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**A SELF-EFFICACY PSYCHO-EDUCATIONAL GROUP
FOR PRE-DIALYSIS CHRONIC RENAL DISEASE PATIENTS**

BY

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**A Practicum
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of**

Master of Social Work

**Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba**

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of Manitoba in partial fulfillment of the requirements of the degree
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ABSTRACT

Masters of Social Work Practicum

A self-efficacy psycho educational treatment group for pre-dialysis chronic renal disease patients

This group work practicum was conducted by the author in her position as research assistant for a study funded by the Kidney Foundation entitled "Evaluation of a Self-Efficacy Educational Treatment Program for Pre-Dialysis Chronic Renal Disease Patients". Two psycho educational groups were conducted for pre-dialysis patients recruited from two city hospital ambulatory care departments. Patients were offered a six week closed psycho educational group based on the principles of self-efficacy theory. Self-efficacy is described as a person's perceived, as opposed to actual capability, of carrying out a particular action (Bandura, 1977 a). To enhance self-efficacy four techniques based on sources of self-efficacy information were incorporated into the group format: performance attainment, verbal persuasion, vicarious learning and emotional arousal.

Evaluation of her practicum included pre and post testing of group participants with a matched control group. Perceptions of carrying out specific positive health behaviours were expected to increase through attendance at the group program. Results indicated that no dramatic changes in self-efficacy perceptions occurred. Individual changes for group participants were noted. The self-efficacy psycho educational group as a practice model for social work has implications for use with varied populations.

ACKNOWLEDGEMENTS

The author would like to express her gratitude to the investigators of the research project “ Evaluation of a Self-Efficacy Treatment Program for Pre-dialysis Chronic Renal Disease Patients” for the opportunity to use this experience toward this Master of Social Work Practicum. In particular I would like to thank Dr. Ed Johnson for his patience and direction, and to Ellen Tabisz and Irma MacKay for their support and encouragement. I am indebted to my advisor to Dr. Len Spearman for seeing me through this process. I am very grateful for the insight and for the learning experiences’ from the men and women who participated as subjects for this study. A great deal of appreciation goes to my wonderful family, especially to my partner Andrew. And, an extra thank you to Aidan, my son, who inspired me throughout the completion of this practicum report.

CHAPTER ONE: INTRODUCTION

The construct of self-efficacy refers to an individuals' assessment of their effectiveness or competency to perform a specific behavior successfully. Understandably, individuals with low self-efficacy expectations are likely to avoid situations and environments that exceed their perceptions of their own coping skills. Instead they will seek out activities and environments which they judge themselves capable of handling (Bandura, 1977 b, 1986). For individuals faced with adjustment to chronic illnesses such as kidney disease, coming to terms with it can be difficult. For these patients, getting enough exercise, following prescribed diets and medications can be overwhelming because they may perceive themselves as not being able to cope with the demands of their illness . Enhancing the perceived self-efficacy of kidney disease patients is the intent of this Master of Social Work practicum. A psycho-educational group based on the principles of self-efficacy was provided to a population of pre-dialysis chronic renal disease patients. It was anticipated this group work intervention would increase self-efficacy expectations so that these patients would feel better prepared and more confident in managing the demands of dialysis.

The concepts of self-esteem and of locus of control are mistakenly used interchangeably with self efficacy. Self-efficacy is behaviour specific, and is based on one's expectancy or confidence that they can successfully execute the behaviour required to produce a given outcome. For example, someone may have a very high level of efficacy for getting dressed in the morning but a very low level of efficacy for flying an air plane (Lorig, 1996). Self esteem refers

to an individual's perception of his or her self worth (Strauser, 1995). Locus of control theory examines how individuals believe their lives are being controlled by either internal or external forces (Rotter, 1966). Some individuals believe that most of the control over their lives is in their own hands. According to Lorig (1996), individuals with internal control "are likely to work hard at making changes in their behaviours that they believe will help them". Some people view control over their lives as being external. These individuals believe that God, doctors, or other forces control their lives. Lorig(1996) states that "these individuals are likely to feel that there is nothing they can do to help their situation.". Locus of control is generalised to one's whole being, and is not behaviour specific as is self-efficacy. Therefore, self-efficacy focuses on one's confidence or lack of confidence in carrying out a specific task, and the ability to predict future behaviours. Conversely, locus of control is one's world view of internal and external forces that govern their lives.

There is an emerging trend in social work practice and in health care delivery that recognises the value of self-efficacy as a construct in promoting health behaviours for individuals confronting a chronic illness (Furnstenberg & Rounds,1995; Becker & Schaller,1995; Rosenberg, 1994). The move toward health promotion is gaining momentum for individuals diagnosed with a chronic illness. Health does not mean being free from disease. Health is seen as an individual actualising information and skills through goal directed behaviour, competent self-care, and satisfying relationships with others (Pender, 1987 in Becker, Schaller, 1995).

Given the accepted current trend in health promotion , the construct of self-efficacy is a relevant topic in our world that rewards self-reliance and self-help. Individuals are encouraged and expected to become active participants

in the management of their health. Rosenberg (1994), urges social workers to consider the changing nature of patients receiving care as patients now want to be involved in the course of their treatment. He argues there is a trend toward individual involvement in one's own health care and community management in prevention that is totally unlike the traditional emergency room, crisis-induced, physician-dependent perception of health care (Rosenberg, 1994).

1.1 RATIONALE AND OBJECTIVES

The shift toward self-directed health care was of interest to this author and hence is the rationale behind her participation in this Master of Social Work practicum. The practicum report details the experiences of the author's involvement and collaboration in a Self Efficacy Patient Education Project. The author chose to participate in the project to focus her learning on strategies in the area of health promotion utilizing self-efficacy and patient education. The author was employed as a research assistant and group facilitator by the investigators of a research project funded by the Allied Health Scientific Program of the Kidney Foundation of Canada, entitled, "Evaluation of a Self-Efficacy Educational Treatment Program for pre-dialysis Chronic Renal Disease Patients". The research investigators of this renal patient education project for pre-dialysis clients included Ellen Tabisz, M.S.W., research consultant, Department of Social Work, Health Sciences Centre, and Adjunct Professor at the University of Manitoba, Dr. Edward A. Johnson of the Department of Psychology at the University of Manitoba, Kenneth Mah, M.A., of the Department of Psychology at McGill University, and Irma MacKay, M.S.W., Director of the Department of Social Work, Health Sciences Centre of Winnipeg.

The author collaborated with the investigators in the development of specific group work techniques and experiences to enhance the design and implementation of the program.

In addition to detailing the experiences of the author, the practicum report also evaluates the success of the program's psycho-educational group intervention. The intervention was administered to two groups, the first group was co-facilitated by Dr. Ed Johnson, and the second group was lead solely by the author. The purpose of the group was to promote self-efficacy and decrease symptoms of depression for pre-dialysis patients diagnosed with chronic renal failure. Tabisz, Johnson, Mah, and MacKay, (1996) reviewed extensive literature supporting their theoretical view that a self-efficacy model of patient education may reduce anxiety/depression and improve subsequent long-term psychosocial adjustment of renal patients. The research investigator's objective was to address the lack of patient education research conducted with pre-dialysis populations. The vast majority of research was limited to either the end stage renal disease population or to those individuals already receiving some type of dialysis, and to individuals having received a transplant.

The focus of the research investigators was also to address and simulate on a smaller scale the findings of a longitudinal study of patient education for pre-dialysis patients by Binik, Devins, Barre, Guttman et al.(1993). This study indicated that "pre-dialysis patients exposed to an enhanced education program developed by the investigators were able to delay initiation of renal replacement therapy by an average of 4.6 months", Binik et al. (1993). While Binik et al. (1993), were unable to interpret the mechanisms of this result, such a finding has profound implications for the needs of this particular end stage

renal disease population, and the potential efficacy and usefulness of an education intervention to serve those needs. Binik et al.(1993) did note that although they were not clear on how the delay of the onset of dialysis occurred that, "increased knowledge typically also results in increased predictability and contributes to decreased anxiety and increased perceived control over threatening events" . This insight further strengthened Tabisz et al. thesis that an element of self-efficacy in the maintenance of ones' health could delay the start of renal replacement therapy. This concept of increasing a patient's knowledge base to enhance his or her coping abilities, is the cornerstone in the development of a self-efficacy based psycho-educational program.

De-Nour (1981) reports in his work with pre-dialysis populations that psycho-therapeutic work should start before the commencement of dialysis. His findings indicate that the work should be dynamic and oriented toward behaviour modification. His research focused on the personality traits of individual's and their predicted adjustment to dialysis. De-Nour (1981) found that compliance was related to an individual's vocational achievements and locus of control, and those with poor adjustment were more likely to have passive dependent traits. De Nour's research also indicated that locus of control plays an important role in predicting health maintenance behaviour. Based on this outcome one could conclude the importance of offering interventions to individuals prior to the onset of renal replacement therapy. This further strengthens the rationale to focus on promoting an individual's sense of self-efficacy or perception that they are able meet the challenges presented by chronic renal failure.

1.2 Personal Goals

The construct of self-efficacy and it's application in a psycho-educational

group for pre-dialysis clients with end stage renal disease is the foci of this Master of Social Work practicum. The author explored the principles of self-efficacy, a concept developed by Albert Bandura (1977 a), and applied them in an intervention that promoted and increased the client's sense of competency (self-efficacy) over their health maintenance. The author developed her knowledge of formulating specific intervention strategies in the promotion and application of self-efficacy theory.

1.3 Learning Objectives and Skill Attainment

- 1) To develop an understanding of the principles of Bandura's (1977 b) self-efficacy social learning theory, and to apply the four elements of self-efficacy in the delivery of a patient education program for pre-dialysis chronic renal disease patients.
- 2) To develop competence in the delivery of patient education, specific to the needs of pre-dialysis renal patients.
- 3) To develop skills in analysing and presenting data for self-efficacy measures.
- 4) To foster growth and confidence in the delivery of psycho-educational material based on cognitive behavioural techniques such as progressive muscle relaxation and cognitive restructuring.
- 5) To design and implement a social work intervention based on self-efficacy, health promotion and empowerment theory in working with chronic disease populations.

The format of this practicum report consists of a literature review in chapter two that details the psycho-social needs of renal patients and examines the need to provide education before the onset of dialysis. In addition, chapter two discusses the role of medical social work in context of the dramatic changes foreseen in the trend towards health promotion, wellness and patient directed care. Following this, chapter three examines how self-

efficacy can be utilised to promote self-determination and empowerment through the vehicle of group work. The fourth chapter will discuss the procedures of intervention, including the recruitment of volunteers, and the assignment of participants to control and treatment groups.

The fifth chapter provides a report on the content and process of the self-efficacy treatment group sessions. The sixth and final chapter will provide an evaluation of the group work intervention based on two scales of self-efficacy. Pre and post scores from two self-efficacy scales are utilised. Those scales are the Generalised Self-Efficacy Scale (GSE), (Tipton, Worthington, 1984), and the Specific Self Efficacy Scale (SSE), by Kaplan, Ries, Prewitt, and Eakin (1994). This will be followed by a conclusion of the practicum

CHAPTER TWO

LITERATURE REVIEW

2.1 PSYCHO-SOCIAL IMPLICATIONS OF RENAL DISEASE

Healthy kidneys play a vital role in the body. Their function is as important as the heart and lungs. There are normally two kidneys located under the lower ribs and are the size of a clenched fist. Their main job is to remove wastes from the blood, such as urea and creatinine, and to produce urine. The kidneys also regulate the body's water levels by removing excess water from the body, or to retain water when the body needs more. Another important role of this vital organ is the production of hormones. These hormones created by the kidneys circulate in the blood stream and regulate important body functions such as blood pressure, the making of red blood cells and the uptake of calcium from the intestine (Kidney Foundation of Canada, 1990).

Kidney disease is a chronic condition that affects an individual in a myriad of ways. Once the kidneys fail or function below 10%, the only treatment options are dialysis or transplantation. There is great variation in the rate of deterioration of the kidneys and the amount of warning patients have. According to Binik et al. (1983), "At one extreme, patients may be told at childhood or adolescence about the possibility of kidney failure which may not occur for 20 or more years; at the other, the deterioration can occur in a matter of weeks or even instantaneously as a result of accident or trauma." Chronic kidney failure is normally caused by a pre-existing chronic illness. The conditions that cause renal failure are diabetes, high blood pressure, and the inflammation of the kidney's capillary loops, otherwise known as

glomerulonephritis (Binik, 1983).

2.2 Chronic Illness and Renal Disease

2.2.1 The Individual

The population of chronic renal disease patients of concern in this practicum were those who are considered to be “pre-dialysis”. These patients’ kidney function is very close to the 10% function margin and require careful observation by their nephrologist. The decision to start dialysis is a medical one. It is based on two criteria: a) “ when blood chemistry values have exceeded a serum creatinine threshold of 1000 $\mu\text{mol/l}$ and b) the patient is sufficiently symptomatic that renal replacement therapy is considered necessary” (Binik et al., 1993). Individuals under study in this practicum had serum creatinine levels of 300 $\mu\text{mol/l}$ or more. A normal creatinine level for the general population is approximately 80 $\mu\text{mol/l}$.

Once the pre-dialysis population is advised of their failing kidney function, they await as the disease slowly diminishes the ability of their kidneys to remove waste byproducts from their body. This period of gradual kidney failure is termed chronic renal disease. This population must contemplate the inevitable consequences of their kidney disease. Among the stressors that await them are the constant threat of death, the potential for reduced life expectancy, the dependence on medical machinery and personnel, and the decrease in physical strength and stamina (Devins, 1983). A patient on dialysis requires self maintenance to restrict fluid intake, follow a prescribed diet, and to independently manage their medications. Personal time must be sacrificed in order to accommodate the treatment regimes of dialysis . Time spent on hemodialysis machines is generally three to four times a week, each session lasting appropriately three hours to five hours. These life saving treatments often take

place at a hospital ambulatory care unit. Kidney failure patients, on continuous ambulatory peritoneal dialysis (CAPD), must have at least four exchanges of fluid per day, and are plagued by the constant fear of abdominal infections. CAPD can be performed by the patient at home or at the work place, making it an attractive alternative to hospital based hemodialysis. In order to meet the demands of CAPD, individuals must be fairly competent to perform the procedure and should have a good social supports to provide care in cases of emergency.. For individuals who receive a kidney transplant they must face a life time of anti-rejection medications accompanied by the ever present anxiety of organ rejection.

There is little doubt that chronic renal failure meets the earliest known criteria for the definition of chronic illness (Siddell, 1997). This definition of chronic illness was provided by the National Commission of Chronic Illness in 1949, " All impairments or deviations from normal that have one or more of the following characteristics: are permanent, leave residual disability; are caused by non-reversible pathological alteration; require special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation or care". (Diamond, 1984, in Siddell, 1997). Literature in the social work field suggests kidney disease is unlike any other chronic illness: "in few other forms of chronic illness does one have to cope with so much so simultaneously" (Tramo, 1978).

Renal failure can permeate every aspect of an individual's life. It is a chronic condition that must be absorbed into their already complicated lives. Tramo(1978.), states that " with the numerous medication and special diet restrictions the pre-dialysis patient is in a constant awareness of his fragility". Renal disease may force some pre-dialysis and the majority of dialysis patients

to reduce their participation in the work place, leisure activities such as sports and travel, sexual activity, and duties and responsibilities in the home.

Certainly these activities can still be managed and enjoyed however, they now require special planning and effort to accommodate treatment schedules and or levels of wellness.

Devins (1983), suggests the intrusions of renal failure can threaten the individual's security and enjoyment of life. These individuals he explains, can also experience other losses such as reduced feelings of personal prestige, self-respect and esteem, and an overall reduction in the perceived quality of life. There is also the potential for the development of depression for 25% of individuals diagnosed with chronic renal failure. Of those 25 %, 70% develop depression between diagnosis and the onset of dialysis (Hong et al., 1987, Craven et al., 1987).

Physical symptoms are a source of stress and loss to both renal pre-dialysis patients and to renal patients already receiving dialysis. Among these symptoms are reduced physical strength and stamina and increased uremic symptoms, (drowsiness, concentration difficulties, nausea, easy bruising or bleeding). In addition to these physical symptoms, the renal disease patients' level of wellness is also compounded by the presence of pre-existing health problems such as diabetes, hypertension, bone and cardiovascular disease (Devins, 1983).

A literature review of adult adjustment issues in chronic illness undertaken by Nancy Siddel (1997), reflects the growing attention on the adjustment processes experienced by individuals with life threatening conditions . A pervading theme in Siddel's review of the literature focused on the loss of control. The experience that the course of the illness is out of the

person's control and hence feels powerless is often experience by pre-dialysis patients. " If this perception of powerlessness continues and is unrestrained, a cycle of low self-esteem, depression and hopelessness is begun" (Miller,1983, in Siddel, 1997) Hong et al. (1987), in their study on depression and end-stage renal disease, noted that 12 of the 17 participants in their study met the DSM-III criteria for major depression before the onset of dialysis. After the onset of dialysis only 5 met the criteria for major depression. They attributed this to the reaction of impending losses, including family role, self-concept and vocation, and further suggested that pretreatment depressions are reactive to the diagnosis of end stage renal disease (Hong et al.1987).

The emotional reactions of individuals confronted by a major life crisis such as a diagnosis of a chronic illness like kidney disease can also experience, aside from depression, many fears and ambivalences about what the future will hold. Newly diagnosed pre-dialysis patients could be overwhelmed the medical systems' culture of language, schedules, and system of interaction and consequently feel panicked by it. These fears are aptly identified by Pollin (1994), who has developed a list of eight fears of a person with a chronic illness (1) loss of control; (2) loss of self-image; (3) loss or fear of dependency; (4) stigma; (5) abandonment; (6) expression of anger; (7) isolation, and; (8) death.

2.2.2 The Family

Family plays a major role in supporting the individual with chronic kidney disease. There is little research that examines the issues of family members of chronic renal disease patients. What is available is quite dated but never the less still relevant. Steinglass, (1981), suggests that the quality of family functioning is strongly predictive of both patient compliance with hospital based

hemo-dialysis and of adjustment to home dialysis. The stress of a chronic illness affects not only the individual but their family as well. The patient may become angry with him or herself for becoming ill, upsetting his/her life plan and his/her social, economic, and family homeostasis (Abrams, 1980). There could be an imbalance in the relationship where one partner takes on too much responsibility. In many cases an individual with a chronic illness becomes over dependent or helpless, causing one partner to over compensate (Strain, 1981). According to Drees & Gallagher (1981), "the marital partner of the dialysis patient has to bear much of the stress during the pre-dialysis phase of diminishing renal function, and then with dialysis itself.". Major adjustments for family members include accepting that there are new restrictions on the pre-dialysis patient such a dietary restrictions: "It is always difficult in family situations to limit the food intake of one member without psychological impact or actual dietary changes for the other members."(Drees& Gallagher, 1981). Personal sacrifice is often a theme for many family members of chronic kidney disease patients. The sacrifices range in degrees of complexity such as: following the same diet as the kidney patient, donating a compatible kidney for transplant , making a long term commitment of attending medical appointments, attending home dialysis training, and becoming a home dialysis partner. At times the stress associated with this chronic disease is more than some marital partners can handle. Divorce and separation are not uncommon in marriages affected by renal failure and dialysis (Drees & Gallagher, 1981).

2.3 The Role of Social Work in Chronic Disease and Health Promotion

A trend, or shift from acute care to chronic care is evidenced in how health care resources are now focusing on early detection and subsequent

management of chronic care illnesses (Simmons, 1994). According to Simmons (1994), eighty percent of all deaths and ninety percent of all morbidity are the result of chronic diseases and of an aging population. People are living longer with chronic illnesses because of advances in medical technology. Hence, the focus of health care resources and of medical social work practice of the future will be on the needs of patients with chronic conditions and those of the elderly. Health promotion programs that emphasis self-care will require special planning to meet the needs of elderly people with chronic health conditions.

