HEAD-INJURY TRAUMA: A FAMILY SYSTEMS APPROACH TO ASSESSMENT AND INTERVENTION

by

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PREFACE

Recent studies indicate an increasing number of head-injuries occur every year. The victims of these injuries are often men and are most often in the age range of 20-35. (Cronholm 1972, Oddy et al 1980)

Many of these men and women physically recover and return to their homes and families. Little is actually known about how the family manage within the ensuing months, other than through studies. Many questions of family functioning are left unanswered.

Hospitals are traditionally geared to ministering to the immediate physical needs of the individual. They are set up for life saving, and as a result families are often left to their own devices for emotionally coping with such traumatic events as head-injuries.

This practicum was designed to look at all of these situations as they specifically relate to the head-injured, and to possibly formulate an intervention for working with these families. With head-injury brain damage often occurs.

> From a social point of view, brain injured patients pose the most difficult problems in rehabilitation as compared with other disabilites. These patients suffer from severe changes in their cognitive, communicative, emotional and behavioral abilities, in addition to possessing certain motor handicaps. (Rosenbaum et al. 1978 pp 1)

Some time will be spent in discussing the problems encountered in the process of intervention. These problems occur within the hospital system itself, within the pre-traumatic family system, and as a direct result of the brain damage suffered by the patients themselves. Each of these problems has direct implications for therapy and its effectiveness.

The literature repeatedly indicates the need for involvement with the family from the time of the injury, with follow-up in the home. (Oddy et al 1978, Romano 1974) There is little written on actual experience in working with these families and the results obtained.

These families experience many and severe problems following the accident. Many times these problems occur after the support systems supplied by the hospital and home care services have been withdrawn. They find themselves on their own with a situation they did not expect: in particular, personality changes that origionally had been expected to "get better".

This report will discuss the necessity of ongoing social work involvement from the time of the accident or injury, with follow-up into the community.

The importance of the involvement of the social worker as an integral part of the hospital team is stressed throughout the report. Follow-up into the community also becomes an important issue, one that has not received enough attention to date.

Families facing a head-injury to a loved one have many crises before them. In retrospect one woman said, "The accident itself and the hospitalization are such a small part of the turmoil our lives have been in ever since."

The need here is great! The difficulties facing the families are great! The difficulties facing the therapist often seem greater.

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Chapter I

INTRODUCTION AND PROPOSAL

This practicum focuses on working with severe head-injured patients and their familes. Head-injuries are usually accidental in nature, as a result of a fall, motor vehicle accident, or a criminal injury. In many cases this injury results in loss of conciousness ranging from hours, days to possibly months and years, with varying degrees of brain damage. (Stern 1978, Oddy et al. 1978,)

Although these individuals may have other injuries, it is the head- injury that is considered to be the most severe and most in need of care and attention.

The numbers of head-injuries do not appear to be decreaing, although neurologists and neurosurgeons repeatedly suggest that with the proper use of seat belts and motor cycle helmets the incidence could be greatly decreased. The majority of head-injuries occur in men between the ages of 20-35 often following use of alcohol. (Cronholm 1972)

Although there is relatively little research done in the area of head-injuries, what has been done suggests that patients are able to reintegrate into the community and function much better when there has been active, constructive, involvement of the family. (Rosenbaum et al 1978, Oddy et al. 1978)

> The more severely disabled a man is, the more dependant on his family, and the more crucial the role his family plays in his rehabilitation. (Rosenbaum et al. 1978 pp 5)

The family and significant others are the main support system of the head-injured patient, and as a result they require continuous nurturing in order for them to maintain the energy required for offering support and encouragement to their loved one. They play a large part in assisting the adaptive process to take place.

> In addition to working with others in the treatment setting it is essential that the patient continue to maintain an active membership in his/her family. He/she must have the engaged committments of their family in his/her own rehabilitative career if the gains he/she makes through the process are to have real and lasting meaning. (Shelhase and Shelhase 1972 pp 545)

For the head-injured patient, involvement of the family is essential as it is they who must ultimately cope with the behavior and life style changes that occur following this type of injury. (Oddy et al. 1978,1980, Romano 1974, Thomsen 1974)

A very real fear of the traumatically injured patient is loneliness, therefore involvement of family and significant others all along the hospital process is important in order that the patient maintain contact with his/her out of hospital support system, and to increase his/her feelings of self confidence. (Steger 1977)

Physical illness and/or injury deals a severe blow to the individual's self esteem and self confidence, especially in the case of head-injuries where the recovery period is suggested to be at least two years. (Stern 1978)

1.1 CONCERNS FOR THE HEAD-INJURED

There are several issues that become intensified for the head-injured individual and his/her family in the months and years following the accident. These will be outlined here, and elaborated upon in later chapters. The first and major concern, is unrealistic expectations of functioning. When the individual appears physically well there is often the expectation that he/she should return to his/her pretraumatic mental and emotional state as well. Often this is not possible, and it is here that problems occur. Romano 1974, Litman 1966)

Shattered self esteem is a second major issue. This is due in part to being physically ill, as well as to the brain damage. Behavior changes reflect the loss of self esteem, for example the consistant focus on themselves, always wanting to be the centre of attention, as well as being somewhat more dependant upon a parent or spouse. For many patients who do not recognize these changes in themselves, it is hard for them to understand the reactions of others to their new behavior patterns. (Stern 1978)

The possible need for changes in roles within the family, plays a large part in this experience. In many cases, prior to the accident the father was the wage earner. As a result of the accident he may be unable to return to work, at least for an extended period of time. Due to the need for finances, the wife may have to make arrangements to go out to work, however,

> for the man, having to relinquish this role can result in loss of self esteem, a feeling of inadequacy,and an accompanying depression. (Lambert 1974 pp 26)

This issue is dealt with in more detail in chapter 2

Behavioral changes constitute the greatest concern for the family of the head-injured person. In many cases it is difficult to accept the person the way they are, and for some it is impossible. In one study, it was found that where behavioral changes were great, mothers of single patients were able to adjust much better than were spouses. Family conflict was significantly greater in the head-injured group than in the comparison group. (Oddy et al. 1980)

These concerns are often identified within the therapeutic process. The patients and families themselves have a difficult time to identify them on their own. The family, however, are all able to state that their main concern is the behavioral changes. These changes take priority above all else. They spend a great deal of energy and experience a high frustration level in trying to understand, or change this new behavior, often, as mentioned before, without understanding the reasons for the problem.

1.2 THERAPY ISSUES

In working with these families it is important to consider many aspects of the situation. Knowledge of head-injuries themselves, and an understanding of the behavioral and mental changes that are a part of this process are essential for helping the families to cope, as well as for helping the therapist to realize the limitations for change that might be faced. As a result of these limitations, it is probable that an important aspect of the therapy be focused on coping mechanisms, learning how to live with the problems, rather than expending the energy for change.

Due to the nature of the changes that occur, (Stern 1978, Oddy et al. 1978, Cronholm 1972) and the inherent problems within these changes, such as the patient being unaware of any difference, some traditional forms of therapy may not be effective.

Dealing with the loss of the person as they were before, is an important aspect of the intervention, in order for them to move on to learning how to live with the present situation. In many cases it has been found that families have totally denied changes that have occurred, and have functioned as if all is as before the accident to the detriment of the patient. For example, patient's reactions are often slower following a head- injury, and this may create some problems when driving, as described in Romano's article 1974. This attitude does not allow the patient the opportunity to grieve his/her loss of functioning as he/she can be easily influenced by the family members on whom he/she depends for their security and reintegration into the community. (Livsey 1966)

Helping the patient and family deal with the phases of the crisis of head-injury or physical illness in general is an urgent therapeutic concern. The phases of shock, defensive retreat, acknowledgement and adaptation, will be discussed in chapters 2 and 4. (Fink 1967)

Pretraumatic behavior is also an important element to consider in therapy.

> Pre accident endowment in terms of intelligence and personality, has significance for recovery, particularily regarding the ability to cope with the consequences of injury, where insight into the level of disability has not been lost, as is sometimes the case. Premorbid emotional instability is associated with an increased risk of emotional illness after injury. (Bond and Brooks 1976 pp 124)

In many cases where there has been an unstable family relationship prior to the accident this becomes enhanced following the accident. This may not be apparent immediately after the accident, however, when the rehabilitation time appears drawn out these problems reappear.

1.3 INTERVENTION

Although the literature repeatedly indicates the need for intervention with the families of the head-injured, there are no specific modes of intervention outlined.

General literature regarding physical illness indicates the need for CRISIS INTERVENTION and suggests family therapy can also be helpful.

Due to the lack of literature specifically related to intervention with the head-injured, this practicum focuses on the use of crisis intervention, and family therapy with specific relation to Communication Theory as used by Virginia Satir and Yetta Bernhard. As a further element to the use of communication theory, Neuro- Linguistic Programming (NLP) will be used as is considered appropriate. This method facilitates an understanding of how some of the reactions occur, some of the mechanisms behind the behavior which are useful in the assessment of these situations.

Treatment may involve the couple, family without the patient (in the case where the patient remains unconcious), or the entire family. The aim of the intervention is to help the family deal with the issues and changes in life style they are facing in order for them to live to their fullest potential. In some cases this may mean separation or divorce, when the spouse is really able to understand what changes have occurred and to decide whether he/she is able to accept this "new person" and carry on.

Working with the family as a unit, is the bias of the author, as a result of years of frustration working in hospital settings where the focus of treatment is the patient and the long term success of reintegration into the family and community is severely limited.

The literature on head-injuries, as described in chapter 2, stresses that family work is the desired direction in order for the process of rehabilitation to reach its fullest potential. (Oddy et al. 1980)

Chapter II

A LITERATURE REVIEW

2.1 THE AFTER EFFECTS OF HEAD-INJURY

A considerable amount of work has been done on the physical and psychological effects of head-injury. It is well documented that in most cases of severe head-injury, there is some degree of brain damage which results in personality and behavioral changes. (Oddy et al 1978,1980, Romano 1974, Thomsen 1974, Stern 1978)

Most of the literature states that although there are some physical deficits such as slower movement, some speech impediment, and perhaps some motor weakness with possible contractures of the muscles if the patient has been unconcious for some time, the greatest problems for readjustment into the community and family are the mental handicaps found. (Ibid)

> Mental features are more consistant and more persistant than physical disabilities, and they contribute more significantly to the overall social handicap. (Jennett 1975 pp 270)

It appears that the physical problems receive a great deal of attention, support and follow-up by the hospital and rehabilitative staff, whereas the behavioral and emotional problems do not receive the same attention. (Oddy et al 1978, Romano 1974, Thomsen 1974)

All of the literature points to the fact that the physical problems are minimized by the tremendous effect of the mental deficits. (Thomsen 1974, Oddy et al 1978,1980; Walker 1972,Rosenblum et al 1978)

It is important to note that these studies were based on the long- term follow-up of these patients and their families, for two years or more. Head-injured patients are not considered to have reached their full potential until at least two years following their injury.

Many definitions are given to the actual "psychiatric" problems that occur. Dr. J. Stern, in his article, consisely describes the problems facing the patient and his/her family. He divides the symptoms into three phases:

1. Phase 1: This occurs on recovery of conciousness, and is referred to as the Acute Phase. The symptoms for this phase are; post traumatic amnesia,disorientation and agitation. There may be transient periods of hallucinations and delerium. Agressive behavior is common.
2. Phase 2: This occurs after the acute symptoms have disappeared. The symptoms here are; introversion, egocentricity,and lack of object relationships; deficits of memory and judgement, loss of self confidence, chronic fatigue, and catastrophal anxiety reactions to change.

If he does not manage to neutralize this anxiety, he will often exhibit an agressive, explosive behavior, and be subject to emotional outbursts.

3. Phase 3: The chronic changes are evident, which include the personality changes. These symptoms include; tendancy to constantly repeat the same ideas very self orientated, inflexible thinking.

Alongside these changes, the patient settles into a state of unawareness regarding his own situation. (Stern J. 1978)

These problems are identified throughout the literature as being a tremendous obstacle for the patient and family to overcome.

In a recent study done in England, 44 patients were followed. 31 patients who had undergone personality changes were compared with 13 patients who had not. They found that those with personality changes had fewer interests, were bored more often, were more dependant on their families and more often suffered some memory loss.

They were surprised to find that there seemed to be an equal amount of family friction between the two groups. They did, however, split those with personality changes into two groups, those more irritable and those who were not. There was significantly more friction found in the families of the irritable patients. (Oddy et al 1980)

The most significant physical injury that relates directly to psychosocial adjustment is the injury to the brain.

Often the damage is in the frontal lobe which results in such marked behavioral changes as have been described.

It is these deficits that will be the focus of much of this practicum report.

2.2 PSYCHOSOCIAL ADJUSTMENT FOR PATIENT AND FAMILY

2.2.1 As a Result of Hospitalization

As the patient is not really aware of what is going on around him for at least the first few weeks, either due to coma, or the acute stage of the injury, the initial adjustment is required by the family.

The family, however, is in a state of crisis. They experience several reactions to the situation, such as shock disbelief or denial, extreme anxiety, feelings of uncertainty, fear and possibly vague hope. These reactions are quite similar to the grief reactions following the death of a loved one. (Kubler-Ross 1979) We will deal with these reactions more fully later on.

It is often difficult for the family to deal with the emotional reactions when the patient is admitted to hospital for several reasons. One of these reasons is the set up of the hospital system which is geared to urgent medical attention, rather than to dealing with the emotional crises that the families and patients are experiencing. This is especially true in the Emergency Room and the Intensive Care Unit.

In both Emergency and Intensive Care, there is of necessity a very busy atmosphere, people running in and out dealing with urgent physical problems. As a result, families are left to their own devices.

The literature repeatedly states the need for contact with the family at this time, to act as a liaison with the hospital staff, to give support to the family, and to assist them in understanding the general operation of the hospital (Mailick, 1978: Williams and Rice 1977.)

Families experience a high degree of frustration when they are unable to talk to hospital personel, to gain the information they require to help them deal with the situation.

