A GROUPWORK APPROACH WITH CHEMICALLY DEPENDENT SENIORS

BY

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A practicum
presented to the Faculty of Graduate Studies
University of Manitoba
in partial fulfilment of the requirements for the
degree of

MASTER OF SOCIAL WORK

School of Social Work

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ABSTRACT

The current report was based on a practicuum experience wherein a groupwork approach was used in the treatment chemically dependent seniors. A review of the literature showed that groupwork with chemically dependent seniors appeared to be a promising treatment approach, however, significant gaps in knowledge remained. The practicuum involved the delivery of a treatment package to a group of seniors who were dependent on alcohol and/or another drug. Group members' chemical use and functioning in various life areas was assessed before and after the three month treatment period. Empirical results indicated that five of the seven core group members had stabilized in terms of their chemical use by the end of the treatment period. Improvements in clients' cognitive/motor functioning, and perception of loneliness and connectedness with others were also noted. Clients' overall perception of life satisfaction remained stable. Results were discussed, and recommendations for further research in the area of groupwork with chemically dependent seniors, were offered.

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CHAPTER 1 - LITERATURE REVIEW

The purpose of completing a literature review is to gain an understanding about the state of our knowledge regarding chemical dependency and the elderly, and the use of a groupwork approach to treat this population. Study reports which have examined the focal area are sparse. For this reason, the literature review has been expanded to include the use of a groupwork approach with seniors in problem areas other than chemical abuse. The review clearly shows that the use of groups with seniors is a promising treatment approach. Because there are few studies involving chemically dependent seniors, and many of these have failed to empirically measure individual outcome, it is recommended that more studies aimed at examining the effectiveness of groups with chemically dependent seniors be done.

Overview of Chapter

The existence and extent of chemical abuse problems among seniors will initially be established. Four of the main factors associated with chemical dependency within the elderly age group will be discussed. Studies which describe group treatment programs with elderly chemical abusers are reviewed, and their shortcomings noted. Because of the need to gain additional information about the use of groupwork with seniors, studies which report on the use of groups with the elderly, outside the focal area of chemical abuse, are reviewed. Practical considerations in facilitating elder-specific groups are highlighted, and the benefits and drawbacks of using a groupwork approach are summarized. Finally, the remaining gaps in our knowledge pertaining to group treatment

of chemically dependent seniors are identified.

Summary of Prevalence Studies

Prevalence studies undertaken in an attempt to measure the extent of chemical[1] abuse[2] and dependency[3] problems among seniors have generally estimated rates to be in the range of 2% - 10% (Mendelson & Kello, 1985). Numerous prevalence studies have been reported in the past twenty years however, the main focus of the current review will be on those studies which have been completed in the past 10 years.

Many prevalence studies have showed that alcohol consumption typically declined with age (Mendelson & Kello, 1985; Christopherson, Escher, & Bainton, 1984; Smart & Adlaf, 1988; Barnes, 1979; Borgatta, Montgomery, & Borgatta, 1982). Nevertheless, an alarming number of seniors appear to be abusing alcohol and various medications.

In one of the few Canadian studies reported, Smart and Adlaf (1988) examined the use of alcohol, sleeping pills, and tranquilizers along with characteristics of users in a sample of Ontario residents over the age of 60. Their data was drawn from a large number of observations, taken from four cross-sectional surveys conducted between 1976 and 1984. The elderly age group's use of chemicals was compared with use among individuals aged 15 - 64. Comparisons between males and females were also made. Smart and Adlaf found that although the elderly were more likely than younger individuals to abstain from alcohol, the percentage of daily drinkers in both age groups was 12%. The elderly were more

likely to report sleeping pill use than younger individuals: 4% used sleeping pills daily compared with .6% in the age range of 30 - 59 years, and .3% in the age range of 18 - 29 years. Older women were more likely to report sleeping pill use than older men. The over-60 age group was also more likely to report daily use of tranquilizers than were the younger age groups.

Whitcup and Miller (1987) who believed that chemical abuse was often minimized among seniors, completed a prevalence study over a period of one year, in New York. Their study was retrospective, and involved elderly psychiatric patients over the age of 65. Of 90 patients admitted to the unit in 1983, 19 (21%) were diagnosed as chemically dependent by the authors' criteria. Ten of these patients were not recognized as chemically dependent upon admission. Alcohol use was prominent among chemically dependent males; benzodiazepine use was prominent among chemically dependent females. The authors concluded that chemical dependency among seniors was frequently misdiagnosed.

A recent study conducted by Bernstein, Folkman, and Lazarus (1989) examined chemical use among 141 relatively healthy and well-educated elderly individuals. The authors concluded that the amount of chemical misuse and abuse by seniors was indeed high. Bernstein and her associates developed a chemical misuse index, which categorized seniors' use of chemicals as (a) no misuse (b) low misuse (little risk of a dangerous drug interaction occurring), or (c) high misuse (considerable risk of a dangerous drug interaction occurring). Nearly 50% of the 141 participants were

found to be misusing alcohol and drugs in one way or another. Alcohol was involved in one-third of the 46 incidents of misuse categorized as potentially dangerous due to the interactions which could occur as a result of taking more than one chemical simultaneously. Twenty-three per cent of the study participants reported daily consumption of wine, and 18.5% reported daily consumption of liquor.

D'Arcy and Bold (1983), in a retrospective study, accessed data on the general population through the Saskatchewan Health Services Commission files. Sixteen thousand individuals were identified as alcohol or drug dependent during the study period of 1969 to 1974. Half of these individuals (n=7893) were tracked in terms of their involvement with the medical system. Age was one of the variables examined. D'Arcy and Bold found that 14.6% of seniors (individuals over the age of 60) were diagnosed as alcohol dependent, and 9.4% were diagnosed as drug dependent.

A study involving 101 participants over the age of sixty was undertaken in England (Bridgewater, Leigh, James & Potter, 1987). Participants were drawn from a list of patients who were actively receiving medical care at a general medical practice. Instruments which diagnosed alcoholism were administered. Twenty-seven per cent of the men and nine per cent of the women in the study were found to be heavy drinkers. The relatively high percentage of heavy drinkers among study participants may have been due to the fact that this group of seniors was receiving regular medical attention and was not representative of the general elderly

population.

Schuckit and his associates (1978) reported that of 195 women admitted to a detox centre in Seattle, 16% were over the age of fifty-five. Of 186 men admitted to a Veterans Administration inpatient program, 24% were over the age of 55. Thus, a high proportion of individuals in treatment programs were over the age of 55. Unfortunately, he did not specify how many of the individuals over the age of 55 were actually elderly, that is, by commonly accepted definitions, over the age of 65. Schuckit (1978) also found that female study participants reported a greater tendency to use drugs than did male study participants.

A study conducted by the Elders Health Program, in Winnipeg, Manitoba, found that approximately 30% of individuals over the age of 65 who presented at the St. Boniface Hospital's Emergency Department, were found to be in need of further assessment regarding their alcohol/drug use (Jacyk, Tabisz, Badger, & Fuchs; 1991). The results were obtained by administering specific alcohol/drug screening tools to a random sample of seniors who sought medical attention for a variety of reasons, during the study period.

Reported prevalence rates of chemical abuse varied, depending on the subgroup of seniors studied. The rate of chemical dependency among seniors in nursing homes was generally estimated to be 15%, and between 15% and 30% among those hospitalized for medical reasons (Mendelson & Kello, 1985). Cohen (1988) estimated that 10% of the general Canadian population aged 65 years and over

engaged in problem drinking, and 6% - 20% of the elderly in institutions were problem drinkers. Brown and Chiang (1983-84) noted that in their estimation, 14% of individuals over the age of 55, living in residences for older adults, were abusing chemicals. The large majority of prevalence studies found that the abuse of chemicals within the elderly age group was extensive.

The overall prevalence rate of chemical dependency among seniors in the general population was estimated to range from 2% - 10% (Mendelson & Kello, 1985). Studies which examined prevalence rates among subgroups of the elderly population however, found that the rates were as high as 15% - 30% (Whitcup & Miller, 1987; D'Arcy & Bold, 1983; Bridgewater et al., 1987). None of the studies provided an estimate of the chemical dependency rates among elderly females versus elderly males. Several studies however, found that elderly women were more likely to abuse medications than were elderly men (Smart & Adlaf, 1988; Whitcup & Miller, 1987; Schuckit, 1978).

Shortcomings of Prevalence Studies

We cannot be certain that the reported prevalence rates of alcohol/drug problems within the elderly population are accurate. Numerous problems pertaining to sampling procedures, size of study samples, and methodological problems inherent in surveys, limit the reliability of the study findings. With the exception of a few (Smart & Adlaf, 1988; D'Arcy & Bold, 1983; Bernstein, Folkman & Lazarus, 1989; Jacyk et al., 1991), studies generally employ a relatively small number of participants. Select populations of the

elderly have often participated in prevalence studies; this limits the generalizeability of the study findings (Borgatta et al., 1982; Mishara & Kastenbaum, 1980; Mendelson & Kello, 1985). Some of them are retrospective (Whitcup & Miller, 1987; D'Arcy & Bold, 1983), which limits the type and amount of data available for analysis.

Definitions of chemical abuse vary between studies (Cohen, 1988; Williams, 1984; Montgomery & Borgatta, 1986). The types of questions asked of participants in an effort to establish chemical abuse vary a great deal. Some questions will obviously be more sensitive than others and are therefore more likely to uncover chemical abuse.

Methodological problems inherent in survey studies, such as self-reported chemical use and voluntary participation also limit the reliability of the findings (Rathbone-McCuan, 1987). Information about seniors' chemical use is usually obtained through self-reports, which do not necessarily provide reliable information (Brody, 1982; Brown & Chiang, 1983-84; Smart & Adlaf, 1988). Denial of a chemical abuse problem by individuals who themselves are having a problem, is common (Alcoholism Foundation of Manitoba, 1985; Johnson, 1986; Levine & Gallogly, 1985; Malcolm, 1984). The fact that all study participants are voluntary also limits our ability to generalize the findings. We cannot be certain that individuals who agree to participate in studies are similar to those who do not.

The definition as to what constitutes "elderly" is

inconsistent between studies (Williams, 1984). In the current literature review, it was found that some researchers defined "elderly" as those individuals over the age of 55; one must question whether individuals over the age of 55 are truly "elderly". Other studies focused on the "young-old" (those individuals between the ages of 60 and 70), whereas others included all seniors over the age of 65.

Has Chemical Abuse among Seniors been Under-estimated?

Many researchers believe that the prevalence of alcohol/drug problems with the elderly age group has actually been under-estimated, for a variety of reasons. Chemically dependent seniors are likely to be under-represented in treatment programs because of restricted access to these programs. Access may be restricted due to "ageism"--a belief on the part of elderly individuals, treatment staff, and society in general that the elderly are too old to change, and are "beyond help" (Atkinson, 1984; Carstenson, Rychtarik & Prue, 1985; Kofoed, 1985; Kola & Kosberg, 1981; Shanahan, 1984).

Physicians and hospital staff may be reluctant to make a diagnosis of chemical dependency in order to protect the senior and his/her family from embarrassment and shame (Pruzinsky, 1987; Atkinson & Kofoed, 1982). Also, physicians may misdiagnose chemical dependency because its symptoms often mimic those of other illnesses (D'Arcy & Bold, 1983; Cohen, 1988; Hartford & Samorajski, 1982; Price & Andrews, 1982).

Chemically dependent seniors are less visible in general

because they are unlikely to be active in the work force, and are less likely than their younger counterparts to experience family or legal problems as a result of their chemical use (Hartford & Thienhaus, 1984; Williams, 1984; Pruzinsky, 1987; Mishara & Kastenbaum, 1980).

The problem of denial on the part of chemical abusers can also result in an under-estimation of chemical dependency among seniors (Alcoholism Foundation of Manitoba, 1985; Johnson, 1986). Atkinson (1984) and Zimberg (1982) point out that many of today's seniors grew up during the period of Prohibition in the United States, at which time attitudes towards alcohol use were extremely conservative. Zimberg (1982) stresses that ambivalence and guilt feelings can result where there is significant variability and inconsistency surrounding the use of alcohol, which is what occurred during the Prohibition Amendment and its subsequent repeal. The American elderly population may therefore be particularly vulnerable to feelings of shame and embarrassment associated with their own chemical abuse. Denial of a problem can serve to protect them from these feelings.

Family members may attempt to cover up their elderly parent's chemical abuse because of the stigma associated with chemical dependency, and a desire to protect their parent and themselves from the negative attitudes of others (Cohen, 1988; Kofoed, 1985; Zimberg, 1974; Atkinson & Kofoed, 1982; Hubbard, Santos & Santos, 1979). Alcohol abuse may even be encouraged by family members who believe that their parent is entitled to have "a few drinks" at

this stage of his/her life (Alcohol Health & Research World, 1975).

It is not known for certain the rate of chemical abuse among seniors. In summary, reliability of the prevalence rates is limited by the following factors: (1) sampling procedures, (2) small sample sizes, and (3) methodological problems inherent in surveys. Furthermore, it is possible that the prevalence of chemical abuse among seniors has been under-estimated due to: (1) seniors' restricted access to chemical abuse treatment programs, (2) a desire on the part of professionals, family members, and friends to "protect" seniors from a diagnosis of chemical dependency, (3) the tendency of seniors to be less visible in our society than younger people, and (4) a tendency by those experiencing a chemical abuse problem to deny or minimize their problem. Based on the findings of the prevalence studies to date however, it does appear that the problem of chemical abuse within the elderly age group is significant and warrants concern on the part of the helping professions.

Causes of Chemical Dependency

There has been a great deal of speculation as to the causes of chemical dependency within the elderly age group. Chemical abuse by seniors has been thought to be associated with a variety of factors:

(1) individual personality characteristics, such as low self-esteem, low frustration tolerance, and difficulty in forming relationships with others (Brown & Chiang, 1983-84; Johnson, 1986; Zimberg, 1982).

(2) an attempt by the elderly individual to regain control over one aspect of his/her life: his/her feelings (Hochhauser, 1981; Williams, 1984; Zimberg, 1982).

(3) stresses concomitant with aging, such as loss of family members and friends, deterioration of physical health, retirement, death of a spouse, etc. (Droller, 1965; Rosin & Glatt, 1971; Malcolm, 1984; Carstenson et al., 1985; Dupree, Browkowski, & Schonfeld, 1984).

(4) a genetic predisposition to become chemically dependent (Alcoholism Foundation of Manitoba, 1985; Johnson, 1986; Zimberg, 1982).