Lorig (1996), echoes the rationale for health promotion and patient education in meeting the needs of an aging population . One of the benefits of patient education cited by Lorig et al. (1996) is what she terms “compressed morbidity”. Lorig et al. explains that people generally have healthy lives until their fifth or sixth decade. By the age of sixty an individual’s health begins to decline over the next 15 to 30 years until death. Lorig proposes that introducing patient education to people with illnesses like hypertension or heart disease may help stabilise the condition rather than have it progress on a steady downward path. They further suggest, instead of having a situation in which people get diseases at age sixty and live with chronic problems for the next 20 years, we may be able to push the onset of the disease back to age 75, thus compressing the morbidity (Lorig et al. 1996). Hence, the rationale for health promotion and patient education is to allow people to live the fullest life possible for the longest possible time, and to compress the time that they are infirm due to health (Lorig et al. 1996).

The role of medical social work is to meet the challenge of health

promotion and anticipate greater participation in the delivery of preventative strategies. The opportunity to “compress morbidity” as detailed by Lorig (1996), in dealing with chronic care populations such as those with chronic kidney disease is an invaluable role for renal social workers . As noted earlier in this practicum report, the causes of kidney disease can be related to pre-existing conditions such as diabetes and hypertension. If these populations can be offered patient education that promotes self-efficacy and they are able to stabilise their condition, it may be possible to delay the onset of progressive kidney disease. The participants in this practicum were at the stage where their condition was irreversible. Yet there may be some self-management activities such as adhering to diet restrictions , getting exercise, using stress management techniques and following their medications that could “buy” them some extra time.

Simmons (1994) suggests that early intervention through prevention, health education, life planning, insurance counselling and health promotion education will be important strategies in working in primary health settings, where the greatest amount of patients are seen and early detection can most readily occur. Simmons (1994) recommends promoting and enhancing patient “self -management”. This also confirms the importance of encouraging patient self-determination and enhancing a patients perception of their self-efficacy toward the development of healthy coping behaviours and involvement in the direction of one's health. Self-determination is a value traditionally associated with the profession of social work. This value reflects a predicted trend towards health promotion and wellness support in community service programs (Rosenberg, 1994).

Simmons (1994) identifies many social work interventions aimed at

optimising patient self-care and family supportive management as follows:

- *Education of patient and family to basic lifestyle and compliance issues and their consequences for medical management;
- *Counselling and encouragement to motivate patients to apply their understanding of these lifestyle factors to their own self management;
- *Consultation to help patients and families understand how to access and use appropriate resources to facilitate self management;
- *Guidance through the maze of service resources such as families and neighbours;
- *Assistance in mobilising natural resources such as families and neighbours;
- *Counselling to encourage adherence to agreed on care plans and working through barriers to them (Simmon, 1994).

2.4 Self-Efficacy and Health

Many health related disciplines are embracing the concept of self-efficacy (Becker and Schaller, 1995; Clark, 1996; Lorig,1996 Strauser, 1995). Gecas (1989) conducted an extensive literature review on the social psychology of self-efficacy which included health behaviours. He concluded that the enhancement of self-efficacy is indeed beneficial in the promotion of health related coping and behaviour. Seeman & Seeman (1982 in Gecas 1989), indicate that individuals with high self-efficacy to be more likely to initiate preventive care, to seek early treatment and be more optimistic about its effectiveness, to rate their health as better, and to be sick less often.

Bandura and others limit the definition of self-efficacy to beliefs about

capabilities of performing a specific behaviour in a specific situation (Fursteberg and Rounds, 1995). Performing specific healthy behaviours can be enhanced by incorporating self-efficacy and health promotion. Becker & Schaller (1995) suggest that, self-efficacy has emerged as a predictor of various health behaviours such as quitting smoking, weight loss, and continued exercise. By demonstrating higher levels of perceived self-efficacy it suggests mastery of one's self-care in matters of health , illness, and recovery.

In contrast, Wortman & Dunkel-Scheetter(1979 cited in Gecas, 1989) suggest a strong sense of internal control may not be helpful in situations in which an individuals' personal control over outcomes is minimal, since patients may become discouraged when their beliefs in personal efficacy are challenged by their inability to control the disease. They report that internals or those with high self-efficacy may be more likely to blame themselves for their deteriorating physical condition. An example of this lack of control over the progress of a disease was demonstrated in a study by Cassileth (1985 cited in Gecas, 1989). Cancer patients who scored high on self-efficacy scales were compared to cancer patients with low self-efficacy scores, with no measurable effect on the outcome of the disease .

A cautious approach should be followed in dealing with individuals with chronic health conditions. Social workers must utilize an approach that encourages personal control over matters in which patients can have influence over, and to accept conditions which they do not have complete control. There is additional research indicating cases where self-efficacy is not associated with favourable health outcomes. Individuals with "type A" personalities may be high in self-efficacy and internal control, yet do not necessarily have better health outcomes (Gecas, 1989). These individuals may be more likely to

demonstrate changes in their health behaviour such as following strict diets, getting enough exercise and giving up smoking. These personality types however, are also at a higher risk of heart attacks, ulcers, and other stress-related ailments . Gecas (1989), clarified that these negative health outcomes may be due to some of the other characteristics associated with “type A” personalities, such as hostility, impatience, and the inability to relax.

2.5 Self- Efficacy and Patient Education

Lorig et al (1996) has demonstrated that integrating self-efficacy theory and patient education programs produce good results . Improved health behaviours and reduced pain for arthritis patients were the results of a 12 year patient education study conducted by Lorig et al. (1985,1992, 1996). Patients who participated in their Arthritis Self- Management program demonstrated that an increased perception of personal control contributed to increased effectiveness in lowering pain and disability. Lorig et al. (1996) determined that reported feelings of personal control could be operationalized as perceived self-efficacy. Based on these positive health outcomes, Lorig et al. (1996) adopted the self-efficacy construct as the central theoretical model for their most recent program, the Chronic Disease Self Management Study.

The benefits of education for pre-dialysis patients are well documented in the literature (Binik, 1993; Devins, 1983; Hong et al. 1987; Tramo, 1978). Devins' (1983) research on patients with end stage renal disease, was aimed at enhancing personal control and minimizing illness intrusiveness. Devins' data indicated that increasing patient education for this population was associated with increased levels of perceived control over non illness aspects of life. Devins (1983) goes further to suggest that enhanced education may contribute

to improved psycho-social adjustment by increasing the ability to anticipate future developments. Devin (1983) recommends simple interventions that could enhance an individuals sense of personal control: "enhanced education; forewarning; choice; and familiarity with unit staff, procedures and policies". Binik et al.,(1993) were able to conclude that the benefits of early education for pre-dialysis patients could result in the delay of dialysis treatment. Tabisz et al. (1996) anticipate that the results of the"Evaluation of a Self-Efficacy Educational Treatment Program for Pre-dialysis Chronic Renal Disease Patients" will delay the onset of the need for dialysis similar to Binik's (1993) study.

Caution must be exercised by not providing false hope to patients with a deteriorating chronic health condition. Binik (1993), was unable to explain what underlying mechanisms were in place to delay the onset of dialysis by at times up to 4.6 months. Gecas (1989) infers that self-efficacy may work as "mysterious" mechanism to affect health or recovery from illness, perhaps affecting the endocrine system or the immune system. Gecas (1989), maintains that self-efficacy, strength of belief, or state of mind seem to play a key role in delaying treatment or providing a miracle cure. The participants of this project were advised of the potential benefits of attending an education program based on enhancing self-efficacy. Some of the benefits highlighted to the patients were the possibility of feeling better about themselves, and the potential delay of the onset of dialysis.treatment. It was however emphasised that their condition was irreversible and that there was no guarantee that this program would slow down the progression of their disease.

2.6 Self-Efficacy and Social Work: Creating a Connection

The role of social work has traditionally emphasized the importance of enabling individuals to perceive themselves as capable and self reliant. It is

only recently that social work literature has integrated the work of Bandura's (1977) "Social Learning Theory of Self-Efficacy" into social work practice (Fursteberg and Rounds, 1995; Gutierrez, Delois and GlenMaye, 1995). Rather than attributing a global personality trait that operates independently of contextual factors, Bandura and others limit the definition of self-efficacy to beliefs about capabilities of performing a specific behaviour in a specific situation (Fursteberg and Rounds, 1995).

To harness the principles of self-efficacy into a model of social work intervention, it is necessary to examine this concept in closer detail. The construct of self-efficacy as defined by Bandura (1977), in his work on social learning theory, is distinguished by two efficacy expectations. The first, "outcome expectations", is defined as a "person's estimate that a given behaviour will lead to certain outcomes" (Bandura, 1977 a, p.193). The second is "efficacy expectations" and is defined as " a judgment of one's capability to accomplish a certain level of performance" (Bandura, 1986, p.391). Efficacy expectations is thought to affect how much effort people will expend and how long they will persist in the face of obstacles and aversive experiences. The stronger the perceived self-efficacy, or conviction to complete the behaviour, the more active the efforts (Bandura, 1977 a). He explains that the difference between outcome and efficacy expectations lie in the belief or conviction an individual has that a particular course of action will produce a certain outcome. If the individual is not confident about performing a certain behaviour, such information does not influence their behaviour to perform those actions (Bandura, 1977 b). The stronger an individual's perceived self-efficacy in performing a difficult behaviour then, the more likely they will try to cope with a difficult situation such as a chronic illness.

Creating opportunities for chronic renal patients to enhance their efficacy expectations was the main challenge for this author and investigators of this project. The development of group work exercises for the pre-dialysis patients utilised guidelines established by Bandura (1977 a). To promote self-efficacy through experiences of mastery, four principle sources of information are needed: enactive attainment (or performance accomplishment), vicarious experience, verbal persuasion, and emotive coping (or physiological states). These sources of information contribute to an individual's perception of being capable of performing specific behaviours in specific situations. The application of these four sources of self-efficacy information for this practicum is detailed in Chapter Three.

Presented below are the four sources of self-efficacy information and corresponding suggestions for social work intervention:

1) Enactive Attainments: Bandura (1977 a, 1986) describes enactive attainment as the most dependable source of efficacy expectations because they are based on one's own personal experience via participant modelling, performance desensitisation, performance exposure, and self-instructed performance. In mastering a task successfully, it will increase an individual's belief or expectation that they can complete that task again, or conversely failure to complete a task will lead to a negative outcome. Therefore the performance of the task and the observation and interpretation are essential elements of enactive attainment. Furstenberg & Rounds, (1995) suggest for social workers, that enactive attainment interventions should to focus on (1) teaching skills and structuring opportunities for performance and (2) guiding observation and interpretation of behavioural performances.

2) Vicariously Derived Information : Bandura (1977 b) reports that observing others perform threatening activities without adverse consequences can create expectations in observers that they too will eventually succeed if they intensify and persist in their efforts. They persuade themselves that if others can do it, they should be able to achieve at least some improvements in performance. This is accomplished by observing live modelling and symbolic modelling (Bandura, 1977 b). There are three ways as noted by Furstenberg & Rounds (1995), in which social workers use vicariously derived efficacy information: by modelling behaviours directly; by creating therapeutic, task-focused, support, or self-help groups in which people can observe or hear how other members perform particular behaviours; and by helping clients to reflect upon the behaviour and experiences of people whom they know.

3) Verbal Persuasion: This efficacy expectation refers to verbal efforts to convince someone that they are capable of carrying out a certain task through suggestion, exhortation, self-instruction, and interpretive treatments. Bandura (1977 b) cites that this type of persuasion leads people to believe that they can cope successfully with certain overwhelming situations. For this to work, the persuader must be credible and the task or situation to be mastered be attainable and realistic. Unrealistic persuasion will discredit the persuader and undermine the recipient's self-efficacy (Bandura, 1986). The role of a social worker should focus on convincing the client that they (the client) can do something, rests on the mutual assessment of the client's capacities rather than on faith alone. Alternately, self-efficacy can be enhanced through verbal persuasion by offering or helping clients to interpret success in ways that highlight their ability and effort. This approach suggests that success does not result solely from external

circumstances. Furstenberg & Rounds (1995) also report this approach will have a greater impact on the client's self-efficacy when the social worker helps the client reflect on recent personal successes and specifically connects these successes to future situations.

It is important that the client perceive the persuader as credible and must believe that the persuader fully understands the demands of the task and the complexity of the situation (Furstenberg & Rounds, 1995). This is a critical skill for any professional engaging in verbal persuasion particularly in leading a psycho-educational group for a specific chronic disease population.

4) Observation of One's Own Physiological State or Emotional Arousal:

Bandura (1977 a) explains that high emotional arousal usually debilitates performance. Individuals are more likely to expect success when they are not beset by aversive arousal than when they are tense, shaking, and agitated. Social workers can assist clients by teaching relaxation techniques, stress management counselling, rehearsal or role playing, and through desensitisation techniques (Furstenburg & Rounds, 1995).

2.7 Summary

This chapter has provided a literature review of the psycho-social implications of chronic renal failure patients. There was discussion on the emotional aspects of renal disease and in general the issue of chronic disease and depression. It has discussed the role of social work and the emerging trend towards the provision of health promotion and patient education to chronic disease populations. This chapter reviewed the construct of self-efficacy theory

(Bandura, 1977 a). The enhancement of an individual's self-efficacy was examined as an important and useful social work intervention. The next chapter will focus on psycho-educational group work.

CHAPTER THREE

3.1 GROUP WORK AND SELF-EFFICACY

There is good reason to pursue the construct of self-efficacy given its benefits to clients with chronic illness. There is ample room for the profession of social work, among other disciplines, to provide a role in the emerging trend toward patient education. The best vehicle to facilitate self-efficacy is in the provision of relevant and structured psycho-educational groups. Within the context of the group, individuals have the opportunity to learn from specific educational presentations, to participate in activities that will enhance their perceived self-efficacy, the opportunity to learn from each other, and to gain social support for themselves and significant others. Concepts such as empowerment theory are useful in developing skills and techniques that enable individuals to become active participants in the management of their health. It is appropriate then to review empowerment theory and its application to group work. The use of empowerment principles in group work can be utilized to encourage positive health behaviours and to “help the patient help themselves”. Enhancing personal power is defined in three ways: the ability to get what one needs; the ability to influence how others think, feel, act, or believe; the ability to influence the distribution of resources in a social system such as a family, organization, community, or society (Gutierrez et al., 1995)

Linking the work of Bandura reviewed in the previous chapter, and having a general understanding of empowerment theory can be an excellent guide for social workers in conducting a group aimed at enhancing and empowering individuals' perception of self-efficacy. The four sources of efficacy information described earlier, (Enactive Attainment, Vicarious

Experience, Verbal Persuasion, and Observing One's Own Physiological State) are activities that can be easily incorporated into a psycho-educational group to enhance the participants perceived self-efficacy in managing a chronic illness. By engaging in these group activities, social work clients who feel powerless in the medical system, may gain confidence in seeking out what they need to better manage their illness. These clients may simply need to seek out more information about their illness, or to feel confident in demanding the distribution of resources needed in the medical system.

Social work is said to incorporate elements of self-efficacy in its focus on empowerment and power themes in the development of group work for disadvantaged populations. Empowerment has elements of self-efficacy in terms of an individuals' beliefs or perceptions that they can overcome what is oppressing them. According to Gutierrez, Delois and GlenMaye (1995, p.535), "Empowerment is a process it consists of the following sub processes: development of group consciousness, reduction of self-blame, assumption of personal responsibility for change and enhancement of self-efficacy." Personal responsibility for change and the enhancement of self-efficacy are ideals that can be fostered and encouraged in group work with medical patients.

Empowerment literature in the social work field is well documented. It has been defined as one of the major skills and responsibilities of today's social worker (Browne,1993). In the field of health, social workers have long advocated for patient rights that include empowering patients to maintain a level of control over their treatment without alienating themselves from medical services. The role of social work in advocating for this empowerment within the health care team is equally important (Simmons, 1994). A recent study by Gutierrez et al. (1995) found that practitioners think of empowerment as a

psychological process of change. Critical in this change was the process of self-awareness and use of a strength based orientation to achieve a sense of personal power. Practice methods identified by Gutierrez et al. (1995, p.541) in contributing to the process of empowerment include: "the importance of relationship and working collaboratively with consumers, the need to involve consumers in developing concrete skills for developing social power, the importance of education, and the importance of recognizing and building on strengths". Encouraging active contributions from participants, focusing on their strengths and experiences, and providing education are methods suggested in enhancing and contributing to the process of empowerment. These practice methods should be considered in the provision of a psycho-educational group for medical patients.

Bandura's social learning theory provides an understanding in human behaviour that group work facilitators can utilize in empowering patients' efficacy toward positive health behaviours. Bandura's behaviorist theory is based on a social cognitive view where human functioning is not simply driven by internal and external forces. Human functioning, he argues, is explained in terms of a model of triadic reciprocity in which behaviour, cognitive and other personal factors, and environmental events all operate as interacting determinants of each others (Bandura, 1977 b). Bandura states that within this reciprocal relationship of person and the environment individuals also have basic capabilities. What is helpful to group facilitators is the knowledge, that in providing a group work experience to enhance one's capacity to cope with a chronic illness, that the group experience in itself will not determine a positive or negative outcome for the participant. Rather, outcome is influenced by what the participant themselves bring to, and process from the group through their own

basic capabilities.

Bandura (1986, pp.18-21) identifies the five basic human capabilities as :

- 1) Symbolizing Capability: "Through symbols people process and transform transient experiences into internal models that serve as guides for future action".
- 2) Forethought Capability: " Images of desirable future events tend to foster the behaviour most likely to bring about their realization. By representing foreseeable outcomes symbolically, people can convert future consequences into current motivators and regulators of foresightful behaviour".
- 3) Vicarious Capability: "The capacity to learn by observation enables people to acquire rules for generating and regulation behavioural patterns without having to form them gradually by tedious trial and error".
- 4) Self-Regulatory Capability: "After personal standards have been adopted, discrepancies between a performance and the standard against which it is measured activate evaluative self-reactions, which serve to influence subsequent behaviour".
- 5) Self-Reflective Capability: " People not only gain understanding through reflection, they evaluate and alter their own thinking. In the self-appraisal of efficacy, there are many sources of information that must be processed and weighed through self-referent thought" (Bandura, 1986, pp.18-21).

Bandura's view of human functioning provides a holistic approach. It also provides a "person in the environment" perspective which is a systems

approach normally found in social work theory. Traditionally behavioural group therapists use learning as the core of its intervention. They utilize methods such as operant conditioning (using reinforcement to increase or decrease a behaviour), and classical conditioning (systematic desensitization), (Bradender & Fallon, 1993). Bandura's approach to changing behaviour does not rely solely on a mechanistic view of human behaviour, but one that encompasses constructs such as expectancies, cognitions, and symbolic processes (Bradender & Fallon, 1993).

The group provides a vehicle or context for change to occur. Bandura (1986) suggests in his social learning theory that learning and change are a result of "reciprocal determinism". Bradender & Fallon, (1993, p.515) comment on Bandura's social learning theory in the context of behavioural group therapy, and find that the construct of "reciprocal determinismthe notion that individuals act on their environment , which in turn influences the individual in an interactive loop- crucially affects the interventions of the behavioural group therapist". They suggest that group therapists encourage the individual to acquire new behaviours and to modify existing responses. Bradender & Fallon (1993) suggest the process of change in the context of group work can be enhanced by designing activities to encourage the patient's engagement in a self-observational tasks. Change can also be enhanced in group work by simply relying on group process, whereas members provide one another with both examples of new appropriate behaviour (vicarious learning) and valued feedback and reinforcements (Bradender & Fallon, 1993).