Initially this is often the main task required of Social Work. The families are experiencing shock and denial, and are unable to deal with much else at this point in time. Any other form of involvement is not really understood or accepted at this time. (Steger 1977, Mailick1978, Williams and Rice 1977)

At this stage it is important that both the patient and the family learn how to cope with the medical system and those supplying the care. This is a fairly difficult task for them as many have not had much experience with hospitals and medical staff. It is easy for them to misunderstand the hospital staff as they often appear too busy to talk, especially with families,and to offer the support that is required. Social Work intervention at this point is useful in helping to put the situation into perspective again, and to serve as a liaison for the family.

As a result of long hospitalizations other difficulties may occur that present new tasks for the patient, family and staff. There are many benefits that may be obtained by the "sick role" which both patients and staff tend to encourage often unconciously. The patient receives a great deal of attention from the staff and his/ her family, which may tend to increase his/her dependency if not properly handled. The family, in many cases, have strong guilt feelings for one reason or another that they try to deal with through lavishing attention on the patient. It is difficult for the patient not to get used to this treatment and to rely upon it.

Both the patient and the family face the task of finding a balance within themselves for dealing with the health care system, while still maintaining their own autonomy and independence as individuals within the family structure. In order to facilitate this task, the social worker has the task of making sure the patient is an active participant in the plans that are being made for his/her treatment and future life planning. The hospital system is such that it is often easier to make plans with the family members only, thus excluding the patient and reinforcing the feelings of isolation that are so much a part of the patient's experience.

Many families also believe that they are protecting their loved ones by saving them the worry of being involved in the plans for treatment and discharge. This is not necessarily seen as creating any future problems of dependency. During this time it is very difficult for both the patient and family to think ahead. It is hard for them to allow the patient to accept some resposibility for him/herself even though he/she will have to do so on return to his/her place in society.

At this stage as well, the social worker offers support to the patient and family throughout the discharge planning process. The threat of loss of support of the hospital staff is very anxiety producing. Mobilizing community resources for these families is an important aspect of social work intervention. These resources are essential for the maintenance of the family system in the community. Establishing psycho-social outlets in the community for the patients help them to maintain their autonomy. One of the problems with the planning, in many cases, is that patients are set up with home care, community nursing, and all of the other community medical services which help to maintain the "sick role" for the patient. Community resources to enhance social functioning are not often included in the planning which is one reason why a great number of "chronic" patients are unable to reintegrate into society. Their whole life has become their illness. (Livsey 1966)

It is in the initial stages of hospitalization that the course of treatment can be determined. Involvement of the family and patient as a unit in the treatment plan can enhance the treatment process, and shorten the time required in hospital. (Shelhase and Shelhase 1972) Although the hospital plays an important and necessary role for the patient and family, it is important to keep in mind it's limitations The fact that the hospital is a stepping stone to return to the community must be kept in mind.

> It is through the early and continuing attention to the family as a unit during the rehabilitation experience that the patient is never far removed from them, affectively and interactionally. In this way the trip home is never a long one. (Shelhase and Shelhase 1972 pp 550)

2.2.2 In Specific Relation to Head Injury

Head-Injuries differ considerably from most other injuries, especially in the initial stages. For most other injuries or illnesses it is possible for the family to have some verbal contact with the patient, or at least have some indication the patient is aware they are there. In the case of head-injuries, this is not so. Often the patient is unconcious, or going through phase 1 as described earlier by Dr. Stern. At this point the patient is not aware of the family, nor is the family able to obtain any reassurance that the patient is "alright" by communicating with him/her.

The literature states that this raises the anxiety level of the family, especially, as described earlier,when they are unable to talk to medical personnel to understand what is really going on.

As the patient begins to recover some comprehension and functioning there are still emotional, behavioral and mental deficits, as described by Stern, with which to cope. For those patients who do not awaken but rather remain in a "vegetative state", other problems are posed for the family.

> Added to the paralysis and structural damage is the problem of whether communication exists with them or not. (Rosin 1977 pp 9)

The uncertainty remains with these families for months and/or years, and can becaome extremely difficult to deal with.

As is also stated by Stern, the patient is often unaware of the changes taking place in his/her personality, or of his/her behavior pattern. It is not a simple matter of explaining that the agressive behavior is not acceptable, as he/she has no knowledge of what actions have been taken.

Families often find this difficult to understand, and often feel rejected by the behavior displayed by the patient. Many sources indicate that this is a strong reason for the need for involvement with the family from the beginning. This is in order to help them understand that this is not a personal affront,but rather a result of the injury. (Steger 1977)

It is important to note that although personality changes often take place in the individual, they are not often perceived as problems by the family until they have attempted to return to the normal routine of daily living.

One of the reasons for this is that there is such turmoil and crisis at the time of the accident which continues into the rehabilitative stages in the hospital environment, that the family is often able to make excuses for the patient's apparent behavior problems. It is only when, in the family's mind the patient ought to be well, and "normal", and is found not to be so, that the problems develop.

Romano, Thomsen and Oddy, in their separate studies, all state that the families are unaware of the potential for behavior problems, and therefore have great difficulty in coping with, or understanding, what is going on. (Romano 1974, Thomsen 1974, Oddy et al 1980)

2.3 CRISIS THEORY AS RELATES TO GRIEF WORK WITH THE HEAD-INJURED

A crisis is described as a state of disequilibrium, or unbalance. Fink in his article states that crisis can be defined in terms of a known precipitating event and slow resolution.

> How intense a crisis a particular event may come to represent to someone depends upon the extent of reorganization required in order to cope with it. (Fink 1967 pp 592)

Illness or injury is described in the literature as a "situational crisis" comprised of several phases. Each author uses different words to describe similar experiences, or phases, however the ones used by Fink appear the most useful here. These phases are, shock, defensive retreat, acknowledgement, and adaptation.

It is recognized that, as Kubler-Ross states, not every patient or family will experience all of these stages. They are also not exclusive to themselves, rather the patient and family move back and forth among them.

2.3.1 Shock

> In the case of physical injury, the shock period is that time when immediate medical attention is required and when the extent of damage, temporary or permanent, is still unknown. The focus of attention is upon repair of the damage. (Fink 1967 pp 593)

In the initial stage of shock, the patient and family have several varied reactions. They are experiencing a threat to their previous way of life which in turn results in such reactions as numbness, detachment, feelings of unreality, confusion, helplessness, and very high anxiety. The state of numbness is described as being a protective mechanism for the body. The body is only able to handle a certain amount of stress at any one time, and therefore has this defense mechanism that allows time for the system to handle the initial stresses before moving on to the next.

At this point in time intervention is limited, however extremely important. The social worker may serve as a liaison between the hospital staff and the family. As information is difficult to come by, especially while the patient is in Intensive Care, he/she is able to act as an advocate for the patient and family. In doing so he/she is able to establish a relationship that will carry on through other areas of treatment. (Mailick 1979)

In some situations the family need to express their feelings of grief and anxiety, and the social worker is able to facilitate this process as appropriate. Actual therapeutic intervention is not advised during the first few weeks following the accident. The families need some time to become acquainted with the experience they are facing, go through their period of shock, and begin some personal adjustments on their own. The addition of another stress, therapy, could be too much for them and hinder the establishment of an ongoing relationship.

> In stressful situations which tax the strength of the adaptive capacity of the individual or family as a whole, it is imperative that social workers assess the acute nature of the situation and intervene at the point of crisis in such a way as to prevent regression and sustain functioning at the highest possible level. (Williams 1979 pp 25)

2.3.2 Defensive Retreat

In the second stage the patient and family attempt to revert to the pre crisis level of functioning. Denial is evident, and the constant thought that, 'everything will be alright' is prevalent. In some cases, as described by Romano 1974, this denial continues even after discharge to the detriment of the family system. It is important that intervention occurs here in order to help the family, patient, and staff deal constructively with the experience.

In some patients this denial is evident through demonstrations of anger and hostility towards staff and/or family members, which may often be misinterpreted. In such cases, the families may feel rejected, as they see this anger as a personal affront . This may inhibit the process of rehabilitation, as it is really important for the family to be involved, and offer the support required to the patient on an ongoing basis. This was discussed in a previous section.

Staff also have difficulty dealing with anger and hostility,as again are not quite sure how to handle it, and it is often taken as a personal affront. In many cases this is not a concious reaction but rather one that naturally occurs as a result of being human. Often this can be dealt with by merely identifying the situation.

For staff, it is much less acceptable, and much harder to deal with, when the anger appears on the part of the family. (Steger 1977, Shelhase and Shelhase 1972)

During this time, patient, family, and staff require support from the social worker in order to enhance the communication between all three systems. It is important that everyone understand that this is a normal part of the process and has nothing necessarily to do with them directly at this point. It may be that the anger from the patient is an after-effect of the head-injury as previously mentioned over which the patient, at least initially, has no awareness or control. (Steger 1977, Maillick 1979, Shelhase and Shelhase 1972, Stern 1978, Weller and Miller 1977)

During this period there are some physical improvements in the patient, and therefore it is easier to reinforce the denial phase. Families have a hard time at this point to fully appreciate the fact that there will have to be some life style changes for them. In the case of head-injuries, where the rehabilitation period is actually considered to be years, this is much more difficult to face. This is particularily true for the mental limitations. The physical limitations are much more easily dealt with and accepted.

This is an extremely difficult phase for all those associated with the physically ill, including the patients themselves. Support and understanding are the two most important factors here for all of those involved.

2.3.3 Acknowledgement

Fink states that it is at this point in the process that the patient and family begin the grieving process. Other literature indicates that this has begun from the initial point of the accident. (Kubler-Ross 1979, 1965) For the purpose of organization the grieving process will be dealt with here, although the author also feels that the process has been going on for some time when this phase appears. The patient and family are able to recognize that an injury has taken place, that changes have occurred, and they can no longer be avoided. It is here that the patient may experience the loss of his self-image, and self esteem. (Fink 1967) Feelings experienced here range from depression, bitterness, some confusion, anxiety to even deep feelings of helplessness. Miller and Weller in their article equate the stage of depression to the "work of mourning".

> The term depression is used here to encompass the whole period of active mourning that the patient (family)experience as they face with deepening awareness the reality of his/her condition and all its implications. The patient grieves both for his past life and his future life and the sudden, unimaginable difference between them. (Weller and Miller 1977 pp 375)

Although this grieving process holds true for most physical illness, due to the extent of brain damage, the patient may be unaware of his losses. (Stern 1978) In such cases it is extremely difficult for this process to be dealt with. Although some families may not be willing to deal with their grief they do have the potential for recognizing the problems at some point. It is this potential that may be lacking for the patient.

In order to facilitate the rehabilitative process it is important that this phase be dealt with to some extent. One of the difficulties with rehabilitation in general is that patients and their families compare the way they were before the injury with being "well". Anything less than this pre accident state does not represent improvement or "health". This can contribute significantly to the depression and severely impede the rehabilitative process. For the patient and the family this represents the ability to at least begin the process of mourning. In the case of head-injuries, with the long term rehabilitation period, patients and families can begin to make this move on the assumption that the patient has a long way to go, or "it's early yet".

At this point intervention focused on dealing with loss of functioning and change in the family roles is essential. There is the potential for the family to take over many of the roles previously held by the patient in order to "help them out" and leave no role for the patient to assume. (Mailick 1979, Livsey 1972) It is important that intervention here allows both the patient and family to maintain their autonomy. It is essential that the family are aware that the patient must maintain a place within the family system, that protection is not helpful but can rather be seen as a rejection on the part of the patient. (Steger 1977)

An element that is important to consider, especially for the head- injured patient is...

> the degree to which the patient and family can be helped to handle the loss, is closely associated with their understanding, and expectations of anticipated medical/surgical procedures and the related prognosis. (Williams 1979 pp 26-27)

The literature repeatedly indicates that this is a severe problem for the head-injured and their families, and therefore their ability to handle the loss is limited. (Oddy et al 1978, 1980, Romano 1974, Thomsen 1974, Bond and Brooks 1976)

For the head-injured patient and his family there are no defined boundaries for this phase. The process of acknowlegement of the full implications of the injury is ongoing.

2.3.4 Adaptation Phase

Fink idicated that this is the phase where change occurs. It is here that the individual is able to develop a new or modified sense of self image and therefore begin to make the change required to move forward. (Fink 1967) The patient and family are then able to see progress through the setting of new realistic goals and thereby gradually lessen the feelings of anxiety and depression.

Due to the brain damage, the need for adaptation is not as obvious for these patients as it is for those with severe physical injury. More time is required by patient and family to discover the limitations and then learn to cope with them. The patient and family must then look to develop coping skills to deal with the situation. Each individual has his/her own coping mechanisms that each has been using with varying degrees of success in the past.

> the premorbid personality, the individual's habitual way of coping with frustrations, his defense mechanisms, his maturity, etc. will determine to a large extent the way he handles the consequences of head-injury. (Cronholm 1972 pp 36)

Intervention to assist with the development of new coping strategies or to adjust old methods to suit the new situation is essential. (Cronholm 1972, Mailick 1977, Williams 1979) Helping the family to recognize the need for new coping skills, is essential. Golan sums up the coping tasks required at this phase by saying...

> To a large extent these revolve around readjustment to the major realignments in family (and community) roles and to the provision of material and emotional support. (Golan 1978 pp 1978)

2.3.5 Summary

All of these phases are interwoven for patient, family and therapist. Although most often the literature deals with these phases from the patient's perspective, it is important to note that the family has similar experiences. One of the problems that occurs is that they do not necessarily go through these phases together. One may move faster than the other, which may cause problems with communications and understanding the meaning of behavior such as anger, which is difficult for most people to handle at the best of times. (Shelhase and Shelhase 1972) This serves to emphasize the continuing need for social work intervention.

2.4 FAMILY THERAPY

Although there is a great deal of material written on family therapy there is little written within the context of physical illness and even less directly relating to the head-injured. The one paper found, by Pope specifically related to head-injury, is based on individual and group psychotherapy as used at Ashby House in Toronto. (Ashby House is a treatment centre for the rehabilitation of patients with head-injuries. It is the step between hospital and return to the community.) Pope's paper was presented at the Head-Injury Conference in Toronto and focuses on the patient with no real reference to the family.