1. Individual Personality Characteristics

The theory which proposed that there were certain personality traits that predisposed an individual to chemical dependency, was not limited to the elderly age group per se. Brown and Chiang (1983-84), Johnson (1986), and Zimberg (1982) discussed the possibility that individuals who were chemically dependent shared certain personality characteristics, which perhaps caused them to be vulnerable to abuse chemicals. Low self-esteem and frustration tolerance, and difficulty in forming intimate relationships were a few of the personality characteristics which were identified as characteristic of chemical abusers (Brown & Chiang, 1983-84; Zimberg, 1982). It was speculated that chronic emotional discomfort, such as anxiety, predisposed an individual to become chemically dependent (Alcoholism Foundation of Manitoba, 1985). Chemical abuse as a pattern of using self-destructive coping

strategies to deal with life stresses (Brown & Chiang, 1983-83; Zimberg, 1982) and unpleasant feelings (Zimberg, 1982) was also speculated.

2. Chemical Dependency as an Attempt to Regain Control

Hochhauser (1981) suggested that chemical abuse by the elderly was related to learned helplessness. He argued that in response to a number of internal and/or external stressors, an elderly person might believe that he/she no longer had any control over what happened. Substance abuse was viewed as a way of regaining control over one aspect of life, in that a senior could choose if, when, and how to feel better. Hochhauser (1981) also argued that if the elderly individual was severely depressed, substance abuse might be a form of suicide. Apparently, there was no research done to test this theory. Ample evidence was found however, which supported a connection between substance abuse and increased suicide rates among seniors (Mendelson & Kello, 1985; Inciardi, McBride, Russe & Wells, 1978; Pruzinsky, 1987; Russell, 1984).

3. Stresses Concomitant with Aging

Related to the elderly age group, most of the discussion about causal factors associated with chemical dependency has focused on age-related stresses. Studies examining this theory provided inconclusive results.

Brown and Chiang (1983-84) found that seniors who abused substances were more likely to be living alone, or to be single, separated, or divorced. The writer stresses however, that cause and effect cannot be assumed. The presence of a chemical abuse

problem may cause a relationship to break down, however, it is also possible that the termination of a relationship results in acute loneliness, and chemical abuse, in turn, becomes a method of coping with this loneliness.

A study described earlier, by Smart and Adlaf (1988), found that there was a negative relationship between a senior's family size and the frequency of his/her alcohol use. The authors proposed two hypotheses to explain this finding: (a) seniors with a greater degree of social support (friends and family) were less likely to experience the negative effects of stress and in turn, were less likely to use chemicals as a coping strategy, (b) the greater the number of family members a senior had, the more familial control there was over his/her alcohol use.

There were numerous other studies which supported the theory that late-onset chemical abuse was caused by age-related stressors. Dupree and his associates found that the most frequently reported event leading to the onset of alcohol abuse among seniors was the death of a spouse, followed by conflict with a spouse. Carstenson, Rychtarik, and Prue (1985) reported that in their study, five out of seven late-onset alcohol abusers began drinking excessively within one year of retirement. Rosin and Glatt (1971) reported that one-third of their seniors (n=approximately 34) had developed an alcohol problem in reaction to bereavement, retirement, or loneliness.

In contrast, Finlayson (1984) questioned whether age-related stressors were the cause of chemical abuse in the elderly age

group. He argued that there appeared to be an even distribution of chemical abuse across all age groups, and if the age-related stress theory was true, one would expect to find a disproportionately high number of chemical abusers within the elderly age group.

Borgatta, Montgomery, and Borgatta (1982) reported that their examination of the literature provided no evidence for the theory of elders' chemical abuse and age-related stressors, and contended that this theory had been falsely nurtured into "fact". Their own retrospective study showed that overall, there was a negative relationship between age and excessive drinking. Within the elderly age group, no relationship was found between measures of life crisis events or measures of well-being, and drinking behavior.

The evidence regarding the assertion that chemical abuse by seniors was caused by age-related stressors has been mixed. A few researchers have argued that there is no real evidence which supports the theory. Other researchers however, have reported clear indications of the theory's validity. It may well be that for a certain number of seniors, the onset of chemical abuse occurs in relation to age-related stressors.

4. Genetic Predisposition to Chemical Dependency

The theory which proposed that some individuals are genetically predisposed to becoming chemically dependent was well documented. This theory was not directed exclusively at the elderly age group. Its proponents considered chemical dependency

as a genetically determined biological disease (Alcoholism Foundation of Manitoba, 1985; Johnson, 1986; Zimberg, 1982). Numerous studies found evidence that there was indeed a genetic link in the development of chemical dependency (Zimberg, 1982). Generally, these studies examined whether the frequency of chemical dependency occurred disproportionately in children who were born to a chemically dependent parent but raised in a family free from chemical abuse problems. Consistently, the evidence from these studies showed that children of chemically dependent parents were at higher risk of becoming chemically dependent themselves even when they were raised in a environment which was free from chemical abuse problems (Zimberg, 1982).

All theories related to the cause of chemical dependency may have some relevance, although some appear to be more firmly supported by research. During the course of the literature review, ample evidence in support of both the age-related stress theory and the disease model of chemical dependency, has been found. The writer found less direct evidence which supports the theories that chemical abuse is an effort to regain control over feelings, or is related to individual personality characteristics. It is important that we do not limit ourselves to any one causal theory of chemical dependency. The elderly age group is a heterogeneous one. As such, it is to be expected that the causes of chemical abuse within this group vary between individuals.

Consequences of Chemical Abuse

The negative consequences of chemical abuse are well

documented. Regular use of alcohol and other drugs by the elderly is known to have negative effects on sleep, sexual behavior, health and longevity, and the nervous system, and is possibly a contributing factor in organic brain disease (Hartford & Samorajski, 1982; Williams, 1984). Substance abuse has been found to be a contributing factor in increased suicide rates among seniors (Mendelson & Kello, 1985; Inciardi et al., 1978; Pruzinsky, 1987; Russell, 1984). Depression is frequently associated with alcoholism (Hyer, Carson, & Tamkin, 1987). Freund (1984) has suggested that alcohol abuse may accelerate the aging process and may be related to memory loss in elderly individuals. Substance abuse has been thought to be linked to mental deterioration in the elderly age group (Russell, 1984; Atkinson & Kofoed, 1982). There is an increasing sensitivity with increasing age to the effects of ethanol, which results in the elderly being negatively effected by even small amounts of alcohol (Hartford & Samorajski, 1982). A decreased tolerance with advanced age to prescription drugs, which results in a greater chance of drug toxicity, has also been documented (Abrams & Alexopoulous, 1988). Possible adverse reactions with the simultaneous ingestion of alcohol and prescription drugs have been noted by several researchers (Mendelson & Kello, 1985; Abrams & Alexopoulous, 1988; Smart & Adlaf, 1988; Williams, 1984). Alcohol use can mask symptoms of other illnesses and prevent the elderly from receiving prompt, necessary medical care (Mendelson & Kello, 1985). Elderly chemical abusers are more prone to falls, self-neglect, social isolation,

and loneliness (Russell, 1984; Mendelson & Kello, 1985). Borgatta and his associates (1982) have reported that in general, elderly alcoholics over-utilize medical services. Chemical abuse by seniors often results in deteriorating family relationships and severed family ties (Dunlop, Skorney, & Hamilton, 1982; Hubbard et al., 1979).

It is clear that chemical abuse within the elderly age group has a negative impact on seniors' physical, mental, social and emotional well-being. Given this fact, the writer argues that the problem of chemical abuse by seniors is a serious one, and warrants concern and attention by the helping professions. One of the most promising approaches for the treatment of chemical dependency in seniors involves the use of a groupwork approach. A review of study reports which have examined the use of this approach, follows.

Origin of a Groupwork Approach with Seniors

The origin of service provision to the elderly, including services provided at a small group level, was relatively recent. Geropsychology in general developed much more slowly than other areas of psychology or psychiatry. Herr and Weakland (1979) believed that this was due in part to the influence of Freud. They stated that Freud avoided working with the elderly age group because he felt that seniors were too rigid to change, and that an infinite amount of time would be required in psychoanalysis in order to deal with the massive amount of historical material which elders accumulated.

According to Griffin & Waller (1985), who examined the origin of group work with seniors, initial reports of this approach with the elderly age group appeared shortly after the Second World War. Originally, therapy focused on teaching daily living skills, rather than developing insight or facilitating personality change. Studies which examined group therapy with seniors increased dramatically in the mid-1960's, according to several writers (Britnell & Mitchell, 1981; Capuzzi & Gross, 1980; Berger & Berger, 1972). Even with the increase in its use, group therapy was limited mainly to the institutionalized elderly (Ingersoll & Silverman, 1978; Mayadas & Hink, 1974; Griffin & Waller, 1985; Britnell & Mitchell, 1981). There were few documented reports on the use of groups with seniors who were living independently in the community.

A Current Review of Groupwork with Chemically Dependent Seniors

As previously mentioned, studies reporting group treatment of elderly chemical abusers are sparse in number, in comparison to reports with other age groups. The current review highlights both what we know about the focal area of interest, as well as the existing gaps in our knowledge.

From the outset, it was noteworthy that several studies which examined the efficacy of treatment services in general, reported that providing treatment to elderly alcohol abusers was as effective as it was with younger age groups (Carstenson et al., 1985; Dunlop et al., 1982; DiClemente & Gordon, 1984; Pruzinsky, 1987; Zimberg, 1974; Mishara & Kastenbaum, 1980; Shanahan, 1984).

Some studies found that elderly substance abusers responded even more positively to treatment than did their younger counterparts (Schuckit, 1977; Zimberg, 1974; Atkinson, 1984; Hinrichsen, 1984; Atkinson & Kofoed, 1982).

Kofoed and his associates (1984) described a treatment program for elderly alcoholics in Oregon. An elder-specific groupwork approach was used because treatment staff found that many older patients were uncomfortable when outnumbered by younger patients. When seniors in the treatment program were interviewed, two-thirds of them said that they preferred to attend an elder-specific program over a main-stream one. The authors reported that the program was too new to permit evaluation of intermediate and long-term client outcomes, however, initial outcomes appeared to be very positive.

Zimberg wrote numerous articles regarding the use of group therapy with elderly alcohol abusers (1969, 1974, 1978, 1982). He highlighted the fact that group therapy was the most widely used type of therapy in the treatment of alcoholism. His own experience was that group socialization therapy, along with the use of anti-depressant medication when appropriate, was effective in the treatment of elderly alcohol abusers (1982). Zimberg described a specific group treatment program for elderly alcohol abusers in a psychiatric unit in New York. Twenty-nine seniors were referred for outpatient treatment during the first year of the program. Eight seniors refused treatment or dropped out prematurely. The group used a supportive, problem-solving approach, and met once

every week. Zimberg stated that all seniors who completed treatment improved symptomatically and functionally to a great extent, and showed a significant gain in self-esteem. He noted that those who did not complete treatment did not appear to be interested in establishing social relationships.

Dunlop, Skorney, and Hamilton (1982) reported on a demonstration program which used several different kinds of treatment groups with elderly alcoholics. Applicable to the current review, they mentioned that a group for alcohol abusers during the inpatient phase of treatment, was an important component of the program. Specific methods which focused on the strengths of seniors, and helped them to regain control over their lives, were used in the group. A major therapeutic contribution of the group process was that it taught seniors how to disclose feelings. The authors did not mention that any formal evaluation examining the effectiveness of the program had been done.

The effects of a behavioral treatment program for late-onset elderly alcohol abusers, were examined by Dupree and his associates (1984). They obtained extensive information from 21 seniors who had completed treatment during a given time period. Collateral information about clients' drinking behavior was also obtained. Most of the individuals in this group had been able to maintain their desired drinking goal (either abstinence or limited, controlled drinking) at the 6 and 12 month follow-up intervals. The average number of alcoholic beverages consumed by clients was zero. Referring to seniors' social networks, the authors reported

that at the time of their admission, clients appeared to have a relatively poor social network. The quality of their social networks gradually improved during treatment, and was maintained throughout the follow-up period. The authors concluded that improved social networks likely contributed to seniors' increased control over their alcohol use. One of the concerns raised by the authors had to do with the low treatment completion rate. Of the 153 identified alcohol abusers, only 48 agreed to participate in treatment. Exactly 50% of these dropped out of treatment prematurely. The authors did not speculate as to why so few seniors followed through with completing treatment.

DiClemente and Gordon (1984) proposed a treatment model which they felt described a comprehensive intervention approach with elderly chemical abusers. Their proposal did not address specific treatment methods, nor did it distinguish between individual and group approaches. They raised an interesting issue however, regarding the effectiveness of any treatment method. Their review of treatment approaches with elderly chemical abusers led them to conclude that treatment factors per se were found to account for only a small portion of outcome variance. Rather, a senior's background and level of motivation to change were the critical factors in treatment outcome. They further reported that recent studies showed that 30% - 50% of individuals who received only minimal treatment for alcoholism, improved.

Ruyle (1987) noted that although groups were a major component of substance abuse treatment for many years, and came to play an

important role in mental health services for the elderly, little was written about group treatment approaches with elderly alcoholics. She based her discussion on personal experience with an outpatient group treatment program in Boston. Two treatment settings were used in her study: a seniors' centre and a substance abuse clinic. Groups met one to three times per week, and were open-ended so that clients who might not be able to stay sober without the support of the group were able to continue on in treatment as long as they wished. Ruyle advised that seniors benefitted greatly from participating in group treatment, but she did not specify what these benefits were. Nor did she formally evaluate client outcome.

Ruyle (1987) stated that in her experience, groupwork with seniors entailed unique issues and concerns that distinguished it from groupwork with younger clients. Group leaders had to be prepared to share more about themselves when working with seniors, and to take an active role in identifying and eliciting feelings from group members. Seniors had a high need for inclusion, control, and affection, and leaders had to work towards ensuring that these needs were met within the group. Ruyle noted that although a number of other authors had spoken in favor of the group leader using a supportive technique with seniors, rather than a confrontational one, no researchers had actually attempted to compare the effectiveness of these two techniques.

In a keynote address presented at the Second Annual Conference on Aging, Rathbone-McCuan (1987) pointed out that "no single

treatment approach has been identified as most optimal for older persons with alcohol-related problems" (p.17). She stated that the variety of treatment and therapeutic settings currently available were beneficial with the problem of alcoholism, because different types of treatment were best-suited to different types of individuals. She went on to say that groups were a key component in meeting the social and psychological needs of elderly chemical abusers, and that they were beneficial in lessening the social isolation of many older seniors who lived alone.

One of the components of the Elders Health Program study, conducted in Winnipeg, Manitoba, attempted to formally evaluate the effects of group treatment with chemically dependent seniors. Based on clinical evaluation, group members appeared to benefit in several ways as a result of their participation in a group program. One of the most noticeable improvements was that seniors' alcohol/drug consumption significantly decreased during the course of treatment. Many group members were able to discontinue their use of all mood-altering substances, and maintain abstinence during the post-treatment follow-up period (D. Kostyk, personal communication, November 7, 1990).

Hinrichsen (1984) stated that "group therapy...appears to be the single most crucial aspect of treatment for elderly people, according to our interview data...where possible, it may be desirable to develop groups exclusively for elderly people" (p.35). He based this argument on his own descriptive research study, conducted between 1979 and 1981, in which a large number of staff

and clients in chemical abuse treatment centres in the U.S. were interviewed regarding the efficacy of various treatment modalities.