3.2 Group Work Structure: Psycho-Educational Model

The availability of literature on group work in health care from a social work perspective is well established. (Bekman et al. , 1988; Rutchick 1990;

Lurie et al., 1982). Time-limited structured groups are ideal for medical patients who require a structured setting that provides both educational and emotional support. Structured groups take form from a variety of issues such as groups for coping with anxiety, in social skill development, and for assertiveness training groups. Drum and Knott, (1977) are frequently referenced in current literature reviews on the theoretical constructs of time limited structured groups. They provide an practical guide in establishing structured time-limited groups, currently referred to as psycho educational groups. Toseland & Rivas, (1995, p.188) explain that, "because they (structured groups) focus on educating members as well as on providing emotional support, these groups are sometimes referred to as "psycho educational " treatment groups.

The orientation of psycho-educational group therapists is based on behaviourist principles. The emphasis on changing or enhancing a target behaviour is the rationale for the behaviourist approach. Rose (1980, p.4), notes these target " behaviours are usually social behaviours and the methods of intervention are derived for the most part, are from social learning theory, eg. reinforcement, coaching, modelling, rehearsal, stimulus control, and discrimination". Hence, the need for the group design to include components of Bandura's social learning theory.

A common element among structured groups, noted by Drum & Knott (1977, p.16) is the "emphasis placed on the educational-experiential format for over coming difficulties or producing growth, rather than the more traditional one-to one verbal process method of helping ". Again, this underscores Bandura's agenda of observational learning or vicarious learning through the context of group work. An additional commonality of structured groups is the

establishment of the goals and objectives. It is normally the sponsoring agency that identifies the goals of the structured group, unlike process or unstructured groups where goals are identified by the participants.

Drum & Knott (1977, pp. 24-25) provide an informative guide for leading time-limited structured groups. They identify eight reasons why structured formats are beneficial facilitators and participants:

- 1). They demystify the process of self-discovery and self-enhancement by systematic structuring for goal attainment;
- 2). Through appropriate structured exercises they encourage people to gently but firmly increase their ability to try new behaviours or examine issues they would normally avoid;
- 3). They allow for both peer and professional feedback relating to a specific interpersonal skill of life issue;
- 4). They present an economical use of treatment time;
- 5). They encourage change and growth by providing a mechanism of active problem solving;
- 6). They help participants become aware of the frequent occurrence of the type of problem situation they are attempting to resolve;
- 7). They reduce the stigma associated with seeking help because they focus on common developmental needs utilising an educational-experiential format;
- 8). They establish the boundaries of the contract between the leader and the participants and thereby create a sense of psychological safety for group members (Drum & Knott, 1977).

There is an abundance of literature that describe the content of psycho-

educational group work (Toseland & Rivas,1995; Glassman& Kates; Garvin, 1981; Drum & Knott 1977; Rose, 1980). Psycho-educational groups are becoming increasingly popular because of the emphasis on education and of the possibility of receiving emotional support. These groups consist of a closed, time limited (6-12 weeks), structured environment led by one or two facilitators. The framework of this type of group is attractive to agencies, as the format can be replicated intact, or modified and adapted to fit different types of client groups.(Toseland & Rivas, 1995).

The content of psycho-educational group work follows a predictable schedule of events such as; **(a)** educational material, **(b)** exercises, role play, and simulations to help members practice the material, **(c)** discussion of the material and the problems members are experiencing outside of the group, **(d)** a brief period to go over weekly assignments for members to do outside the group, and **(e)** and evaluation of the meeting (Toseland & Rivas,1995, p.188).

When developing the structure of a psycho-educational group Drum & Knott (1977, pp.37-39) suggest formatting should include the following considerations:

1) Elaboration of the goal.

Participants should clearly understand what is to be changed by attending the group. For example, participants will need to understand in non-technical terminology what is the meaning of enhancing their self-efficacy. Stating to the participant that the goal of the group is to increase their *confidence* in management of the renal disease might suffice.

2) Specification of major program elements.

It is important that the participant understands how specifically self efficacy can help *them* cope with renal disease. They would need to

understand what the components of self-efficacy are, its definition and the four sources of information needed to enhance it. (Enactive Attainment, Vicarious Experience, Verbal Persuasion, and Observing One's Own Physiological State).

3). Identification of objectives and selection of appropriate exercises and techniques.

For example, a renal group work participant may require assistance in communicating their needs to medical personnel. They may benefit from the fifth session in the pre-dialysis self-efficacy program on assertiveness training. (See Appendix A). The participant will learn specifically what assertiveness means and how to implement it. (body language, tone of voice, their right to seek out information etc.)

4) Provision of the opportunity for reality testing

The individual is given the opportunity to test out their new learning and receive feedback from the other group members within the context of the group. This helps to operationalize newly acquired skills and increases the likelihood that these skills can be utilized outside the group. For example, the take home assignment for the assertiveness training lecture in session five (see Appendix A), is a performance attainment exercise. The exercise instructed participants to use new skills outside of the group environment. Participants were asked to contact someone in their medical team with specific question concerning their renal disease.

5). Determination of size, duration and membership.

The size of the group depends on how much individual attention each member is to receive. The duration and number of sessions will vary according to the group goal and size. The pre-dialysis self-efficacy group

was comprised of six to eight members. These members all have progressive renal disease at the same level of severity (creatinine level of 300 or more). The basic inclusion criteria for any group is the commonness of a specific need, and willingness to achieve the group objectives and goal. To select appropriate members, a pre-screening interview with each prospective participant is recommended to assess the potential members motivation and suitability (Drum & Knott, 1977, pp.37-39).

3.3 Group Process

The format of psycho-educational group work relies heavily on the delivery of a preplanned structured and time limited educational program. Psycho-educational groups are therefore less process-oriented than open ended groups such as therapy or support groups. Because there is less focus on process, psycho-educational groups may be characterised as ignoring the interpersonal and emotional interactions of its members. In many cases, this characterization is untrue. The leader must not only attend to aspects of task or action oriented themes in structured group work, but must also balance this with the socio-emotional needs of the participants (Bales, 1950). Research on task and therapy groups by Bales'(1950), found that task groups focused two thirds of the group interaction on task accomplishment and one third on socio-emotional aspects, such as giving support and releasing tension. Toseland & Rivas (1995), suggest there is no magic formula in the group worker's role of attending to the balance between task and socio-emotional needs of the group participants. They suggest that dissatisfaction and a less effective group

experience can occur among members in structured psycho-educational groups if attention to socio-emotional issues are ignored. Therefore, a balance between structured activities and attention to the socio-emotional aspects of group process in structured groups is essential.

Yalom, (1995) identifies 12 curative factors that contribute to the effectiveness of all psychotherapy groups. They are as follows: the instillation of hope, universality, the imparting of information, altruism, the corrective recapitulation of the primary family group, the development of socializing techniques, insight, imitative behaviour, interpersonal learning, group cohesiveness, catharsis, and existential factors. Ulman-Hubb (1993), reports for medical patients, the most important curative factors for them is the imparting of information and universality. She states "medical patients come to groups to deal with their medical problems, rather than to learn about their emotional lives" (Ulman-Hubb, 1993, p.460). For medical patients, it is important to explore emotional themes as they arise in structured group work. Ulman-Hubb (1993), suggests that the relative importance to the curative factors of participants may change, as after participation in a group, medical patients often develop increased curiosity about their emotional functioning.

In group work the facilitator should be knowledgeable about group process. The group leader needs to be cognizant of the difference between content and process. The leader must attend to the content of the group, or of what is said, how it is said, and to whom, but also understand the underlying communication patterns and dynamics of the members and of the group itself. Yalom (1995, p.131), defines group process "as the group therapists' role in understanding what a particular sequence reveals about the relationship between one patient and the other group members, or between clusters or

cliques of members, or between the members and the leader, or finally between the group as a whole and its primary task.”

The leader of the group not only attends to the dynamics and relationships between its member, but also on the group as a whole and its developmental process. Borg & Bruce (1991, p.106), in their extensive literature review on group work, found some writers emphasise the emotional changes that characterize group process, while others emphasise changes in how the group accomplishes a specified task. In either case, both emotional issues and task oriented goals are inter-related in most group work. They cite the work of Schutz (1973), who identifies three phases of emotional development that group participants must deal with in the process of group development:

Phase 1) Inclusion:

Will I be in or out of the group? What will be my commitment to the group? This phase is characterized by small talk, watching other members, and getting to know members in a superficial way.

Phase 2) Control:

Who will be in charge? How will power be distributed in the group? This phase is characterized by struggles for leadership and approval, competition, and disagreements.

Phase 3) Affection: Will I be emotionally close or distant? Do the members in the group like me, or I them? This phase is characterized by behaviour that connotes positive and negative feelings, heightened emotional reactions, and pairing (Schulz, 1973 in Borg & Bruce, 1991, p106.).

Borg & Bruce (1991), cite the work of Tubb (1984), who integrates the work of Tuckman (1965), Fisher (1980), Thelan and Dickerman (1949); and Bennis and Sheppard (1956, 1961) in a four phase model of how group process develops in task oriented group work. These phases can be generalized to most types of psycho-educational group work: 1). forming, orientation, dependence or inclusion, 2). storming, conflict or independence 3). norming, emergence, harmony or focus work. 4). performing, reinforcement or productivity phase (Tubb, 1984, in Borg & Bruce, 1991, p.107)).

Phase 1) Forming, Orientation, Dependence or Inclusion Phase:

A period during which group members are tentative with each other; trying to establish a basic social relationship and beginning to learn about each other. In this phase, participants familiarize themselves with each other and the group's purpose.

Phase 2) Storming, Conflict or Interdependence Phase:

A period during which the group begins to work on ideas and procedures for getting its job done. The group realises the time for small talk is past and it needs to move to its central task. Conflict may emerge as members vie for power and status within the group.

Phase 3) Norming, Emergence Harmony or Focus Work Phase:

This is a period in which group cohesion becomes more evident. The group settles down to work. Dissent is dissipated for the sake of group unity.

Phase 4) Performing, Reinforcement or Productivity Phase:

The period in which the group not only performs optimally but also recognizes its own success. Members tend to "pat each other on the back' for doing a good job. Participants recognize that the group is

coming to a close, even if they are not fully satisfied, the participants generally have a need to leave the group feeling it was a worthwhile experience (Tubb, 1984, in Borg & Bruce, 1991, 107).

In a structured group environment, such as psycho educational groups, social workers view structure as a tool that is used to help members and the group as a whole achieve agreed upon objectives. (Toseland, 1995). Structure as a construct is not enough to create change. The worker as a change agent must strive to influence the group towards its objectives. There are four areas in which the group facilitator can influence the process of the group that will help the group members achieve their goals. Toseland (1995, pp.283-289) identifies these four areas as critical to the effective functioning of any group: 1) communication and interaction patterns; 2) attraction; 3) social controls; and 4) culture.

1) Communication and Interaction Patterns:

The group facilitator may intervene to change the frequency, duration, distribution, or content of the groups' communication and interaction processes. For example, encouraging the participation of a silent member by asking their opinion about content of the group discussion.

2) Attraction:

Social workers can facilitate group cohesion by providing a warm, caring and empathic group environment. By modelling genuine concern and interest in each member's experience, the leader encourages members to tune in to each other's needs, and to reach out in supportive, mutual helping interactions.

3) Social Controls:

Social controls are exerted through norms, roles, status hierarchies, and the various power bases from which the leader draws authority. Workers help group members adhere to therapeutic group norms and change norms that are interfering with the group in accomplishing its goal.

4) Culture:

One way to change group culture is to challenge commonly held beliefs and ideas held by members. Workers can also introduce taboo subjects and create contracts with hard to engage members (Toseland, 1995, pp.283-289).

3.4 Role of Facilitator:

The role of the facilitator is heightened given the brief duration of short-term group work. Glassman & Kates (1990) note that facilitators must move participants towards more interactive, experiential, and didactic activity in the short-term group. The role of the group facilitator in psycho-educational formats is not one that is based on a therapeutic relationship between themselves and the participants. Rather, Brabender & Fallon (1993) suggest the role of the group leader is to facilitate behavioural change as a credible and authoritative source of information and education. They recommend psycho-educational group leaders should also motivate members and provide a comfortable environment in which to skills can be learned. Brabender & Fallon (1993), indicate that the most successful facilitators of structured time limited groups are those group therapists who are expressive, active, lively, and even charismatic participants in the group. Drum & Knott (1977) contend that it is not essential

for the leader of a structured group to have actually developed the program being offered. They caution that the leader have some experience apprenticing or co-facilitating the group first before becoming the primary leader.

The issue of co-facilitating the group for the renal patients was addressed by this research team, and determined that the first group be co-facilitated by this writer and Dr. Ed Johnson. This arrangement was considered appropriate, and beneficial as apprenticing or co-facilitating allows the future group leader to obtain "hands-on" experience that will enable him/her to develop flexibility and avoid total dependence on the original design (Drum & Knott, 1977).

In terms of the efficacy of group work, studies have demonstrated that groups with specific purposes, homogeneous concerns, clear agendas, and structured group meetings were found to be more effective than groups with less structure (Toseland & Rivas, 1995). There is literature available that deals with the specific issues of dialysis patients in group work, (Abrams, 1980; Steinglass et al. 1982) yet there is little or no research available regarding group work with pre-dialysis patients. Hong et al., (1987, p.190), suggest that group participation in the pre-dialysis phase would decrease depression and increase adaptation to dialysis through what he describes as "period of active intervention which includes a comprehensive psycho-social assessment and the provision of frequent opportunities for patient support and education". Devins (1983), also recommends including a period of patient education and orientation to lessen the affects of illness intrusiveness and increase the pre-dialysis patient's sense of personal control.

3.5 Summary

This Chapter reviewed the application of self-efficacy and psycho-educational group work. This chapter also provided a review of group work dynamics that included the use of empowerment theory in group work, process, group structure, development, and role of group leader. A review of psycho-educational group work was conducted with emphasis on the needs of medical patients. The need and absence of group work interventions for pre-dialysis populations was indicated. The next chapter will discuss the issue of intervention, focusing on the setting, the client , the recruitment phase, and the procedures and methodology used in the establishment of a pre-dialysis self-efficacy patient education project.

Chapter Four

Intervention

4.1 Recruitment of Participants

The self-efficacy psycho-educational project involved the recruitment of pre-dialysis candidates with a blood creatinine serum levels of 300 or more, the completion of self-report questionnaires and the participation in a six week two hour psycho-educational group. The writer's responsibilities as a research assistant involved the process of recruitment , interviewing, and organising and scheduling group sessions. The writer's duties included administering the pre and post tests, and liaison with two hospital renal failure clinics (The St. Boniface General Hospital and The Health Sciences Centre). The analysis of the enhanced self-efficacy program was based on two treatment groups conducted in July, 1997 and November, 1997. The author co - facilitated the first group with investigator Dr. Ed Johnson and was the sole facilitator for second group. Each treatment group had a corresponding control group. All group participants agreed to complete instruments at the study entry, post group, and again in three months time. For the purposes of this author's practicum,. findings for the pre and post tests of both the treatment groups and of the control groups will be cited only at the study entry and at post group.

- The original recruitment process entailed recruiting pre-dialysis patients at the chronic renal failure clinics. This was not a successful method in recruitment . It was found that screening for willing participants and those with appropriate creatinine levels, physical tolerance, and language ability was immensely time consuming. Many patients attending the clinics had little time to meet with the writer due to the extensive tests undertaken at each clinic visit. Many patients were fatigued by their clinic schedule and not willing to spare

additional time with the writer. Finding interview space at the renal clinics also posed a problem. This writer was only able to recruit 5 participants within a two month period.

There was also an issue of setting resistance, where gate keepers at one of the hospitals were cautious and unwilling to cooperate with the author and investigators. A formal presentation was made to the nephrologists and support staff, to provide information about the project and to address any concerns. This was thought to have alleviated any misconceptions about the project, and assured individuals that the researchers were not planning to replace or duplicate the education program already in place at the hospital.

To address the difficulty in recruiting participants, the writer and the researchers developed a letter with a literacy level of grade six to grade eight using a program on Word Perfect 6.0. (See Appendix E) The letters were sent to patients with the creatinine levels criteria level lowered from 400 to 300 to increase the opportunity to reach more patients. The writer manually reviewed medical charts to gather information to determine if the candidates met the criteria. Criteria for participation included: meeting the minimum serum creatinine level of 300, the ability to speak and to understand English, having no unstable psychiatric disorders or unresolved substance abuse issues, and candidates who are not palliative or reside in a personal care home. The letters were signed by the patients' attending nephrologist to inform the patients of the project and their anticipated participation. Participants were sent the letter and were then contacted by the writer to schedule an interview.

The response from the letter writing campaign was reassuring. Of approximately 60 letters mailed, a total of 12 pre-dialysis patients responded and met with this author. From the authors original recruiting efforts at the

chronic renal clinics, three patients were still interested in participating and two individuals were excluded because they had started dialysis. In total then, there were 17 individuals recruited for the first group session but only 15 were eligible due to the exclusion of the two who started dialysis.

With a strategy in place, recruitment efforts for the second group proceeded with less difficulty. Approximately 64 letters in the second recruitment were sent to pre-dialysis individuals. Of these 9 were successfully recruited. There were less eligible candidates in the second recruitment. Efforts were made to recontact individuals from the first recruitment whom the author was unable to reach. Approximately 15 of the 64 were from the first recruitment. Letters were also sent to people who lived in rural Manitoba who would have originally been excluded because of distance. Surprisingly 7 people from rural Manitoba were interested in the project, and of those, 4 were successfully recruited. Hence the composition of the two treatment groups varied greatly in that the first group was comprised of urban pre-dialysis patients and the second comprised mostly of rural patients.

The writer contacted each letter recipient by phone to enquire if they had received their letter and if were they interested in participating in the self-efficacy education group. The majority of telephone contacts were pleasant. Those who declined cited health problems would not permit them to attend, others were too busy with work or their children to commit to a group, and others simply did not want to spend time talking about their illness. For those individuals who were interested in the group, the writer arranged to meet with them at the Department of Social Work at the Health Sciences Centre. Some individuals brought a family member with them to the intake interviews. One participant with a physical disability was interviewed in their home. At the intake

meeting the writer explained to the participants the purpose, benefits and risks of the project. Part of the risk in agreeing to participate was being selected for the control group and not to be offered the treatment group. When contacting the participants about their selection into the control group, some were quite disappointed but were still agreed to continue with the project.

The project statistics consultant age-matched patients before being randomly assigned to treatment or control groups. He determined the first group would comprise of eight individuals , five women and three men, with a mean age of 58.5 years. The control group would be comprised of two men and five women with a mean age of 59.2. The second group comprised of two women and four men with a mean age of 53.1. The control for the second group consisted of 3 men with a mean age of 52.6.

The control group was tracked with follow up questionnaires immediately after the end a treatment group and again three months later. The writer maintained telephone contact with both control and treatment groups to call and remind them to send in their post tests or to thank them if they already had. This gave the author a opportunity to check in on those who were not a part of the treatment program, and also to inquire on the well-being and progress of the treatment group members.

4.2 Procedures of Intervention and Structure:

The first pre-dialysis education group was conducted at the St. Boniface General Hospital July 16th to August 20, 1997, Wednesday evenings from 7pm to 9pm. The second group was held at the same hospital, October 15th to November 19, 1997, Wednesday afternoons from 1:30pm to 3:30.p.m. The author conducted the second treatment group in the afternoon to accommodate the travel needs of the rural participants, of which three participants drove over

two hours. The sessions were two hours in length with a fifteen minute break. Group one was a test pilot. It was co-lead by this writer and Dr. Edward Johnson. Group two was lead solely by the writer. All sessions were audio recorded. The writer met with Dr. Johnson regularly for supervision throughout the first and second group.