As a result of this lack of material, this section of the literature review is quite general in nature, and has been adapted to suit the head-injured and his/her family.

The need for work with families is well documented in the literature, as previously mentioned. Due to the lack of material on the kind of intervention required, I have chosen several techniques of family therapy based on communication theory, for treatment.

The area of communication is discussed in the literature as often presenting problems for the staff and families. (Romano 1974, Steger 1977) Most families attempt to "protect" their loved one from heavy decisions, being involved in the planning for rehabilitation etc.. They state that they don't want to upset the patient any more, "he has enough to handle at the moment". All of these presuppositions present real problems for communication. Several problems occur which affect relationships. For example, when the patient is not included, he/she may feel rejected and respond with anger which in turn produces confusion and anger on the part of the family. (Steger 1977)

The methods used by Virginia Satir and Yetta Bernhard have been chosen because they are straight forward, they get behind the outer shell people put up to protect themselves, and get to the feelings where the work can really begin. These methods work very quickly which serves to facilitate the process.

The "fair fighting" technique was used in a specific case where the other modes of therapy were not successful, and the need for structure was very apparent. This method was not a part of the original plan for therapy, but was implemented later as it fit with the situation.

NLP is used in the assessment process as a quick and efficient method for establishing a relationship with the family members, and for interpreting where each member of the family is with this relationship. This is also an effective method for assessing how the family communicate with one another. This technique is of special interest to the author and is not specific for head-injuries. Its use shortens the assessment process and allows more time for therapy.

Grief and bereavement therapy are an essential part of medical social work, and are necessary in order for the patient and family to move through the rehabilitative process. (Mailick 1979, Kubler-Ross 1965,1979,) and therefore are included in the work with the head-injured and their families.

For the purpose of this practicum, specific aspects of the work of Virginia satir, Yetta Bernhard, and John Grinder and Richard Bandler will be discussed, some time will also be given to the discussion of Elizabeth Kubler-Ross' work with children and loss. Other therapists will be discussed as appropriate to the situation.

There are several stages which make up a "pattern" for family therapy. I have chosen to use my own combination of stages outlined by other family therapists, to suit the purpose of this report. The "pattern"chosen for this report is comprised of the following...

1. Assessment: A time for information gathering and establishing rapport with the family.
2. Contracting: When agreements are made between each family member and the therapist, as to the plan for work, and the desired outcome of the therapy sessions.
3. Treatment: The implementation of the therapy. Communication skills training is begun here with various methods. Reframing plays a large part here, through the use of various methods such as "fair fighting",

family sculptures, or perhaps other forms of psychodrama. In this way the therapist is able to demonstrate the family reality directly to them, and is able to facilitate getting to the feelings where therapy can really begin. (Satir 1972)

4. Closing: The termination of therapy.

These stages are not entities in themselves, but rather overlap continuously throughout the therapeutic process. From the time the family first enter the therapist′s office the therapy begins. The therapist sets him/herself up as a role model for the family. All of the processes from the beginning of the interview onward are used as "teaching tools" for the process of communication. (Satir 1967,1972: Bandler, Grinder,and Satir 1976, Cameron- Bandler 1978)

2.4.1 Assessment

This phase is devoted to obtaining information from the family about their perception of the situation, and helps the therapist to understand what "communication patterns" are presently in operation within the family system. (Satir 1967)

Bandler and Grinder describe this as identifying each individual′s "representational system", that is, how they relate to the world around them. They say that each individual relates to the world through one of his/her senses. These representational systems are, visual auditory, feeling or kinesthetic, and olfactory (taste or smell). For the purpose of this report the author will refer to the first three systems as they are the most common. Each of these methods of relating to the world has its own language, and its own way of understanding and relating to emotions and feelings. Bandler and Grinder state that each individual, although he/she may experience two or more of these systems, has one main system through which he/she relates to others. It is useful to discover what representational systems are being used by each family member, because this may have implications for their ability to communicate with one another.

Many people see pictures, images in their mind's eye about their experiences, what they had for dinner, etc.. Others may have a kinesthetic response to events, or remember how good it felt to dance all night, rather than see a picture of the event.

Still others can hear word for word the conversation they had with their wives just prior to coming into the therapist's office. It is important to note that kinesthetic and auditory people do not see pictures until their feelings and auditory memory are in place. Visual people respond with feelings following the picturing of the event.

The two main ways of discovering which representational system a person is oriented to, are through observing his/her eye movements, and by listening to their language.

The eye movements referred to as "accessing cues", are a method for the therapist to quickly discover which system the person is using. This is extremely helpful when the therapist is "making contact" with the family members. It is important to be able to identify the representational systems for the purpose of being able to communicate individually with each person.

As a listener, attending to the "process words" the person uses can give an idea as to which system the person conciously represents. These key words are taken from Leslie Cameron-Bandler's book.

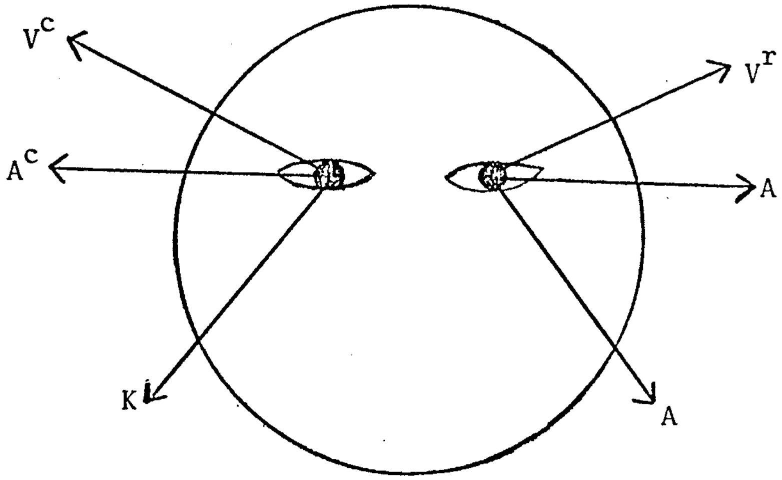
(Cameron-Bandler 1978 pp 37)

" VISUAL	AUDITORY	KINESTHETIC	SMELL & TASTE
picture	scream	feel	bitter
vague	hear	warm	salty
bright	screech	touch	fragrant
flash	shout	handle	pungent
blue	loud	grasp	smells
see	amplify	soft	stale
focus	tune	tight	fresh
perspective	tone	smooth	sweet/sour
clear	harmonize	rough	tastes "

(Cameron-Bandler 1978 pp 37)

The following diagram and description of accessing cues are included in their book Frogs into Princes pp 25

"



V^c visual constructed images

V^r visual remembered eidetic images

(Eyes defocused and unmoving also indicate visual accessing)

A^c auditory constructed sounds or words

A^r auditory remembered sounds or words

K kinesthetic feelings (also smell and taste)

A auditory sounds or words "

N.B. The visual accessing cues described are for normally organized right handers. The reverse is often the case for the left-handed person. For some therapists such as Virginia Satir, these methods come naturally, however, the majority of us are able to relate well with some people, and not so well with other people. This method of becoming aware of the differences each of us has in our communication, allows us to understand why we have problems with relating, and gives other choices for behavior.

Virginia Satir in her therapy is aware of the subtlties, quick glances, slower responses, etc. as well as the verbal responses given by family members. In her books she encourages other therapists to pay attention to these other behaviors, that often tell more about the person and the relationships they have, than words can possibly say. (Satir 1967, 1972) Neuro-Linguistics help to give the tools to become more aware of the subtlties of behavior to further enhance therapy methods. (Bandler, Grinder Satir 1976; Bandler and Grinder 1976; Cameron-Bandler 1978.)

2.4.2 Contracting

This process usually occurs during the initial interview. The therapist requests that the family contract with themselves and the therapist as to the goals they have for the outcome of therapy, as well as the practical matters of number and length of sessions. (Satir 1965,1972)

The family are requested to be specific about what it is that they want to change. Rather than stating the problem as "She doesn't appreciate me", the husband is encouraged to spell out exactly how he knows she does not appreciate him.

Since each individual attaches certain meanings to their own phrases it is important to have the husband describe what "appreciate" means to him. For their own learning, to have the wife explain what she thought he meant is also useful. Often the two are not related as each partner had separate meanings attached to the conversation.

Making sure that there is total verbal and non-verbal understanding about what is meant is essential. The operational words of "How will you know", are often used to expand the understanding. (Cameron-Bandler 1978, Satir 1972)

2.4.3 Treatment

Although this section is designated as 'treatment', the previous discussion constitutes treatment as well.

> The process of therapy is learning. At times it is the unlearning of patterns and processes that are no longer functional. (Duhl et al. 1973 pp3)

Throughout the treatment process the aim of the therapy is to facilitate congruent communication between family members, constantly checking out with other members to be sure that each has understood the intent of the communication. That is, to hear what is being said through the words, and to help the person giving the information to understand the distortions that occur when messages are being sent. (Satir 1972, Minuchin 1981, Bernhard 1975)

There are many reasons for communication problems within families, far more than can be dealt with here. It is useful to note, however, that a great many problems occur as a result of MINDREADING (Satir 1972, Bandler, Grinder, Satir 1976, Cameron-Bandler 1978)

This occurs when individuals make assumptions about what the other is thinking. For example, "I know what you are going to say,""I know what he thinks". This is when a large number of problems occur due to misunderstanding. The therapist enables the clients to see, and hear that they are quite possibly misreading what the other person thinks. Often they find that rather than knowing what the other person is saying, they are only reflecting their own thoughts.

The therapist acts as a translator for the family, helping them to clarify what is being said, using each person's "language" when talking to them, enabling the individuals to obtain the "intent" of the communication. In order to translate accurately for the other family members, it is important that the therapist understands the representational systems of each family member, as mentioned previously.

Another aspect of therapy, is challenging the families reality, how they perceive themselves. Various therapists have different methods of achieving this; Whittaker constantly confronts, jokes, teases, acts apparently irrelevantly, all to achieve this purpose. Minuchin in his work focuses on the redistribution of the problem from the identified patient to the family as a whole. In this aspect, Satir is similar in her therapy, based on the systems theory which states that when one part of the system is dysfunctional, all of the rest of the system must experience some changes. Her approach deals with the family as a unit, who have a "problem" in common.

(Satir 1972, Minuchin 1981, Whittaker 1974)

> Family therapy postulates that transactional patterns depend on,and contain the way people experience reality. Therefore, to change the way family members look at reality requires the development of new ways of interacting in the family. (Minuchin 1981 pp 71)

In order for the family to "experience reality, that is for the family to actually see and feel, as well as hear what is happening to them, Satir often makes use of "family sculptures".

> Sculpture is a dynamic, active, nonlinear process that portrays relationships in time and space so that events or attitudes may be perceived and experienced simultaneously. It is meant to provide the meanings, metaphors, and images of relationships in a way that can be shared by all who participate and observe. Information is not talked about but experienced through action and observation. An opportunity is provided for the presentation as a map rather than word description. (Duhl et al. 1973 pp 6)

During this process, the family are asked to describe the picture of how they each see their family, and to put themselves into the positions suggested. This helps to give them a definite experience of their reality, even though it may not be the way they had expected. With this new understanding of their reality they are able to see symbollically how they must change in order for the situation to improve. For example, the wife who always blames her husband, must stop blaming him in order for him to come out from behind the chair, and vice versa. (Satir 1972)

This method challenges the family reality by confronting each of them with the way they feel, as well as the way the therapist sees their family situation. Often each member has no idea of how the other sees him/herself within the system, but rather builds his/her images on assumptions. Sculpture also helps to get the family out of the verbal mode...

> where it has been locked and unresolved, into the actional mode, thus allowing the entire family and the therapist to clearly experience each individual's meanings, in sequence, within a short time. (Duhl et al. 1973 pp14)

Another method of dealing with verbal conflict within the interview sessions is to use what Yetta Bernhard refers to as "fair fighting techniques".

Fighting and/or arguing are a normal part of family life. It is when fighting is constantly destructive that problems can occur. Such destructive arguing may increase problems of low self esteem, and decrease the ability to communicate, as feelings run high and hurt is usually camouflaged by more anger.

Yetta Bernhard is very structured in her approach to dealing with this, however she uses several tools that are helpful in working with families. Two of these tools that will be discussed here are "hostility rituals", and "impact procedures".

She states that...

> hostility rituals de-escalate feelings of rage, through cathartic release and give information of the specifics of the anger, frustrations and hurts. Through this process, avenues are opened to increase the bonding capacity of the relationship by such procedures as specifically naming a future time to deal with specific issues of discord. (Bernhard 1975 pp 14)

All of these rituals occur at a mutually agreed upon time, and last a limited period. The Vesuvius she describes as a "verbal and time limited rage". This is when each individual is allowed to angrily talk of all the things that are bothering them both, about the other, both in and out of the home. The other member is then asked for how long he/she can handle hearing this, and a mutually agreed upon time limit is set. The roles are then reversed for an equal time period.

During this out burst the listening person is reminded by the therapist, that this is for information only, not to be responded to, or to feel defensive about. In this manner each individual is able to let out frustrations he/she has previously held in, have someone hear what he/she has to say, and begin to establish some openness and trust in the relationship.

The "impact procedures", used by Bernhard are described as...

> Confrontation exercises that emphasize the what and how of being in a relationship. They are based on pair-specific tasks to create intimate involvement as well as independence. (Bernhard 1975 pp16)

One such procedure is referred to as the Museum. This is comprised of historical information about the family, their hurts past and present, their reasons for being in therapy. Initially the couple are requested to make a list of their "museum" includung all of their hurts. Following this they are asked to decide which items on this list are

1. "non-negotiable"...those items which cannot change, or which the partner is not prepared to compromise,or perhaps what must change.
2. "negotiable" ... the items that the individuals are prepared to work on for change.

The overall focus for this exercise is based on what the couple each decide they want from the relationship. The process of working through this museum is to establish priorities contracts for change, and committment for work.