Gaps in Our Knowledge-Groups and Chemically Dependent Seniors

The gaps in our knowledge regarding the use of a groupwork approach with elderly chemically dependent individuals are directly related to the deficiencies inherent in the studies reviewed. There are only a handful of reports which deal in any depth with the issue of group therapy and seniors who are abusing chemicals. The scarcity of literature in this area confirms that a limited number of practitioners have attempted to use groupwork with this particular elderly population. Studies which have examined this issue are weak in several areas:

(1) Often, no rationale for using a groupwork approach is provided--the reader is simply advised that the use of groups is important (Anonymous, 1975; Dupree et al., 1984; Mishara & Kastenbaum, 1980; Sumberg, 1985).

(2) Most studies have made no attempt to objectively evaluate client outcome. Subjective, loosely defined evaluations of client outcome are all too common.

(3) Many studies are methodologically poorly designed.

(4) Most studies base their conclusions on a very small number of study participants

(5) Those studies which have attempted to formally measure the effectiveness of a groupwork approach provide inadequate information as to how client outcomes were measured.

Groupwork with Seniors in General

In an attempt to fill some of the above gaps, the writer reviewed the literature pertaining to groupwork with the elderly outside of the problem area of chemical abuse. There was significantly more literature regarding groupwork with seniors in problem areas other than chemical abuse. Some of the reports focused on the use of a particular type of therapy within a group setting. Others focused on the use of a general groupwork approach in a particular problem area.

That the use of groupwork with the elderly resulted in positive outcomes in a variety of areas, was supported by numerous researchers and clinicians (Beaulieu & Karpinsky, 1981; Berger & Berger, 1972; Borowsky-Deutsch & Kramer, 1977; Britnell & Mitchell, 1981; Chaisson, Beutler, Yost & Allender, 1984; Davis-Whelan & Leader, 1989; Lazarus, 1976; Milinsky, 1987; Steuer & Hammen, 1983; Utley & Rasie, 1984).

Various types of groups for seniors were described and summarized in an excellent review article written by Capuzzi and Gross (1980). They stated that reality orientation groups for the elderly were developed to assist individuals who were experiencing disorientation. These groups focused primarily on education, rather than therapy, and tended to be very structured. Several positive reports about their usefulness in increasing members' self-sufficiency and interest in people and events, were been made.

Remotivation therapy groups were designed to motivate and stimulate seniors who were no longer interested or involved in the

present or future (Capuzzi & Gross, 1980). Group discussions about members' personal problems were avoided because remotivation therapy was viewed as preliminary to other types of group experiences. According to Capuzzi and Gross, these groups were found to be effective in remotivating elderly persons who had seemingly given up any hope or interest about the present or future.

Reminiscence groups for seniors were used in both institutional and non-institutional settings (Capuzzi & Gross, 1980). They were considered therapeutic because they increased group members' opportunity for socialization, helped to develop and increase self-esteem, improved communication skills, and assisted members to come to terms with the totality of their life experience.

Psychotherapy groups offered seniors the opportunity to express fears, questions, and concerns in a group setting, among peers who had similar concerns (Capuzzi & Gross, 1980). Group members benefitted by realizing that they were not "crazy", and that they were not alone with their problems. These types of groups allowed seniors to work through various life experiences and develop healthier and more satisfying potentials.

Both Capuzzi and Gross (1980) and Burnside (1978) stressed the importance of the group leader taking an active role in initiating group discussions and facilitating self-disclosure by elderly group members. Burnside stated that the leader's communication had to be clear and consistent, and had to show

support, encouragement, and empathy to help alleviate the high amount of anxiety which the elderly often experienced in new situations. She argued that groupwork with seniors resulted in a modification of behavior but because change often occurred slowly, group leaders did not always recognize the positive impact of the group.

In a rigorously designed study, Beutler and his associates (1987) compared the effects of cognitive group therapy versus medication therapy and minimal supportive counselling with seniors diagnosed as depressed. Pre- and post-treatment measures were administered to assess seniors' level of depression, cognitive functioning, and sleep efficiency. Seniors assigned to the cognitive therapy groups demonstrated consistent improvement in depressive symptoms and sleep efficiency compared with seniors who received medication and minimal supportive counselling. These improvements were maintained during the three month follow-up period. The authors also noted that seniors assigned to group cognitive therapy were less likely than other participants to prematurely terminate treatment. They concluded that over time, cognitive group therapy was more effective in alleviating depression in the elderly, than was medication treatment. Because a relatively small number of subjects participated in this study, results were not generalizeable. Beutler and his associates also noted that they were unable to find specific cognitive changes that related to seniors' improvements.

A groupwork approach with depressed elderly was also used by

Saul and Saul (1988-89). They stressed that mental health groups were proven to be invaluable vehicles for ventilation of feelings, sharing of ideas, and mitigation of depression. Based on Saul and Saul's personal experience with group treatment, they concluded that the therapeutic value of the group was that it served as a mutual support system for members, and allowed seniors to re-discover their own identity within a peer group. No empirical evaluation of client outcome was made. Saul and Saul based their conclusions on group members' feedback.

In a well-designed study, Weiner and Weinstock (1979-80) compared two different groupwork approaches with outpatient geriatric patients: (1) two treatment groups, led by a trained leader who used intervention techniques such as interrogation, clarification, confrontation and verbal reinforcement, and (2) two "talk" groups, led by a leader who played a non-interventive, passive role. The authors stated that the group tempo (the number of verbal interchanges between members) was significantly and consistently higher in the treatment groups in which the leader used intervention techniques. The treatment groups also moved to the problem-solving stage of groupwork, whereas the "talk" groups remained fixed at the problem-identification stage. Thirdly, members in the treatment groups had a much more favorable attitude towards the group experience than did those members in the "talk" groups. The authors argued that "...community living elderly can learn to utilize a problem-solving approach to the problems of aging even within a short-term

framework with the help of a trained leader in a group setting" (p.184). It must be noted that although Weiner and Weinstock reported that two instruments to measure client change were administered before and after participation in group (the Weschler Adult Intelligence Scale and the Cornell Medical Index), they did not provide us with any information regarding the results of these measures.

DeBor and her associates (1983) reported on the use of a cognitive, supportive group counselling approach, with recently widowed elderly men and women. The goal of the group was to facilitate a positive adjustment to members' losses. The authors found that at the one month post-treatment period, all group members reported that: (1) they had a better understanding of the grief process due to having participated in the group,
(2) the group provided a safe place to express thoughts and feelings, and (3) the group enabled them to better cope with the stresses of bereavement. Further, the majority of seniors reported that their ability to cope with loneliness had improved, and they were feeling more "normal". Two areas in which the group appeared to have little or no impact included resolving conflicted family relationships and changing seniors' level of daily activities. Because the study design was not rigorous (no control group was available, the study group was small, and no objective measures of client change were made), DeBor and her co-writers cautioned that causality between the reported changes and group treatment could not be assumed.

Evans, Smith, Werkhoven, Fox and Pritzl (1986) conducted a study in which 21 seniors participated in telephone group therapy for one hour per week. The treatment goal was to assist seniors to solve problems related to feeling generally dissatisfied with their lives, lonely, or discontent with their activity levels. Three standardized instruments which measured depression, loneliness, and life satisfaction were administered before and after treatment. At the end of the eight week treatment period, only 3 seniors reported minimal goal achievement; 2 reported partial goal attainment, and 16 reported that their goals had been achieved. Most of the goals established by participants related to reducing their dependence by either increasing their activity level, or changing their attitudes about physical and emotional dependence. The post-treatment measure of loneliness showed that there was an overall significant decrease in perceived loneliness, and this change remained stable at the three month follow-up period. Little change in both life satisfaction and depression was noted over time. The authors speculated that the instruments may not have been sensitive enough to measure change, or alternately, group telephone counselling was simply not an intense enough intervention for this group. This study was one of the few which attempted to objectively measure client changes in specific areas.

Griffin and Waller (1985) reported on the use of group therapy with seniors who had a primary diagnosis of depression, in addition to other psychiatric disorders. Their study findings were based on clinical observations. The purpose of therapy was to maintain

or enhance older adults' capacities despite loss and change. They stressed that there were numerous advantages in using a groupwork approach over an individual one, and observed that older adults responded favorably to group therapy. With the development of trust between group members, followed the ability to explore painful emotions and life experiences. With time, members became quite open, self-disclosing, problem-solving oriented, and supportive of one another. Group process tends to be very smooth. Attendance was consistently high, disrupted only by weather, illness, or vacation. Griffin and Waller concluded that "...group treatment has helped older adults to be less depressed and to function at a higher level emotionally as well as socially and interpersonally...the program is helping to limit the severity of regression in response to life stresses" (p.269-70).

Rosen and Rosen (1982) used a quasi-experimental design to evaluate the effectiveness of group therapy with seniors who attended a local seniors' centre. Both comparison and control group were available. Several therapeutic groups were fun simultaneously, to accommodate as many seniors as possible. Sixty-eight seniors participated in a given therapy group for 40-49 sessions, over a period of 12-15 months. Pre- and post-test measures were administered to assess individuals' social, psychological, and physical functioning. The results showed that group therapy participants displayed substantial increases in social and non-social activities, morale, and self-satisfaction. Perceived loneliness was found to be reduced, although not

significantly. Ratings by both group leaders and senior centre staff confirmed that 89% of the group therapy participants made at least some improvements in the areas of interpersonal relations, self-esteem, and ability to cope with age-specific problems. By the end of group therapy, participants were functioning at a level identical to the comparison group. In contrast, seniors in the control group showed little improvement in the same areas, or deterioration.

Rosen and Rosen (1982) contended that group members' increased participation in activities, and their increase in morale and self-esteem, were directly related to their involvement in group therapy. They speculated that involvement in the group resulted in a decrease in seniors' perceived social isolation, and that this was associated with an increased willingness to try new activities and learn new social skills. An increase in self-esteem and morale followed.

A descriptive report based on clinical observation, involving the use of psychodynamic group therapy with older women, was provided by Shulman (1985). Her results were based on a six-year case study with women who had experienced many early losses, were unable to tolerate sadness, and utilized negative defense mechanisms. Shulman summarized the various benefits of using a groupwork approach. She reported that as a result of her clients' involvement in group therapy, members became increasingly supportive of one another, and increasingly altruistic. In addition, their physical symptoms and the number of visits to

medical services were reduced, their coping skills were enhanced, and their functioning outside of the group was improved or stabilized. Unfortunately, Shulman did not formally evaluate the impact of group therapy.

Both Babins (1988) and Barry (1988) reported that their use of group therapy with seniors had a positive impact with seniors. There were numerous other reports pertaining to group therapy with the elderly which supported the argument that this approach was an effective one.

Limitations of Studies Examining Groupwork with Seniors

The studies which examine the use of a groupwork approach with seniors in multiple problem areas, suffer from the same problems as do those that deal with group therapy and elderly chemical abusers. Methodological problems such as the lack of control groups, small study samples, and voluntary participation by seniors, are a few of the problems. Most of the reports are anecdotal. Very few have used formal evaluation techniques to measure pre- and post-treatment changes in seniors' functioning. Finally, specific outcomes tend to be reported on the basis of the overall group: this fails to provide enlightenment as to which seniors did not benefit from group treatment, and why. It may be that for some individuals, a groupwork approach is not the treatment of choice. It would be helpful to know if there are individual characteristics which are associated with greater or lesser benefit from group therapy.

Regardless of the problems inherent in the studies reviewed,

the preceding examination of the literature lends credibility to the argument that using a groupwork approach with seniors appears to be effective. The literature review also serves to highlight what we do know about the use of group therapy with this age group. Our knowledge in this area can be summarized under three main headings: (1) rationale for an elder-specific approach to groupwork, (2) practical considerations when conducting groups with seniors, and (3) benefits versus drawbacks of a groupwork approach.

Rationale for an Elder-specific Approach to Groupwork

Many studies supported the argument that group therapy with seniors was most effective when it was used in groups composed specifically of elderly individuals (Atkinson, 1984; Zimberg, 1978; King, Altpeter, & Spada, 1986; Ruyle, 1987; Sumberg, 1985; Hinrichsen, 1984). Several reasons for using an elder-specific approach were presented. Atkinson (1984) and Zimberg (1978) argued that the technique of confrontation was less frequently required with elderly chemical abusers than it was with younger individuals. They reported that the use of supportive techniques, rather than confrontation, was more conducive in effecting change with seniors and for this reason, supported the use of an elder-specific approach. Zimberg (1978) also stated that in order for treatment to be effective, it had to be directed at age-related social and psychological stresses. King, Altpeter, and Spada (1986) argued that seniors were more likely to share personal feelings and past experiences in groups where topics were relevant to their own age. Thirdly, the physical distress associated with alcoholism was found

to be less prevalent among the elderly because of their decreased tolerance to alcohol (Zimberg, 1978). If seniors and younger adults participated in the same treatment group, seniors might have difficulty relating to the health problems which younger alcoholics often faced as a consequence of their chemical use (Zimberg, 1978). Likewise, younger adults might have difficulty relating to seniors. Sumberg (1985) and Hinrichsen (1984) also argued that elder-specific groups were the most beneficial when one used a group treatment approach with chemically dependent seniors.

Practical Considerations in Conducting Groups with Seniors

(1) Seniors often experienced a high level of anxiety about participating in groups, especially in the initial sessions (Ruyle, 1987; Burnside, 1978). In order to alleviate some of this anxiety, Ruyle (1987) suggested that group sessions should be fairly structured. Presumably, the need for structure would decrease as members became more comfortable with the group.

(2) Effective groupwork with seniors often required that the group leader take an active role in facilitating self-disclosure by members (Capuzzi & Gross, 1980; Burnside, 1978; Ruyle, 1987).

(3) It was important that meeting rooms be wheelchair accessible (Dunlop et al., 1982; Capuzzi & Gross, 1980). Fluctuations in temperature and noise, uncomfortable furniture, poor lighting, stairs, and slippery floors had to be avoided (Capuzzi & Gross, 1980). Because hearing and sight deficits were common in this age group, group leaders and members were required to speak slowly and distinctly, and use large print for any written material (Dunlop

et al., 1982; Capuzzi & Gross, 1980).

(4) Scheduling meetings during the daytime was preferable over nighttime meetings because seniors were often reluctant to travel at night (Dunlop et al., 1982). It was important that the treatment site was centrally located and accessible, because the elderly often had difficulty arranging transportation (Ruyle, 1987).

Benefits versus Drawbacks of a Groupwork Approach

There were numerous benefits in using a groupwork approach with seniors, as opposed to an individual approach:

(1) groups were both time-efficient (Zimberg, 1982; Griffin & Waller, 1985; Rosen & Rosen, 1982) and cost-effective (Rosen & Rosen, 1982).