The program structure was based on psycho-educational presentations, followed by discussion and take home assignments. The facilitator provided the lead in establishing the programs purpose and rationale to ensure that all members present were reminded of their common reason for attending the group. This included welcoming all participants to the group and providing an overview of the programs purpose and key educational aims. (See Appendix A for the outline of group sessions). These educational aims were listed on the black board and an agenda for the six week program distributed among the group members. The members were asked to describe their medical condition as it related to renal disease and what they anticipated from the group. The first session included a discussion of common housekeeping rules prevalent in all group work such as confidentiality, respect for other members opinions, the freedom to questions and to ask for clarification, and notifying the facilitator if a member cannot attend a session.

The format of the first session was adjusted in Group Two to include a video on end stage renal disease patients demonstrating and discussing forms of dialysis treatment and kidney transplantation. At the end of each session all members were given written homework assignments to be completed by the next meeting. The ensuing meetings would start with a review of the home work assignment and difficulty or success in completing the assignments. The session would continue with a educational presentation by the facilitator,

followed by discussion, or by opened ended questions by the facilitator to generate member response. The facilitator would also request examples from the group when presenting material to promote vicarious information sharing among the members.

Integrating techniques and strategies that encompassed the four main sources of self efficacy into the format of the group were achieved in the following ways:

4.2.1 Performance Attainment:

The facilitators role in enhancing self-efficacy through performance attainment was accomplished by (1) teaching skills and structuring opportunities for performance and (2) guiding observation and interpretation of behavioural performances. Examples of this were in the assignment of homework for the members to complete between the group sessions. The home work assignments were designed to link what had been presented and discussed in that days session, with a task which was to be completed by the next session. The rationale behind incorporating take home assignment was to encourage the members to start taking steps toward change, and if the experience was a positive one, that it would increase their level of confidence to try other new coping behaviours.

Five home work assignment were designed specific to pre-dialysis issues and are as follows:

I) List three personal uncertainties, concerns or fears you have associated with living with Kidney Disease. For each one, identify the specific physical, psychological, and lifestyle problems/demands it raises. What resources are needed to meet these concerns /uncertainties successfully?

II) Tell someone whom you have **not** confided in before about some fears you may have about Kidney Disease. Or tell someone you know a fear you have about progressive Kidney Disease that you have not told anyone before. Ask

that person to just listen and not solve the problem for you. Note how you felt after having done so.

III) Choose one problem you face in maintaining your renal diet and carry out a problem solving analysis. Carry out and begin implementation of this analysis this week and report back next week. Issues to consider are eating out at a restaurant, shopping for groceries, a gift of food from others, resentment from friends or family, or your own attitude towards the renal diet.

IV) Conduct progressive muscle relaxation at least once a day. Keep a record of it and note any observations.

V) Generate a set of 3 or more questions you have about your condition and get answers from one of more members of your multidisciplinary team. Practice assertive information seeking practices. Or simply practice assertiveness skills in getting your needs and rights met during the course of the next week. This could be regarding your diet, or simple interactions with family and friends. Record your responses you receive and how you dealt with them.

4.2.2 Vicarious Experience:

Bandura (1986), cites that vicarious learning is one of the most successful forms of enhancing self-efficacy expectations. The most powerful way to demonstrate vicarious learning is through a role model who has the same disability and is the same sex and race. (Strausser, 1995). This was achieved by the sharing of information between group members of their real life experiences of how they may have successfully dealt with a problem related to their kidney disease. The format of group work itself provides many opportunities for vicarious learning. "Group counselling is a very effective means of vicarious learning" (Strausser, 1995, p.10). If actual role models are not available, films, books, and video provide an alternative. The video entitled, Choices; Options for Living with Kidney Disease, portrayed actual end

stage renal disease patients discussing how they managed the demands of dialysis and transplantation. This video was shown to the second pre-dialysis treatment group. Reaction to the video by the group members generated discussion and problem solving.

4.2.3 Verbal persuasion:

The use of verbal persuasion was utilized by encouraging and educating individuals through presentations. If a counsellor is perceived as competent and trustworthy, he/she will be able to provide constructive feedback to the individual and assist the individual in identifying appropriate actions, facilitating continued effort (McAuliffe, 1992). Group members also encouraged and supported each other in attempting new strategies. In one instance, a member described how another member persuaded her to make an appointment with a renal dietitian. She would not have made the appointment without the persuasion of the other group member. This demonstrates that receiving a verbal persuasion cue from a role model or a peer can be just as influential as receiving it from a professional.

4.2.4 Emotional Arousal:

Anxiety and nervousness can affect one's self-efficacy in performing task oriented behaviours. The structure of the group sessions allowed for a presentation on stress management techniques. One session was devoted to learning and conducting progressive muscular relaxation training.

Client Profiles for Treatment Group One and Two

Table 1.3

Participant No.	Age	Gender	Marital Status	Employment	Group Attendance
Treatment Group One					
No. 2. Ms. E.	61	female	widowed	full time	3 sessions
No. 7. Ms. K.	56	female	married	full time	5 sessions
No. 8. Ms. S.	72	female	married	retired	4 sessions
No. 11. Mr. L.	83	male	married	retired	3 sessions
No. 14. Ms. Y.	42	female	single	full time	5 sessions
No. 15. Mr.C.	72	male	married	retired	5 sessions
No. 16. Mr. M.	49	male	divorced	full time	6 sessions
Treatment Group Two					
No. 18. Mr. R.	66	male	widowed	retired	2 sessions
No. 19. Mr.T.	62	male	married	disability pen.	6 sessions
No. 25. Mr. P.	50	male	common law	full time	5 sessions
No. 26. Ms.A.	49	female	married	part time	6 sessions
No. 29. Ms. O.	54	female	married	sick leave	6 sessions
No. 30. Mr.W.	82	male	married	retired	3 sessions

4.3 Treatment Group One Biographies

Treatment group one included three men and four women. In addition to these seven participants, two spouses also attended the group sessions. The following is a brief biography of each participant :

Participant Number 2, Ms. E. is a 61 year old woman. She is employed full-time. She has a history of Cardiac Obstructive Pulmonary Disease, Diabetes, and one amputation below her ankle. Her blood creatinine level at the start of the program was 395 umol per litre. Ms. E. lives with two of her adult children. Her main problem, she stated was water retention which resulted in gaining 70 pounds in one year. She also described herself as "lazy" but hopeful she could learn something from attending the group. Ms. E. attended group after work and arrived by Handi-Transit. Ms. E. dropped out of the

program but completed all the post tests. In total she attended the first three sessions.

Participant number 7, Ms. K, is 56 year old Afro-Canadian female. Ms. K. lives with her spouse who is retired. She has diabetes and is visually impaired in one eye, her creatinine level at the start of the program was 390. During the length of the program Ms. K. babysat full-time for a neighbour. She attended all but the final session.

Participant number 8, Ms. S. is a 72 year old married female. She experienced a toxic reaction to a substance 18 years ago which necessitated acute dialysis for about 2 months. Since then, she described herself as very vigilant in adhering to a renal diet and in exercising regularly. Ms. S. missed the first two sessions, and attended the remaining four with her spouse. Her creatinine level at the start of the program was 372.

Participant 11, Mr. L. is a 83 year old married male. He is retired and very active as a musician . He has a history of diabetes, and a blood creatinine level of 519. Mr. L. dropped out of the group sessions but did complete the post study instruments. He attended the first three sessions.

Participant 14, Ms Y. is a 42 year old single female. She works full time as an office clerk and lives with her elderly mother. She has a urinary tract disorder and a creatinine level of 589. Ms.Y. had one acute episode of renal failure which required dialysis a few years ago for approximately 2 weeks. She attended all but the last session.

Participant 15, Mr. C. is a 72 year old married male. He is retired and attended the first session with his spouse. He recently completed chemotherapy for Hodgkin disease, has cardio pulmonary heart disease, and high blood pressure. Mr. C.'s creatinine at the start of the program was 378. He

attended all but the fourth session.

Participant 16, Mr. M. is a 49 year old single male. He owns and manages a store. Mr. M. has a history of childhood diabetes. His creatinine level at the start of the program was 307. Mr. M. was the most reluctant to join the program and said he would only attend the first session and decide from that point if he planned to continue attending. He was the only member in treatment group one to attend all six sessions.

4.4 Treatment Group Two: Biographies

Group two comprised of six individuals, two women and four men. One spouse attended all but one session. There were three individuals in this grouping that commuted from rural Manitoba to attend the group sessions. There were two individuals who dropped out of the sessions, one because of the initiation of dialysis, and the other died unexpectedly.

Participant 18, Mr. R. is a 66 year old male widower. He lives alone and is on a retirement pension. Mr. R. had polio as a child, and was uncertain why he has kidney disease. At the start of the session his creatinine was 516. He only attended the first two sessions. Apparently, Mr. R. was informed by his renal failure clinic that he was booked for urgent catheter surgery to prepare him for CAPD. When the facilitator called to inquire on his well-being, he said that the surgery had been cancelled, but did not want to continue with the group sessions.

Participant 19, Mr.T. is a 62 year old married male. He is on a disability pension and lives with his spouse who is employed. Participant 19 has a childhood history of diabetes and is visually impaired. Mr.T. would attend group sessions by taking the bus or by walking from his home. His creatinine level at the start of the sessions was 313. He attended all six sessions.

Participant 25, Mr. P. is a 50 year old male who lives with his common-law wife and two teenage children. He is employed as a labourer and travelled in from rural Manitoba approximately four hours to attend the sessions. Mr. P.'s creatinine level at the start of the sessions was 655. He attended all but the last session, as he was scheduled for urgent catheter surgery on the day of the final group meeting.

Participant 26, is Ms. O. a 49 year old married aboriginal woman. She is on sick leave from her teaching position. She commuted approximately five hours to attend the sessions. with her spouse, who has cancer. Her spouse did not attend the sessions. Ms. O. has a history of diabetes and difficulty with her eye sight . Her son had been a hemo-dialysis patient and died after four years of treatment. From her description of his death he chose not to attend his scheduled dialysis treatment and died as a consequence. Her creatinine was 548 at the start of the sessions. Ms. O. attended all six group sessions. Although, during the fifth session she was ill and excused herself from group .

Participant 29, Ms. A. is 54 year old married woman. She has three grown adult children. She works part-time in a grocery store in rural Manitoba. She attended the sessions with her spouse, who was able to attend all but one session. They commuted approximately 4 to 5 hours to attend each session. Ms. .A. has a history of high blood pressure, her creatinine level was 422 at the start of the sessions.

Participant 30, Mr. W. was a 82 year old married man. He was a volunteer on various boards throughout Winnipeg. and was chairperson of a local charity organisation. Mr. W. had a history of high blood pressure and heart disease. His creatinine level at the start of the session was 491. The facilitator called his home to inquire on his absence from the group and was

informed of his death. Apparently, Mr. W. died at home of a cardiac arrest shortly after a family gathering. He attended three of the group sessions before his unexpected death.

4.5 Summary

In summary, this chapter provided an overview of the organisational structures and recruitment phase for the self-efficacy project. The intervention was detailed to include how the each group session was structured to achieve the goal of enhancing self-efficacy through application of the four sources of self-efficacy information. This was followed by a detailed profile of each treatment participant.

CHAPTER FIVE

5.1 Process and Comparison of Treatment Group One and Two

5.1.1 Treatment Group One

The first group of the pre-dialysis self-efficacy education program was lead by the writer and investigator Dr. Ed Johnson. The educational format was based on information from the Living with Kidney Disease Manual produced by the Kidney Foundation of Canada, and from the Arthritis Self-Management Program developed by Lorig et al. (1996) . The structure of the group, as noted in Chapter Three, is based on a psycho-educational format with a focus to enhance participant's self-efficacy via presentations by the group leader or leaders, followed by discussion and take home assignments. Biographies of each member can also be found in Chapter 3. The following information is a report of the content of the group sessions and an analysis of the group dynamics and process observed by this writer.

The focus of the first session was to elaborate to the group members the goals and purpose of the group. Knott & Drum (1977), suggest that members have a clear understanding of the major program elements, including a non-technical explanation of what is to be changed in their lives by attending the group. The premise of the group was described as a vehicle to promote and encourage their abilities to meet the challenges presented by kidney disease. After a brief introduction of the writer and the investigator, individuals were encouraged to share a brief personal history of their kidney disease and what they hoped to gain from attending the group. All the members were attentive and some quite hesitant and uncertain if they wanted to commit to the group. This apprehensive reaction is quite typical in the beginning stages of group

development when inclusion issues are most evident (Schutz, 1973).

The first member to introduce himself to the group was Mr. M. His arms were crossed in a defensive manner and stated that he was there to listen to what we had to say but preferred not to participate. Another member, Mr. C who attended with his spouse also expressed reluctance and ambivalence at joining group. He stated that perhaps his time would be better spent at his summer cottage. This open resistance to engaging with the group was short lived, yet quite revealing. The open conflict is common when individuals are struggling with their commitment to the group, whether they are "in or out". This initial phase of group development is described as "forming". where individuals are tentative and unsure of their commitment to the group (Tuckman, 1965),. The remainder of the participants were more positive. Some members expressed how they hoped the group would provide them with medical information and emotional coping information needed in managing their kidney disease.

The writer and investigator presented a lecturette on stress and its relationship to managing kidney disease. Stress was described as existing when perceived demands exceed perceived resources (Folkman & Lazarus 1984). A group exercise was distributed to stimulate discussion called "Kidney Disease as a Multi-Dimensional Stressor", (See Appendix A) . This exercise is also referred to as "force field analysis", and is used in different formats to help with member ambivalence. The goal of the exercise is to list the psychological , social and environmental factors that hinder and promote a specific goal. This exercise can be done by the group as a whole, in pairs or as a home assignment (Toseland et al. ,1995). In preparing for the exercise, the writer asked the group what was their definition of stress, ie; "So, what is stress?". Mr.

C. exclaimed, "Stress sucks!". This comment created some laughter establishing him in the role of "class clown". He continued in this role throughout the six sessions providing occasional diversions from the topic yet also instilling some fun and cohesion for the group members.

During the first session there is a need to engage participants into feeling the desire to return for more sessions. Making the group attractive to the participants is a critical role for the group leader. This may have been achieved through encouraging active sharing of common interests among the members. Universality, noted by Yalom (1995) is a standard curative factor shared among group members. For example there was the opportunity for individuals to share vital health tips related to the management of their renal disease, ie "Don't drink Coke it has too much phosphorous!". There was also the chance to develop new friendships and foster mutual aid. This was displayed by female participants Ms. K. and Ms. Y., when they discovered they lived within walking distance of each other. Since Ms. K. didn't drive, Ms. Y. offered to give her rides to all of the proceeding meetings.

The second session was attended by all of the group members. The presentation material focused on the emotional aspects of kidney disease and how to cope with some negative feeling the members could be experiencing, ie depression. Some members of the group had difficulty in engaging in the discussion and stated they would just avoid thinking about their illness as a way of coping with it. As noted earlier by Ulman Hubb (1993) most medical patients attend groups for medical information and could be reluctant to focus on their emotional lives and relationships .

Some of the participants were found to be resistant to the word "disease", when discussing renal disease and it's implications. The members

who were resistant to the word "disease" may still be in a process of accepting their diagnosis. These individuals may not be ready and may want to avoid being labelled as someone with a chronic illness. The group discussed their common physical symptoms and how they were able to manage them. This form of vicarious information sharing strengthened the members ties to the group. Ms. K. commented that since the first meeting she has now "figured out that maybe why I feel so tired all the time is because of the kidney disease." Mr. M., who was initially quite resistant to engage in the group, joined in and freely shared how he manages his kidney disease, but was reluctant to admit that kidney disease is affecting his lifestyle. Ms. E. stated it was difficult to convince herself that she had diabetes and would often sabotage her health by eating any she wanted. "I just don't want to think about it". Mr.L, responded by saying, "sometimes ignorance is bliss", perhaps meaning that it's easier not to confront your problems, and suffer the repercussion later.

An expected change in communication patterns between participants was noted by session two. A shift of engaging in conversation was observed between the participants on the discussion topic of the emotional adjustment to renal disease. This shift reflects a developmental phase in the group process, that Tubb (1984) describes in Chapter 3 as "storming, conflict, or interdependence". Discussion in session two became quite engaging as people discussed how much they thought or did not think about kidney disease. Conversation became productive by describing avoidance and denial of kidney disease as normal coping mechanisms. Some members were able to share their initial feelings of shock and fear they experienced when initially dealing with kidney disease.

The third session was marked the arrival of a new member, Ms. S., who

was accompanied by her spouse. She was quite instrumental as a role model to other group members in her capability and tenacity to stick to her diet and do her utmost to avoid dialysis for almost 16 years. According to Lorig(1996), the best ways noted to enhance self-efficacy and change behaviour is to observe someone else with the same problem cope successfully with it on a day to day basis. Ms. S. proved to be an ideal role model. The focus of the session was the discussion of problem solving in relation to the participants diet requirements. After a brief presentation on the common elements of renal diet, individuals were encouraged to brainstorm and discuss the obstacles of following their diet. Ms. S. was able to provide other participants with a multitude of ideas and promises to share her cook book she was completing on recipes for renal diets.

Some member cited that at times family members and friends had difficulty in accepting their rigid dietary requirements. Members stated that their friends and family were supportive, but that it was up to themselves to enforce their own limits. Mr. M. stated that he didn't feel that sharing his dietary restrictions with others to be beneficial, " It's an exercise in futility". He then challenged Dr. Johnson to explain to him why it was so important to share this information with others. Ms. Y. spoke out in an attempt to challenge Mr. M.,. She said that it wasn't that big of a deal to share with others why these dietary restrictions are necessary; that it only helps your friends or family understand you better. Mr. M still objected to sharing this information. This exchange of discourse between Mr. M. and Ms. Y., marked by the open conflict and challenging of authority is reflective of the storming phase. Yalom (1995, p.297), expands on Tuckman's (1965), storming phase as a "shift from a preoccupation with acceptance , approval, commitment to the group, definitions

of accepted behaviour, and the search for orientation, structure, and meaning, to a preoccupation with dominance, control, and power. The conflict characteristic of this phase is among members or between members and the leader”.

Session four exposed the members to emotive focused coping. Examples of each of the four sources of information to enhance self-efficacy were described to the group members. Discussion focused on creating reappraisals or reinterpretations of the stresses in their lives related kidney disease. The second half of the session was reserved for a lesson in progressive muscular relaxation training. The induction into this relaxation technique was lead by Dr. Johnson. The members appeared to have benefited from the half hour induction. Mr. M. was pleased with his own performance in accomplishing the relaxation exercise. He shook Dr. Johnsons’ hand and said it was the “greatest thing” he experienced so far in these sessions. All members were asked to practice the progressive muscular relaxation exercise at home and make note of their progress. Ms. E failed to show at session 4 and all the subsequent sessions. Her withdrawal from the sessions could be due to the denial of her illness. This was marked in session two by her open admission of not coping with the severity of her condition and apprehension of learning new skills, and changing of old behaviours.

Session five focused on empowering members to feel more confident and assertive in communicating their needs to medical professionals. Some of the group members were quite capable of asserting themselves with doctors and other health professional. Ms. S. stated “ I fired my doctor... and hired a new one...they’re only allowed to make one mistake!”. Mr. M. exclaimed, “ It’s my life I ‘m not going to sit back and let them screw it up!”. Discussion ensued

on the various medical professionals that are involved in their care, and their right to assert themselves. Increasing the members self-awareness, as noted by Gutierrez et al.(1995), is central in empowerment work. The group members were informed of their basic rights as health care consumers. A bill of patient rights was read out to the members. This was followed with an exercise that divided the group into dyads to practice scenarios based on the difference between assertive, non-assertive and aggressive styles of dealing with medical personnel. Mr. C. had some difficulty with the concept of assertiveness, and asked " Why are things so complicated. Why do you have to be your own case manager?". Members were encouraged to contact members of their kidney treatment team and to seek out information about their health.