Another aspect of the museum is that often families live in the past hurts and events that have occurred. During the sessions the family are repeatedly instructed that such problems are history and belong in the museum. These events cannot be changed, only learned from for changing future behavior. More merit is given to discussing what could be done differently should the situation arise again.

Although there are many other aspects to Bernhard's work these are the important elements for use in this practicum. Throughout her therapy Yetta Bernhard consistantly uses communications training as a part of these rituals and procedures. These procedures are merely "tools" for therapy.

Another "tool for therapy" used by many therapists is reframing. Watzlawick describes this process as...

> reframing presupposes that the therapist learn the patient's language... In this approach it is the very resistances to change which can be utilized to bring it about. Reframing does not draw the attention to anything - does not produce insight - but teaches a different game thereby making the old one obsolete. (Watzlawick et al. 1974 pp 104)

Reframing is used by these therapists as a method for turning negative experiences into more positive ones, offering the family more options from which to choose.

Often the process of translating from one representational system to another involves a process of reframing in order that the intent of the communication is clear for the receiver.

It should be noted here that although NLP uses a reframing method, this is not the method used here. The NLP method is much more individualized and internalized than is intended here. (Bandler and Grinder 1979)

2.4.4 Children and Grief

Kubler-Ross has worked extensively with children in the last several years. She has found that they are more honest and open than adults and says we have much to learn from children.

Her most recent work has focused a great deal on children's drawings as their means of communication with the adult world. In this mode they are able to share their innermost thoughts and feelings symbollically.

Parents often attempt to protect their children from sadness, such as illness and death, and therfore avoid talking to them about what is going on around them, even if they themselves or others dear to them are ill or dying. Kubler-Ross identifies this as the problems of the adults and not the children.

She states that children are able to freely express their feelings and thoughts on paper, much better than in words, and we can learn much from these expressions. Often when a child is unable to explain how he/she feels he/she can be eloquent in their drawings. (Kubler-Ross 1981)

It is not the author's intent to explain how Kubler-Ross interprets these drawings, but rather to emphasize that this is another choice for therapy in work with children. This will be dealt with again in chapter 4.

2.4.5 Termination

Termination of therapy is a process that begins in the first interview when the contract for treatment is made, which includes the number of sessions to be held. At the actual termination, however, there are several crucial issues to be considered. Those listed by Compton and Galloway are most helpful.

1. Hanging on to therapy. For some families this may take the form of not completing homework, in the attempt to perpetuate therapy. At times therapists fall into this trap and allow this to continue for reasons of their own, although this is often an unconcious reaction. For example, therapists like to be successful in their therapy, and may want to prolong treatment until they are sure that the client will succeed.
2. Recurrance of old Problems and the Repetition of Symptoms. In order to prevent termination clients may begin to experience a resurgence of the same old problem.
3. Introducing new problems. Finding new reasons for the therapy to continue is not uncommon.
4. Finding new Substitutes and Replacements. Looking for a new therapist to take the place of the impending termination.

As a result of these issues it is important that the therapist deal with the termination. The therapist must help the client to deal with the sense of loss that is felt and go through the mourning process. It is important that the therapist do the same him/herself in order not to perpetuate treatment.

Family therapy is a rather complex treatment process with many different techniques and methods that may be used. For the purpose of this practicum the methods used have been combined in order to produce a form of therapy for use with the head-injured patient.

Chapter III

WORKING WITHIN THE HOSPITAL SYSTEM

How to "get into" the hospital system is an ongoing problem for social work. Once established, social work has been able to have great influence on specific programs within the hospital, however the problem of "how to become established" remains.

3.1 GENERAL INFORMATION

Although in the past social work has been seen as doing discharge planning and providing practical help, in most hospitals social work has been able to expand its role. Most hospitals now believe, in theory, in the value of "team" work for the "holistic approach" to health care, which includes social work as a part of that team.

The difficulty arises in being able to apply the theory to practice. Each team member has his/her own idea of how a team functions and does not necessarily agree with the other. Applying the theory implies other changes within the system that also must occur. These changes are sometimes very difficult to implement.

With this background in mind, there are several facts that are a part of hospital work, and must be taken into consideration when attempting to become involved on the general hospital wards. Social work has found a place for itself, however, there is always room to progress and grow, and social work is no exception.

3.1.1 FACTS

The "facts" as listed here, are directly related to establishing social work on the general wards of an "acute" hospital, although they may apply to other areas as well. These facts are found as a result of several years of experience in hospital social work, and most particularily my experience in the setting up of this practicum.

1. The acute hospital is primarily set up to deal with the physical manifestations of medical problems. This includes the funding set up, and the great numbers of medical and technical staff hired to facilitate this process.
2. The doctor is the person in charge of the care given to his/her patient. The system is set up such that he/she is the one who admits, discharges and prescribes for the patient. Ultimately it is the doctor who has legal resposibility for the care of the patient.
3. Budget constraints play a great role in the way a hospital is able to operate. There is a continuous need for bed space, operating time etc.. As a result

"quick, efficient treatment" is emphasized with all of its implications.

4. Doctors and nurses along with other hospital staff ARE concerned about the mental and emotional health of their patients.
5. Nurses have the most contact with the patient on a regular, ongoing basis.
6. Hospitals are a secondary setting for social work, with all of the implications. It is not possible to work with the patient and family in isolation and have the desired degree of success.
7. The patient is admitted to the hospital for medical diagnosis and/or treatment, and not for the purpose of seeing a social worker.
8. Some knowledge of the history of social work in hospitals is useful. This often indicates discharge planning and practical help as the focus for social work input. An understanding of the reasons for this, and the present status of the social work department in the hospital in question, is necessary.

All of these facts should be kept in mind when planning to work in a hospital. As in working with clients, it is important to start where the staff is and then lead them into other areas for social work.

3.1.2 Role of Social Work

In my experience it has been useful to define my role as a social worker within a hospital setting. This has made it easier to interpret my input to the other disciplines and to the patients themselves. This is not the only input required by social work in hospitals, but rather offers a framework from which to expand. The overall definition this author uses is as follows.

"Being in hospital is in itself a disruption in one's life, and causes changes to occur within the individual and family life. The illness or injuiry will cause additional changes that must be dealt with.

The role of social work in hospitals is to help the patient and family to adjust (change, adapt) to the implications of this illness or injury, from a psycho-social and emotional point of view. When the illness or injury exaggerates already existing problems, the social work input is geared to dealing with these issues, in the light of the illness."

I have found that it is necessary that the social worker believes that he/she has something to offer, and has a reason and/or purpose for his/her intervention. Without purpose it is difficult to educate other health personnel to your place within the system, and to gain the respect you desire. Lack of purpose also presents problems for working with patients.

3.2 RECOMMENDATIONS

My experience indicates that the following steps with regard to hospital social work are very useful. These are specifically geared for the student, but anyone anticipating hospital social work may find them useful.

1. Contact the Social Work Department in the hospital in question, and gain their support for your program. Establish a system with the social worker on the ward to let you know when something comes up. This is especially important if you are not always in the hospital.

   N.B. It is extremely difficult to become involved in an area where social work involvement has not been established. Even when you are a full time worker, and have the time and energy to invest in setting up the system, this is difficult.

   As a student your time is limited, and without a ready made support system, case finding and follow up is practically impossible.

2. Present your overall plan to the medical staff involved, and obtain their agreement.
3. Talk to the nursing staff, and include them in your program. They are your most important support system. They spend the most time with the patients and often gain their trust. They can support your input with the patient.

The nurses may be able to tell when there are problems between the patient and family, and can let you know about changes as they occur, if not to you directly, through the worker on the ward.

4. NEVER attempt important changes in your contact, such as therepeutic methods for behavior control, inclusion of family, active involvement of outside agencies, without informing the staff verbally, and in writing.

   If the staff are not aware of what you are doing they can unconciously sabotage your treatment plan. Let them know what is expected of them, what role they have in the process so that they understand and are able to participate in the program.

   N.B. This is not a breach of confidentiality. The issue here is not necessarily content but rather process. You need the support of the team to be able to succeed in your plan.

5. A student's time on the unit is limited. As a result it is important to set up a working schedule and keep to it as much as possible. Pass on this information to the Social Work Department and the ward. The social worker on the ward is an important contact when you are not available, and as such should be kept up to date on what is happening with the various cases.

6. Attend rounds where possible, to pass on, obtain information and to give the staff an opportunity to get to know you better. Doctors rounds may appear somewhat boring at times for social work, however, the contact is extremely valuable.

My experience in hospital social work indicates that the essence of this involvement is the ability to work with the other disciplines. This rates higher in priority than the ability to work with patients and their families, although this is also essential.

To be an effective social worker in a hospital setting, one must have the qualities of a diplomat, politician, humanitarian, be able to act as an advocate and mediator, while at the same time have self confidence, flexibility, a good sense of humor, and the ability to be oneself.

3.3 DIFFICULTIES IN SETTING UP THE PRACTICUM

There were several problems encountered in the setting up of this particular practicum that were unanticipated and which caused several anxious moments as to the feasibility or the advisability of such a narrow focus as head-injuries for such a project.

1. An initial problem for setting up the practicum was lack of cases. It appears that in Manitoba, the greatest number of head-injuries occur in the spring

and summer when the motor cycles are back on the road. (There is no helmet law in Manitoba) This presented a problem because the author wanted to be finished all of her work including this report, by August 1982.

In order to combat this problem, an attempt was made to work out of the Health Sciences Centre NeuroSciences Unit as well. The fact that social work was not well established on that ward, other than to focus on discharge planning made things very difficult. My time was split between the Health Sciences Centre, and St. Boniface Hospital and with no back up support from the Health Sciences Social Work Department it was impossible to follow the cases. The ward staff were enthusiastic but really had no ideas as to the possibilities for patient care with social work involvement. There were also administrative problems on that particular unit that had direct implications for multidisciplinary involvement with the patients. This was in the process of being sorted out, but added to the difficulty of setting up the practicum.

Splitting my time between Health Sciences and St. Boniface was a big problem for me. I felt frustrated and disconnected, unable to give or develop the kind of service anticipated.

2. Support: Although the medical and nursing staff were really interested in this project and appreciated the need, this knowledge was hard to translate into practise. The NeuroSciences Unit is extremely busy, and the neurosurgeons at St. Boniface rotate through the Health Sciences Centre as well, as a result of those administrative problems previously mentioned. This created some problems as they have an increased case load and may be feeling fragmented and split as was my own experience. As a result of this my program got lost in the shuffle.

3. Limits of the Practicum: Initially the practicum was set up to follow the patients and their families from the time of the accident onwards, for a period of approximately four months. The idea originally was that input was necessary at the time of crisis in order to establish contact and follow through. This became a significant problem when there were not enough cases. As a result the base of the practicum was expanded to include patients who had suffered a severe head-injury, but it was not necessarily from the "time of the accident".

N.B. The actual setting up of the practicum did not present many technical problems for me. I had been the social worker on the NeuroSciences Unit at St. Boniface for a few years previously, and therefore the doctors, nurses and the Social Work Department had some knowledge of my work and trusted me to involve myself appropriately. This was a great advantage, and facilitated my practicum a great deal.

Chapter IV

THE PRACTICUM

The families with whom I worked were all going through an extremely stressful period that ultimately would change their lives. We learned a great deal, over the months we were together. They each had tremendous resources for coping with this very difficult time which they were able to use effectively. The names of these individuals have been changed. The quotations used are from the tapes and process recording.

4.1 THE SETTING

The practicum was set up out of the St. Boniface Hospital Social Work Department. All together a total of 24 individuals were seen from 9 families. Seven families were obtained from the NeuroSciences Unit at St. Boniface, and 2 families were obtained through family therapy referrals to the Psychiatric Department,referred to as the McEwen Building at St. Boniface Hospital. The 7 Familes from the Neurosciences Unit were seen in the hospital or in their own homes. The 2 familes from the McEwen Bldg. were seen in that building.

4.2 DESCRIPTION OF THESE FAMILES

All of these familes had one member who had suffered a severe head- injury. Two patients were children, 1 male, 1 female ages 17 and 15 respectively Six of the remaining patients were male, all married or living common- law, and ranging in age from 29-54. The remaining patient was a 79 year old divorced woman.

Four of these head-injuries occurred as a result of a fall, 3 in a motor vehicle accidents (only one a motor cycle accident), and 2 were of unknown origin, presumed to be falls.

Three cases were one time assessment interviews who wished or saw no need for further follow-up from social work. These cases consisted of 1 individual, 1 couple, and one young girl and her mother. Although in at least 2 of these cases there were family problems prior to the accident, follow-up was not desired. In 2 of these cases the injury resulted in no reported behavioral changes following discharge.

One family was seen very briefly following the accident, and further follow-up was not desired by the family. This patient, age 17, was in hospital for three days following his accident. This case was, however, monitored by the author, and will be discussed later due to its implications for follow up. The 79 year old woman was followed for 1 month.

The remaining 4 familes were seen, and worked with in depth. They consisted of 1 family of 4, 1 couple,1 family of 5, and one family where the patient remained unconcious from the time of injury, throughout the intervention, and to the time of writing this report. The members of this family followed were the wife and 2 children.

Of the 9 cases, 7 were seen from the time of accident, including 2 where the involvement was extensive. The other 2 cases (seen through McEwen), were seen post injury. One 7 years following, and the other 1 year after the accident.

Of the 9 patients seen, 4 returned to work, 2 of these returned to a more sheltered situation within their jobs than was previously necessary, although both were considered to be good workers. One individual was unable to return to work because of memory loss, and the loss of the use of his left eye; the two students resumed their studies with some difficulty due to their shortened concentration span; one is retired and returned home to function well; and the other remains in hospital in a coma. In two of these situations the wives returned to work. One said she needed something to do instead of worry, and the other returned for financial reasons.

4.2.1 Presenting Problems for the Families

In the two cases where the accident occurred in the past, marital problems were evident. Both couples were on the verge of separation, and saw family therapy as their last resort. These couples were both referred for treatment by their family doctor. In both cases the families saw the physical problems as being resolved, and it was the personality changes that became the major issue. For example, increased irritability and potential for violence were of high priority in each case.