(2) groups permitted a sharing of experiences and feelings among peers (Zimberg, 1982; Ruyle, 1987) which tended to reduce members' feelings of isolation.

(3) groupwork was found to be a powerful tool in increasing clients' motivation to change their chemical use behavior (Levine & Gallogly, 1985) and dysfunctional behaviors in general (Capuzzi & Gross, 1980).

(4) participation in groups allowed seniors to both give and receive support; this often increased their self-esteem (Barry, 1988; Griffin & Waller, 1985; Rosen & Rosen, 1982; DeBor et al., 1983; Zimberg, 1982; Capuzzi & Gross, 1980; Saul & Saul, 1988-89; Shulman, 1985). Experiencing mutual aid also resulted in improved interpersonal relationships with seniors' significant others

(Griffin & Waller, 1985; Hinrichsen, 1984; Zimberg, 1982; Shulman, 1985; Rosen & Rosen, 1982; Capuzzi & Gross, 1980).

(5) groups served as a forum for teaching seniors how to disclose feelings (Dunlop et al., 1982; Ruyle, 1987; DeBor et al., 1983; Saul & Saul, 1988-89).

(6) groups allowed seniors to share problem-solving and coping strategies with one another (Ruyle, 1987; Hinrichsen, 1984; Griffin & Waller, 1985; Shulman, 1985; DeBor et al., 1983; Saul & Saul, 1988-89; Weiner & Weinstock, 1979-80; Rosen & Rosen, 1982).

(7) groups allowed seniors to meet others, and thus expand their social networks (Shulman, 1985; Dupree et al., 1984; Ruyle, 1987; Rathbone-McCuan, 1987; Mishara & Kastenbaum, 1980; Sumberg, 1985; Rosen & Rosen, 1982; DeBor et al., 1983; Griffin & Waller, 1985). A senior's distribution of attachment feelings among several individuals helped to cushion him/her from future losses (Shulman, 1985; Sumberg, 1985).

(8) participation in a group tended to increase the development of insight into personal chemical use behavior, by allowing seniors to listen to and share experiences with peers who had faced similar problems (Hartford & Thienhaus, 1984). The development of insight into personal behavior in general was also facilitated (Barry, 1988; Griffin & Waller, 1985).

(9) participation in a group tended to increase seniors' ability to understand their own attitudes and defense about chemical dependency by seeing peers' attitudes and defense (Ruyle, 1987; Sumberg, 1985).

Zimberg (1982) discussed two drawbacks of using a groupwork approach:

(1) because several individuals shared a given session, group leaders were often unable to get as much detailed information from group members which would permit targeted interventions.

(2) group therapy tended to remain at a more superficial level than individual therapy.

The literature clearly shows that the advantages of using a groupwork approach outweigh the disadvantages. It appears that further examination of the use of groups with seniors is warranted.

Remaining Gaps in Our Knowledge - Recommendation

As mentioned, a review of the literature regarding groupwork with seniors in multiple problem areas, serves to reinforce that groupwork is a promising treatment approach with this age group. It is not yet known however, whether the use of groups is in fact an effective treatment approach with chemically dependent seniors. Very few studies examining the use of this approach with this particular problem area have been undertaken. Those which have attempted to do so suffer from the methodological problems identified earlier in this report. Few studies have made any attempt to empirically measure client change. As a result, the assertion that a groupwork approach with chemically dependent seniors appears to be promising, is at best, a tentative one.

How a groupwork treatment approach with seniors compares with an individual treatment approach, is not known. The writer was unable to find any studies which examined the effectiveness of

group therapy as opposed to individual therapy, with the elderly age group.

Secondly, there are many unanswered questions related to whether groups are beneficial for only certain individuals within the elderly age group, and if so, what the characteristics of these individuals are. That is, who benefits from a group treatment approach? Who does not, and why? Are there certain needs which are best met in a group treatment modality, and others which are best met in an individual treatment modality? If so, what are these needs?

Additional studies examining the use of a groupwork approach with chemically dependent seniors, need to be done. Researchers must make an attempt to design methodologically sound studies, and empirically evaluate client outcomes. Studies which compare the effectiveness of group therapy versus individual therapy with chemically dependent seniors, must also be undertaken. Characteristics of seniors who appear to benefit from group treatment versus those who do not, must be identified. This would allow one to identify preferred treatment methods, and direct seniors to the treatment modality most appropriate for their needs.

The following chapters outline the writer's practicuum experience with a groupwork approach which was used to treat chemically dependent seniors. Empirical measures of client outcome were made. One of the objectives of the practicuum was to obtain a better understanding of the effects of treating chemically dependent seniors in a group format.

Endnotes

1. A **chemical** is any substance which has a mood altering effect. Within the elderly age group, chemicals which are most frequently abused include alcohol, over-the-counter medications, and various types of prescription drugs.

2. Chemical **abuse** is defined as non-warranted, intentional use of a chemical to cause intoxication or a "high" (Atkinson, 1984).

3. Chemical **dependency** is defined as: "An illness where dependence upon mood altering substances has attained such a degree as to disrupt academic or work performance, interfere with family and interpersonal relationships, disrupt smooth social and economic functioning, and impair the state of physical and/or mental health" (Alcoholism Foundation of Manitoba, 1985).

CHAPTER 2 - INTERVENTION

The current chapter describes a group intervention method with chemically dependent seniors. The Elders Health Program, located at 403 - 400 Tache Ave. in Winnipeg, Manitoba, provided both the setting in which the intervention was carried out, and the treatment model which formed the basis of the writer's intervention.

History of the Elders Health Program

The Elders Health Program, a demonstration project, was established in September, 1987, and ended in the fall of 1990. It was initiated by the Departments of Social Work and Geriatric Medicine at the St. Boniface Hospital. The goals of the program were to: (1) develop an efficient, easily administered screening procedure to identify chemical dependency in the elderly, and (2) develop and evaluate an age-specific method of intervention and treatment for chemically dependent seniors.

Related to the second goal, a groupwork approach was selected as a major component of treatment. The goals of group treatment, as identified by the Elders Health Program, were to: (1) establish responsible use of mood altering medications, (2) maintain abstinence from alcohol, (3) increase each group member's sense of life satisfaction, and (4) reduce negative biological/psychological/sociological consequences of aging and chemical dependency. The overall group purpose was to provide a therapeutic group atmosphere that would create an opportunity for chemically dependent seniors to begin to explore issues related to chemical dependency, and improve the quality of their lives.

For several years, the writer had provided social work services to chemically dependent adults and adolescents, but had not had any exposure to seniors experiencing chemical abuse problems. Certainly in Manitoba, the Elders Health Program provided leadership in the area of treating chemically dependent seniors, and since the writer had an interest in working with the elderly, she approached Elders Health with a proposal to carry out her practicuum with their clients. Since the Elders Health Program had been funded as a demonstration project, and funding was about to terminate, an opportunity arose in the spring of 1990 which allowed the writer to facilitate a final treatment cycle for seniors, from the Elders Health Program's location.

Professional Learning Objectives

(1) to develop groupwork skills related to elder-specific groups.

(2) to gain knowledge about seniors and the unique issues they face related to their life cycle stage

(3) to become more effective at providing social work services to seniors at a group level.

Practicuum Objectives

(1) to provide treatment to chemically dependent seniors in a group format.

(2) to compare outcome of therapy in specific areas of functioning.

(3) to replicate a similar study completed by the Elders Health Program.

Practicuum as Replication of a Previous Study

A previous study conducted by the Elders Health Program had demonstrated that seniors' chemical use stabilized after completion of a group treatment program (D. Kostyk, personal communication, November 7, 1990). One of the writer's practicuum objectives was to determine whether a similar improvement in seniors' chemical use behavior would occur if a different group leader facilitated the same treatment package as that used by the Elders Health Program.

Replication has been defined as a repetition of a research study using the same procedures but on a different sample or in a different setting (Rose, 1982). Several researchers have noted that if the main findings of a study can be replicated by using identical procedures to those used by the original study, one can feel more confident about the validity and generalizeability of the findings (Babbie, 1979; Smith, 1975; Rose, 1982). Menzies (1982) has noted, however, that replication of a study cannot be expected to produce identical results because any new social setting will result in some outcome changes.

The writer predicted that similar (but not identical) positive changes in clients' chemical use would be observed as had been in the previous study. If this indeed occurred, one could feel more confident that the original Elders Health Program findings were valid and not simply due to chance.

Rationale for Providing Service to Chemically Dependent Seniors

The premise on which service provision to seniors is based proposes that seniors are capable of making both attitudinal and

behavioral changes. The elderly will be more likely to change their behavior if they see the benefits of change, if they have direction and support in making changes, and if they believe that change is possible.

The premise which holds that the elderly are capable of making positive changes in their lives is clearly supported by the literature. Erikson (1980) recognizes the older person's capacity to grow and adapt to the aging process in a healthy manner. Butler (1980) supports this belief by stating that: "Old age is a period where there is unique developmental work to be accomplished...optimum growth and adaptation may occur all along the course of life..." (p.355). Butler's statement supports a developmental view of aging, which views the elderly as remaining engaged in life insofar as their capacities allow. The developmental view of aging fits with the writer's premise that the elderly are capable of making positive attitudinal and behavioral changes.

The reader is referred to the literature review in chapter one which points to the chemically dependent seniors' capacity to make positive changes related to their chemical use behavior. Along with a change in chemical use behavior, are noted changes in seniors' level of participation in activities and relationships, self-esteem, and feelings of depression and loneliness.

Description of Practicuum Setting

The Elders Health Program, which served as the practicuum setting, is centrally located in Winnipeg, and is easily accessible

from most areas of the city. The Program's offices are situated on the fourth floor of a medical building. The building is wheelchair accessible. The room in which the treatment groups meet is spacious, and in close proximity to a washroom. The room is comfortably furnished.

Source of Client Referrals

Seniors were referred to the writer's treatment group in a variety of ways. Two seniors had heard about the Elders Health Program through a special television presentation, and had referred themselves. One was referred by her family physician. Two were referred via a hospital's chemical withdrawal unit. One was referred via an Employee Assistance Program. Another senior was referred by his social worker at the seniors' housing complex where he lived. With the exception of those seniors who self-referred, an initial assessment of a chemical abuse problem had already been completed by the referring agency at the time of referral to the treatment group. Most often, the expression of concern on the part of someone else provided the impetus for the senior's willingness to participate in treatment.

Treatment Group

1. Length of Treatment Cycle - the treatment cycle consisted of 36 sessions, held over a period of 12 weeks (April 18 to July 20, 1990). The group met on Mondays, Wednesdays, and Fridays, from 10:00 a.m. to 12:00 noon, with the exception of holidays.

Adult treatment programs have generally ranged from three to six weeks in duration. Besides the practical need to structure

the treatment program after the Elders Health Program model and thereby replicate their study, the rationale for providing seniors with a relatively lengthy treatment program can be found in the literature. Hinrichsen (1984) reports that seniors who have participated in treatment programs have identified the need to lengthen all phases of treatment. One report (Anonymous, 1975) suggests that group therapy with seniors should continue for three to six months. Atkinson (1984) and Small (1984) state that treatment programs for seniors must be lengthy because the tempo of response among seniors is much slower than with younger individuals. It has also been argued that in order for treatment goals to be met, the timespan required to treat seniors must be lengthened because the elderly often need more time to integrate new information (King et al., 1986).

It was noted in the previous chapter that substance abuse often has a negative effect on cognitive functioning. One could argue that the effects of natural aging processes, combined with the effects of substance abuse, can have a significant impact on cognitive functioning. This further substantiates the need for a relatively lengthy treatment period.

2. Open-ended Group - the treatment group was open-ended, that is, seniors were allowed to begin treatment as late as five weeks after the treatment cycle had begun. The cut-off point of five weeks was established because this group, as already mentioned, was to be the final one available from the Elders Health Program offices. It was felt that seniors who joined the group more than

five weeks into treatment would be unlikely to benefit from the limited, remaining time in treatment. Had the treatment groups been continuing, no cut-off entry period would have been drawn, and seniors would have been allowed to begin treatment at any point in the cycle.

There are clear advantages in using open-ended treatment groups, rather than closed groups:

(a) seniors in need of treatment can begin immediately, rather than having to wait until the next treatment cycle begins. It is important that once an individual has agreed to accept treatment, treatment is immediately available (Johnson, 1986). If there is a lengthy wait to begin treatment, individuals' motivation to participate in the process will likely decrease (Alcoholism Foundation of Manitoba, 1985).

(b) chemically dependent seniors may be unable to maintain abstinence for any length of time without formal support; open-ended groups allow seniors to access formal support quickly, and stay connected with this support as long as they need to in order to stabilize their chemical use (Ruyle, 1987; Levine & Gallogly, 1985).

(c) the use of an open-ended group allows the group to be composed of seniors in various stages of recovery (Ruyle, 1987). This is advantageous in that new members have the opportunity to learn from those who have already begun to make chemical-free lifestyle changes. Likewise, seniors who have been in treatment for some time may be encouraged to continue their own recovery efforts when

they see new members who remind them of the often debilitating consequences of chemical use.

The main disadvantage in using an open-ended group is that group cohesion tends not to develop as quickly as it does in a closed group. Group dynamics are effected whenever a new member enters an established group (Corey & Corey, 1977; Hartford, 1971).

Open-ended groups thus have several advantages over closed groups. For this reason, it was decided that the current treatment group would be an open-ended one, similar to the groups previously facilitated by the Elders Health Program staff in their study.

3. Use of Peer Counsellor as Co-facilitator of the Group -

A male peer counsellor co-facilitated the treatment group in conjunction with the writer. He had maintained long-term abstinence from chemicals, and had co-facilitated the treatment groups in the previous Elders Health Program study. The role of the peer counsellor involved sharing his own experience regarding chemical dependency and recovery issues. It was hoped that through this sharing, group members' feelings about their own substance abuse problem and the struggles pertaining to recovery, would be validated. The peer counsellor also offered practical suggestions to members when appropriate. In addition, he served as a role model, in two primary ways:

(1) he often opened discussions and thereby gave group members permission to talk about emotionally-laden issues, and (2) he provided group members with a sense of hope that recovery from chemical dependency was possible. Talking openly about his own

substance abuse problem and attempts at recovery served to provide group members with a tangible picture of recovery.

Tasks related to planning and structuring group sessions remained the primary responsibility of the writer.

A peer counsellor is an individual who is approximately the same age as clients, and who has experienced similar problems. Based on the literature, it appears that the use of peer counsellors in treatment groups is beneficial. Sumberg (1985) notes that: "The most successful education about alcoholism and its effects on the older person is probably carried out by a recovered elderly person in conjunction with a social worker trained in alcoholism education" (p.173). He goes on to say that the hope offered by the recovered person, and the social worker's knowledge of what to do and how and where to access resources is an effective combination in treatment. The benefits of using peer counsellors in the treatment of chemically dependent seniors have also been noted by Rathbone-McCuan, (1987) Hinrichsen, (1984) and Kaufman (1983).