Session five also focused on the issue of planning for the next and final group meeting. In preparing for termination the members proposed that the last session be marked with sharing food and setting aside time to socialize. This notes the development of cohesion between the group members. Group cohesiveness is noted by Yalom (1995) as essential in the success of any group. He reports that group cohesiveness results in better group attendance, greater participation of members, and greater influenceability of members. This sense of group "we-ness" is also similar to the emotional development that group participants experience in the last phase of Schutz's (1973) group development termed "affection".

Session six was the last group meeting for treatment group one. This meeting entailed an overview of the sessions and encouraged feedback from the members on what they found helpful about the group. The members did not have any negative comments. Perhaps if a confidential way of expressing their satisfaction were made available, they may had some constructive comments

to share with the facilitators. The lack of negative feedback may be reflective of Tubb's (1984) last group developmental stage termed "performing, reinforcement or productivity", whereas members need to leave the group feeling it was a worthwhile experience even if they were not fully satisfied. Unfortunately two participants Ms. K. and Ms. Y. did not make the last session due to an illness experienced by Ms. Y. These two members seemed to share much in common and have since paired as friends in the community.

The last presentation by the writer was perhaps repetitious. Energies should have focused more on sharing and discussing concerns by members that were not addressed in previous sessions. Overall the members seemed to express appreciation and affiliation with each other and the group leaders. There were two members who dropped out after the third session. Otherwise a high attendance rate for the five members who remained would attest to the group cohesiveness and an overall satisfaction with the educational sessions.

5.1.2 Treatment Group Two

The format of the educational sessions remained the same for treatment group two. This group was lead solely by the writer. Two structural changes to the program included the addition of a video for the first session and less emphasis on structure for the last session. Biographies for each participant can be found in Chapter 3. The following are highlights of the group sessions and discussion of applicable group process.

The first session of group two commenced with six participants and one spouse. After the introduction by the writer on the program goals and objectives, the group members were invited to introduce themselves. The members shared their histories with great detail, creating an immediate eagerness among the members to get past the stereotypical awkwardness

normally present in the beginning formation of group development. As the group members introduced themselves to each other, one male member, Mr. R. became tearful discussing his medical history of childhood polio. Another member, Ms. O. openly expressed her fears about dialysis to the group and her desire to learn and benefit from the group. Participant 30, or Mr. W. who died after the fourth session, provided a jovial role, which assisted in creating a relaxed atmosphere.

The participants reported that the video presentation, "Options: Living with Kidney Failure", was informative. The video provided real life models who performed several types of dialysis treatment. This led to an active discussion on forms of treatment for kidney disease, particularly transplantation. Some participants were able to provide accurate medical information which they shared readily with each other. Participants were encouraged to seek out more detailed information from their kidney treatment team. Cross cultural discussion ensued with Ms. O., an aboriginal woman who has had diabetes for 16 years. She discussed the issue of the increasing rate of diabetes in her community. The writer noted to the group that the First Nations communities are facing an epidemic and the need to educate people with diabetes to prevent further complications such as kidney disease. After the discussion had subsided from the video presentation, there was a brief presentation on stress and kidney disease. Members were encouraged to cite demands that their disease plays in their lives and what resources are available to cope with those demands. After some prompting by the leader, members discussed the demands of doctors visits, particularly for the rural participants. Ms. O. shared how she was also a care giver to her spouse who has cancer and stated she utilised the help of other family members to cope.

The second group was attended by all group members. The focus of the group session was to complete the presentation on stress and to provide information on psychological adjustment to chronic disease. Members discussed reactions by family and friends to their kidney disease of how some were very supportive and how others were insensitive to their needs. Mr.R. stated that since he was a widower that he had no one to share his personal thoughts with except his cat. This comment was met by sympathy. It was perhaps Mr. R's way of seeking out social support from other group members, and possibly an underlying reason for attending the group. He stopped coming to group after this session. One reason he cited was "everyone has someone". Mr. R. was the only widower in the group and did not feel included because he did not have a partner. If his grief issues are unresolved, attending the group where everyone is still married may remind him too much of his loss. Many individuals come to groups to expand their social network. Mr. R. may have benefited more from a support group where his emotional needs could be met

In the discussion on the stages of psychological adjustment, one member Ms.A., commented that it was like "you were telling my story". She meant that she could relate to all the feelings being identified. One member Ms. O. commented how she felt like life was not worth living after being "saddled" with progressive kidney disease. This was an obvious sign of depressed feelings and mood that can develop in the pre-dialysis stage, as noted in the work of Hong et al.(1987). Ms. A., immediately responded by saying to Ms. O. "I felt the same way when I was told; I cried all the way home". Mr.W. identified feeling angry and frustrated at not being able to do what he was able to in the past. He attributed his restrictions to his advanced age of 82, and his varied chronic illnesses. The leader observed clear developments in group intimacy and

cohesiveness among group members through their ability to share personal information and to comfort one another.

The third session focused on problem solving related to the specific self management issues of renal diets. Before the discussion on diet and problem solving ensued, the leader asked members to report back on their home work. The assignment entailed seeking out a friend, family member or a good listener to share some of their fears and concerns regarding kidney disease. This was an instrumental exercise in enhancing the members social supports. Hobfoll & Stokes (1988) report in general that social support has been linked to lower levels of psychological and physical symptomatology and enhanced stress resistance. Mr.P. an attentive but quiet member, commented that he shared information about his condition with a friend who is being treated for cancer. Mr. P. said he felt that on some level he could relate with this friend more than before. Balancing the socio-emotional needs of the members with new learning experiences, is evident in Mr. P.'s report. Mr. P.'s insight demonstrates reflective capability, which according social learning theory is a basic human capability of being able to evaluate and alter one's own thinking (Bandura, 1977 b).

Discussion on dietary management and problem solving created an exchange of information between participants on restaurants that catered to their diabetic and renal needs. They also discussed how they managed their dietary needs with family celebrations. The leader was able to give examples from Treatment Group Ones' problem solving seminar on dietary needs, which provided some good examples of vicariously derived information. Ms. A. spoke of feeling "stressed" out by her cravings for pizza and pasta, and the guilt her

family experiences when they eat her favourite foods in front of her. This comment was met with laughter and affirmation by other group members regarding their common struggles with restrictive diets. As noted previously, for families dealing with kidney disease disagreements around the issue of food can create some psychological trauma (Drees & Gallagher, 1981).

Shared medical complaints and symptoms can create "all in the same boat" phenomenon. This can increase members feelings of belonging and inclusion toward the group (Schutz, 1973). At the end of the third session, the leader had all members sign a get well card for participant Mr. R. He withdrew from the program because of a planned catheter insertion for CAPD and, in part due to his unease of being the only member without a spouse. The members voiced concern for his lack of social support. For example, " Mr. R. only has his cat". In all the proceeding meetings some members would ask for any news regarding his well-being. The group members' actualized warmth and expressed concern for Mr. R's welfare notes the groups' emotional development toward cohesiveness.

Session four focused on cognitive restructuring and the mechanics of enhancing one's self-efficacy. Mr. T noted some good examples of reappraisals his condition drawn from his lengthy management of diabetes. The leader instructed the group on progressive muscular relaxation exercises in the social work lounge of the St. Boniface Hospital. Members seemed to enjoy the new locations' comfortable furniture and surroundings. They were able to relax and enjoy the session except for Mr. P. He listened to the instructions but " couldn't get my legs to settle down". This account of physical symptoms regarding cramped and jittery legs was often cited by members as one of the most bothersome aspects of progressive kidney disease. Group members offered

vicariously derived information to Mr.P. in the form of suggestions on how to manage future problems with leg cramps. One member stated " I get my husband to massage my legs" and another member offered, "my doctor gave some medication for my cramps".

Session five was attended by only three participants and Ms A.'s spouse. Ms. O. arrived but was very short of breath and after some encouragement, went to the emergency department. Mr. W. was uncharacteristically absent. The advantage of the smaller group in this session afforded the leader to individualize and attend longer to each member (Knott & Drum, 1977). Discussion focused on reviewing the take home assignment. that required the observation of one's own physiological state through the use of progressive muscular relaxation exercises. Ms. A. described practising the exercises at her home before bed time and reported it was beneficial in facilitating her sleep. Mr. T., stated that he had previously attended a patient education program at the CNIB and was taught progressive relaxation techniques at that program. He reported he ordinarily conducts relaxation exercises on a regular basis. These two individuals, Ms. A. and Mr. T., regularly completed their take home assignments which reflects their pre and post test scores for the GSE and the SSE. Their scores indicate high self-efficacy expectations. (To review individual SSE scores Appendix D, for GSE scores refer to table 1.6, ie Ms. A. #19, and Mr. T. #26).

Discussion in session five focused on communication with medical professionals and the use of assertiveness in getting needs met. Mr. P. and Ms. A., having the opportunity to work together on a group exercise, discovered they are both from the same rural area of Manitoba and had friends in common. This new alliance strengthened their relationship and they discussed staying in

contact after the termination of the group. In planning towards the last group session, these group members were less concerned with having a socializing experience than in group one. The leader offered to have coffee and some special dainties for the last half of session six.

Session six was marked by several losses. Mr. W. had died the previous weekend of a sudden heart attack. The group members responded normally; they were stunned at first and immediately began to grieve his loss. The members began to process Mr. W.'s death by recounting his unique qualities and many life stories he had shared with the group. The leader circulated his obituary from the newspaper for members to read. This added to the realism of his death. All members were in agreement to send a card of sympathy to Mr. W.'s spouse. Sending a card of sympathy to Mr. W.'s spouse was an example of modelling supportive interactions and contributes to attaining group cohesion (Toseland & Rivas, 1995)

Mr. P. was also absent from the last session. He had contacted the leader before the session to say that he had catheter surgery scheduled for the same day as the last group meeting. Members were concerned for Mr. P. and also struck by realism of his condition and how closely it related to their own. In cases where there are unexpected shifts in a structured time-limited group, such as a participant's death or unexpected withdrawal, it is imperative to attend to these issues and allow the other members to process the event rather than simply stay with the program format.

The group members all had an opportunity to communicate their thoughts and feeling about Mr. W.'s death and to comment on Mr. P.'s unexpected catheter surgery. When the task of processing these losses was completed, the leader continued the planned group format and lecture. Ms. O.

updated the members regarding her visit to the emergency department. She reported she had pneumonia. Ms. O. confided she was relieved, as she feared her shortness of breath was a symptom related to fluid retention. A symptom which requires immediate medical intervention for individuals with progressive kidney failure and could indicate the need to start dialysis. Ms. O. also related that she conducted her progressive relaxation exercises at bedtime to help her sleep and to "calm down her jittery legs".

Discussion focused on recapping the purpose and goals of the group. Recounting the behaviours taught from the program format were reinforced, such as improved communication skills, problem solving skills, and relaxation skills. The leader also provided a lecturette on community resources available to the group such as the Kidney Foundation's Peer Support Program. She provided literature and contact numbers should members require the extra information or support. Members discussed that once they start on dialysis, how complicated their lives would become and the adjustments to make in terms of vocational and recreational interests.

The termination phase can stimulate feelings of unresolved loss (Garvin, 1981). Difficulty in coping with the ending phase of the group was observed in Ms. O.'s disclosure regarding the death of her son who died after skipping his hemo-dialysis treatment. This sharing could also have been prompted by the untimely death of Mr. W. The complexity of her story and open grieving was perhaps too intense for some members. This was noted in the group by an uncomfortable break of silence.

In the termination phase of group work, there are specific tasks that the group leader needs accomplish. These tasks include dealing with feelings, evaluating the group, reinforcing gains, promoting the transfer of learning, and

making appropriate referrals to new resources (Garvin, 1981). In evaluating the group, soliciting feedback from group members helps in two ways. Feedback provides the leader with ways to improve for future group programs and also provides a way of measuring the member's view of the group's effectiveness in helping members achieve their desired goal (Knott & Drum, 1977). Ms. O. offered her feedback and noted a positive change in her behaviour. She commented that her self-awareness has increased as a result of participating in the group. "I'm more honest with myself. I've noticed that I'm not sneaking chocolate bars anymore. I only hurt myself by doing that". Ms. A noted that she enjoyed "learning from the people in the group".

The curative power of universality and the imparting of information appeared to be the most beneficial processes imparted from the group process. As Ms. A further commented in private to the leader that she had no idea what to expect from the education program, but was "hooked" after the first meeting, "I even skipped a funeral to attend a session, I didn't want to miss out". Most of the feedback was positive, indicating a need for the members to leave the group feeling it was a worthwhile experience (Tubb, 1984).

5.2 Discussion of Treatment Group One and Two: Differences

The composition of members for group one and group two were quite different. Group one comprised of individuals from urban Winnipeg, whereas half of the individuals that attended group two were from rural Manitoba. The blend of rural members in group two with their common health problems also shared concerns regarding the access of medical care from their remote communities. Compared to group one, the second group had an added shared similarity of living a rural lifestyle. This difference may explain why group two

appeared more cohesive and progressed more smoothly through the task and emotional stages of group development. Group one also had some very outspoken individuals who challenged the authority of the group leaders. This conflict may have attributed to less intimate relationships and expression of emotions. Both group one and two experienced individuals who withdrew from the program. Yet only group two had individuals who left because of the need for dialysis. The initiation of dialysis treatments for group two's members provided a rich basis for group discussion. It created heightened emotions for members of the group through the realism of the dialysis event and the opportunity for reality testing.

The author experienced difficulty in grappling with the concepts of behaviour modification. The writer felt herself resistant with what seemed to be a calculated interventions in manipulating peoples behaviour. This initial resistance to embrace social learning theory and behaviour modification is also noted by Heap (1977). He states that the reluctance to integrate learning theory into social work practice may be caused in part by the social work professions reluctance to intrude on the terrain of another profession and because of the highly manipulative nature of the some techniques of behavioural modification proposed on the basis of social learning theory. Although Heap (1977) clarifies that there is a shift, which is very prevalent in the 1990's, to seek out theoretical frameworks for group work practice. Heap (1977), admits in fact that social learning theory has a place in social work with groups, but that social workers were unaware they were practising it. He states "much of social work with groups consists of achieving attitudinal or behavioural change primarily, or exclusively, by just such "doing things together"(Heap, 1977, p.125).

This author noted the terminology utilized in lectures to enhance

concepts of self-efficacy were complicated and too removed for individuals in the group to comprehend (ie, emotive coping). To clarify any concepts found to be too complicated or unclear the leader often used lay terminology and sited examples.

Perhaps the greatest difference observed by this writer between group one and group two were the changes in the writer's own confidence in conducting and leading the group sessions. Balancing the socio-emotional needs of the pre-dialysis group members with that of the program structure was a challenge. Being a novice psycho educational group facilitator, the leader found comfort adhering to the program format rather than attending to the group dynamics and process. The format of the group was highly structured in an effort to provide the members with new skills and with opportunities to enhance perceptions of self-efficacy. The time limited nature of the group and need to cover pre-planned material lessened the opportunity for meaningful exchanges between group members. A leaders' resistance to attend to the groups' changing needs and to only focus on structure, as noted by Toseland and Rivas (1995), is a sign of an inexperienced leader. It was felt, however, that the leader did influence the groups' process by increasing the attractiveness of the group through her emphatic and caring manner.

The second group of participants were able to benefit from a more experienced group facilitator and an improved format. The program may have benefited by administering satisfaction questionnaires to the group members to ensure information and changes for future groups. The writer did informally ask the members to write her some comments. Basic comments such as a desire to meet individuals already on dialysis, for the group facilitators to use less technical language and the need for attendance of other family and spouses

were cited as was to improve the group experience.

Feedback from the members suggested they were satisfied with their group experience. Group members verbalised feeling more confident in addressing the issues related to managing the demands of renal disease. Providing learning experiences through the four sources of self-efficacy information is felt to have been accomplished in this group. Although self-efficacy was initially an abstract concept to the members, they were now able to operationalize the concept by testing new ways of coping with renal disease. The use of homework assignments gave the members performance attainment opportunities. Listening and observing to other group members perform originally perceived difficult behaviour provided vicariously derived learning opportunities. Performing progressive muscular relaxation provided the members a with natural way cope with tension and decrease symptoms of anxiety. All of these activities to increase self efficacy expectations will enable the group members to approach the need for dialysis with more confidence. Hopefully the group experience will also increase the members' adoption of positive health behaviours in preparation of needed dialysis treatment.

5.3 Summary

This chapter highlighted the process recordings of the group sessions of the first and second self-efficacy treatment groups for pre-dialysis patients. Inclusion of relevant literature on group process was integrated with the content of each group. Discussion ensued on role of the facilitator and of the comparison of the similarities and differences of each treatment group. The next chapter will evaluate the group intervention with use of two standardized tests, the Generalized Self-Efficacy Scale and the Specific Self Efficacy Scale.

CHAPTER SIX

6.1 EVALUATION OF INTERVENTION

In the evaluation of this self-efficacy group work intervention for pre-dialysis patients the author has selected two of nine measurements utilised by the investigators of this project. The measures selected by the author measure self-efficacy on both a general and specific level.

6.2 The Generalised Self-Efficacy Scale (GSE)

The GSE was used to assess the overall self-efficacy strength of participants. It was used solely for pretesting purposes. This measure will assist in providing a profile of the individuals self-efficacy in predicting the persistence and success at changing health-related behaviour. (Tipton & Worthington 1984). The purpose of the scale is to measure some relatively enduring sets of beliefs that one can cope effectively in a broad range of situations (Tipton &Worthington, 1984, p.548.) The scale was only used for pre-test purposes due to the enduring quality of the beliefs. These beliefs are not expected to change overtime and simply give the project researchers a broad baseline to compare other scales utilized in the project which are not part of this writers practicum report.

Questions asked on the GSE scale are broad and general in scope such as "I am a very determined person" to " I would endure physical discomfort to complete a task because I just don't like to give up". The GSE has two versions, a 27 item scale and a brief 10 item scale version. The project researchers selected the latter version as it has fewer questions, making it less burdensome for participants to complete. The ten item scale has an established Cronhbach's Alpha of 0.77 (Lennings, 1990). Please refer to appendix B to view the entire scale.

Table 1.6: General Self-efficacy Scale

Range of Measure 10-70

Treatment Group

Participant Number	Score
2	50
7	18
8	44
11	56
14	50
15	41
16	56
18	54
19	49
25	50
26	44
29	33
30	54
mean of treatment group	41.92

Table 2.6 : General Self-efficacy Scale

Range of Measure 10-70

Control Group

Participant Number	Score
1	62
6	53
9	39
12	61
13	65
17	58
21	59
22	42
27	50
28	48
mean of control group	53.7

6.3 Analysis of General Self-efficacy Scale

The General Self-efficacy Scale was developed to analyse one's willingness and determination to initiate and tenaciously stay with an undertaking in the face of physical and emotional adversity (Tipton & Worthington, 1984). In the analysis of the mean score for the treatment education group (Table 2.5), and its corresponding control (Table 2.6), it is found that the control has a higher mean for the trait of self-efficacy than does the treatment group. This could be interpreted in several ways. The control group, because of their higher level of perceived self-efficacy of 53.7, will be more likely to endure a physically challenging disability. On the other hand the treatment group, with its lower score of 41.92, may in the long run benefit from the intervention by exposing this group to the opportunity to increase their level of self-efficacy. Any conclusions about the benefits of intervention will need to be summarized from a detailed analysis of the pre and post scores of the specific self-efficacy measurement.