The other two cases, followed extensively from the time of the accident, focused more on the physical problems and physical progress. Although in one case the behavioral changes were evident, these were "explained away" by the family who wished to concentrate on the physical concerns. It appeared that it was too soon to deal with these issues although there were major problems developing between the patient and his young son.

The family where the patient remains unconcious experienced quite different concerns. The children had difficulty visting and talking about their father, they generally kept their feelings inside. Their mother was concerned about how to deal with this, as well as dealing with her own feelings, and practical plans for coping with the uncertainty of her husband's health.

In all 4 of these families, the spouse described marital problems prior to the accident. In one case these problems had begun to be resolved, and things were improving about six months prior to the injury.

The 2 families seen later in the process felt that things were better prior to the accident, even though there were problems then, and compared their life now regularly with the past. This was often described by saying, "he's not the same person", or "this behavior is not normal", and therefore must and should be changed. There appeared to be a great deal of misunderstanding on the part of the wives as to the mental effects of the head-injury. In one case the wife said she felt these problems, (of increased anger, potential for violence, self centeredness) were psychiatric. This was 7 years post injury.

Other problems encountered by these families included financial need, vocational rehabilitation, and care at home when the patient was discharged from hospital and remained confused.

Each of these families experienced numerous problems. There were specific elements that created problems for some families, and not for others. For example, in one case, although behavior problems were evident, they were not the focus of the family concern. In all the other families where behavior changes were evident, this was the main issue.

In two cases, (the students) some of the nursing staff had difficulty in dealing with the behavior problems on recovery of conciousness. Both chidren were described as "spoiled and uncooperative". These 2 teenagers were disoriented on awakening, lashed out at the nurses and were quite loud and hostile. In each case the families were very attentive and constantly at the bed side.

It is important to note that this Unit does not often have anyone under the age of 18 as a patient and this could influence the situation. This same behavior, however, is a part of the adult response following coma as well. This was not a major issue in any of the adult cases, it was accepted as a part of the process.

Both families were very upset and confused by the staff reaction to their children. These incidents resulted in a fair amount of trauma on both sides and had implications for the way the patient, family and nursing staff were able to communicate. In both cases the families were very anxious to have their children discharged as soon as possible. In one of these two cases this may have had some influence on why the family did not contact anyone when behavioral changes began to occur.

Social work in both situations acted as a mediator between patient, family, and staff, offering reassurances to the families who were also distressed by their chilren's behavior, as they found it unusual and not in keeping with their knowledge of their son and daughter. They were frightened by the situation but found it difficult to know what to do or how to explain it.

Another patient was transferred to St. Boniface from an out of town hospital as a result of "administrative pressure". This patient required further treatment, his family live in Winnipeg and wanted him to be close to them. This "administrative pressure" created some political problems that were reflected in the treatment process to some extent. For example, their contact with the doctor was quite limited, and their questions were unanswered for long periods of time.

Follow up also became difficult as appointments were not made. The family were aware of the problem, but did not know what else they should have done under the circumstances.

Social work acted as a liaison for the patient and family with the hospital, and as a resource person to connect them with the sevices or information required.

4.3 CASE ILLUSTRATIONS

Three cases have been chosen for detailed discussion here. Two of these situations are similar in the presenting situation and problems within the system. The third is quite different and presents other aspects of this most difficult family crisis. A fourth case has been added to indicate the importance of social work input and follow up even in apparent minor head-injury situations.

4.3.1 Kelly and Mike

Kelly and Mike are a young couple ages 26 and 29 repectively. They were married for one year when Mike was in a motor cycle accident after he had been drinking one evening, and received a severe head- injury. At the time of these family therapy sessions it was one year following the accident.

Both Kelly and Mike are working. Mike was able to return to his previous job, however his position has been altered to accomodate the results of his head-injury. He is described by his boss as being "quite different" in the work situation, than prior to his injury. They have no children, and each are closely affiliated with their own families. Mike describes himself as being his mother's "baby" and spends a great deal of time with her. Kelly states she often feels left out when they are together.

Kelly and Mike describe their year of marriage prior to the accident as being good. (It later became apparent that this statement was in fact a comparison between then and now, and has no reflection on the state of their marriage which had many problems then as well.)

At the time of the interview, Kelly has left Mike following an incident where he hit her, and is living with her parents. Mike wants her to return home as soon as possible.

4.3.1.1 Assessment

The presenting problem as described by Kelly is that Mike is not "the same person that I married". She states that he is now violent at times, easy to anger, constantly focuses attention upon himself often inappropriately, which results in some embarrassment.

Mike describes the presenting problem as the fact that Kelly has moved out and he would like to know when she plans to come home. He states he is not aware of the other problems, although he does remember hitting her and promises not to do that again if she will just come home. This is the second separation for the same reason in as many months.

Kelly states that she has lost touch with Mike, she cannot talk with him without an argument, and he constantly plays solitaire in his room, even when they have company.

During the conversation it became clear that both had their own concerns and feelings about the situation that were totally separate from each other. There was no interaction between them. Neither was able to see the other's point of view, nor did they understand where the other was at.

Mike tends to talk a great deal before coming to the point of his conversation, and therefore he is difficult to follow. Kelly became frustrated as soon as this occurred and no longer paid attention to what he was saying. This was noted through watching her body language as she rolled her eyes upward, crossed her legs, and put her head in her hands.

Several concerns were identified.

1. Severe problems with communication. They could not interpret their feelings to one another, although each thought the other understood what was happening to them. Mike is a very kinesthetic or feeling person and responds from his emotions. Kelly on the other hand is quite visual, and sees things quite clearly and then becomes depressed as she sees no changes occurring. In NLP terms, each was talking in their own language.
2. Mike's violent behavior was very frightening for Kelly. She felt that Mike was unable to control his temper, and she was afraid that he would hurt her more than before.
3. Each sees the other's family as an interference, creating expectations that can not be met. For example, Mike's mother thinks Kelly should be more loving and understanding, and blames her for the break up of the marriage.
4. Kelly does not want to return home at this point. She feels a need to regain her trust and perhaps even her love for Mike before she would be able to do this.

5. The roles have changed. Whereas prior to the accident Kelly was able to "lean " on Mike, he now "leans" on Kelly. The dependecy has reversed and she is not comfortable with this.
6. After listening and participating throughout the session, Mike felt that Kelly "just doesn't want to get back together". He felt that she was using the sessions as a means to get that message across.

4.3.1.2 Contracting

We contracted for 4 interviews with Kelly and Mike together, in co- therapy with Maria Gomori and myself. Maria was away for one session and they agreed to see me alone for that session. It was agreed that at some point there may be a need to involve the extended family, however we would begin with the couple alone.

We pointed out that we could not guarantee the reinstatement of the marriage. We agreed to work together to come to some decision regarding their relationship whatever that might be.

4.3.1.3 Treatment:

In the first session Kelly made it clear that she was not ready to return home at this point. She did want to work on their relationship but felt it was necessary to start from the basics again. All of the contact since the separation had been in anger.

This session concentrated on finding the "fun" side of their relationship. They had not been able to have fun for a very long time.

The homework task for this session was for Kelly and Mike to attempt "dating", to try to revive the fun they used to have together. In order to make sure this task was attainable, all the steps for the "date" were discussed, from who would make the initial phone call, to what they would do.

The following session began by discussing the "date". (This was the session without Maria.) They had gone to a movie, had an argument, and had not spoken to one another all the way home. There had been no other contact between sessions.

The problem occurred when Mike attempted to put his arm around Kelly. She said, "it's too soon, he's going too fast, I just want to start out as friends", Mike stated that he was trying to give Kelly, "someone to lean on, like she said she wanted when we were here before".

At this point Mike felt that he had been rejected, and did not want to make the initial approach the next time. He again stated that he could not believe that Kelly was interested in getting back together, as her behavior to date did not show any desire to do so. Kelly agreed that she would make the first contact, and ask Mike for a "date". The process for this date was outlined and clarified, as we had done in the last session.

The third session brought no progress in the dating. Kelly stated she had contacted Mike to set up a date, but they got into an argument on the phone, and she decided she didn't want to ask him any longer. They had not seen one another since the last session.

Kelly states that Mike has not changed at all, and shows no desire to do so. As a result Kelly does not see any way that she can return home at this point. This served to reinforce Mike's belief that Kelly had no intention of returning home, and was just going through the motions of therapy.

The final outcome of this session was that Kelly and Mike agreed to separate for one month, then we would meet again and re-evaluate the situation. They planned to meet once during the month as there were relatives coming in from out of town that each wanted to see. Each was to see how life would be without the other, and attempt to have some fun on his/her own.

4.3.1.4 Termination:

The final session was held one month later. There had been no change in the situation and Kelly really wanted to separate but did not know how to break the tie. Mike was very blaming and accused Kelly of not caring. "You got what you wanted."

The session focused on supporting Mike to enable him to be able to manage on his own. All comments he made, although they were often made in anger towards Kelly, were supported and often reframed so to concentrate on his ability to be independant.

Mike was extremely angry at Kelly, and our attempt to redirect his anger toward us as a buffer was unsuccessful. He did mention suicide in passing but would not elaborate.

Even though Mike had told Kelly repeatedly throughout the session that he did not want her to come home, at the end of the session Mike asked, "When do we meet again?" This was the only place that he had seen Kelly in the last few months and he wanted to hang on to this as long as possible. The differences were too great for a reconciliation at this point, so we continued to confront him with the reality of the situation. The decision was made to separate for an indefinite period. It was pointed out that things might change, however, as things stood now, separation was the reality.

As both Maria and I felt very uncomfortable following this interview, we contacted his family doctor and warned him of the possibility of Mike attempting suicide as a means of getting back at Kelly. We also contacted Kelly, offered her follow up on an individual basis if so required, and supported her decision to separate. Her feelings of guilt had been able to be worked through during the sessions, and she felt that she could be more comfortable with her decision now. She declined further follow up.

4.3.2 Comments

Mike was experiencing the behavior changes as described by Stern in his article. Mike was virtually unaware of what was happening to him or how his behavior was affecting those around him, Kelly in particular. He was very "self" oriented, and was fixated on Kelly's return home. He was unable to see beyond this. It was only his needs and desires that were valid and important.

Neither one was prepared to compromise because each thought he/she was right. This marriage did not appear to have a solid base that could withstand such a devastating event as a head-injury. Mike's self esteem took a severe beating, and it appeared that he measured this by his ability to maintain his relationship with his wife.

Both Maria and I felt that this relationship could not survive this stress. Their motivation for change was severly lacking. Each wanted his/her own way with no room for compromise, which presented many problems for treatment.

4.3.3 The Kirby Family

The family consists of Warren, age 34, Gayle age 33, and two children Jane and Matt, ages 11 and 9. Warren and Gayle have been married for 12 years. About 7 years ago, when Warren was building their house, he fell off the roof, sustaining a severe head-injury.

Physically Warren has recovered well, although he has some problems with head shaking, especially when anxious, and speaks quite slowly and carefully in a monotone. This is said to be different from his previous conversation. Other than these, there are no physical symptoms of disability.

Both Warren and Gayle are working. Warren was able to return to his previous job and is doing well there. He reports some problems with his direct superior, as far as harrasing him to work harder, although he states this is not a problem because the next level up are sympathetic to his needs, and have been very supportive of Warren since the accident.

Warren and Gayle had been involved in marriage counselling twice before coming to see me. Warren is also seeing a psychiatrist to help him deal with the adjustment to his behavior changes.

Gayle describes their marriage as always having had some problems, however the problems have never been as severe as at this time. She states that Warren's behavior is "not normal" and something must be done about it or she will have to leave.

At the point of intervention Gayle had refused to return to their previous counsellor because she felt "blamed" for the state of the marriage, and generally felt misunderstood. She stated that changes must occur by June 1982 or else she will leave with the two children. Both she and her husband appear motivated for therapy and anxious for changes to take place.

4.3.3.1 Assessment:

The presenting problem was the impending separation. Warren was extremely motivated for change as he desperately wanted to keep the family together. Both individuals had very definite ideas on the way their family "ought" to be, and initially it apreared that compromise was out of the question.

Gayle was very demanding of Warren, blamed him for many things to which he always responded with a lengthy "defense". This appeared to be a consistant pattern of the couple's interaction. Gayle describes herself as a "perfectionist", "I know that's not right but that's just the way I am". She "will not tolerate" certain forms of behavior, and tended to treat Warren like a third child rather than her husband. Warren was fighting hard to maintain his identity as husband, father, and provider. Warren believes that the husband ought to be the head of the household and as such his word ought to be respected, and obeyed. (Warren does, however, have some difficulty with this, because he also wanted to be equal. The problem arose because he saw himself as having no say at all, hence the move to the other extreme position.)

The children appeared to be the centre of most of the arguments, where Gayle always moved in to "protect" them from their father.

The focus of the problems appeared to be the "temper tantrums" for Gayle, and for Warren, his desire for respect and support from his wife when he attempted to discipline the children.

4.3.3.2 Contracting:

A contract was made for four sessions to be held two weeks apart. Initially this contract was set up to work on the relationship between the couple,Warren and Gayle. At the end of these sessions we would review the progress, with a view to including other family members such as the children. It was also agreed, that since they had been in therapy before, if there were methods being used that they had tried before, and did not work they would let me know, and we would change the approach. They also consented to having the sessions taped for consulting purposes.

4.3.3.3 Treatment:

Because there were so many concerns initially, and both Warren and Gayle had trouble sorting out what they really wanted to work on, they were given homework to help out with their thinking. This homework was to be done independently and brought to the next session for discussion with the purpose of creating the focus for therapy.

This homework consisted of making two lists:

1. Things I will not tolerate
2. Things I would be willing to change.

N.B. The second session was held one month after the first. They did not show up nor did they cancel the scheduled interview. Another was set up and the same thing occurred. The third time I called prior to the interview to ensure their attendance, and they did come.

At the second session Warren had forgotten about the homework, and Gayle had completed hers. The homework is summarized as follows:

GAYLE: Things I will not tolerate:

1. Warren's interference in my privacy, that is: "going through my purse, listening to my telephone conversations, reading my mail, always asking where I am going, etc.
2. Warren's constantly picking on Jane and Matt. His "rushing" around. That is, he cannot sit still, everything has to be done "at once".
3. His wild temper tamtrums.