There are also potential problems related to the use of peer counsellors in professional settings. Clark (1987) has addressed the possibility of conflict between the peer counsellor's approach and that of the professional's.

Treatment Package

The treatment package used in the practicuum was developed by the Elders Health Program. There were no changes made pertaining to the focal topics of each session, or the order in

which these topics were addressed during the treatment cycle. The task of replicating the previous study required that the identical treatment package be delivered.

Of the three group sessions held each week, two were pre-planned, and focused on a specific topic (see Appendix A for an outline of the group sessions). In total, there were 24 "specific-topic" sessions. In contrast, the topics for the Wednesday group meetings were not pre-determined. Group members were encouraged to take responsibility for deciding how they wished to use this session. Altogether, there were 11 "open forum" sessions.

The "specific-topic" sessions formed the basis of the treatment package, and incorporated two major components of substance abuse treatment: (1) education, and (2) group psychotherapy. Although individual sessions could be categorized as predominantly educative or therapeutic, in actuality, both treatment components were visible in any given session. No session remained exclusively focused on education or therapy.

Incorporating components of both education and psychotherapy in the treatment of chemical dependency has been legitimized (Ruyle, 1987). Education seeks to provide individuals with factual information related to substance abuse problems. Educating individuals about chemical dependency is most frequently the goal during the initial stage of treatment (Johnson, 1986). Focusing on education in the initial stage of treatment facilitates a "low risk" entry for clients, as they are not expected to discuss highly emotional issues when they first enter the treatment group

(Alcoholism Foundation of Manitoba, 1985). Most commonly, the group leader provides members with information about the illness of chemical dependency, its signs and symptoms, and its effect on various life areas. The teaching method is often a dydactic one (Johnson, 1986) and the group leader normally takes a fairly directive role.

The objectives of educating individuals about chemical dependency are twofold:

(1) by providing group members with factual information, in a non-judgmental manner, it is hoped that they will be able to examine their own use of chemicals, and accurately assess whether they themselves are chemically dependent (Johnson, 1980). An individual cannot assess whether a problem exists if he/she lacks information regarding the signs and symptoms of a chemical abuse problem.

(2) teaching group members that chemical dependency is an illness tends to lessen their feelings of shame and embarrassment regarding their chemical use, and sets the stage for more openly discussing their use in group sessions (Alcoholism Foundation of Manitoba, 1985).

Education as a major treatment component is necessary throughout the treatment process. Often, group members require factual information about the effects of certain prescription drugs, or about a drug's potential to induce dependency. By simply providing clients with factual information, individuals' chemical use behavior may be altered, or further problematic use avoided.

Psychotherapy, like education, is an integral component in

the treatment of chemical dependency (Johnson, 1986; Alcoholism Foundation of Manitoba, 1985). Group psychotherapy has been defined as "...regularly scheduled, voluntarily attended meetings of acknowledged clients with an acknowledged trained leader for the purpose of expressing, eliciting, accepting, and working through various aspects of the client's functioning, and developing the client's healthier and more satisfying potentials" (Maynard, 1980, p.232).

Thus, the goal of group psychotherapy, as defined by Maynard, is relatively broad and closely parallels the goal of chemical dependency treatment. Chemical dependency is viewed as not simply a chemical use problem, but as a living and feeling problem (Alcoholism Foundation of Manitoba, 1985). As such, one of the goals of providing treatment is to help individuals who are experiencing this problem to identify past negative cognitive, affective, and behavioral patterns, so that these patterns can be changed in a way that facilitates ongoing sobriety. Becoming aware of oneself is critical if one is to change longstanding, negative patterns of coping. The use of psychotherapeutic techniques facilitates the development of insight, and sets the stage for behavior change (Storr, 1988).

A warm, positive, and accepting relationship between the therapist and client is critical in psychotherapy (Storr, 1988; Leszcz, 1987; Pitt, 1982; Debor et al., 1983). Specific techniques which are identified by the literature as key techniques in psychotherapy include: (1) providing reassurance and guidance,

(2) facilitating clients' identification of their feelings,
(3) interpreting clients' feelings and behaviors, and
(4) confrontation. Psychotherapy, unlike education, allows the practitioner to take on an increasingly non-directive role.

The literature overwhelmingly supports the effectiveness of using psychotherapeutic techniques with elderly clients in both an individual and group treatment modality (Storr, 1988; McGee & Lakin, 1977; Shulman, 1985; Debor et al., 1983; Maizler & Solomon, 1976; Ruyle, 1987). Thus, group psychotherapy is viewed as an important and effective component of treatment with seniors. Its incorporation as a major treatment component with chemically dependent seniors, is appropriate.

As mentioned, components of both education and psychotherapy were adopted in the current treatment package. Although techniques related to both an educative and therapeutic approach were found in any given group session, "specific-topic" sessions could be broadly classified as predominantly educative or therapeutic by focusing on the goal(s) of the session. The following sessions were viewed as primarily geared towards education: #'s 1, 2, 3, 5, 6, 8, 9, 30, 32, 33, 35 (see Appendix A). The goal of the initial sessions was to provide group members with information regarding the effects of chemical dependency on various life areas. Near the end of the treatment cycle, information regarding available resources which would support ongoing sobriety, was provided. The following sessions were viewed as primarily geared towards therapy: #'s 11, 12, 14, 15, 17, 18,

20, 21, 23, 24, 26, 27, 29 (see Appendix A). The overall goal of these sessions was to enable group members to identify how their use of negative coping strategies to deal with uncomfortable feelings and stressful events had effected them, and to facilitate their adoption of more positive coping strategies.

An actual transcript of one particular group session, entitled "Guilt and Shame", can be found in Appendix B. This session was focused primarily on therapy, although it is clear that the group leader also took on an educative role at times.

Roles of Group Leader

The writer as group leader filled multiple roles throughout the treatment period and within any given session. Specifically, five major roles were identified: educator, therapist, referral agent, advocate, and provider of information.

(1) the writer attempted to **educate** group members about the illness of chemical dependency, its signs and symptoms, and its effects on various life areas.

(2) as a **therapist**, the writer facilitated group members to identify and understand their own feelings regarding their chemical use behavior. Another goal of therapy was to help group members see that their chemical use had become a predominant method of coping with day-to-day problems, uncomfortable feelings, and often highly stressful life events. Two sessions which focused specifically on loss attempted to help seniors identify unresolved losses, and to facilitate the delayed grieving process. Throughout sessions, group members were encouraged to identify their

strengths, in an effort to build self-esteem.

(3) as a referral agent, the leader made referrals to a variety of community resources throughout the treatment phase. Where appropriate, group members were referred to physicians, residential alcohol/drug treatment programs, geriatric psychologists, seniors' centres, and other community agencies.

(4) the group leader acted as client advocate on several occasions. One situation in which an advocate role was played involved phoning a group members' doctor, at her request, after her doctor had verbalized anger towards her for wanting to discontinue her anti-depressant medication. In another situation, the group leader contacted a group members' social worker at the housing unit in which he lived, to advocate for continued investigation into the aggravation caused to the client by another tenant.

(5) information was provided to seniors on an on-going basis wherever possible. Group members were given basic information about the pharmacological effects of various medications, including their side-effects. Information about their rights in a patient-physician relationship, where seniors' resources were located and what services they offered, are other examples of the type of information provided.

Group Process

A great deal has been written regarding stages of group development, and some of the typical tasks and issues which groups tend to struggle with depending on their phase of development (Hartford, 1971). One particular model of group development has

been proposed by Corey and Corey (1977). Although they caution that it is somewhat arbitrary to divide a group's history into stages because the borderline between stages is often blurred, Corey and Corey define six phases of group development: (1) initial, (2) transitional, (3) working, (4) final, (5) evaluation, and (6) follow-up. For the purpose of examining the writer's practicuum group, it is useful to use Corey and Corey's model of group development as a guide for discussion. Because stages five and six are post-group phases, the following discussion will focus on the first four stages of group development.

(1) **Initial** - in the initial phase of group development, members' expectations of the group must be clarified. Structuring of the group must occur early on in its life.

Expectations around confidentiality and attendance need to be clarified, and group norms established. In most groups, resistance on the part of at least some group members must be addressed. Issues related to trust, and power and control must also be dealt with. According to Corey and Corey, the primary task of the group in its initial stage of development is to determine whether members can form a group, and if so, how they will work together.

In the initial stage of the writer's treatment group, many of the tasks as outlined by Corey and Corey were accomplished. During the first session, members and facilitators took time to introduce themselves, and to share with the group what their expectations were. Group members were asked for their input into

establishing group norms, in an effort to promote each members' sense of group ownership. Once group norms were established, both members and co-facilitators struggled to stay within the boundaries of these norms. Although some of the members quickly showed that they trusted the group by sharing very personal information about themselves, several chose to remain guarded in the type of information they shared. The writer attempted to maintain a balance between encouraging members to share information, and allowing each individual to take the time he/she needed to feel comfortable in doing so. Group members tended to direct most of their comments to the two facilitators, rather than to each other.

During the initial stage of the group, most of the sessions were educational. As previously mentioned, this facilitated a "low risk" entry for group members. While some of the members shared personal experiences regarding chemical use and its effect on their lives, others were more resistant to doing so. Because the primary goal of these sessions focused on education, resistance on the part of group members to discuss their personal experiences did not detract from the sessions. Rather, it gave these members more time to feel comfortable in the group before being asked share increasingly personal information.

(2) **Transitional** - the transitional stage of group development immediately follows the initial stage. Many of the characteristics of these stages are similar. Group members must continue to define how they will work together. Issues related to trust, and power and control, may continue to surface. New tasks must also be

accomplished. Since the transitional stage precedes the working stage in which the group tends to deal with very personal and highly emotional issues, group cohesion must begin to become visible during this stage. Corey and Corey identify cohesion as an essential characteristic of a group, and state that it results from group members actively working together to develop unifying bonds. In the transitional stage, group norms should be firmly established, and if the group is to accomplish its work, members' roles as well as group goals must be clear.

During the transitional stage of the treatment group, the writer attempted to facilitate the development of group cohesion by consistently encouraging all group members to share their own experiences relating to chemical use and its effect on their lives. Group members were also encouraged to talk to one another as much as to the co-facilitators. Goals of the group needed to be clarified and reinforced in an effort to keep the group focused.

(3) **Working phase** - if a group has reached the working stage of development, group members will begin to actively search for and practice new behaviors, to replace those which they perceive as requiring change. Group leaders must recognize that members themselves are responsible for their lives. Key issues which the group must resolve if they are to continue working in a positive manner, include such issues as disclosure versus anonymity, honesty versus game-playing, spontaneity versus control, acceptance versus rejection, cohesion versus fragmentation, and responsibility versus blaming. Corey and Corey suggest that if the group seems very

resistant and productive work is occurring slowly, the group leader may need to confront the group on his/her perception and clearly state what this perception is based on.

It was during the working stage of the treatment group that the co-facilitators attempted to shift the group from a focus of "what is the problem?", to "what can be done about the problem?", particularly in the area of chemical use. Group members were also helped to differentiate between problems over which they had control, and those over which they did not have control. Alternate ways of coping with uncomfortable feelings and stressful events were identified, and as group members began to test new behaviors, they were encouraged to continue their efforts. The co-facilitators tried to avoid telling group members what to do; instead, the group was encouraged to brainstorm a number of action plans and determine the costs and benefits of each plan. The writer encouraged group members to identify unresolved issues in their lives, and share these issues within the group. Several group members came to the realization that they carried serious unresolved issues, such as the death of a spouse, ongoing conflict with adult children, or guilt related to an earlier event in their life. These unresolved issues, for the most part, were identified and discussed in the group during the working phase, when group cohesion and a sense of trust between members had been established.
(4) Final - Corey and Corey identify the final stage of a group as vital. During this time, members have an opportunity to clarify the meaning which the group has had to them, and to consolidate the

gains they've made. As group members sense that the group is approaching termination, there is a danger that members will begin to withdraw prematurely. For this reason, Corey and Corey stress that it is important for group leaders to help members put into perspective what has occurred in the group. Members must be given an opportunity to talk about what the group has meant to them, and share both positive and negative feedback concerning their membership in the group. Feelings of loss which may be precipitated by the group's impending termination, must be addressed. The group leader may need to assist members to face the reality of termination, and facilitate their saying good-bye to the group.

In the practicuum group, the final sessions focused on identifying and discussing resources and supports which group members could use on an ongoing basis to support a chemical-free lifestyle. The writer attempted to shift the focus from one of "how can we support each other here?" to "how can we find support for ourselves outside of this group?". For several members, a very real concern was related to how they would fill their time, previously taken up by attending the treatment group, in other ways. Education about leisure activities, ongoing groups for chemically dependent seniors, and other programs was undertaken in an attempt to help group members access other resources. Altering the primary focus of the sessions from a therapeutic to an educational one also allowed members to leave the group on an emotionally lower-key level.

Several group members verbalized feelings of loss related to the group's termination. For one member in particular, anger and sadness were predominant emotions when she verbalized how she felt about the group ending. The writer attempted to validate group members' feelings about termination by encouraging them to take as much time as they needed to talk about what termination meant to them. At the same time, members were reminded of the positive gains they had made, and encouraged to plan how they would make additional gains by accessing new resources.

CHAPTER 3 - ASSESSMENT AND EVALUATION

The current chapter provides a description of the seven core treatment group members. The assessment procedures related to clients' chemical use and functioning pre- and post-treatment, are described. Procedures used to evaluate group process and leadership are outlined, and results presented. A discussion of the results of the assessment and evaluation procedures concludes the chapter.

CLIENTS

Seven seniors entered the treatment group within the first five weeks of the treatment cycle, and regularly attended treatment sessions one to three times per week thereafter. An eighth individual joined the group, but dropped out after three sessions. The seven remaining seniors formed the basis of the core client group, and were included in the assessment and evaluation procedures. The writer obtained written consent from new members, upon their entrance into the group, to participate in the treatment group. (see Appendix C for a copy of the consent form). Five seniors who had participated in the previous treatment cycle chose to continue to attend the group, and were also present for one to two sessions per week. These five seniors, although regular attenders, were not included in the writer's assessment and evaluation data.

(a) **Mrs. L.** - Mrs. L. was a 63 year old Metis woman who referred herself to the treatment group after hearing about the Elders Health Program on a television documentary. She had been taking

two prescribed mood-altering medications sporadically for many years, and regularly for four years: (1)alprazolam, an anti-anxiety medication - .5 mg., one to two times per day (2)triazolam, a sleeping medication - .25 mg., one to one and a half tablets at bedtime. She reported that without the alprazolam, she experienced headaches and dizziness, and that she could not sleep without the use of the sleeping medication. Mrs. L. requested help to discontinue her use of these medications. She suspected that the medications were causing frequent periods of moodiness and sadness, and stated that she often cried "for no reason". She reported that her use of medications had begun many years prior when her children were young, and she was caring for her sick mother who lived with them. Four years ago, she had undergone surgery to remove her gall bladder, and had been unable to return to her full-time job as a homemaker since that time because of chronic stomach pain. At this point, she began using the medications daily, and in fact, found that she had to increase the dosage over time in order to obtain relief from a perpetual feeling of anxiety. She reported also that for many years, she had been a heavy user of alcohol, but in the past two years, drank only on rare occasions.