6.4 The Specific Self Efficacy Scale (SSE)

The SSE was adapted from Kaplan, Ries, Prewitt, and Eakin (1994). It was used to assess if the group experience has an impact on pre and post testing of predicted specific health behaviours of the participants. This scale focuses on predicting the future practice of the following six health behaviours: seeking out information, diet, exercise, taking prescribed medication, discussing concerns with medical professionals, and expressing concerns to natural supports. These six specific behaviours are assessed on four temporal periods: Today (immediate); this week (short term); this month (medium term); the next three months (long term). This is not a standardized measure and was adjusted by the investigators of this project to fit with the demands of kidney

disease. This scale is based on six questions based on the six health behaviours, each question will be listed with corresponding results and groups.

The SSE rates the participants degree of confidence or strength of their expectation to perform an activity on a 100 point probability scale. This scale ranges in 10 point intervals from no confidence (0) to total confidence (100). Forms of this scale have been used to measure self-efficacy for carrying out self management behaviours related to health status (Lorig et al., 1996, & Kaplan et al., 1994). Although the SSE used in this project is not standardized, it does have some merit on the basis of it's relationship to the SSE scale developed by Lorig's et al. (1996). Lorig et al. (1996), who has lead the field in chronic disease self-efficacy based educational programs, recently published the results of her use and development of self-efficacy measures. Lorig et al. rated their specific self-efficacy measure as having a test-retest reliability coefficient of .82 to .89 , and an internal-consistency coefficient of .77 to.92. The specific self-efficacy scale administered in this project does not have a reliability value, yet it is structured on the format developed by Kaplan et al. (1994) and Lorig et al.(1996). To view the scale please refer to Appendix C.

The findings reported in Table 4.3 to Table 4.8 show the pre and post scores of the specific self-efficacy expectations for both treatment and control are as follows. Each question regarding a specific health related behaviour will be listed and it's results discussed. The results are described in two forms . The first result is the overall group score for both the treatment groups and for the control groups. The second result is the overall temporal scores for each of the four time frames, again for both the treatment and the control groups. To locate individual scores recorded from each participant of the treatment and control please refer to appendix D.

6.5 Analysis of The Specific Self-Efficacy Scale:

Table 3.6: Question One: To inform myself about my illness, for today, for this week , for this month and the next three months:

Table 3.6

	Pre test	Post Test	Difference		Pre test	Post test	Difference
Total Tx Group mean	75.7	56.14	-19.6	Control Gr	71.3	84.3	+ 13.04
Temperol Mean Scores							
For today	82.3	76.9	- 5.4	Control Gr	80	67.7	-12.3
For this week	67.6	53.3	- 14.3		70.5	65.5	-5
For this month	57.6	49.1	- 8.5		67.5	64.4	-3.1
For the next 3 months	52.6	45	- 7.6		70.5	65.5	-5

Of interest in the results above is the dramatic drop in the treatment group members' expectations " to inform myself about my illness". There was an overall decline of -19.6 in their expectancy of informing themselves about their illness. This decline in expectancy behaviour could be linked to the treatment groups view that since they have completed an educational program regarding their specific health concerns, that there is no longer the urge to seek out what knowledge they have already found. This could be a valid argument, as the control group reports a post increase of +13.04 in predicting their need to inform themselves about their illness, a result likely of not participating in the psycho-educational meetings. The treatment group reports over the four time periods a gradual decrease in confidence in informing one's self about their illness. The control group also reports a similar decrease in pursuing information seeking behaviour.

Table 4.6 Question Two: For Treatment and Control Group : I can “stick to the recommended diet” over the next month. For today, for this week, for this month and for the next 3 months.

Table 4.6

	Pre Test	Post Test	Difference	Control	Pre Test	Post Test	Difference
TX Group mean	81.24	68.5	-12.74	Mean	76.35	69.91	-6.44
TX Temporal Mean Scores:							
For today	93.46	60.83	-32.63		82	83.3	+ 1.3
For this week	83.46	63.33	-20.13		84	72.2	-11.8
For this month	71.15	58.3	-12.85		76	77.7	+ 1.7
For 3 months	67.3	57.5	-9.8		66.5	66.6	+ 0.1

The combined scores of the treatment group to stick to the required diet notes a decrease in confidence of -12.74 post intervention. The control group also reports a decrease of confidence of -6.44. One could speculate that these decreases reflect the treatment groups realistic assessment of their abilities to abide by the strict renal diet. Perhaps the treatment group is more realistic regarding this health management behaviour since participating in the group sessions. Hence, the post scores may reflect a more realistic expectation of their self-efficacy behaviour. The temporal scores for the four different time frames for the treatment group reveals an overall expectancy that dietary behaviour is more difficult predict. That is, it is easier to predict one's behaviour in the near future rather than the distant future. This is displayed in the gradual decrease of confidence for both pre and post test scores. The treatment groups' gradual lack of confidence to predict one's behaviour is also found in the controls groups pre and post scores.

Table 5.6 Question Three: I can get the exercise I need, for today, this week, for this month and for the next three months.

Table 5.6

	Pre Test	Post Test	Difference	Control	Pre Test	Post Test	Difference
TX Group mean	45.59	50.54	+ 4.95	Mean	58.72	46.55	- 11.99
TX Temporal Mean Scores:							
For today	51.15	52.54	+ 1.35		58	40	-18
For this week	44.23	45	+ 0.7		61.5	37.7	-23.8
For this month	44.61	42.5	-2.1		58.5	36.6	-21.9
For 3 months	43.46	42.5	-0.96		63	44.4	-18.6

In Table 5.6 there is a positive sign that the treatment group is more likely to get the exercise they need by an increase of +4.95 post intervention. The control group conversely, reports a drop of -11.9 in their confidence to exercise. This is the only self-efficacy behaviour in which the treatment group has reported greater self-efficacy than the control group. There is a possibility that an increased confidence to exercise may be linked to the treatment participants being less depressed and more energised post intervention than the control participants. That is, to predict that you may have an increased level of confidence to exercise or need to, touches upon your level of energy and if you feel less depressed you may be more apt to exercise. The issue of depression and results from a standardized questionnaire completed by participants will be reviewed briefly in the discussion section. The temporal scores for the control group note a steady decline in confidence to get the required amount of exercise, whereas the treatment group shows a similar decline but not as severe. These results could be inaccurate as two individuals, participants number 6 and 22 in the post phase of the control group failed to complete their required section of information on exercise.

Table 6.6 Question Four: I can follow my medication schedule closely so that I take the medications I need in the right amounts at the right times for today, this week, this month, and the next three months

Table 6.6

	Pre Test	Post Test	Difference	Control	Pre Test	Post Test	Difference
TX Group mean	97.97	96.47	-1.5	Mean	72.5	92.5	+ 20.0
TX Temperol Mean Scores:							
For today	90.76	87.5	-3.26		86	85.5	-0.5
For this week	90.76	81.6	-9.16		87	84.4	-2.6
For this month	90	81.25	-8.75		86	83.3	-2.7
next 3 month	90	87.06	-2.92		85	90	+ 5

The confidence level of participants in taking their medications notes some variations between the treatment and control group. Overall the treatment group's pre and post scores for the group mean score remains stable with a slight decrease of 1.5. Whereas, the control group notes a jump of +3.39 post intervention. The treatment group still reports higher a self efficacy with regards to medication adherence and little change at post intervention. The temporal scores for both treatment and control note a steady decline of confidence. The unusual variations in the self reporting , such as the +5 noted in the control cell, could be attributed to participants failing to complete their questionnaires, as noted with participants 6 and 22. (Please see individual Scores in Appendix D)

Table 7.6 Question Five: I will discuss any concerns with my treatment team, whenever I need to for today, this week, this month, and the next 3 months.

Table 7.6

	Pre Test	Post Test	Difference	Control	Pre Test	Post Test	Difference
TX Group mean	88.4	84.34	-4.06	Mean	79.57	84.16	+ 4.59
TX Temporal Mean Scores:							
For today	88.46	70	-18.46		70	56.6	-13.4
For this week	80.76	62.5	-18.26		75	67.7	-7.3
For this month	80	62.5	-17.5		76	67.7	-8.3
For 3 months	79.23	76.6	-2.63		76	65.5	-10.5

The mean for the control group reports an increased self-efficacy expectation with regards to, “I can discuss any concerns with my treatment team” with a post test score of +4.59. The treatment group reports a decreased post test score of -4.06 (Table 7.6). This drop in seeking out information for the treatment group and increase for the control group may be linked, as noted in Table 4.3, to the participants view that if they had the opportunity to attend the educational sessions they have less of an urgency to discuss matters with their treatment team. In reviewing the temporal scores for both the treatment and control group, both groups appear more likely to seek out their concerns with the medical treatment team in the distant future rather than today or this week. This could be linked to the uncertainty and fragility of their health condition, whereas if their symptoms worsen only then are they are more likely to seek out information. Some participants may base this question on when they have their next clinic visit. Many of the participants see their nephrologists once every three months.

Table 8.6 Question Six: I can discuss any concerns with my family/spouse whenever I need to for today, for this week, for this month and for the next three months.

Table 8.6

	Pre Test	Post test	Difference	Control	Pre test	Post test	Difference
TX Group mean	82.37	85.5	+ 3.13	Mean	73.3	77.02	+ 3.72
TX Temporal Mean Scores:							
today	86.15	62.5			73	65.5	- 71.5
this week	77.69	55			73	64.4	- 8.6
this month	77.69	60.8			73	64.4	- 8.6
the 3 months	76.15	63.3			73	71.1	-1.9

In discussing their concerns with natural supports, the overall individual scores in the group mean for both the treatment and the control group display an increased efficacy score, of +3.13 and +3.72 . The effect of the educational sessions in encouraging communication skills with family and friends about their kidney disease may account for the increase for the treatment group. However, since the control group has the same increase in efficacy, it could be viewed as a natural progression that as time goes on their kidneys will continue to deteriorate and thus necessitating the need to share information with natural supports. The temporal scores of the treatment and control groups responses, note a tendency to share information with natural supports in the future rather than today or this week. Again this may be linked to the nature of kidney disease whereas the participants may be more confident in sharing information with family and friends when the uncertainty of their condition seems more apparent.

6.6 Discussion of Data : The GSE and The SSE

The evaluation of the pre and post test scores of the treatment group and of the control group, are both revealing and confusing. At first, it would appear the control groups' post scores reveal that their self-efficacy expectations to carry out specific behaviours are higher having not participated in the treatment intervention. The control group post scores increased in four health behaviours; informing ones self about their illness, (Table 3.6), taking their medication, (Table 6.6), expressing concerns with the treatment team, (Table 7.6), and sharing concerns with family or spouse, (Table 8.6). The treatment group on the other hand, decreased in their perceived self-efficacy expectations at post intervention in all behavioural areas except for getting the exercise they need (Table 5.6), and sharing concerns with family or spouse (Table 8.6). This is quite surprising, as one would hypothesise that after exposure to an group education intervention aimed at the enhancement of their self-efficacy, that the treatment group would report greater confidence in carrying out positive behaviours related to their health.

The control group increased their perceived self-efficacy scores in carrying out specific health behaviours compared to the treatment group whose efficacy expectations declined at post intervention. One factor is the issue of the GSE scale , which evaluated the participants expectations about their abilities in handling adversity in general. As reported in the GSE Tables 1.6 to 2.6 the control group scored higher than their matched treatment group. The GSE is meant to evaluate self-efficacy as an enduring characteristic, not known to change over time. Based on the higher average, the control group may have the advantage of being more self efficacious than the treatment group. It might

have been revealing to have used the GSE scale as a post test measure to evaluate indeed if self-efficacy is an enduring characteristic .

Data reported from the SSE indicated a steady decrease in confidence experienced by the treatment group. One explanation for this decline of confidence could be the role that optimistic self-belief plays, whereas an individual may over-estimate their abilities. The phenomenon of optimistic self belief is reported by Schwarzer and Fuchs, (1995, p. 262) who have written extensively on the works of Bandura, report "behavioural change goals exert their affect through optimistic self-beliefs. These beliefs slightly overestimate perceived coping capabilities". The treatment group may have attained a better appreciation of the complexities in performing the tasks necessary in managing their condition. This could explain why their confidence at the on set, which may have been an overestimate of their capabilities, declined at post intervention.

Another variable affecting the post scores of the treatment and control groups were the inconsistency in which some of the participants completed their self-reports. It is noted that more individuals in the control groups failed to complete their questionnaires for the GSE and the SSE. This may be in part the result of not being a part of the treatment sessions whereas they may have felt more connected to the project and more inclined to complete their questionnaire. This variability could be due to misunderstanding how to complete the scales, as all the sections were completed when originally administered by the research assistant. The difficulty in completing the SSE scale could also be attributed to the organization of the scale itself, as it may be too complex for some participants to complete on their own.

The wellness of members from both the control and treatment groups

could have affected the post results. Kidney disease is a serious illness and can be unpredictable. Overtime it drains these individuals of their stamina, concentration, and their ability to carry out their daily activities. This fragility in their health could play a factor in their responses at post intervention. Four members of this project have started some form of dialysis. Yet, the decline in health status for these members does not reflect a decline in self-efficacy expectations. In the control group, participants 13 and 17 have started dialysis. Participant 28 of the control group, had a stroke at post testing but completed the measurements. Two members of the treatment group, participant 18 and 25 have both started dialysis. Self-efficacy expectations declined at post intervention. for Participant 28 who had a stroke. Three participants, 13, 17 and 18 who have started dialysis seemed to have maintained or have increased their self-efficacy expectations. (Please see the appendix D for individual scores). For these individuals who have started dialysis, their increased self efficacy in predicting positive health behaviours in the future may be due to their desire to adapt to demands of their new treatment regimes

The treatment group demonstrated higher post scores on levels of exercise and seeking support from others.. Increased reports on getting enough exercise may indicate treatment members feel more energized and therefore less depressed. The treatment group may also be feeling more connected with their families and be less isolated . The argument that the treatment group is less depressed since the group intervention may be supported by the preliminary findings of this project by Tabisz et al. (1996). They included the CES-D (The Centre for Epidemiologic Studies Depression Scale, Radloff, 1977) among the scales that were administered to the study participants. Overall the CES-D at pre testing showed clinically significant levels of

depression for both the control and the treatment groups. Which Johnson et al., (1997) noted is consistent with literature indicating that diagnosis of renal disease is a risk factor for depression. The pre-test mean for the treatment group(n=8), was 16.88, and at post treatment 13.38 , a difference of -3.5, a standard deviation of 6.78, and a probability value of .188. The control group at pre-test for the CES-D, (n=8) was 16.00, at post treatment 18.77, with a difference of +2.77, a standard deviation of 11.29, and a probability value of .51. At post treatment , it would appear that the treatment group was less depressed after the intervention, and the control group more depressed at post testing. Since the data is based on such a small pool of subjects it is early to speculate on the merit of the self-efficacy group. Yet, the treatment group did show some overall improvement in their depression scales. This suggests the group intervention may have impacted the depression levels of the treatment members. "This evidence provides initial support for the value of providing active psychological treatment interventions for pre-dialysis renal disease patients" (E. Johnson et al., 1997).

Conclusion

The construct of self-efficacy and applying it to a group intervention is what initially attracted this author to the pre-dialysis Self-efficacy Education Program. The increase in learning for this author is acknowledged in areas of group work, chronic disease adjustment, and stress management training. The needs of pre-dialysis patients are varied and complex. Providing an educational model tailored to their specific issues is a valuable exercise. This intervention is timely given the increasing need for dialysis evidenced by a growing chronic disease population most notably diabetes and heart disease. Given the positive feedback from treatment group members, this psycho-educational program would be a valued asset to any ambulatory care unit dealing with chronic renal failure patients.

The use of self-efficacy in group work is really no different from what other treatment groups have to offer. The basic sources of information to enhance self-efficacy expectations are regular strategies used by most group leaders. For example, performance enhancement with exercises and homework assignments, verbal persuasion, vicarious learning and observing one's physiological functioning. What is different perhaps is being purposeful in ensuring that each component of enhancing self-efficacy is included and that the participants are aware of these components. The participants are not considered passive recipients of the treatment but are informed of how precisely we intend to enhance their ability to cope and meet the demands of their declining health. The group members were informed of what self-efficacy is and how it is to be enhanced as a effort to empower them further with the skills and knowledge of the program leaders.

Facilitating a behaviour modification group from the perspective of a

social worker was a great learning experience. Bandura provides a "person in the environment" perspective as noted in Chapter Two in describing human functioning and basic learning strengths. From a theoretical standpoint, "person in environment" is a strong tenet in social work theory, ie "start where the client is". It was heartening to learn that a theorist so closely linked to psychology had some beliefs and practice methods that this writer is committed to. One of the main differences between the psychological perspective and the social work perspective is the gap in the social and political issues that impact on our clients. For example health promotion is readily becoming a practice method that our governmental health care bodies are recognizing as a valued vehicle in health prevention. The role of health care social workers is to advocate on the behalf of patients within the health care network for changes to program planning to meet these advances. Therefore the social worker can interface with the clients needs on many levels, as a facilitator of a self-efficacy treatment group, or advocating health care professionals to release needed funds to provide such groups in the community.

The statistical outcomes for the study did not reflect an increase of the self-efficacy expectations of the treatment population. Nevertheless, this author believes that the group sessions did have a positive impact. There is some evidence that the treatment group participants may be less depressed and are more apt to get the exercise they need compared to control group. Interesting post testing results, such as the control group reporting a higher level of self-efficacy in predicting future health behaviours, may be due to over estimates of their coping compared to the treatment group who may have a more realistic idea of the demands of dialysis. A low drop out rate and a high attendance to the group sessions further indicate a successful outcome. Generally the group

members reported to the writer that they were satisfied with their group experience. Some members were practising their new skills and others felt more informed about their condition and better prepared to manage the demands that dialysis would make of them. The spouses of the members who attended group were vital to the groups composition. There is a need to get more family and spouses to these sessions. The spouses can reinforce the skills acquired in session and apply them to coping with their roles as care givers.

This writer would make several recommendations for future self-efficacy groups for pre-dialysis populations: To increase recruitment and access to patients in the renal outpatient clinics, a renewed relationship with the chronic renal clinics would be encouraged to include their input and cooperation for any future groups. To create an enhanced learning experience for the group participants, this writer would suggest the inclusion of live models, or individuals on some form of dialysis, to provide the members with valued subjective information on the life style challenges of renal disease. The writer would also suggest the group be facilitated by two leaders, one a professional, the other a lay person with kidney disease. The power of observational and vicarious learning was impressed upon this writer; changing the format to reflect this with the inclusion of positive role models may affect

For the purposes of future study, the author would suggest including the General Self-Efficacy Scale (Tipton & Worthington, 1984) not only for pre testing but as a post test measure to confirm if self-efficacy is in fact an enduring characteristic. Bandura's (1977 a) definition of self-efficacy is based on viewing it as perceptions about one's capacity to carry out a specific behavior and was not intended as a generalization of an individual's overall being. Thus

clarification is needed in using the definition of self-efficacy, particularly when operationalizing the concept for research into health promotion.

And one final recommendation. Given the positive response from the treatment group regarding the benefits of this program, this author would encourage Tabisz et al. (1996) to offer the self-efficacy psycho-educational program for pre-dialysis patients to any control participant not currently in receipt of any form of renal replacement therapy.