The things I would like to change:

1. Not to be so critical of Warren
2. To be able to give support when applicable.

After listening to Gayle, Warren was able to outline his criteria.

WARREN: Things I will not tolerate.

1. Lack of equality in the marriage.
2. Lack of respect for my disciplining the children.
3. Gayle interfering in the way I do the renovations around the house.

The things I would like to change:

1. Not to be so nosy.
2. To control my temper.

Through the use of "fair fighting" techniques we were able to establish priorities for this work in order that the couple could see some progress. Again the most critical areas for each of them were, the "temper tantrums", and the respect for Warren in his dealings with the children.

Areas outlined for work in the next two weeks were, for Warren to decrease his interference in Gayle's privacy, and for Gayle to allow Warren the freedom to renovate as he saw fit. In this last instance it became important for Warren not to ask Gayle what she thought about what he was doing, unless he was prepared for a negative answer. (Gayle stated that since the accident Warren has not taken as much care in his work as he did previously. This is difficult for a perfectionist to handle.)

The third session was held one month from the second. This session was extremely difficult for the therapist. Both Warren and Gayle kept their contract from the previous interview and both reported that things were better in the areas of privacy and household chores.

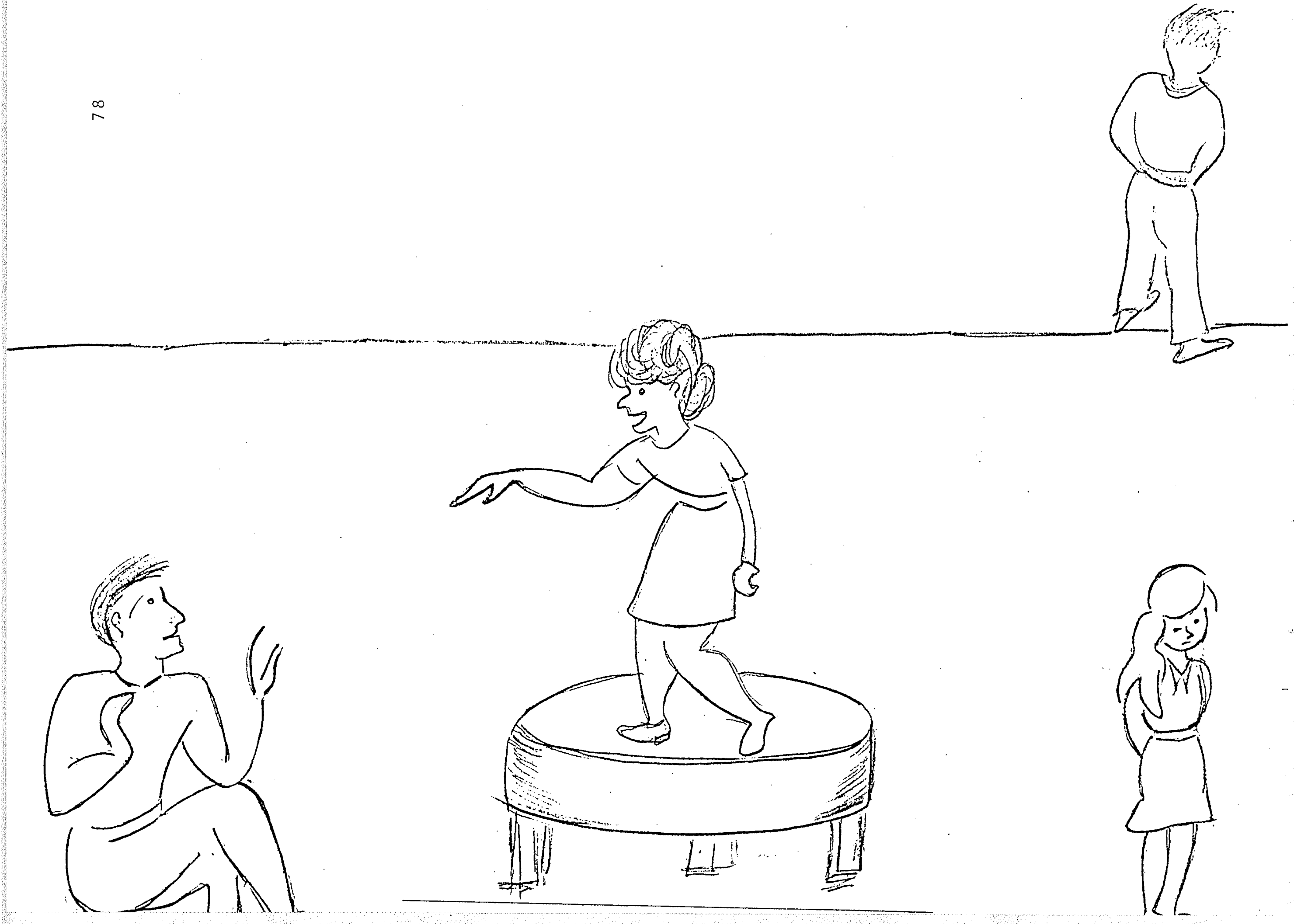
This session revealed that Cayle was unaware of the fact that many of Warren's problems are a result of "brain damage". She was under the impression that Warren had only "psychiatric problems". This had many implications for her interaction with Warren. Gayle constantly refered to him in the sessions as being "not normal" and had begun to undermine Warren's attempts to control his anger as also being abnormal. This placed Warren in a very awkward position because he had been trying hard to control himself by talking to himself in a mirror, going away to another room and yelling, along with other methods as discussed with his psychiatrist.

The remainder of the session was full of arguing, blaming and defending. The therapist had difficulty handling the situation and finally terminated the interview.

The following session was to include the two children, as all conversation returned to them, and how they were being treated by both patents. Warren constantly interprets how the children react to him as indicating lack of respect. We agreed that as well as including the children, the next session would be a co-therapy session with Maria Gomori and myself.

Following this session I spoke with Warren's doctor and requested that he include Gayle the next time he saw Warren, and explain the mental and psychological implications of Warren's injury to her.

The fourth session was held as scheduled! The 2 children were somewhat shy, and appeared afraid that they would have to "take sides". After some discussion that appeared very superficial, and not related to how the family really felt, a "sculpture" of the family was made. This sculpture was a dramatic picture of the pain and suffering within the family that brought everyone's feelings to the surface. The sculpture is shown in the following diagram.



Once the family saw and felt what their picture looked like, they were asked to indicate how they would like their picture to look. They all moved together to stand arm in arm. The children of their own accord pushed themselves between their parents where they had not been before.

The sculpture then served as a reference point for the rest of the session. Each member was able to see what specific changes each had to make in order for the family to reach its goal.

Gayle had to stop blaming Warren and come down from the table. Warren had to stand up on his own feet and move closer to the family. The children were required to participate more and move from behind their mother to be closer to their father. As a part of this Gayle had to move over to let the children closer to their father.

There were several other significant points in this session. It became evident that Warren was not listening to what was being said, rather he assumed he was being put down all the time and therefore was unable to hear the positives that the family were expressing. The children were also able to tell Warren that they were afraid of him. They said that he had hurt their mother in the past, and they were afraid that he would hurt them as well. This had much more impact coming from the children than from Gayle.

This session did show that they all do love one another, and that they are all committed to working to keep the family together.

4.3.3.4 Termination:

The final session was held three weeks later. All four family members reported a really good three weeks. Gayle said that she was working hard not to stand between Warren and the children. The children reported, "there's not so much yelling", and said that they were happier. Warren said that although things were better, he still did not have the respect that he desired.

Gayle stated that she had been with Warren to see his doctor, and had learned things about his "brain damage", and the possibility that things may not get any better. She was very tearful when expressing this.

The sessions were terminated here, as the family were leaving for 3 weeks holiday, and on their return I would be leaving as my practicum had ended. They did not really comment on the fact that the sessions were over, however they have decided to continue on as a family. Gayle has no further plans to leave at this point, and says that as long as she is able to see change she will stay. They will be followed by their family doctor.

The family had become aware of the areas for change and the methods to achieve this change. They had some success, so they had the experience of having this process work, and as such were more willing to carry on with it. My suggestions for continued work at the time of termination were:

1. Warren: He lacks in self respect and as a result he looks to build this self respect through others. I suggested that he concentrate on finding his own self respect in order to recognize it when others show him the respect he so urgently desires.
2. Gayle: She has only now begun her grieving for the changes that have taken place in Warren. I emphasized how important this is to deal with before she can move on to the way things are today.
3. The children: They must help their parents to know when they are hurting , especially in their interaction with their father, as he has no knowledge that he upsets them.

4.3.4 Comments

The use of sculpturing and "fair fighting" techniques appeared to have a strong impact on the outcome of treatment. The family was much more responsive and took much more interest in what was going on when these methods were introduced. Grief therapy was also used here as Gayle needed to be encouraged to deal with her grief and have it brought into the open.

This was a very difficult case for me to deal with. In order for me to finish the sessions, I had to do a lot of soul searching to find out why I was stuck so often, especially in session 3. One of the issues between client and therapist that became essential to deal with, was the question of control. The missed appointments, made things appear as if I had more stake in seeing them, than they did in coming. (This may have been so!) I found this extremely hard to deal with and caused Maria a great deal of frustration by my hesitation to do so. In the end I was able to face the issue, which made a significant difference in the outcome of the final session, in my opinion.

This family did represent a great deal of learning for me, and I am grateful to them for the experience of working with them.

4.4 THE ROBERTSON FAMILY

This family consists of Peter, age 29, Brenda age 27, Barry age 8, and Bert age 5. Brenda and Peter have been married for nine years. One evening, after he had been drinking, Peter fell down the basement stairs, and sustained a severe head-injury. A few hours after the injury he lost consciousness and at the time of writing this report, he remains unconcious.

Prior to the accident Brenda and Peter had been having some marital problems. Peter was drinking heavily, which always resulted in an arguement. He had been a steady worker, however, and he was working at the same job for the last 4 years.

Peter has had a drinking problem for some time, and in order to combat the problem they bought a house in the country and moved in. This was only successful for a short period of time.

Brenda's parents were very supportive of her, and were able to help out with the children to give her a much needed break at times. Peter's family, on the other hand, were rather "difficult" and Brenda found them "hard to handle" at times. Drinking was a large problem for his entire family, which created additional pressures.

Following the accident I spoke with Brenda as her husband was critically ill. At that point she did not really want input. About 2 months later she contacted me herself for an appointment. She stated that originally she did not want to see me because she felt that would mean "giving up" on Peter. It was only when she discussed this with one of the nurses, and received support for my input that she decided to contact me.

4.4.0.1 Assessment:

At the point of intervention, several problems were identified.

1. Financial: Peter had not been working long enough at his job to receive maximum benefits. Brenda was only working a few hours a week, and was hoping to increase her time in order to help the situation out.

2. Brenda had a lot of feelings and anxieties that she wanted to discuss. She generally kept things to herself, and stated that she was at the point where she needed some release.
3. Brenda was also concerned about her children. They were having trouble talking about their father, and refused to see him in the hospital. She identified this as her most crucial concern.

Brenda appeared exhausted from running back and forth between the hospital, her home, and her work, a distance of about 45 miles daily, each way, as well as caring for her children. She felt that the children needed more of her time, and therefore felt she had no choice but to cut down on her trips in to see Peter and spend more time with them. This was a real dilemma for her.

The oldest son, Barry, was extremely hyperactive. He spoke very fast, and always managed to distract the conversation away from his father. Bert was more open to listening, but would also rather not talk about what had happened. Both were eager to talk about their father as he used to be, when he played baseball with them, fixed the truck, or painted the house.

4.4.0.2 Contracting:

It was agreed that I would make homevisits, as they live out of town and it was awkward for Brenda to bring the children in. We decided on a short term trial period of about 2 weeks, one session a week, to see how the children responded, then renegotiate if appropriate. The main focus would be to help the children deal with their father's injury.

4.4.0.3 Treatment:

Initially Brenda and I talked to the children about how the accident happened, where everyone was at the time, and how their father was taken to the hospital. As they had both been asleep, they really had no idea other then they knew their mother and father had an arguement earlier. Brenda also indicated that there had been some talk in town about her "pushing" Peter. We discussed this with the boys as well.

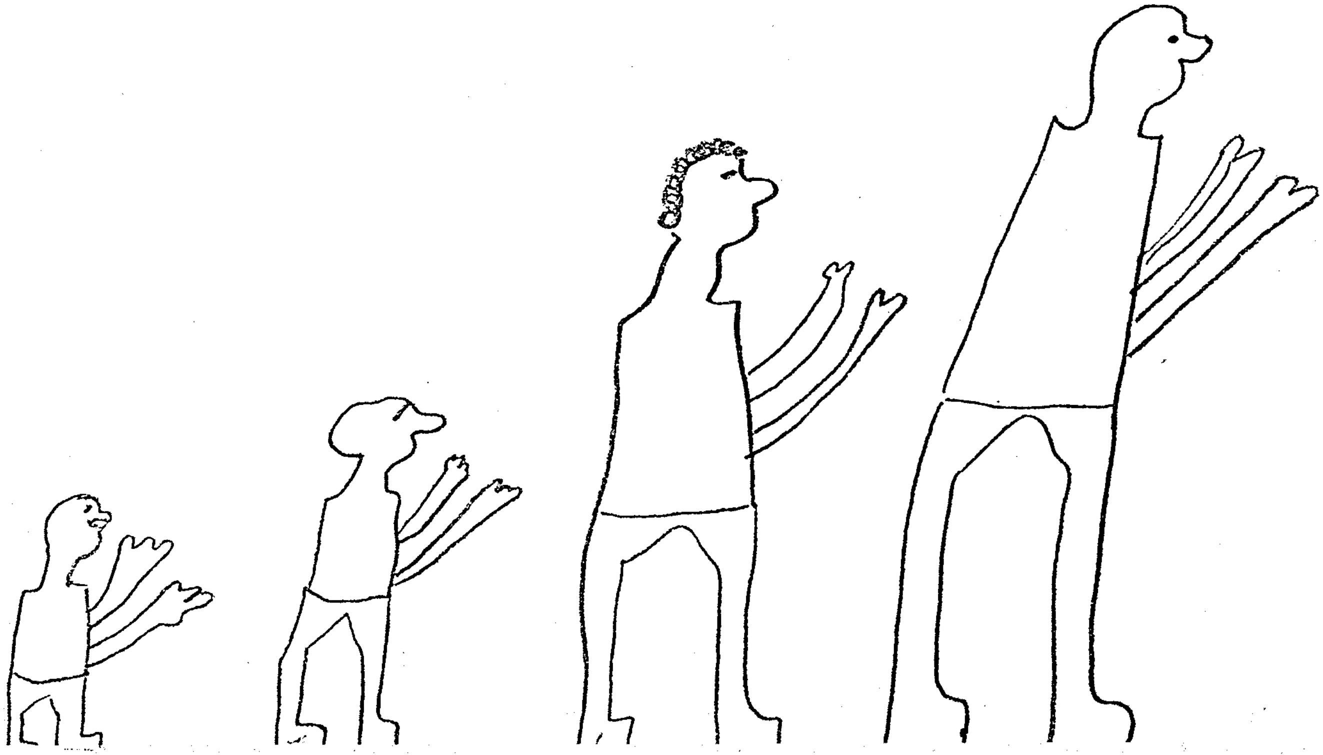
As they had only seen their father once in hospital and would not visit again, we discussed what their father looked like now, and how they could tell he was alive. I suggested they go close to the bedside and look at his eyes, because they could see them move and respond.