Mrs. L.'s four adult children were now living on their own. She had been married once, to a man who was physically abusive and alcoholic. He had died 30 years earlier, leaving her alone to raise the children and care for a sick mother. In the previous three years, she had also experienced the loss of two siblings to whom she was close. At the time of her contact with the Elders

Health Program, Mrs. L. was living with her common-law husband of twenty years. She expressed satisfaction with her current relationship.

In addition to her desire to discontinue her medications, Mrs. L. verbalized that she wished to become involved in regular community activities again. She often felt lonely and bored during the day when her husband was at work, although she spent a great deal of time with both her husband and children in the evenings. She reported that the only regular daytime activity she had was making lunch for one of her grandsons.

Mrs. L. presented as a soft-spoken, rather timid individual. The writer first interviewed her in her home in April, 1990, and she agreed to attend the treatment group three times per week, beginning a week later.

(b) **Mrs. L.G.** - Mrs. L.G. was a 63 year old woman of French background. She was referred to the Elders Health Program through her employer, via an Employee Assistance Program. Her employer had become increasingly concerned that her alcohol use was interfering with her job performance as a cafeteria worker. Mrs. L.G. admitted that she consumed alcohol daily because it helped her to sleep, but denied that her use was interfering in any way with her part-time job. She reported that she also had a prescription for trazodone (100 mg.), an anti-depressant medication, which she rarely took during the daytime because it made her sleepy. On odd occasions, she used the medication at nighttime. She verbalized that she wanted to reduce her alcohol consumption, mainly because of the

cost, but felt angry and resentful towards her employer for "forcing her" to attend the treatment group.

Mrs. L.G. reported that she lived with her 78 year old sister, and 26 year old son. She had five other children who lived on their own. She had been married, but her husband had died very suddenly 13 years prior, leaving her with six children to raise and support. Mrs. L.G. stated that prior to her husband's death, she did not drink; her alcohol consumption began shortly after he died. She described her marriage and family life as happy, and viewed the loss of her husband as a major turning point. Her social network consisted largely of family members, both children and siblings. She did not participate in any particular hobbies or activities other than her job and household responsibilities.

When first interviewed in April 1990, Mrs. L.G. presented as extremely nervous, somewhat embarrassed, and angry. She frequently made humorous comments which appeared to be an attempt to relieve tension. She did not identify any changes that she wished to make in her life, with the exception of reducing her alcohol consumption. She reluctantly agreed to attend group sessions, three times per week, beginning immediately.

(c) **Mr. M.** - Mr. M. was an 83 year old man of European background. He was referred to the Elders Health Program in May, 1990, by the Chemical Withdrawal Unit staff at a local hospital. He had been admitted to hospital by his family, who had found him at home intoxicated and disoriented. The staff at the hospital had concerns about Mr. M.'s alcohol use for some time, since he had

been admitted to the Chemical Withdrawal Unit in the past. Mr. M. freely admitted that his alcohol use was causing problems in his life, and verbalized that he wanted to attend the treatment group in an effort to stay sober. He stated that he occasionally used tylenol #2 at nighttime, to help him fall asleep, but did not see this use as problematic.

Mr. M. had emigrated to Canada, from Europe, in the early 1900's. He worked as a superintendent for a local taxi company until his retirement in 1971, and was active with many public organizations throughout his life. He was married, and had five children. His wife of 57 years had died of cancer in 1989. He stated that although he had been a social drinker all his life, it was not until his wife died that his alcohol use became problematic. Mr. M.'s daughter and son-in-law contradicted this information, and stated that Mr. M. had been a problem drinker for at least 10 years prior to his wife's death. Mr. M. relayed that he was close to his children, and had regular contact with all of them. He also reported that he had numerous friends whom he saw regularly, and many interests.

Mr. M. was first interviewed in May 1990. He was very verbal, and spoke proudly of his family and his accomplishments. He displayed a keen sense of humor. He expressed shame and embarrassment regarding his alcohol use, and verbalized that he wished to attend the treatment group two times per week, beginning immediately.

(d) **Mrs. O.** - Mrs. O. was a 66 year old woman who was referred to

the treatment group by staff at a local hospital's chemical withdrawal unit. She had referred herself to the hospital after her family physician refused to prescribe her with any more anti-anxiety medication. She arrived at the hospital displaying numerous symptoms of acute withdrawal including anxiety, feelings of paranoia, insomnia, and headaches. She reported that she had been using various types of sedatives for approximately 30 years. For the past seven years, she had been taking 10 - 14 mg. of ativan per day. The hospital began administering 2.5 mg. diazepam, an anti-anxiety medication, two times per day, and referred Mrs. O. to the Elders Health Program for ongoing treatment and further step-down from her medication. Mrs. O. verbalized that she was addicted to sedatives, and that she wished to continue to make an effort towards discontinuing her use of medications.

Mrs. O. reported that she had married for the first time when she was in her early twenties. She subsequently had a son who died in infancy, and shortly afterwards, her husband also died. She remarried a few years later, and had two more sons. Mrs. O. described her second husband as emotionally abusive, but said she stayed with him while the children were growing up because he offered financial security. She explained that her ex-husband had been a drug user ever since she'd known him, and that he had in fact, hidden drugs in her food and was indirectly responsible for her use of medication. They had separated three years earlier, and were currently divorced. Her ex-husband continued to live in Ontario, where they had resided during their married life. In an

effort to escape her ex-husband's ongoing harassment, Mrs. O. had moved to Winnipeg shortly after their separation. Neither of her children resided in Manitoba. She reported that the only people with whom she maintained regular contact was an elderly sister who lived in California, and her two sons. With the exception of a few acquaintances, Mrs. O. knew no one in Manitoba. Although she lived in a seniors' housing complex, she did not wish to establish friendships with any of the other residents because she did not feel that she had anything in common with them. Mrs. O. had worked as a hairdresser for a number of years, and most recently, as a homemaker for Red Cross. She had stopped working when she moved to Winnipeg.

The writer first interviewed Mrs. O. in May, 1990, while she was still in hospital. She was very verbal, and expressed enthusiasm about attending the treatment group three times per week, beginning two days later. Besides wanting to discontinue her use of medications, Mrs. O. also expressed a desire to become involved in community volunteer work, and establish friendships with people her own age.

(e) **Miss H.** - Miss H., a 76 year old woman, was referred to the treatment group by her family physician, upon her discharge from the hospital. She had been admitted to hospital with an analgesic overdose. Her family physician reported that he had been concerned for some time about Miss H.'s use of alcohol, and a variety of over-the-counter and prescription medications. Miss H. stated that her use of alcohol had been problematic for a number of years and

that she had in fact received treatment for alcoholism in the past. At the time of her referral, she had discontinued her use of all mood-altering medications, and expressed a desire to maintain abstinence from alcohol.

Miss H. never married. She was born in Manitoba, but moved to Ottawa while she was young. She worked as a civil servant until her retirement. Miss H. moved back to Winnipeg in 1989, after having had a heart attack which resulted in a minimal degree of cognitive impairment. Both a cousin and a nephew who resided in Winnipeg, whom she was close to, convinced her that she should return to Manitoba. She stated that she did not yet have any close friends in Winnipeg, and often felt lonely. However, she was beginning to become more involved in activities at her senior's complex, and had met a number of other residents with whom she socialized. She frequently visited with her nephew and his family. Although her health problems restricted the types of activities she could undertake, she frequently organized bingo in her residence, and was an avid reader and bird watcher.

As she had previously been assessed by Elders Health program staff in the fall of 1989, the writer arranged for Miss H. to begin treatment immediately. Another admission to hospital, however, after she attended one session, resulted in her being unable to attend treatment for several more weeks. Regular attendance at the treatment group became possible on June 1, 1990. Thereafter, whenever she was feeling well enough, she attended once a week. Short-term memory impairment was apparent, but she consistently

presented as cheerful, outgoing, and energetic.

(f) **Mrs. S.** - Mrs. S., a 77 year old woman, referred herself to the Elders Health Program after hearing about it on a local television documentary. She stated that she wished to receive help to discontinue her use of surmontil, an anti-depressant, which she had been taking for ten years. She reported that she had thought that the medication was prescribed to help her sleep, and had been taking 100 mg. once a day at bedtime. She felt that her use of surmontil was no longer helping her in any way, and after several of her family members expressed concern about her taking the medication for so many years, she decided that she wanted to try to discontinue her use. A psychiatrist had originally prescribed the anti-depressant for her after numerous tests failed to pinpoint the cause of severe leg pains which she had experienced in 1981. She reported that she had previously asked her family physician to take her off the medication, but he had discouraged this.

Mrs. S. had married at a young age. She and her husband had two sons. Eight years earlier, her husband had died quite suddenly. Mrs. S. reported that since her husband's death, she felt increasingly lonely, and unless her son or one of his grandchildren was available to drive her, she felt confined in her apartment block. She lived alone, although two of her sister-in-laws and a close friend lived in her apartment block.

She reported that she was a housewife all of her adult life. In addition, she spent many years caring for her sick mother, and an elderly uncle and aunt. One of her sons resided in B.C., and they

maintained regular telephone contact. Her second son lived in Winnipeg, and was himself a recovering alcoholic. Although she felt close to him, she stated that their relationship involved a great deal of conflict, particularly during the period in which he had an active drinking problem. She had maintained contact with a few close friends. Although Mrs. S. had been very active in volunteer work with a religious organization, she now felt that it was "someone else's turn". She no longer engaged in any other hobbies or activities to speak of.

Mrs. S. was initially interviewed in April 1990. She presented as somewhat suspicious of the writer and her co-worker. Her affect was flat, and she appeared to be angry. Although she was adamant in her desire to discontinue her medication, and wanted to see the physician at the Elders Health Program to arrange a step-down plan, she was very reluctant to participate in the treatment group, stating that she did not see any need to become involved in any type of group. In the end, she agreed to attend group sessions, one to two times per week, because of the writer and physician's need to monitor her closely during the step-down period.

(g) **Mr. S.** - Mr. S. was an 86 year old man of European background. He was referred to the Elders Health Program by the social worker at the seniors' housing complex in which he resided. His social worker reported that Mr. S. had been found intoxicated on numerous occasions, and frequently disturbed other residents during his drinking episodes. The housing complex had advised Mr. S. that if

another complaint regarding his drinking occurred, he would be evicted. His social worker, a nurse at a day hospital program where he was a patient, and two peer counsellors from the Elders Health Program, under the co-ordination of an Elders Health staff member, performed a structured intervention on Mr. S. and confronted him on his drinking behavior. Although initially denying that he had an alcohol problem, Mr. S. agreed to attend the treatment group.

Mr. S. was born in northern Europe, and emigrated to Canada as a young man. For most of his adult life, he worked as a labourer for Winnipeg Hydro. He and his wife never had children. His wife died in 1988, after a one and a half year confinement in a nursing home. Mr. S. described his marriage as a happy one. He reported that he had been a heavy social drinker for most of his life. When his wife died, he moved into his own apartment in the seniors' housing complex, where he drank regularly with other residents. Mr. S. stated that since his wife had died, he felt that life was meaningless and empty. There were no other family members in Canada, and few friends, in fact, he stated that he had only had one visitor in the previous two years. One remaining brother still lived in Europe. Mr. S. reported that his main activity was walking, but he was afraid to leave his apartment for more than brief periods of time because he was being harassed by someone and his suite had been broken into on more than one occasion.

Mr. S. presented as friendly and cheerful. He was keen on

talking about himself and about the past, although he had a difficult time expressing himself in the English language. He also suffered from a severe hearing deficit, and even with the help of a hearing aid, had difficulty understanding what was said to him. He seemed quite willing to participate in the treatment group, nevertheless, and attended three sessions per week beginning in April, 1990.

METHOD

Assessment and evaluation efforts were aimed at three primary areas: (a) clients' chemical use, cognitive/motor functioning, level of life satisfaction, loneliness, and connectedness with others (b) the group process, and (c) leadership skills.

A number of instruments were used to assess group members' alcohol/drug use, cognitive/motor functioning, feelings of life satisfaction and loneliness, and connectedness with others. All of the instruments used in this study were previously used by the Elders Health study. With the exception of two instruments, all were administered both pre-and post-treatment in order to ascertain whether any changes had occurred during the period of members' participation in the treatment group. An effort was made to administer all instruments to clients within the first two weeks of their entering the treatment group, and again within two weeks following completion of the group. Unfortunately, pre-test administration of the instruments occurred as late as three weeks

after group entry, for three of the clients. Health problems, scheduling difficulties, and for one client, a reluctance to initially commit to attending the group, contributed to the delayed assessment.

Instruments used to assess the group process and the writer's leadership skills were self-administered after every group session, so that comparisons of group process and level of leadership skills could be made at different points in the treatment cycle. Again, the instruments which were used had previously been used in the study completed by the Elders Health Program.

A clinical evaluation of group members' functioning, group process and leadership skills was made on an ongoing basis throughout the treatment cycle.

1. Instruments administered to clients

(a) **Instruments used to diagnose alcoholism/assess degree of risk for dependency on medications**

Rationale: The main criteria for group membership was a chemical use problem. It was important, therefore, to assess group members' chemical use at the point of group entry and again at the point of group exit, to determine whether any changes in chemical use behavior had occurred. The expectation was that if the treatment group was effective, group members' chemical use would stabilize during the treatment period.

(i) **CAGE** - this questionnaire contains four items to which participants answer "yes" or "no". It is designed to assess an individual's recognition of a drinking problem, and is quick and

easy to administer. Two or more affirmative answers are indicative of a drinking problem. The CAGE has been standardized, and has proven reliability and validity, with sensitivity rates of 84-85%, and specificity rates as high as 89-95% (Bush, Shaw, Cleary, Delbanco, & Aronson, 1987; Skinner & Holt, 1986). It is designed to be used with individuals of any age, and is widely used by alcohol/drug treatment programs throughout North America, as a screening instrument. As such, permission to use the CAGE is not required. Because it was designed to screen alcohol problems, rather than measure change in alcohol consumption, the CAGE was administered to group members only once, at the point of initial assessment. A copy of the CAGE questionnaire is included in Appendix D.

