of support to people who brought special problems to the group.

- I got what I wanted from the group.

- There was a bond among the group members to a certain point because we were all "coming back." The bond was sufficient for this type of group.

- Some ideas I benefitted from--some "backfired" on me.

- I didn't mind people bringing personal problems to the group. I felt that a certain member would come to the group in a bad mood, after having a rough day at work, and would "snap" at me, but I didn't mind. This was what the group was all about--to talk about life after head injury.

- The group "jived" because we did it our way. We attempted agendas--but we had priorities. We were more concerned about ourselves than anyone else. We didn't have all of the answers.

- The group helped me a lot. I'd like to see this go on again but not with the same people or with these same people and more additional members. I would try another group if it was offered by a professional. I could not help to set up a group.

- Unfortunately, I didn't get all my questions answered in this group.

- I have not formed any relationships outside of the group with the other men from the group.

- I met one group member from the group in another setting. I did not feel that he was behaving outside of the group as he did in the group. He wasn't the same person.

- I would like to form more of a relationship with Fred. There were others in the group that, perhaps, I wouldn't give the time of day

to.

- I felt comfortable with the number of people in the group.

- I would have liked to have some women who experienced head injury in the group. More people in the group might have brought more experiences to the group.

- I was comfortable having a female practitioner in the group. I'm more at ease with a woman.

- There should have been a co-leader. The practitioner was in a difficult position. It was difficult for one practitioner to manage all that was going on in the group. The practitioner handled it well.

- I didn't want to take a leadership role in the group. There were too many things going on in my personal life that I was thinking about.

- Meeting once a week for two hours would have been enough if we got out everything we wanted to and got the momentum going. We seemed to run out of time just as we were getting results.

- The group members were given sufficient time to decide whether or not to extend the group. I would try it again with some changes.

- I miss the group to a certain degree but I also don't like to dwell on my misfortunes. Twelve weeks was enough.

- The group boosted my morale.

- The group definitely changed my attitude. By coming and getting together with others going through the same thing or worse I relieved a lot of frustration--that's what changed my attitude.

- I thought that the group's focus on anger was great. The group was a place to get a lot of frustration out.

- I got to say what was on my mind. We all shared something in the

group.

- I was curious, more than anything else, to see if anyone else had the same problems as me--some had worse problems.

- Having a female practitioner helped as well. I felt that I could confide and trust.

- If things could have been done differently I would have liked to have more guest speakers; female head injury victims in the group; co-leaders; and longer meetings--maybe once very two weeks for three hours.

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