The learning objectives and skill attainment for this author was achieved in this practicum. She has developed a sound knowledge of Bandura's (1977) social learning theory of self-efficacy. She has developed competence in the delivery of patient education specific to the needs of pre-dialysis patients. The author has developed skill in interpreting and presenting self-efficacy measures. Based on her learning experience from this practicum, she is able to apply her skills in the delivery of health promotion activity through group work with a variety of chronic disease populations,

The investigators Tabisz et al. (1996) of this project, with which this writer has conducted her Masters of Social Work practicum, anticipate that the effects of their pre-dialysis self-efficacy patient education program will delay the onset of dialysis for pre-dialysis patients much like in Binik's (1993) study. Results to test this hypothesis are not completed at this time. It would appear that several participants in both the treatment and control group have started dialysis. One participant urged that self-efficacy groups for pre-dialysis be offered much earlier in the course of their disease in hopes of helping to delay the onset of dialysis by increasing their capacity to cope with the disease from its earliest detection. There is much to be gained from this project for both the participants and the researchers; for the participants it could mean delaying dialysis and for

the researchers, a promising new advancement in patient education.

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Appendix A

Outline of Self-Efficacy Pre-dialysis Psycho-educational Group

Outline of Self-Efficacy Pre-dialysis Psycho-educational Group
Program Outline

Session 1

Introduction and Program Overview:

- 1) Welcome and discussion of purpose and content of six week program
- 2) Start with how each group is structured. Raise group boundary issues for participants conduct, ie issue of confidentiality, respect for individuals right to differing opinions, consideration of time and allowing others to speak.
- 3) Have introduction of each participant, about themselves, their medical history with regards to kidney disease, and what they hope to achieve by attending the group

Education Component

What is stress: Kidney disease as a stressor

Introduction of kidney disease as a stress:

We all deal with stress differently. Lets look at this model of stress

Folkman & Lazarus's model of stress appraisal: Draw a diagram.

Stress results when perceived demands exceed perceived resources.

Definition of Stress : Exists when perceived resources (skills, capacities, resources) are not sufficient to meet perceived demands.

3 Types of Stress

- 1) Cataclysmic: universal stressor, ie happens to large number of people, for example natural disasters or wars
- 2) Major Changes: events beyond your control, for example death of a loved one, losing a job, or having a life threatening illness
- 3) Daily Hassles: having too much responsibility, feeling lonely, an argument with your spouse or friend.

*Note that people who have daily hassles on a constant basis have a difficult time in adapting or managing their health needs. Why is that? Discussion.

How stress affects you physically:

- 1)The fight or flight response : psychological and physical responses to stress (Cannon, 1929, in Cotton, 1990).
- 2)The General adaptation response: Alarm reaction, stage of resistance, stage of exhaustion (Selye, 1956 in Cotton, 1990).

The adjustment to stress depends on two things

- 1) The extent to which a person has control over the event or can predict it
- 2) the positive or negative power of the event

Preventative measures: Stress related disorders are greatly reduced when people understand how stress occurs, what it does, and how to cope with it.

Studies have shown that the stresses of dialysis create conflicts that interfere with living a normal and independent lifestyle. Many individuals while awaiting for dialysis experience fear, anxiety and depression.

Stress is viewed as a negative emotion which comes from how we view our lives. Stress results when perceived demands exceed perceived emotions. Or more simply stress arises when we have doubts about the energy or help we need to cope with the demands we confront.

Rationale: Kidney Disease as a chronic multi-dimensional stressor. List possible stressors on black board to stimulate discussion and brain storming:

Physical Demands

Uremia: Fatigue, weakness, bad taste in mouth, nausea, itching, difficulty sleeping, shortness of breath, forgetfulness

Psychological Demands

Negative thoughts and feelings: Anger, depression, fear, worry, catastrophizing, self-pity, uncertainty

Lifestyle Demands

Diet changes

Medication regimen

Dealing with appointments and treatment staff

Discussion topic: What demands are you personally facing in dealing with Kidney disease?

Goal: Identify a range of specific problems and demands under the headings of physical, psychological, and lifestyle categories. Note similarities as well as differences

in the issues identified by group members. Ideally, members will discover they are not alone in the fears and frustrations they experience because of kidney disease.

Homework Assignment: List three personal difficulties associated with living with Kidney Disease. For each one, identify the specific physical, psychological, and lifestyle problems/demands it raises. What resources are needed to meet these problems/demands successfully?

Session 2

Homework Review: Discuss resources needed to meet demands. Note range of solutions identified and use this to underline that each individuals solutions may be different.

Educational Component:

Meeting the Challenge of Living with Kidney Disease I:
Psychological Adjustments and Psychological Resources

Psychological Adjustment to Renal Failure

- 1) Expecting and identifying negative thoughts and feelings
- 2) Impact of chronic illness on mood and thinking
- 3) Coming to terms with illness
- 4) Acceptance is not defeat!
- 5) Coping with negative thoughts and feelings
- 6) Not overreacting

Mood repair

Seeking and enhancing social support

Exercises: Get group members to generate alternative strategies to common unhealthy emotional responses to Kidney Disease (e.g., depression, denial, escapism).

Homework Assignment: Tell one person about some fear you have about Kidney Disease that you haven't told anyone before. Ask that person to just listen and not solve the problem for you. Note how you felt after having done so.

Session 3

Homework Review: Were members able to confide in someone? Was it difficult? (If yes, why?)

Was sharing their fear with another helpful or not? Discuss.

Educational Component: Psychological Resources II -- Instrumental Coping Strategies

Problem-Solving

- 1) Problem Definition
- 2) Generating alternative solutions
- 3) Evaluating and ranking solutions
- 4) Implementing solutions
- 5) Evaluating solution effectiveness

Discussion: What sorts of uses could this general strategy be applied to in your life? In particular, what about your health or lifestyle (e.g., diet, medication regimen) could benefit from this kind of analysis? How?

Homework Assignment: Choose one important area such as diet or medication regimen that is directly related to your management of your illness and carry-out a problem-solving analysis.

Carry out and begin implementation of this analysis this week and report back next week.

Session 4

Homework Review: What problems did members choose for problem-solving analysis? What solutions did they generate? Were the solutions implemented? If so, with what success? If not, where did the process break down? Can this breakdown itself be a target for problem-solving?

Educational component: Emotion-focused coping

Reappraisals of the Kidney Disease and Relaxation Training

Reappraisals: Avoidance, minimization, distancing, selective attention, positive comparisons, find positive value from negative events

For one person a diagnosis of kidney disease and the need for dialysis or transplantation may be seen as unfair, similar to a life sentence in prison. For others the thought of dialysis may not be pleasant but seen as a necessary measure to continue with life in the face of impending death as an alternative.

What is Self-Efficacy and How is it Used.

Review the Four Sources of Efficacy Information: 1) Performance

Accomplishment, i.e. homework assignments, 2) Vicarious Experience: i.e. what other members say and do, role models, 3) Verbal Persuasion, i.e., getting encouragement from others 4) Emotional Arousal: i.e. Relaxation training, paying attention to how your body responds to stress etc. The focus of today's session after the break.

Relaxation Training Why relaxation?

Incompatibility of relaxation and anxiety. Known benefits of relaxation

Progressive Muscle Relaxation Overview Forearm illustration Induction

Discussion: What did the experience feel like for each member? Do members see this as an activity they would like to do more often? Can they imagine building this into their lifestyle as a means of relieving stress? Homework: Conduct progressive muscle relaxation at least once a day (twice if possible).

Session 5

Homework Review: Were members able to complete relaxation exercise? How often?

Any difficulties? Did they enjoy it? Discuss.

Educational Component: Instrumental Coping II: Assertiveness Primer

Being assertive versus unassertive or aggressive Excuses for unassertiveness

When do you need to be assertive?

Practising assertiveness

Discussion: What reaction do you have to acting assertively? Expressing your feelings assertively? Any fears about doing so?

Homework Assignment: Identify an area (preferably related to management of your disease) where you would like to practice behaving more assertively in the coming week(s). Possible target behaviours include assertively discussing meal planning and dietary needs with family members, expressing difficult emotions more straightforwardly, making needs known, interacting with treatment staff assertively.

Session 6

Homework Review: Were members successful in carrying out assertiveness exercise? What difficulties did they encounter? How might they improve their performance? What effects did their assertiveness have? Were they surprised?

Educational Component: Overcoming obstacles to maintaining an active lifestyle

Maintaining physical activity levels: Benefits

Muscle tone

Metabolism and appetite

Sleep

Mood maintenance

Cardiovascular Health

Financial Considerations/Resources

Travel across/outside Canada

Services offered by Kidney Foundation of Canada

Educational materials

Financial Assistance

Peer support and self-help groups

Patient Workshops

Scholarship/Bursary programs

Medic/alert bracelets

Wrap-up discussion: Discuss questions specific to presentation. Address any lingering unresolved

issues/concerns. Ask for feedback about aspects of the program that were and were not beneficial.

Conclusion: Distribute Time Two assessment packages. Stress importance of completing and returning these quickly. Remind them that a final assessment will be sent at 3 months or once they go on dialysis whichever comes first.

Kidney Disease as a Multi-dimensional Stressor

Circle the stressors below in each demand category that apply:	Other stressors not noted, that you have encountered related to the demand	What resources are needed to meet these problems/demands successfully
<p><u>Physical Demands</u></p> <p>Uremia - fatigue, weakness, bad taste in mouth, itching, difficulty/shortness of breath, forgetfulness</p>	Other Physical Demands	
<p><u>Psychological Demands</u></p> <p>Negative thoughts and feelings, anger, depression, anxiety, fear, worry, catastrophizing, self-pity, uncertainty.</p>	Other Psychological Demands	
<p><u>Lifestyle Demands</u></p> <p>Diet changes, medication regime, dealing with appointments and staff, loss or reduction in employment, new financial demands</p>	Other Lifestyle Demands	
<p><u>Relationship Demands</u></p> <p>role changes, dependency on others/spouse, communication problems, conflict with family 'routine', negative affect on friendships, negative impact of illness on social life.</p>	Other Relationship Demands	

Appendix B
The Generalised Self-Efficacy Scale (GSE)
(Tipton & Worthington, 1984)

The Generalised Self-Efficacy Scale (GSE)
(Tipton & Worthington, 1984)

The following statements concern attitudes and feelings you might have about yourself and your performance on a variety of tasks. You are asked to indicate the extent to which you agree or disagree with each of these statements using the following rating system:

- 1 = Completely Disagree
- 2 = Somewhat Disagree
- 3 = Slightly Disagree
- 4 = Neutral
- 5 = Slightly Agree
- 6 = Somewhat Agree
- 7 = Completely Agree

- a) I am a very determined person 1 2 3 4 5 6 7
- b) Once I set my mind to a task almost nothing can stop me . . . 1 2 3 4 5 6 7
- c) I believe that it is shameful to give up something that I start. 1 2 3 4 5 6 7
- d) Sometimes things just don't seem worth the effort 1 2 3 4 5 6 7
- e) I would rather not try something I'm not good at 1 2 3 4 5 6 7

- f) I can succeed in most any endeavor to which I set my mind. 1 2 3 4 5 6 7
- g) Nothing is impossible if I really put my mind to it 1 2 3 4 5 6 7
- h) When I have difficulty getting what I want, I just try harder. 1 2 3 4 5 6 7
- i) I have more will power than most people 1 2 3 4 5 6 7
- j) I would endure physical discomfort to complete a task
because I just don't like to give up 1 2 3 4 5 6 7

Appendix C
The Specific Self Efficacy Scale (SSE)
(Kaplan, Ries, Prewitt, & Eakin, 1994)

The Specific Self-Efficacy Scale (SSE)
(Kaplan, Ries, Prewitt, & Eakin, 1994)

Making a healthy adjustment to kidney disease requires being able to carry out a number of new and sometimes challenging activities on a regular basis. We would like to know how confident you are at present that you will be able to carry out these activities in the future.

For instance, one item asks about how confident you are that you will be able to follow a new diet. To indicate how confident you are use the following scale, which ranges from zero to one hundred. A very low rating near zero would indicate that you are very unconfident and uncertain that you can carry out this behavior, whereas a very high rating at or near 100 would indicate that you have complete confidence and certainty of being able to carry out this behavior.

Finally, we would like you to make these ratings for four different durations for each behavior. The durations are arranged from shortest to longest, beginning with today, this week, this month and the next three months.

Example: You might be very confident you could follow the new diet today and so rate your confidence at 100, slightly less confident you could follow it for a whole week and so rate it at 70, even less confident that you could follow it for a whole month, and so rate it at 40, and be completely uncertain about following it for the next three months, and so rate it at 10.

Scale of confidence:

0 10 20 30 40 50 60 70 80 90 100
None low mild moderate strong very strong total

<u>Behavior</u>	<u>Duration</u>	<u>Rating</u>
a) I can work at informing myself about my illness as much as possible:	Today	_____
	This week	_____
	This month	_____
	Next 3 months	_____
b) I can stick to the recommended diet for:	Today	_____
	This week	_____
	This month	_____
	Next 3 months	<u>110</u>

[Continued on next page...]

Scale of confidence:

0 10 20 30 40 50 60 70 80 90 100
 None low mild moderate strong very strong total

<u>Behavior</u>	<u>Duration</u>	<u>Rating</u>
c) I can get the exercise I need for:	Today	_____
	This week	_____
	This month	_____
	Next 3 months	_____
d) I can follow my medication schedule closely so that I take the medications I need in the right amounts at the right times:	Today	_____
	This week	_____
	This month	_____
	Next 3 months	_____
e) I will discuss any concerns I have about my condition with the treatment team <u>whenever</u> I need to.	Today	_____
	This week	_____
	This month	_____
	Next 3 months	_____
f) I will discuss any concerns I have about my condition with my family/spouse <u>whenever</u> I need to.	Today	_____
	This week	_____
	This month	_____
	Next 3 months	_____

Appendix D
Individual spread sheet results of Specific Self-efficacy Scale
Listed by Participant Number of both treatment and control subjects

Specific Self-Efficacy Scale:

Question One: For Treatment and Control Group: To inform myself about my illness, for today, for this week, for this month and the next three months:

	Pre Test	Post Test	Difference	Control 1	Pre test	Post Test	Difference
Participant Number 2							
For today	100	40	- 60		70	70	0
For this week	50	40	-10		30	70	+ 40
For this month	10	40	+ 30		30	70	+ 40
For the next 3 months	10	40	+ 30		20	70	+ 50
Participant Number 7				Control 6	30	blank	0
For today	90	blank			10	blank	0
For this week	50	blank	.		10	blank	0
For this month	40	blank			10	50	+ 40
For the next 3 months	30	40					
Participant Number 8	Pre Test	Post Test	Difference	Control 9	Pre test	Post test	Difference
For today	90	100	+ 10		90	50	- 40
For this week	90	90	0		85	50	- 35
For this month	90	90	0		85	70	- 15
For the next 3 months	90	90	0		85	70	- 15
Participant Number 11				Control 12			
For today	100	blank	0		100	100	0
For this week	100	blank	0		80	80	0
For this month	100	blank	0		50	70	+ 20
For the next 3 months	100	blank	0		20	60	+ 40
Participant Number 14	Pre Test	Post Test	Difference	Control 13	Pre Test	Post Test	Difference
For today	80	100	+ 20		90	90	0
For this week	80	100	+ 20		90	90	0
For this month	80	100	+ 20		90	90	0
For the next 3 months	50	30	- 20		90	90	0
Participant Number 15				Control 17			
For today	50	30	- 20		90	90	0
For this week	50	30	- 20		90	90	0
For this month	50	30	- 20		90	90	0
For the next 3 months	50	30	- 20		90	90	0
Participant Number 16	Pre test	Post test	Difference				
For today	blank	30					
For this week	blank	30					
For the next month	blank	30					
For the next 3 Months	blank	30					
Participant Number 18	Pre test	Post test	Difference	Control 21	Pre Test	Post Test	Difference

For today	70	100	+ 30		90	80	+ 10
For this week	70	100	+ 30		80	80	0
For this month	70	100	+ 30		80	80	0
For the next 3 months	70	100	+ 30		80	80	0
Participant Number 19				Control 22			
For today	100	80	- 20		100	no results	
For this week	100	80	- 20		100	no results	
For this month	80	60	- 20		100	no results	
For the next 3 months	75	30	- 45		100	no results	
Participant 25				Control 27			
For today	90	60	- 30		90	80	+ 10
For this week	90	70	-20		90	80	+ 10

For this month	80	60	-20		80	60	+ 20
For the next 3 months	70	60	-10		75	80	- 5
Participant 26				Control 28			
for today	100	20	- 80		50	50	0
For this week	blank	20	0		50	50	0
For this month	blank	40	0		50	50	0
For the next 3 months	blank	40	0		50	50	0
	blank						
Participant 29							
For today	100	10	-90				
For this week	100	40	-60				
For this month	100	40	-60				
For the next 3 months	100	50	-50				
Participant Number 30							
For today	100	died					
For this week	100	died					
For this month	50	died					
For the next 3 months	40	died					
	Pre test	Post Test	Difference		Pre test	Post test	Difference
Total Group mean sco	75.7	56.14	-19.6	Control	71.3	84.3	+ 13.04
Temperol Mean Scores							
For today	82.3	76.9	- 5.4	Control	80	67.7	-12.3
For this week	67.6	53.3	- 14.3		70.5	65.5	- 5
For this month	57.6	49.1	- 8.5		67.5	64.4	-3.1
For the next 3 months	52.6	45	- 7.6		70.5	65.5	- 5

Question Two: For Treatment and Control Group : I can "stick to the recommended diet" over the next month. For today, for this week, for this month and for the next 3 months.

Participant Number 2	Pre test	Post Tes	Difference	Control 1	Pre Test	Post Tes	Difference
For today	100	10	- 90		100	100	0
For this week	50	10	- 40		100	100	0
For this month	10	10	0		100	100	0
For the next 3 months	10	10	0		100	100	0
Participant Number 7				Control 6			
For today	100	blank			60	blank	
For this week	70	blank			80	blank	
For this month	60	blank			80	blank	
For the next 3 months	40	40	0		30	40	+ 10
Participant Number 8				Control 9			
For today	100	100	0		100	70	- 30
For this week	100	100	0		90	70	- 20
For this month	100	100	0		90	70	- 20
For the next 3 months	100	100	0		85	70	- 15
Participant Number 11				Control 12			
For today	100	blank	0		100	100	0
For this week	100	blank	0		90	90	0
For this month	100	blank	0		60	70	+ 10
For the next 3 months	100	blank	0		30	50	+ 20
Participant Number 14				Control 13			
For today	80	70	- 10		90	90	0
For this week	30	70	+ 40		90	90	0
For this month	30	40	+ 10		90	90	0
For the next 3 months	30	40	+ 10		90	90	0
Participant Number 15				Control 17			
For today	90	50	- 40		70	90	+ 20
For this week	90	50	- 40		70	90	+ 20
For this month	80	50	- 30		70	70	0
For the next 3 months	80	50	- 30		60	70	+ 10
Participant Number 16							
For today	100	90	- 10				
For this week	100	90	- 10				
For this month	100	70	- 30				
For the next 3 months	100	50	- 50				

Question two continued:

Participant Number	Pre test	Post Test	Difference	Control	Pre Test	Post Test	Difference
Participant Number 18				Control 21			
For today	80	100	+ 20		100	100	0
For this week	80	100	+ 20		90	80	- 10
For this month	80	100	+ 20		80	80	0
For the next 3 months	80	100	+ 20		80	80	0
Participant Number 19				Control 22			
For today	65	100	+ 35		50	no results	
For this week	65	100	+ 35		80	no results	
For this month	65	100	+ 35		50	no results	
For the next 3 months	55	70	+ 15		50	no results	
Participant Number 25				Control 27			
For today	100	90	- 10		100	90	- 10
For this week	100	90	- 10		100	80	- 20
For this month	80	80	0		90	70	- 20
For the next 3 months	80	80	0		90	70	- 20
Participant Number 26				Control 28			
For today	100	20	- 80		50	50	0
For this week	blank	50	0		50	50	0
For this month	blank	50	0		50	50	0
For the next 3 months	blank	50	0		50	50	0
Participant Number 29							
For today	100	100	0				
For this week	100	100	0				
For this month	100	100	0				
For the next 3 months	100	100	0				
Participant Number 30							
For today	100	died					
For this week	100	died					
For this month	100	died					
For the next 3 months	70	died					
	Pre Test	Post Test	Difference	Control Mean	Pre Test	Post Test	Difference
TX Group mean scores	81.24	68.5	-12.74		76.35	69.91	-6.44
TX Temperol Mean Scores:							
For today	93.46	60.83	-32.63	Control Mean	82	83.3	+ 1.3
For this week	83.46	63.33	-20.13		84	72.2	-11.8
For this month	71.15	58.3	-12.85		76	77.7	+ 1.7

Question Three: For Treatment and Control Group: I can get the exercise I need, for today, for this week, for this month and for the next three months.