(ii) **Brief-Michigan Alcoholism Screening Test** (B-MAST) - this instrument is a revised version of the MAST, originally developed by Selzer in 1971, for the purpose of screening for alcoholism within the general population. The B-Mast contains 10 items to which respondents answer "yes" or "no". Answers are assigned a score of either 0, 2 or 5 points, and are added to compute a total score. A total score of five or more is indicative of alcoholism. The B-MAST is quick and easy to administer, has been standardized, and found to have a high degree of reliability and validity (Selzer, 1971). It has been tested with the elderly population, and found to have a sensitivity rate of 91% and a specificity rate of 83% (Willenbring, Christensen, Spring, & Rasmussen, 1987). Because it is widely used by alcohol and drug treatment programs

throughout North America, its use does not require prior permission from the author. Since the B-MAST was not intended to measure change in alcohol consumption, it was administered only once, at the point of initial assessment. A copy of the B-MAST can be found in Appendix E.

(iii)**Manitoba Drug Dependency Screen (MDDS)** - the MDDS was developed by the Elders Health Co-investigators and associated staff to assess seniors' drug use upon their presentation to the St. Boniface Emergency Department. It was designed specifically for use with the elderly, and was used throughout the Identification Phase of the Elders Health study to identify seniors at risk of physiologic dependence. The questionnaire was not intended to be diagnostic of chemical dependency, but was designed to investigate behaviors which suggest chemical dependency (Jacyk, 1990). Specifically, it was designed to identify patients at risk of physiologic dependence to a variety of mood-altering medications commonly used by seniors. A formula applied to medications which are capable of inducing physiologic dependence allowed one to calculate degree of risk for dependence, and classify dependency as either unlikely or possible. It has not been standardized, nor proven reliable or valid, and therefore was used with caution. A decision to use the MDDS was made because: (1) it appeared to provide detailed and accurate information about medication usage, and (2) it was the only instrument which had been designed specifically to measure drug use in the elderly population. The MDDS was administered both pre-and post-treatment. See Appendix

F for a copy of the MDDS and Appendix G for a letter of permission, from one of its authors, to use the MDDS in the current study.

(b) **Instruments used to assess cognitive/motor functioning**

Rationale: As discussed in Chapter 1, researchers have found that chemical abuse may accelerate the aging process and may be related to memory loss in elderly individuals (Freund, 1984; Russell, 1984; Atkinson & Kofoed, 1982). Chemical abuse has also been thought to be a contributing factor to organic brain disease (Hartford & Samorajski, 1982) which can effect both cognitive and motor skills. An assessment of group members' cognitive/motor skills at the point of group entry and again at the point of group exit was made in order to determine whether improvements in cognitive/motor functioning would occur in conjunction with a stabilization in chemical use.

(i) **Weschler Adult Intelligence Scale (WAIS)** - this test assesses various aspects of adults' cognitive and motor functioning. It allows the user to compare an individual's functioning with members of the general population who are approximately the same age as the person being tested. The WAIS has been standardized, and has been found to have high ratings of both reliability and validity (Weschler, 1981). As mean performance scores have not been calculated beyond the 70-74 year age category, Weschler recommends that test scores for seniors over the age of 74 be compared with mean scores in the 70-74 year age category. In the current study, four components of the WAIS were selected to measure group members cognitive/motor functioning: (1) picture completion test,

(2) digit-span test, (3) vocabulary test, and (4) block design test. Use of the WAIS required that the writer be trained to administer it by someone with authority to do so. In April, 1990, Dr. Gary Rockman, a licensed psychologist who served as a consultant to the Elders Health Program, trained the writer to administer the selected components of the instrument. The WAIS was administered to group members both pre- and post-treatment. Because the instrument had been purchased by the Elders Health Program, permission to use it was not required. The test as well as its scoring instructions are complex, therefore, it was not included in an Appendix.

(ii) **Bicycle Drawing test** - this test serves to assess an individual's mechanical reasoning, eye-hand co-ordination, and ability to visualize an object (Lezak, 1983). It is simple to administer and score. Participants are provided with paper and pencil, and instructed simply to "draw a bicycle". A 20-point scoring system is used to quantify the test, based on which parts of a bicycle are included in the drawing. The test was administered both pre- and post-treatment. Permission to use it was not required. Instructions for scoring the test were included in Appendix H.

(c) **Instruments used to assess life satisfaction and loneliness**

Rationale: Feelings of loneliness and a low level of life satisfaction were viewed as inter-related variables. The writer, however, made no assumptions about the causal ordering of these variables.

Social isolation has been identified as a common problem amongst elderly substance abusers (Sumberg, 1985; Rathbone-McCuan, 1987; Dupree et al., 1984; Mendelson & Kello, 1985; Zimberg, 1978). One can reasonably assume that if seniors perceive themselves to be socially isolated, they are likely to report feelings of loneliness. The writer administered a measure of loneliness both pre- and post-treatment, and expected that feelings of loneliness would decrease as chemical use stabilized and as group members began to feel connected with each other.

If elderly substance abusers are subject to feelings of loneliness, it follows that they will also tend to report lower levels of life satisfaction. The measure of life satisfaction used in this study examined areas such as finances and health as well, which are often negatively effected by chemical abuse. The writer administered a life-satisfaction questionnaire at the point of group entry and again at the point of group exit, and hypothesized that reported life satisfaction would increase as chemical use stabilized, and as feelings of loneliness were alleviated.

(i) **Terrible-Delightful Life Satisfaction Scale** - this scale was developed in the 1970's by Andrews and Withey. It has been standardized, and found to have a reliability of 70% (Andrews & Withey, 1976) and a validity of 80% (Andrews & Crandall, 1976). It is easy to administer and simple to score. Respondents are asked to indicate, on a seven point scale, how satisfied they are with various aspects of their life. The writer examined 12 major life areas, and computed a general life satisfaction score by

adding the response numbers, and dividing by the total number of responses, excluding those designated as "not applicable" . A copy of the Terrible-Delightful Life Satisfaction Scale can be found in Appendix I, and a letter of permission authorizing its use, in Appendix J.

(ii) **Brief UCLA Loneliness Scale** - this scale was developed by Perlman and his associates (Perlman, Gerson, & Spinner, 1978). It was adapted from the original UCLA Loneliness Scale which had been developed to assess loneliness in the general population. The original scale was reported to have a reliability of 96%, a test-retest correlation of 73%, and a validity of 79% (Russell, Peplau, & Ferguson, 1978). The Brief UCLA Loneliness scale was tested with the elderly population, and found to have construct validity (Perlman et al., 1978). The brief version of the scale contains nine items which describe how someone might feel. It is simple to administer and score. The respondent is asked to rate how often he/she feels the statement describes his/her feelings. There are four possible responses, ranging from never to often. Each response is assigned a score between 1 and 4, depending on the response chosen, with three items reverse scored. A total loneliness score is then computed by adding the scores together. The following cut-off scores have been suggested, and were used in the current study: a score of 27 or more indicates probable loneliness, a score of 20 - 26 indicates possible loneliness, and a score of less than 20 indicates that there is no evidence of loneliness (Perlman et al., 1978). A copy of the Brief UCLA

Loneliness scale is located in Appendix K, and a letter of permission authorizing its use, in Appendix L.

(d) **Instrument used to assess connectedness with others**

Rationale: Social isolation has been identified as a common problem among elderly substance abusers (Sumberg, 1985; Rathbone-McCuan, 1987; Dupree et al., 1984; Mendelson & Kello, 1985; Zimberg, 1978; Dunlop et al., 1982). There is evidence to suggest that participation in treatment groups may be beneficial in reducing social isolation (Rathbone-McCuan, 1987; Dupree et al., 1984; Sumberg, 1985), although how this might occur has not been speculated. By administering a tool which examined group members' connectedness with others at the point of treatment entry and again at the point of exit, the writer was able to ascertain whether significant changes had occurred.

(i) **Social Network Screening Questionnaire (SNSQ)** - this questionnaire was developed by the Elders Health Program for the purpose of assessing seniors' connectedness with others. It was used as part of a battery of screening instruments which were administered to seniors presenting at the St. Boniface Hospital's Emergency Department. The questionnaire has not been standardized, nor tested for reliability or validity. Its strengths are that has been developed specifically for use with the elderly population, and is simple to administer. The SNSQ contains five questions, which ask seniors to identify whether or not they have significant others in their lives, who those significant others are, and what type of support they provide. Although it was not designed to

measure change, the writer felt that it would adequately reflect major changes in seniors' connectedness with others, and therefore administered it both pre- and post-treatment. A copy of the SNSQ can be found in Appendix M, and a letter of permission authorizing its use, in Appendix N.

2. Instruments/Methods used to evaluate group process

Rationale: As mentioned in Chapter 2, much has been written about stages of group development, and tasks and issues which groups must address if they are to accomplish the work they were formed to do (Corey & Corey, 1977; Hartford, 1971). The development of group cohesion is critical if groups are to perform productive work. The writer wished to assess the treatment group's process and its ability to function as a cohesive group.

(i) **Formative Task Accomplishment Instrument** (FTAI) - this instrument measures critical dimensions of an open-ended group's development (Schopler & Galinsky, 1990). It contains 12 items which provide a measure of the extent to which a group has accomplished formative tasks related to goals, bonds, roles, and norms. The FTAI has not been standardized as of yet, however, Schopler and Galinsky (1990) state that the items have conceptual validity, and face validity has been established. Currently, instruments which are both easy to use and which measure whether open-ended groups have accomplished formative tasks, are sparse in number. The FTAI is easy to administer and score. It is completed by the group leader, and asks the leader to indicate how often he/she has observed certain conditions among group members.

Responses are assigned a number between one and five, depending on how frequently the condition has been observed. The numbers corresponding to the responses are summed, providing a total score which indicates the extent to which the group has accomplished formative tasks. The FTAI is not specifically designed to measure changes in a group's formative task accomplishment, rather, it assesses the completion of formative task development at a particular point in time. The writer decided nevertheless to complete the FTAI after every group session, in order to examine both overall task accomplishment and to identify whether certain tasks were more consistently accomplished than others. A copy of the FTAI can be found in Appendix O, and a letter of permission authorizing its use, in Appendix P.

(ii) **Leader's Group Summary Reports:** This report was developed by staff at the Elders Health Program. Its purpose is to provide a format for the group leader to record what has occurred during a group session. Session date, main topic, and attendance are recorded. Information pertaining to group process and individual group members' progress is also recorded. Relevant to assessing group process, the writer recorded group members' level of interaction with one another, and level of perceived group cohesiveness. The leader's group summary reports were completed after every session. A copy of the report can be found in Appendix Q.

(iii)**Review of session videotapes by practicuum supervisor(s)** - all group sessions were videotaped, with group members' awareness

and consent. The writer's practicuum supervisor viewed select videotapes of sessions, and provided the writer with feedback pertaining to group process. An interim supervisor, who filled in for the main supervisor during a one month absence, carried out a similar role.

3. Instruments/Methods used to evaluate group leadership skills

Rationale: Much has been written about the role of the group leader. Hartford (1971) states that the group leader must facilitate the group's achievement of its goals and ensure that all members engage in the group process appropriate to their capacity. Corey and Corey (1977) have summarized the group leadership role: "...a group leader's job is to initiate certain types of interaction, to direct the activities of the group, and to create a climate conducive to exploration of personally significant experiences" (p.78). They further stress that specific communication skills, and skills related to leading groups, are critical in effective group leadership. Furthermore, these skills can be learned and constantly improved. The writer wished to evaluate her group skills throughout the treatment cycle, and ascertain whether her leadership skills did indeed improve with practice.

(i) **Group Leadership Skills Rating Scale** - this instrument was developed by Corey and Corey (1977) for the purpose of assessing specific group leadership skills identified as important in providing effective group leadership. Although it has not been standardized, it appears to have face validity. It is easy to

self-administer and simply asks the group leader to rate him/herself, on a scale of one to seven, with regards to how well he/she performs each of the 15 skills identified. The writer completed the Group Leadership Skills Rating Scale after every group session. Doing so allowed her to identify which skills were being performed well, which needed to be improved, and over time, to identify which skills were improving. A copy of the instrument can be found in Appendix R, and a letter authorizing its use, in Appendix S.

(ii) Review of session videotapes by practicuum supervisor - based on a viewing of videotaped sessions, feedback was provided as to which leadership skills appeared to be strong, and which required improvement.

RESULTS

1. (a) Empirical results related to clients

An attempt was made to objectively assess client change during the course of the treatment group. Of the seven core group members, one was unable to complete any of the instruments due to a language barrier. The six remaining group members were included in the formal assessment and evaluation procedures. Post-test results were unobtainable for two of the six members: One resumed drinking just prior to the treatment cycle ending, and was in fact intoxicated on the day on which post-tests were to be administered; the second member cancelled three scheduled appointments to administer the post-tests. Pre- and post-test data was therefore

available for only four group members. The writer was unable to administer the CAGE, B-MAST, bicycle drawing test, and W.A.I.S. to one of the four members because she was admitted to a residential treatment program before pre-testing could be completed. The end result was that complete pre- and post-test data was obtained for three group members, and partial pre- and post-test data was obtained for the fourth member.

(a) Alcoholism/degree of risk for dependency on medications

(i) CAGE (ii) B-MAST (iii) M.D.D.S.

Of the five group members who completed the CAGE, three obtained scores of two or more, indicating that a diagnosis of alcoholism was warranted. The other two clients scored 0.

On the B-MAST, three of the five clients scored positive for alcoholism. Scores ranged from 14 - 25. As expected, the three clients who scored positive for alcoholism on the B-MAST had also scored positive on the CAGE. Of the remaining two group members, one had a score of 0 and one had a score of 5, which indicated that there was no evidence of alcoholism.

Of the six clients who completed the M.D.D.S. at the initial pre-test, only one obtained a score of 2, indicating possible dependency. One obtained a score of 1, indicating that dependency was unlikely. Another client scored 4, indicating irregular use. The three remaining clients all scored 6, which meant that the medications they reported using were not considered ones capable of inducing physiologic dependence.

Scores for the four clients who were available for the post-

test administration of the M.D.D.S. were identical to those obtained in the pre-test, with the exception of one. The client who had obtained a score indicating possible dependency in the pre-test, scored 6 at the time of post-testing, indicating that she had discontinued all use of medications which could potentially induce physiologic dependence.

It must be noted that although the MDDS results indicated that drug dependency was possible for only one client, there was clinical evidence to the contrary, which suggested that other clients were dependent. Two group members were regularly using medications capable of inducing dependence prior to their entering the treatment group. They had been tapered off their medications by their physicians, however, immediately prior to group entry. Had the M.D.D.S. been administered while they were on these medications, their pre-test results would have fallen into the category of possible dependency.

(b) Cognitive/motor functioning

(i) W.A.I.S.

The pre- and post-test results of the four components of the W.A.I.S. are summarized in Tables 1, 2, 3, and 4.

Table 1 shows clients' pre- and post-test scores on the picture completion component of the W.A.I.S., which assesses whether individuals are logical in their thought processes, and their ability to see detail. Two of the group members' scores increased by two points on the post-test, which was considered to be a significant improvement. The third group member obtained the

same score on both the pre- and the post-test. Mean group scores were computed for both the pre- and post-test, and found to be 7.0 and 8.3 respectively.