In the next session, the children, who had been to see their father, both described an incident whereby they knew that their father was "really mad" at them. They both said, "he looked really mad, as if he would hit us:". This experience seemed to set their fears at rest somewhat. They now knew that he was alive even though he did not look the same as he had before, nor could he move. Following this episode the children began to make cards for him and brought him presents for Father's Day and his birthday. They still did not want to visit him often, but they were able to talk about him more freely.

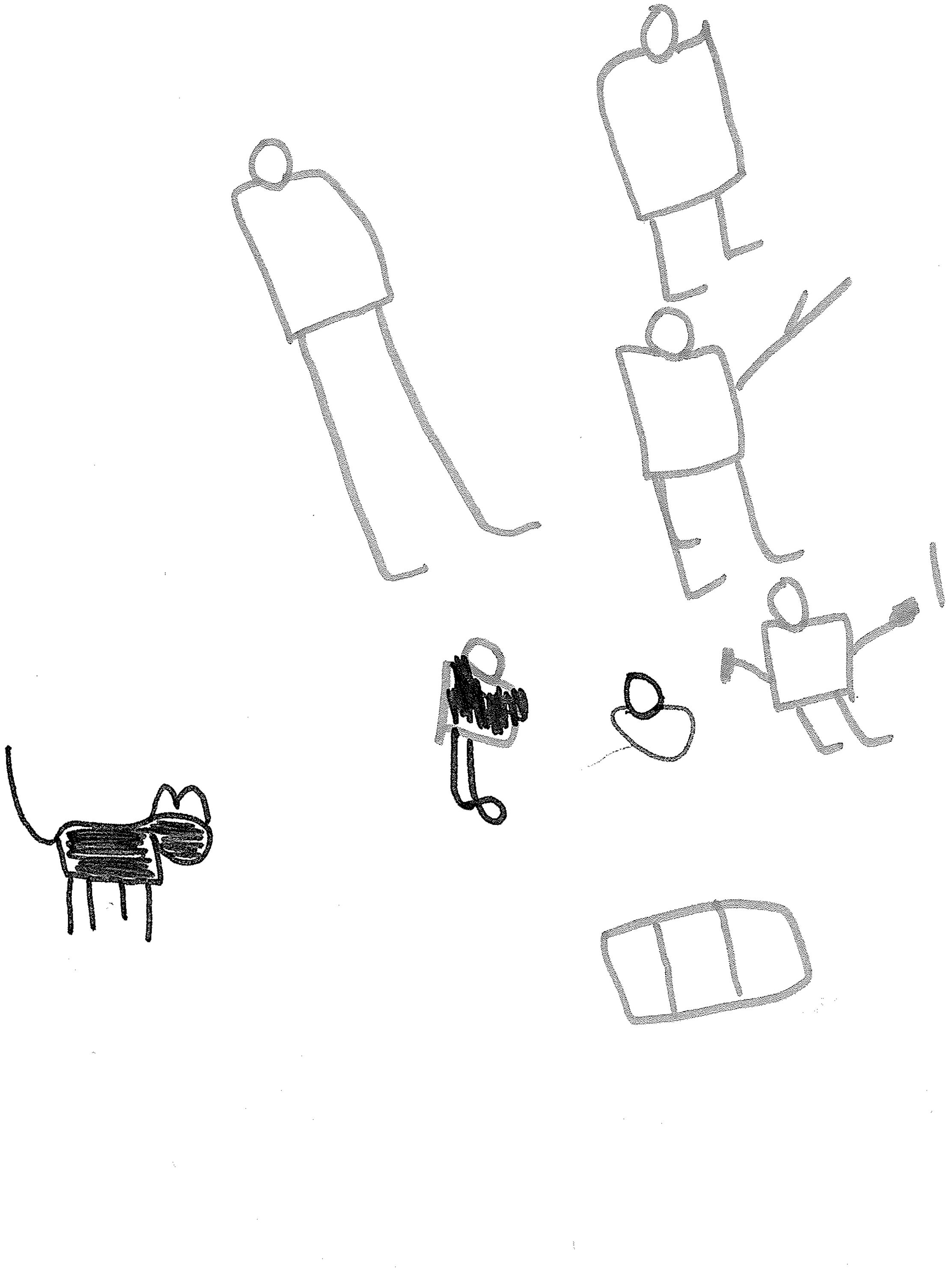
At this point Brenda and I discussed the need for futher input, and she felt that she would like to continue, for the boys and herself. We reduced the sessions to once every two weeks, for five more sessions.

The following session the children were asked to draw pictures of their family. They were presented with the crayons, and then left on their own. These pictures were interpreted by Elisabeth Kubler-Ross at a conference in Calgary. She did not have the full story of the family, but was able to outline the problem areas easily.

BARRY age 8



BERT age 5



The interpretation of these pictures is based on my understanding of Kubler-Ross' conversation with Maria after looking at these pictures.

BARRY: Barry uses no color in his picture. (This was his own choice as he said he could draw better with a pencil.) This may indicate a colorless life at this point. His picture is located at the very bottom of the page, with nothing included at the center. This also indicates lack of a central focus in his life. The lack of floor, or solid ground indicates some insecurity, a feeling of being "up in the air". There is no significant difference between the figures, other than height, and Brenda was given hair. All of the rest of them look the same. Kubler-Ross states that it is very rare for children to leave out their house, although this is the case here as well. It is as if the family is in total isolation, and each member is isolated from each other. Kubler-Ross described this as a very "unusual" picture for a child to draw, because it is lacking in so many things and appears so "rigid" and "ordered".

BERT: This picture has more life as there is color, and the figures focus outward from the centre of the page, which indicates that Bert's family are the centre of his present world. Again there is no floor, and the family appears to be floating around in the air also signifying lack of security, and roots. Bert does include his house and his cats which give a more complete story of the family. Neither of

Bert's parents have any arms. This indicates a feeling of powerlessness with some difficulty in reaching out to others. The color orange indicates a life or death struggle, which is very approprite in this case.

As the pictures indicated, both boys found it difficult to let their mother go out. Bert in particular hung onto her tightly every time she left them with someone else. He was afraid she would leave him like his father did.

Brenda had many concerns of her own that we dealt with as well. She was extremely open, and glad to talk about what was happening to her. Other men that she knew were approaching her to offer to help her to get "rid of my frustration". This in itself she found extremely annoying, and hard to handle. Financial concerns also brought a great deal of worry. Brenda decided to sell the house in order to keep her "head above water", and she was able to get more hours at work to help out on a temporary basis. She anticipated a move to the city in order to find better work, and a more financially feasible place to live.

4.4.0.4 Termination:

Both boys were able to reach a state of equilibrium where they could talk about their father, and ask about him after their mother had been up to see him at the hospital. They did not want to pursue the issue, and as things appeared to be going alright, intervention was terminated. There would be need for further involvement should there be any change in Peter's condition.

Brenda also appeared to have settled into a routine. She was more comfortable with the state the boys were in, and felt that they could manage on their own at this point. She also felt that she would need further support should Peter's condition change or should he be moved to another hospital. An arrangement was made for follow up with the regular worker on the NeuroSciences Unit.

4.4.1 Comments

Brenda progressed very easily from dealing with Peter's immediate injury to being able to look at the long term implications, and even consider the possibility of his never being able to recover. As the literature describes she is in that horrible state of "not knowing", of being kept in limbo. She is a very strong, and well put together woman, who faced these difficulties head on. Brenda has many of the resources required to cope with the situation, but needs reinforcement and support for her decisions, as well as a place to ventilate her frustrations.

The children taught us both a great deal, as did Maria in helping myself in particular to understand the reasons for some of their reactions. It appears that the children wanted to keep the memory of their father as he had been before the accident. They know that he is sick, and are able to accept that, however he is still their father and the important things for them are the things he did for them and with them.

Grief therapy played a large part in the process of intervention. Brenda and the boys had to deal with the loss of Peter from their immediate daily life in order to keep the family together.

4.4.2 The Dick Family

This family is included in this discussion to indicate the need for social work follow-up even when the head-injury appears to be minor.

The family consists of Mr. and Mrs. Dick, ages 42 and 39, David age 17, and Sally age 16. David was involved in a car accident and suffered a head-injury, he was admitted to the hospital in an unconcious state. He recovered conciousness about 12 hours later and became quite aggressive and somewhat hostile with the staff.

There was some concern that he might have a fractured spine, and therefore he was required to lie still with a cervical collar around his neck. When he awoke he did not want to do anything he was told and caused quite a rukus.

The nursing staff that day were having a lot of trouble coping, the unit was very busy, and David was an additional handful. As a result, when his parents came up they got quite a blast from the nurse as to how difficult their son was being. This upset the parents condiderably, and at this point social work became involved.

As described earlier in this chapter, the family did not understand what was happening. Their son had not reacted like this in the past and they found it quite frightening, especially when the staff seemed to think this was "just the way he is".

Social work intervention consisted of mediating between the parents and the staff and helping the family to interpret the reactions of the staff given the situation. I explained that David's response was "normal" given the circumstances. (Confusion, disorientation and episodes of anger are common reactions after waking from a coma, as described in chapter 2. [Stern 1978]) (At this point I did discuss the possibility of some behavior problems on discharge, however this was very difficult for the family to hear at this point and I could see that I did not get too far.) The situation was discussed with the staff in question. As discussed earlier, it was interesting to note that the staff's tolerance of teenage behavior following head-injury was low whereas they were able to accept the same behavior from adults with no real problem. Again it is emphasized that this reaction is limited to some staff only. Other staff managed well with this family, and David, with no conflict.

As it turned out David did not have a fractured spine, and was able to be discharged home only 3 days after admission. No problems were anticipated. The family were given my name and number to call if there were any concerns.

About one month later Mrs. Dick called regarding David. They did not send him back to school, but rather set him up with correspondance courses at home. She found that David was having trouble concentrating, became easily angered, and was lacking in motivation. My suggestion to meet and discuss this with the family was rejected. Mrs. Dick said she was sure this was a "stage" and that David would get over it. She said she was sorry to bother me and felt they would manage.

Four months later I called to see how the situation stood. Mrs. Dick stated that there were still behavior problems that appeared more marked these last few weeks. She described such problems as:

1. increased irritability
2. David now completes tasks quickly and carelessly where he had previously been meticulous.
3. trouble remembering things,
4. problems with concentration,
5. fixed interest, limited to his 17 year old car that he is remodelling.
6. no interest in planning for the future.

Mrs. Dick stated that, "David is doing so well physically, that I thought that meant he would be doing well mentally also." He has some hearing deficit in his right ear, but this is the only physical problem that remains from the accident. David is working for the summer, and they hope that he will go back to school in the fall to complete his grade 12 although he shows no real interest in doing so.

Mrs. Dick stated that she remembered our previous discussion about behavioral changes, but her husband said that David was just going through his "teenage rebellious stage". This has created a great deal of strain in the family and on the marriage. Sally apparently told him that he had "gone crazy", when she found him too hard to handle. David apparently has no awareness of these changes.

We discussed the above changes in David as being "common" following head-injury. I suggested that she contact the neurosurgeon involved, and inform him of these changes, so that he could talk to the family, especially her husband and explain what is happening. This would give them more information to enable them to cope appropriately with the problem. I also suggested Neuropsychological Testing for David, for an assessment of potential and some ideas for further vocational training.

As a follow up to this conversation, I spoke with the neurosurgeon myself, then sent him a letter outlining the situation, for his follow-up and input with the family.

4.4.3 Comments

This family has the potential for future difficulties, at least with the marriage if not between David and his father, unless there is intervention now.

The fact that the family was not informed of the potential for future difficulty made it hard for them to sort out the idea that some of David's problems can be related to the head-injury. Even now they are reluctant to make waves in case their son is just "acting out".

This situation indicates how important it is to follow with these families because of the misunderstandings that can occur, often needlessly if there is accurate information and input in the first place. It has been my experience that it is extremely difficult to work with these familes once these problems have been mishandled for several years. It is so much better to start at the beginning when there is more potential for change and success.

4.5 MY PERSONAL EXPERIENCE

This practicum presented me with many challenges of both a personal and professional nature. For the purpose of discussion I will separate these areas, although there was actually much overlap.

4.5.0.1 Professional:

1. The "traditional" forms of therapy are not sufficient in themselves to use in working with these families, and therefore it is necessary to be creative, and use as many new and different methods as possible to find one that works. The behavior changes may place limitations on areas such as reasoning ability, memory, and comprehension, which must be taken into account during therapy.