Participant Number 2	Pre test	Post Test	Difference	Control 1	Pre Test	Post Test	Difference
For today	0	10	+ 10		10	10	0
For this week	0	10	+ 10		10	10	0
For this month	0	10	+ 10		10	10	0
For the next 3 months	0	10	+ 10		100	100	0
Participant Number 7				Control 6			
For today	40	blank			60	blank	
For this week	40	blank			50	blank	
For this month	30	30	0		30	blank	
For the next 3 months	20	blank			20	blank	
Participant Number 8				Control 9			
For today	100	100	0		50	0	- 50
For this week	100	90	-10		50	10	- 40
For this month	100	90	- 10		50	20	- 30
For the next 3 months	100	90	- 10		50	20	- 30
Participant Number 11				Control 12			
For today	50	60	+ 10		30	100	+ 70
For this week	50	blank	0		100	90	- 10
For this month	50	blank	0		90	80	- 10
For the next 3 months	60	blank	0		60	80	+ 20
Participant Number 14				Control 13			
For today	30	30	0		30	10	- 20
For this week	50	30	- 20		30	10	- 20
For this month	50	50	0		30	10	- 20
For the next 3 months	50	50	0		30	10	- 20
Participant Number 15				Control 17			
For today	10	50	+ 40		90	90	0
For this week	10	50	+ 40		90	90	0
For this month	20	50	+ 30		90	90	0
For the next 3 months	20	50	+ 30		90	90	0
Participant Number 16							
For today	50	20	- 30				
For this week	50	20	- 30				
For this month	50	20	- 30				

Question three continued:

Participant Number	Pre test	Post Test	Difference	Control	Pre Test	Post Test	Difference
Participant Number 18				Control 21			
For today	10	50	+ 40		90	60	+ - 30
For this week	10	50	+ 40		80	40	- 40
For this month	10	50	+ 40		80	40	- 40
For the next 3 months	10	50	+ 40		80	40	- 40
Participant Number 19				Control 22			
For today	75	80	+ 5		80	no results	
For this week	75	80	+ 5		80	no results	
For this month	75	70	- 5		80	no results	
For the next 3 months	75	70	- 5		80	no results	
Participant Number 25				Control 27			
For today	100	80	- 20		90	80	- 10
For this week	90	80	- 10		75	80	+ 5
For this month	80	70	- 10		75	70	- 5
For the next 3 months	70	70	0		70	50	- 20
Participant Number 26				Control 28			
For today	100	70	- 30		50	10	- 40
For this week	blank	50	0		50	10	- 40
For this month	blank	30	0		50	10	- 40
For the next 3 months	blank	30	0		50	10	- 40
Participant Number 29							
For today	100	40	-60				
For this week	100	40	- 60				
For this month	100	40	- 60				
For the next 3 months	100	40	- 60				
Participant Number 30							
For today	0	died					
For this week	0	died					
For this month	0	died					
For the next 3 months	0	died					
	Pre Test	Post Test	Difference	Control mean	Pre Test	Post Test	Difference
TX Group mean scores	45.59	50.54	+ 4.95		58.72	46.55	- 11.99
TX Temperol Mean Scores:				Control Mean			
For today	51.15	52.54	+ 1.35		58	40	-18
For this week	44.23	45	+ 0.7		61.5	37.7	-23.8
For this month	44.61	42.5	-2.1		58.5	36.6	-21.9
For the next 3 months	43.46	42.5	-0.96		63	44.4	-18.6

Question Four: For Treatment and Control Group : I can take my medication, for today, for this week , for this month, and for the next three months.

Participant Number 2	Pre test	Post Test	Difference	Control 1	Pre Test	Post Test	Difference
For today	100	90	- 10		100	100	0
For this week	100	90	- 10		100	100	0
For this month	100	90	- 10		100	100	0
For the next 3 months	100	90	- 10		100	100	0
Participant Number 7				Control 6			
For today	90	blank			90	blank	
For this week	90	blank			90	blank	
For this month	90	blank	0		90	blank	
For the next 3 months	90	70	- 20		90	60	
Participant Number 8				Control 9			
For today	100	100	0		90	80	- 10
For this week	100	100	0		90	80	- 10
For this month	100	95	- 5		90	80	- 10
For the next 3 months	100	95	- 5		90	80	- 10
Participant Number 11				Control 12			
For today	100	80	- 20		100	100	0
For this week	100	blank	0		100	100	
For this month	100	blank	0		100	100	
For the next 3 months	100	blank	0		100	100	
Participant Number 14				Control 13			
For today	100	100	0		100	100	0
For this week	100	100	0		100	100	0
For this month	100	100	0		100	100	0
For the next 3 months	100	100	0		100	100	0
Participant Number 15				Control 17			
For today	100	100	0		100	100	0
For this week	100	100			100	100	0
For this month	90	100	+ 10		100	100	0
For the next 3 months	90	100	+ 10		100	100	0
Participant Number 16							
For today	100	100	0				
For this week	100	100	0				
For this month	100	100	0				

Question four continued:

Participant Number	Pre test	Post Test	Difference	Control	Pre Test	Post Test	Difference
Participant Number 18				Control 21			
For today	100	100	0		100	100	0
For this week	100	100	0		70	90	+ 20
For this month	100	100	0		60	80	+ 20
For the next 3 months	100	100	0		50	80	+ 30
Participant Number 19				Control 22			
For today	100	100	0		30	no results	
For this week	100	100	0		30	no results	
For this month	100	100	0		30	no results	
For the next 3 months	100	100	0		30	no results	
Participant Number 25				Control 27			
For today	100	90	-10		100	100	0
For this week	100	90	- 10		100	100	0
For this month	100	90	- 10		100	100	0
For the next 3 months	100	90	-10		100	100	0
Participant Number 26				Control 28			
For today	100	90	- 10		90	90	0
For this week	blank	100	0		90	90	0
For this month	blank	100	0		90	90	0
For the next 3 months	blank	100	0		90	90	0
Participant Number 29							
For today	100	100	0				
For this week	100	100	0				
For this month	100	100	0				
For the next 3 months	100	100	0				
Participant Number 30							
For today	90	died					
For this week	90	died					
For this month	90	died					
For the next 3 months	90	died					
	Pre Test	Post Test	Difference	Control Mean	Pre Test	Post Test	Difference
TX Group mean scores	97.97	96.47	-1.5		72.5	92.5	+ 20.0
TX Temperol Mean Scores:				Control Mean			
For today	90.76	87.5	-3.26		86	85.5	-0.5
For this week	90.76	81.6	-9.16		87	84.4	-2.6
For this month	90	81.25	-8.75		86	83.3	-2.7
For the next 3 months	90	87.06	-2.92		85	90	+ 5

Question Five: For Treatment and Control Group: I can discuss any concerns with my treatment team, for today, for this week, for this month, and for the next 3 months

Participant Number 2	Pre test	Post Test	Difference	Control 1	Pre Test	Post Test	Difference
For today	100	40	-60		10	100	+ 90
For this week	100	40	- 60		10	100	+ 90
For this month	100	40	- 60		10	100	+ 90
For the next 3 months	100	40	- 60		10	100	+ 90
Participant Number 7				Control 6			
For today	50	blank			30	blank	
For this week	50	blank			30	blank	
For this month	40	blank	0		30	blank	
For the next 3 months	40	70	+ 30		30	blank	
Participant Number 8				Control 9	3		
For today	100	100	0		90	blank	
For this week	100	100	0		90	blank	
For this month	100	100			90	blank	
For the next 3 months	100	100			90	blank	
Participant Number 11				Control 12			
For today	100	90	- 10		10	100	+ 90
For this week	100	blank	0		80	100	+ 20
For this month	100	blank	0		90	80	- 10
For the next 3 months	100	blank	0		90	80	- 10
Participant Number 14				Control 13			
For today	100	100	0		100	90	- 10
For this week	100	100	0		100	90	0
For this month	100	100	0		100	90	0
For the next 3 months	100	100	0		100	90	0
Participant Number 15				Control 17			
For today	10	50	+ 40		100	100	0
For this week	10	50	+ 40		100	100	0
For this month	10	50	+ 40		100	100	0
For the next 3 months	10	50	+ 40		100	100	0
Participant Number 16							
For today	100	100	0				
For this week	100	100	0				
For this month	100	100	0				
For the next 3 months	100	100	0				

Question five continued:

Participant Number	Pre test	Post Test	Difference	Control	Pre Test	Post Test	Difference
Participant Number 18				Control 21			
For today	90	100	+ 10		80	60	- 20
For this week	90	100	+ 10		60	60	0
For this month	90	100	+ 10		60	60	0
For the next 3 months	90	100	+ 10		60	60	0
Participant Number 19				Control 22			
For today	100	100	0		100	no results	
For this week	100	100	+ 5		100	no results	
For this month	100	100	- 5		100	no results	
For the next 3 months	100	100	- 5		100	no results	
Participant Number 25				Control 27			
For today	100	90	-10		80	70	- 10
For this week	100	90	- 10		80	70	- 10
For this month	100	90	- 10		80	70	- 10
For the next 3 months	90	90	0		80	70	- 10
Participant Number 26				Control 28			
For today	100	blank			100	90	- 10
For this week	blank	blank	0		100	90	- 10
For this month	blank	blank	0		100	90	- 10
For the next 3 months	blank	100	0		100	90	- 10
Participant Number 29							
For today	100	70	- 30				
For this week	100	70	- 30				
For this month	100	70	- 30				
For the next 3 months	100	70	- 30				
Participant Number 30							
For today	100	died					
For this week	100	died					
For this month	100	died					
For the next 3 months	100	died					
	Pre Test	Post Test	Difference	Control Mean	Pre Test	Post Test	Difference
TX Group mean scores	88.4	84.34	-4.06		79.57	84.16	+ 4.59
TX Temperol Mean Scores:				Control Mean			
For today	88.46	70	-18.46		70	56.6	-13.4
For this week	80.76	62.5	-18.26		75	67.7	-7.3
For this month	80	62.5	-17.5		76	67.7	-8.3
For the next 3 months	79.23	76.6	-2.63		76	65.5	-10.5

Question Six: For Treatment and Control Group: I can discuss any concerns with my family/spouse whenever I need to, for today, for this week, for this month and for the next three months.

Participant Number 2	Pre test	Post Test	Difference	Control 1	Pre Test	Post Test	Difference
For today	100	30	- 70		10	100	+ 90
For this week	100	30	- 70		10	100	+ 90
For this month	100	30	- 70		10	100	+ 90
For the next 3 months	100	30	- 70		10	100	+ 90
Participant Number 7				Control 6			
For today	30	blank			50	blank	
For this week	30	blank			50	blank	
For this month	30	40	+ 10		50	blank	
For the next 3 months	30	blank			50	60	+ 10
Participant Number 8				Control 9			
For today	100	100	0		90	70	
For this week	100	100	0		90	70	
For this month	100	100			90	70	
For the next 3 months	100	100			90	70	
Participant Number 11				Control 12			
For today	100	90	- 10		90	100	+ 10
For this week	100	blank	0		90	90	0
For this month	100	blank	0		90	90	0
For the next 3 months	100	blank	0		90	90	0
Participant Number 14				Control 13			
For today	100	100	0		90	90	0
For this week	100	100	0		90	90	0
For this month	100	100	0		90	90	0
For the next 3 months	100	100	0		90	90	0
Participant Number 15				Control 17			
For today	100	100	0		100	100	0
For this week	100	100	0		100	100	0
For this month	100	100	0		100	100	0
For the next 3 months	100	100	0		100	100	0
Participant Number 16							
For today	0	50	+ 50				
For this week	0	50	+ 50				
For this month	0	50	+ 50				
For the next 3 months	0	50	+ 50				

Question six continued :

Participant Number	Pre test	Post Test	Difference	Control	Pre Test	Post Test	Difference
Participant Number 18				Control 21			
For today	90	blank			10	blank	
For this week	90	blank			10	blank	
For this month	90	blank			10	blank	
For the next 3 months	90	blank			10	blank	
Participant Number 19				Control 22			
For today	100	100	0		90	no results	
For this week	100	100	0		90	no results	
For this month	100	100	0		90	no results	
For the next 3 months	100	100	0		90	no results	
Participant Number 25				Control 27			
For today	100	80	- 20		100	100	0
For this week	90	80	- 10		100	100	0
For this month	70	80	+ 10		100	100	0
For the next 3 months	50	80	+ 30		100	100	0
Participant Number 26				Control 28			
For today	100	blank			100	30	- 70
For this week	blank	blank			100	30	- 70
For this month	blank	blank			100	30	- 70
For the next 3 months	blank	100			100	30	- 70
Participant Number 29							
For today	100	100	0				
For this week	100	100	0				
For this month	100	100	0				
For the next 3 months	100	100	0				
Participant Number 30							
For today	100	died					
For this week	100	died					
For this month	100	died					
For the next 3 months	100	died					
	Pre Test	Post test	Difference	Control Mean	Pre test	Post test	Difference
TX Group mean scores	82.37	85.5	+ 3.13		73.3	77.02	+ 3.72
TX Temperol Mean Scores:				Control Mean			
For today	86.15	62.5			73	65.5	- 71.5
For this week	77.69	55			73	64.4	- 8.6
For this month	77.69	60.8			73	64.4	- 8.6
For the next 3 months	76.15	63.3			73	71.1	-1.9

Appendix E
Recruitment letter for
Pre-dialysis Self-efficacy Treatment Program

Dear

I am writing to you to let you know about a research project we are doing at the Health Sciences Centre and St. Boniface Hospital. The name of this project is "Evaluation of a Self-Efficacy Educational Treatment Program for Pre-dialysis End-stage Renal Disease Patients." The monies to do this research project will come from the Kidney Foundation of Canada. This study will determine the benefits of giving patients the chance to communicate with other patients to learn ways to cope with the demands of kidney disease.

The research project involves answering and completing a number of questions and possibly participating in a 2-hour, 6 week meeting with a group. Group activities will focus on self-management activities like diet, exercise, effective communication with health care professionals such as doctors, nurses, social workers, dietitians, etc. Individuals will also learn how to deal with stress and uncertainties related to kidney disease. This approach to patient education where individuals are encouraged to "take charge" of the management of their health will provide valuable information in the design of future education programs for pre-dialysis patients.

The research coordinator, Julie Abgrall-Cowan, will telephone you to discuss your possible participation. If you want to contact her yourself with any questions, please call at 787-2474. If you do not wish to participate in the project, please note that this will in no way affect your medical treatment.

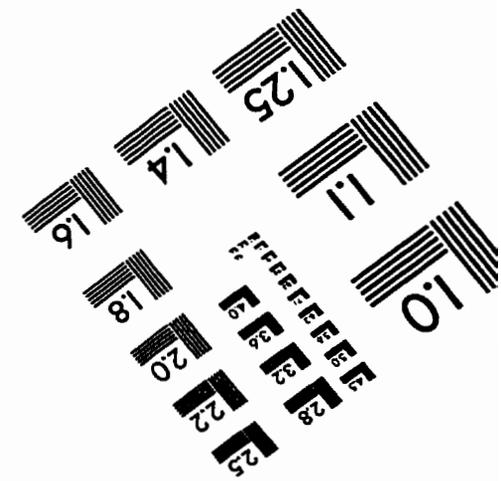
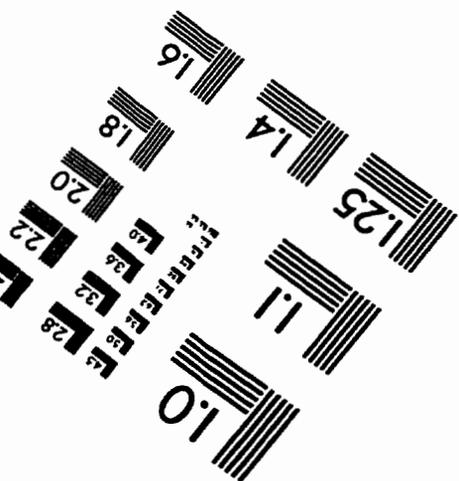
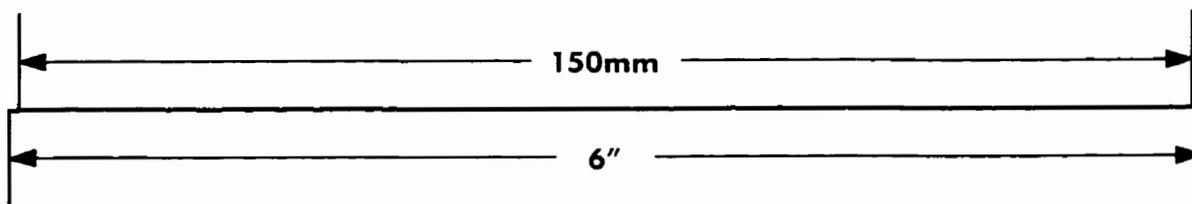
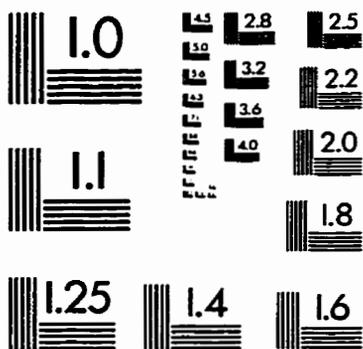
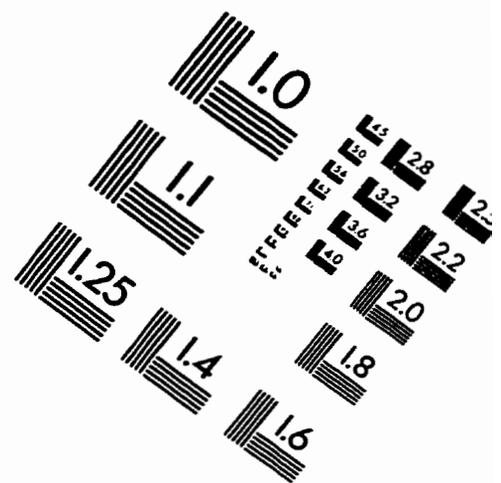
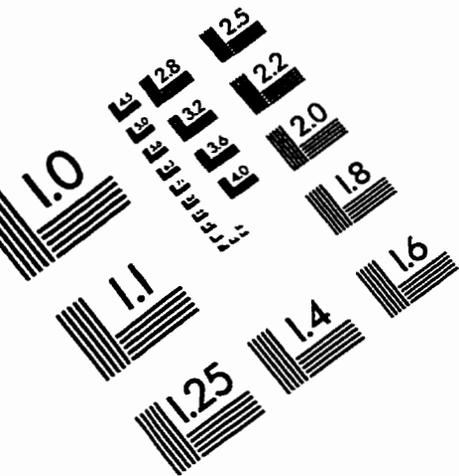
Thank you for considering this project.

Sincerely,

Nephrologist

RA/ep

IMAGE EVALUATION TEST TARGET (QA-3)



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