    This presented a great challenge to me. Although I have been exposed to many different forms of therapy, I have always been rather reluctant to implement these methods myself. Until this year I have been able to rationalize this in part by saying "their use is not appropriate here", or "the family wouldn't go along with it". These reasons, however good they may sound, were not the reality. I was scared to use them for fear I would make a mess of things. In this practicum I had no choice, and thankfully so. Sitting and talking with these families, trying to sort things out in that manner only, was not enough.

    I was really amazed and thrilled at how quickly and effectively the use of sculpture enabled one family to deal with their feelings. The use of drawings with the two boys cut through their resistance to talking with me and instantly created a story of where they were at. There were many other instances where this experience occurred, and every time the results were remarkable.

Although I am still somewhat apprehensive, as to how I will be able to handle the situation, I am more convinced than ever that new methods should be tried, especially when we find ourselves stuck, or appear to be in a "routine" of therapy which bores the family as much as the therapist.

I was fortunate that Maria Gomori, my supervisor, is extremely creative in her therapy, and was able to come up with many different methods for me to try. This also indicated to me how much there is to learn. It creates a feeling of " the more you learn, the less you know", which I find somewhat frightening, but certainly challenging.

2. There is a great need for much more active involvement of social work on the hospital team. This challenge was very hard to deal with at this time, however, it presents a direction for future work.

I was under the impression that we (social work) were a part of the "team" at St. Boniface Hospital, in the NeuroSciences Unit. Any other member of that team would agree that we are, however throughout the practicum it became evident that we have a long way to go in this area. I became very frustrated when trying to connect patients wih their physicians on discharge for general information and follow up. Family conferences are really essential, however this is not a part of the normal routine as yet, and although we are able to schedule family conferences with the nursing staff, it is the doctors that the patient and family look to for direction and the final word.

Much work is still needed to build up the "in hospital system" where can all support one another's input. I see this largely as being up to social work, because we are the ones who have the "ecological perspective" on the situation. The challenge for me throughout the practicum was to vent my anger and frustration constructively, rather than how my instincts would have liked me to.

4.5.0.2 Personal:

1. Returning to school after 8 years, and again beconming a "student" was very difficult for me to handle. In some ways it was as if all of a sudden I was back to square one where I had to learn everything all over again. My natural response to this was to rebel, and to actually overcompensate in the other direction. This took some time to sort out, and as a result my level of self confidence varied from time to time.

2. I have very high expectations of myself, which sometimes sets me up for failure. This practicum was no exception, and this I believe was in part responsible for my intense feeling of helplessness in session 3 with the Kirby family.

   Maria suggested that when one becomes "stuck" like that in a situation, there is usually something that happened in your personal life that is connecting with what is happening in the interview and preventing you from making progess. After thinking this through and making the connections necessary for myself, I had a better understanding of what happened and more control over the possibility of it happening again.

   It was necessary for me to take a realistic look at my limitations and then learn how to work within them.

Throughout the practicum I experienced emotions ranging from anger, frustration and helplessness to elation and relief. I learned a great deal about myself, and about how complex the issues are that face the head-injured patient and his/her family. I found this practicum to be quite difficult, because there is little or no information accumulated on how to work with these families, and because the personality changes are so extreme and limiting. Although this certainly presented a good opportunity for learning, it is always difficult to be a pioneer of sorts.

Chapter V

EVALUATION

The evaluation of my practicum took place on an ongong basis throughout the time spent in the field. There was no formal method used, rather the evaluation is quite informal in nature drawing from the families, myself, and my supervisor. Some of this information has been alluded to in previous chapters, but is again discussed here for clarification.

5.1 SELF EVALUATION

Following each session with the families, and with my supervisor, I went over what had happened, and how I had dealt with the various situations. Problems that were identified, were then discussed with Maria during supervision. These problems were related to the methods of therapy being used, as well as to the method of delivery. I spent some time going over the tapes myself in order to plan the intervention for the next session, especially when there appeared to be problems.

This process of self evaluation included evaluating the need for intervention in this area, especially in the beginning when there was a difficulty obtaining cases.

5.2 SUPERVISORY EVALUATION

To some extent this was a part of the self evaluation. Maria and I did co-therapy with two families and as a result she was able to give me direct feedback on what I had done that was effective, what other choices I may have had, and where I could make changes that would increase effectiveness. Where co-therapy was not possible tapes were used or discussions were held about the interviews, highlighting the problem areas. We went over the tapes together, with Maria giving suggestions for alternate methods, and pointing out where changes were needed.

5.3 CONSUMER EVALUATION

On termination and at various points in the intervention, the 4 families I worked with intensively were asked their evaluation of what was happening and their perception of the social work role.

The Kirby Family: They saw the role of social work as being family therapy and felt that they were making progress with their situation. Throughout the sessions they asked questions about what was happening, mainly for clarification, and if they were not in agreement with what was happening in the sessions, we renegotiated. At the end of the sessions Warren did not feel that he had been able to attain the goal that he desired, that is, he had not attained the level of respect within the family that he wanted. He felt that there could have been more work in that area.

All 4 family members agreed that the fighting and yelling had decreased considerably and this made the living situation much more pleasant. The sculpture was identified as the most useful part of therapy with the "fair fighting" techniques a close second.

Kelly and Mike: Mike really felt that the sessions did not help him out. He wanted Kelly to come home, and in the end she decided to remain separated. He felt that this had always been her plan, and therefore the therapy was awaste of time. The only real advantage, from his point of view, was that he was able to see her at the sessions. Mike stated that as we had made no promises at the beginning he was not disappointed. Kelly also did not really feel that therapy was helpful, other than she was able to see that Mike was not able to change at this point. Maria and I felt that she was able to deal with her guilt, and this helped her to be able to separate.

The Robertson Family: Brenda found the sessions extremely helpful. She stated that the most useful input was giving her a place to vent her feelings and frustrations as she was unable to do so otherwise. She also felt that the children had benefitted as their reactions to their father appeared to be much more natural.

I regret that I did not have the boys do another family drawing to see if their perception of the family situation had changed at all.

Family 4: This family saw the function of the social worker as being a "mediator" between themselves and the hospital staff. They felt that the most important aspect of my intervention was providing them with information about the plan for the patient, and connecting them with the services required on discharge. They had difficulty connecting with the system due to political and administrative misunderstandings. (This was described earlier in chapter 4)

Although there was other input, this was the area that the family felt was most useful for them. This family was not yet at the point where they felt the need for therapy, they were still focusing on the physical damage, as the patient was not yet able to return to work.

5.4 EVALUATION OF THEORY, BASED ON THE FIELD EXPERIENCE

My experience in the field was directly related to the description of the problem in the literature. (See chapter 2) The behavior problems found in these patients were parallel to those described by Stern 1978, and Oddy et al. 1978,, 1980.

The families all stated that they were not informed of the possibility that such behavior problems would occur. Some doctors did say that there were problems, but they could not tell how severe they would be because the rehabilitation time for these patients is from one to two years. These families also stated that the information on these changes was minimal. These families reported ongoing problems with coping, because they kept hoping that things would improve.

My experience supports the need for ongoing follow up as is indicated by the Dick family. In this way perhaps some of these problems may be prevented.

5.5 RECOMMENDATIONS

As a result of reading the literature and working with head-injured patients and their families for this past year, I have several recommendations for ongoing treatment and intervention.

1. That social work become involved from the time of injury of ALL head-injured patients and follow them through into the community. If intervention is not required immediately follow up later will be easier as a result of having made the initial contact. This will also give the families some options of people to contact if and when problems occur later on.

   It appears that input in the beginning of the process can give some hope for alleviating the family's distress in the future. When input is confined only to a later time, as in two of the cases described, it becomes much more difficult to deal with the problem.
2. That a group be established for the spouse and parents of the head-injured patients. This group

should include the spouse and parents of recent and long term patients in order to form an appropriate support group.

N.B. I am uncertain whether this group should include the patients themselves. As long as the patient is unaware of his behavioral changes, this could be a block for the group process. This is what prompts the recommundation not to include the patients, at least initially.

The group would focus on dealing with the "loss", and learning how to cope with the changes in behavior.

3. That the hospital unit be set up as a full and operating TEAM, where all disciplines may have input and plan a treatment program together. This way each team member could support the other's input, thereby strengthening the program.

N.B. I realize that this is an ideal and is difficult to put into practise, however it has implications for treatment outcome, as described in the Dick family case.

This team process may also serve as a support group for the staff to air their feelings and frustrations and to clarify misunderstandings. (This is also a reference to the Dick family, as well as to the family mentioned earlier who encountered administrative problems.)

This team process would also ensure that accurate information is passed from the staff to the family about the potential outcome of head-injury, includung the possiblity of behavior changes.

The care of the head-injured needs to be a coordinated and well organized system. Family support is essential but is still the most neglected area. Panting and Merry in their study of the head-injured and their familes in 1972 state that the family support ought to be provided by several methods.

> Firstly the provision of a more detailed prognosis by the doctors concerned with the case is obviously necessary, with particular emphasis on warning the relatives of emotional difficulties which may occur during recovery. ... The greatest need is for a co-ordinator who would follow up with the patient from the time of the acute accident to complete recovery and who, with full knowledge of the patient's history would be able to mobilize the appropriate resources when contacted by the patient's relatives when in difficulty. (Panting and Merry 1972 pp 36)

They go on to state that the coordinating function could be carried out by a medical social worker.

There is much to be done in this area. It is hoped that the plan to set up a Canadian National Interest group for the care of the head-injured and their familes will be a move toward further programs being established.

Appendix A

DO THESE METHODS WORK WITH THE HEAD-INJURED?

The methods of therapy chosen, NLP, crisis theory, communication theory as used by Virginia Satir and Yetta Bernhard with particular reference to sculpturing and fair fighting, as well as grief, all had varying degrees of effectiveness.

A.1 NLP

There has been very little research done to support the efficacy of NLP as a method of intervention. As a result it is difficult to assess its validity. NLP is not a proven method and is considered to be a "fad" by many. At present it can be considered in the experimental stages only.

The theoretical strength of this method is the fact that it is based on Communication Theory. It is not something originated from out of the blue. All of the methods described, for the purpose of this report, are based on analysis of the work of Milton Erickson, Virginia Satir and Carl Rogers, as mentioned in Chapter 2. NLP took the theory used by these therapists and analyzed it to discover how these methods worked for those therapists. This method is a further refinement of communication theory.

It is the bias of the author that this method was used in this practicum for work with the head injured. In my experience I have found NLP to be extremely useful for assisting with assessments and to give a "quick" overview as to the communication patterns within the families. It was used as an adjunct to communication theory because it is a further explanation of the communication process.

This method is not necessarily the best one for work with the head-injured themselves as there are some problems with it. The eye movements are hard to detect, as often there has been some eye injury, and there is a "blank look" in at least one eye. This can create some confusion as to the individual's major representational system, and other methods such as the vocabulary must be given more attention. Direct application of NLP in theory was not used. NLP was used as an assessment tool for the therapist to increase my understanding of the situation. There is no specific advantage to the use of NLP in work with the head-injured other than the bias of the author who finds it elaborates on the communication process and thus can be quicker and more efficient. She would use it when working with other individuals as well.

A.2 CRISIS THEORY

Crisis theory as described in chapter 2 was extremely useful in working with these patients and their families, to help give an understanding of the process they were going through. An important note is that often the families tried hard to return to the "previous level of functioning" which in most cases is not possible. Fink's outline of crisis theory with the focus on adaptation rather than on return to the previous level of functioning helps to put the situation in a better perspective for the therapist.

A.3 COMMUNICATION THEORY

As was mentioned in chapter 2 there is no empirical evidence for the use of any method of intervention with regard to the head injured due to the lack of literature on the subject.

The use of communication theory for working with the head-injured is again the bias of the author. The need for its use is, however, indicated in the studies done by Oddy 1978/1980, Romano and Thomsen (1974) who state that lack of communication is a severe problem between patients, families and staff, and has implications for future difficulty.

In the initial assessment of the families we worked with intensively, it was agreed by the families and the therapists that this was a huge problem that should be worked on, and we therefore proceeded on that basis.

The theoretical strengths of communication theory lie in the ability to understand the importance of communication within a system, and how the system can be affected when the communication breaks down, or when it is ineffective. The theory helps in the analysis of the family functioning and in the formulation of a direction for therapy.

There are times in working with the head-injured when other methods such as crisis intervention and grief therapy are necessary to implement. Communication theory is not all encompassing and is used when considered to be appropriate as mentioned.

If the patient does not acknowledge that there are problems, as in the case of Kelly and Mike, it is practically impossible to use this method to work with the family. Intervention at the time of the accident also indicates a different apporach, with the use of crisis intervention rather than communication theory.

During the rehabilitation process, however, communication theory is extremely useful and often necessary to keep the lines of communication open between the other family members, hospital staff, and between family and staff. Also at the point where the patient is able to understand the problems affecting the family and wishes to work together on the problem communication theory is invaluable.

This was especially true in this practicum with the Kirby family.

Sculpturing was extremely useful as it was able to get behind the intellectualization, blaming and defending of the family and quickly get to the feelings where the work could really begin. Fair fighting methods were also extremely useful because of their structure. It would appear that victims of head-injuries need a framework to work within and setting situations up with a well defined structure for interaction seems to do the trick.

Lack of insight is a common problem following head-injury. Because of this it is important to use methods of intervention that are able to actively demonstrate where the problems lie, rather than to depend upon an individual's ability to think things through. This is one reason that I see for the sculpturing to be so effective in this work.

A. 4 GRIEF THERAPY

In work with the head-injured grief work is essential. Dealing with the loss of functioning is necessary in order for the rehabilitation process to continue. Without this the family get "stuck" on the past. The use of drawings with children was very helpful for me, however, unless someone has a lot of experience in the interpretation of these drawings some mistakes can be made. Kubler-Ross cautions about this in her book, as do others in the field.

One additional element here that was not originally seen as being a part of the involvement with these families, is the need for education. The education as to the possible effects following the head-injury is an essential element as was used often in this practicum. This education is also directed to the medical staff who need feed-back of the problems within the system in order to effect change for the future.

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