Table 1

Client Scores on Picture Completion Test

Client	Pre-test	Post-test
1	7	9
2	5	7
3	9	9

Table 2

Client Scores on Block Design Test

Client	Pre-test	Post-test
1	3	7
2	5	7
3	10	11

Table 2 shows group members' scores on the block design component of the W.A.I.S., which assesses whether individuals are logical in their thought processes, and also tests their eye-hand co-ordination. All of the members performed better on the post-

test administration than they did on the pre-test administration. Two of the three clients were considered to have made a significant improvement in their performance. Mean group scores were computed for both the pre- and post-test, and found to be 6.0 and 8.3, respectively.

Table 3 shows group members' scores on the digit span component of the W.A.I.S., which tests individuals' short-term memory. One client scored slightly lower on the post-test than on the pre-test, whereas two scored higher on the post-test. The mean group score was 8.7 on the pre-test, and 10.3 on the post-test.

Table 3

Client Scores on Digit Span Test

Client	Pre-test	Post-test
1	12	11
2	6	11
3	8	9

Table 4 shows the results of the vocabulary test component of the W.A.I.S., which assesses individuals' knowledge and understanding of specific words. None of the clients improved significantly in their performance on the second administration of the test. The mean group score was actually lower in the post-test (9.3) than in the pre-test (10.0).

Table 4

Client Scores on Vocabulary Test

Client	Pre-test	Post-test
1	14	11
2	7	7
3	9	10

(ii) Bicycle drawing test

Table 5 summarizes group members' scores on the bicycle drawing test, which assesses individuals' mechanical reasoning ability, eye-hand co-ordination, and their ability to visualize an object. As shown, only one client made significant improvement in her performance between the first and second administration of the test. One client's score was identical both times, and one client's score decreased by half a point on the post-test.

Table 5

Client Scores on Bicycle Drawing Test

Client	Pre-test	Post-test
1	4	7
2	9	9
3	10	9.5

(c) Life Satisfaction and loneliness

Six group members participated in the initial administration of the life satisfaction and loneliness instruments. As mentioned, two members were not available for the post-test, therefore, both pre- and post-test data was available for four clients.

(i) Terrible-Delightful Life Satisfaction Scale

As shown by Figure 1, there was very little difference between clients' pre- and post-test scores, indicating that group members' life satisfaction over time did not change significantly in either a positive or negative direction. Most clients reported feeling generally satisfied with their lives, as opposed to dissatisfied. The two clients who were not available for the post-test did not differ significantly from the other four clients in their level of perceived life satisfaction.

(ii) Brief UCLA Loneliness Scale

Figure 2 depicts group members' pre- and post-test scores on the loneliness scale. Two group members scored significantly lower on the post-test administration, and moved from a level of "possible" loneliness to "no evidence" of loneliness. The other two group members' scores did not differ significantly from the time of pre-test to the time of post-test, although it happened that a one-point decrease in one client's score moved her from the level of "probable" loneliness to "possible" loneliness. Of the two clients who were available for the pre-test only, one fell into the category of "no evidence" of loneliness, and the other into the category of "possible" loneliness.

Figure 1

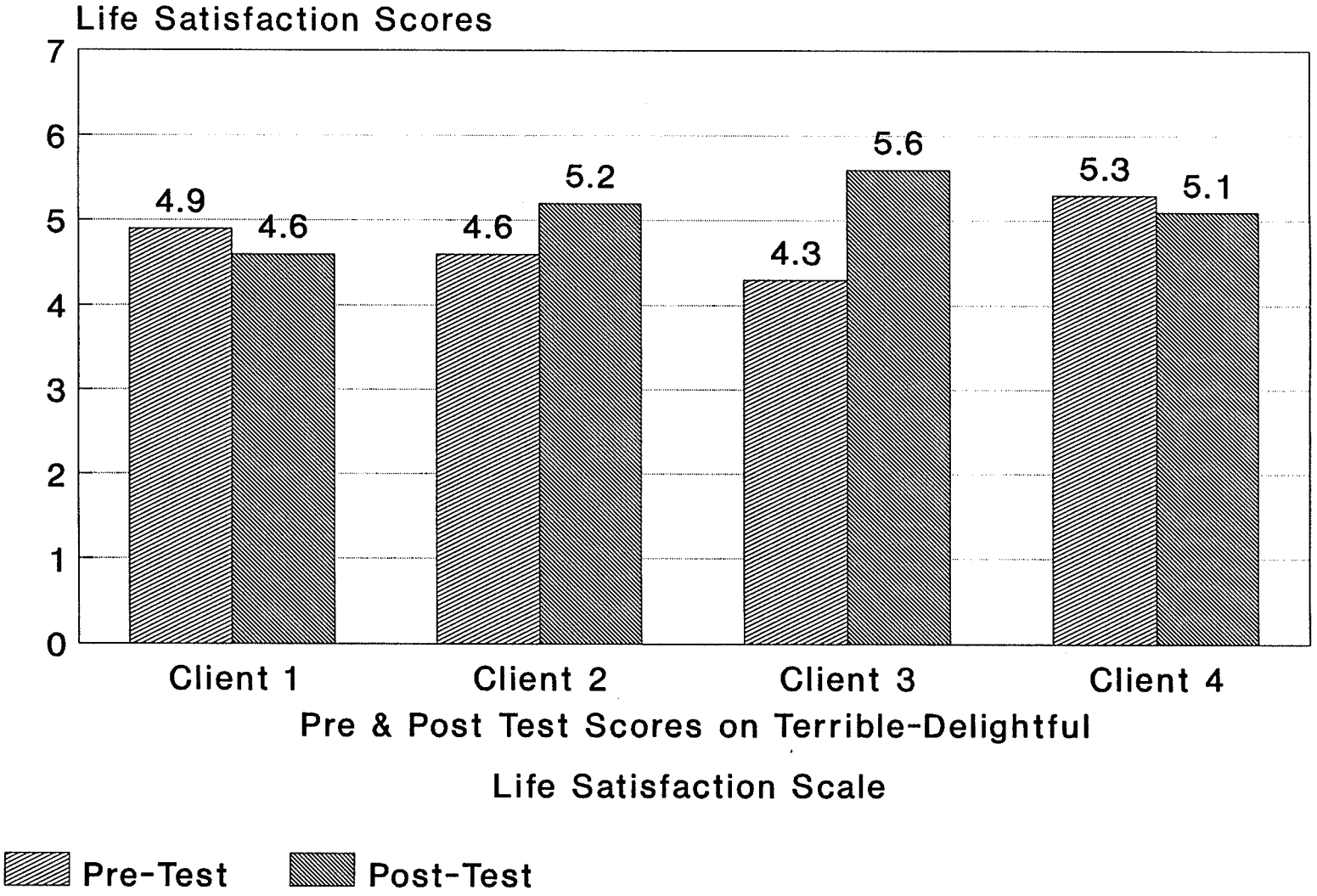
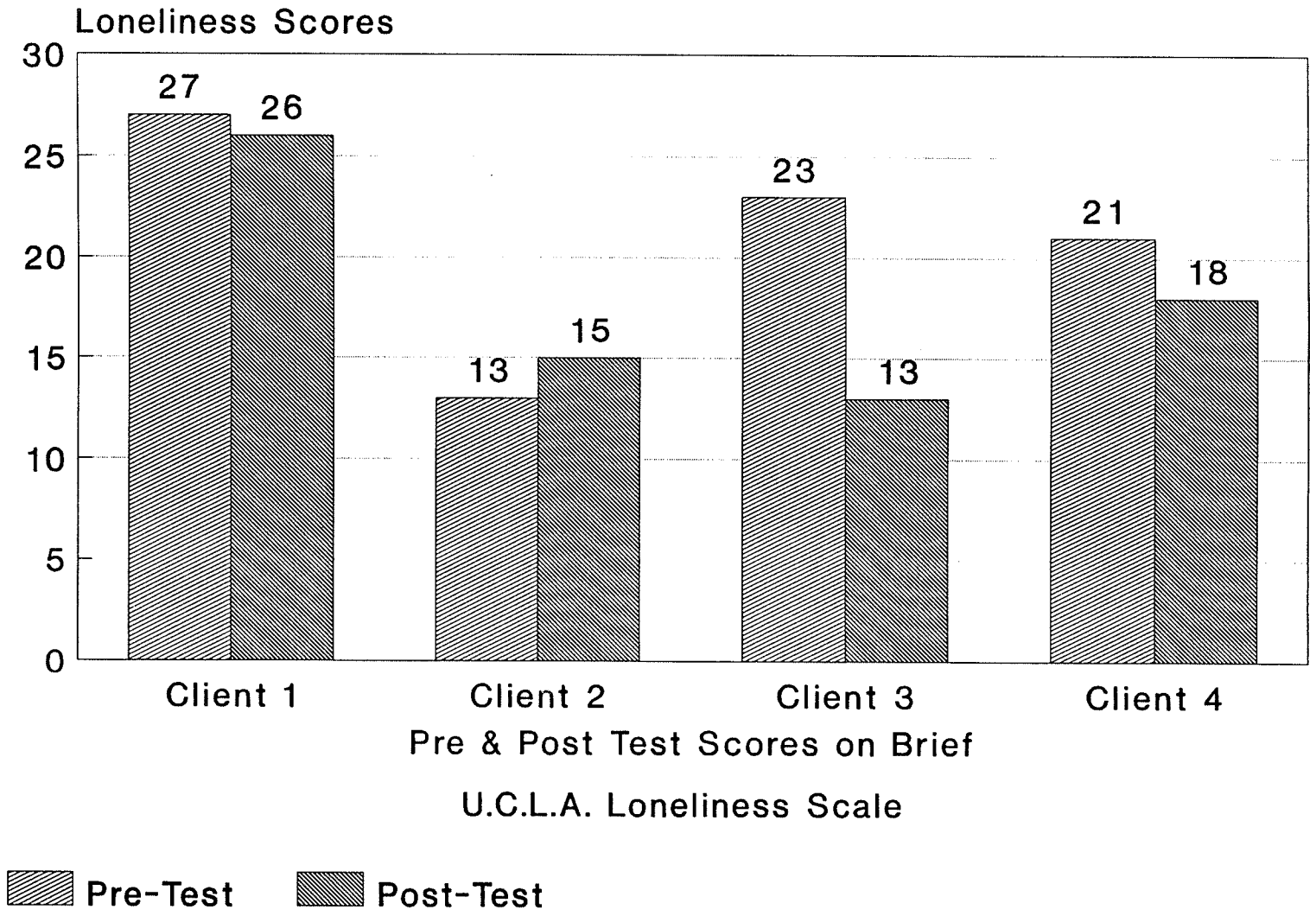

Life Satisfaction Scores
7
6
5
4
3
2
1
0
4.9
4.6
4.6
5.2
4.3
5.6
5.3
5.1
Client 1
Client 2
Client 3
Client 4
Pre & Post Test Scores on Terrible-Delightful
Life Satisfaction Scale
Pre-Test
Post-Test

Figure 2


Loneliness Scores
30
25
20
15
10
5
0
27
26
13
15
23
13
21
18
Client 1
Client 2
Client 3
Client 4
Pre & Post Test Scores on Brief
U.C.L.A. Loneliness Scale
Pre-Test
Post-Test

(d) Connectedness with others

(i) SNSQ

Five group members provided data on the initial administration of the SNSQ, and three were available for the post-treatment administration. Comparisons made between the pre-and post-treatment data confirm that all three group members reported at least one additional person in their social network at the end of the treatment cycle. One client who had previously not identified her son as a source of emotional support, did so at the time of post-testing. The second client, at the time of post-testing, identified a cousin and other group members as a source of emotional support. This client appeared to form particularly strong emotional bonds with the other group members during the course of treatment. The third client identified three cousins, previously not recognized, as a source of emotional support. It is unclear whether she re-established connections with these relatives during the treatment period, or whether she simply failed to report them as a source of support on the initial administration of the SNSQ.

1. <u>(b) Clinical observations related to clients</u>

In addition to the findings already reported, a discussion of the clinical observations related to six of the core group members, follows. A detailed description of one group member, and the changes that occurred in her life during the course of the treatment cycle, can be found in Appendix T.

(i) Mrs. L.G. - this woman had been referred to the treatment

group by the Employee Assistance Program at her place of employment. Although she initially verbalized a great deal of denial around her alcohol use, she agreed to attend treatment in order to keep her job as a cafeteria worker. She attended sessions regularly, and began to recognize that her drinking was interfering with her life. She also began to make a conscious connection between her husband's death, several years earlier, and the onset of her drinking. Four weeks into the treatment group, Mrs. L.G. reported that she had made an attempt to quit drinking but was unable to do so. The writer recommended that she attend a residential treatment program, and as a result, she was admitted to the Women's Treatment Program at the Alcoholism Foundation of Manitoba, after being detoxified. She completed this program and returned to the treatment group at Elder's Health, however, due to her holidays and work schedule, was only able to attend a limited number of sessions. Near the end of the treatment cycle, Mrs. L.G. stated that she had started to drink again, but reported that she had only had a few drinks. Due to the fact that Mrs. L.G. cancelled three successive appointments at the end of the treatment cycle, the writer was unable to complete the post-treatment assessment and obtain more information about how she was doing. Concerns that her alcohol use would probably escalate again, certainly remained.

(ii) Mr. M. - this gentleman, who had been referred to the group by the staff at a local hospital's chemical withdrawal unit, attended sessions regularly throughout the treatment cycle. He

participated freely during sessions, and seemed to enjoy interacting with the other group members. He identified the death of his wife, two years earlier, as the catalyst in his drinking problem, although his children stated that he had displayed symptoms of problematic drinking several years prior to his wife's death. Although he claimed to have many friends and participate in many activities, his family reported that he continued to isolate himself a great deal of the time. He often appeared to be "painting a rosy picture" of his current life situation, denying and minimizing "feeling and living" problems. During the final week of treatment, his daughter reported that Mr. M. had started drinking again. On the day of the scheduled post-treatment assessment, when the writer arrived at his home, Mr. M. was found to be intoxicated, and somewhat disoriented and confused. Arrangements were made for Mr. M. to enter the chemical withdrawal unit at A.F.M., and thereafter maintain contact with an outpatient counsellor. He also agreed to attend the seniors' chemical abuse after-care group at Lion's Manor.

(iii)**Mrs. O. -** this woman had been referred to the treatment group by the staff at a local hospital's chemical withdrawal unit. She regularly attended sessions, and engaged freely in group discussions. She verbalized a desire to be placed on a step-down program under the supervision of the Elders Health Program physician, and make changes in her life related to becoming more active in the community by investigating volunteer work opportunities. Although she was able to identify that the death

of a husband and an infant son, thirty-five years earlier, was an unresolved issue for her which continued to impact a great deal on her life, she was unable to begin to share her feelings related to her tragedy. Concerns about her mental health status arose when she began to make frequent reports about being persecuted. She believed that although her landlady was directly involved in harassing her, her ex-husband was responsible and was trying to drive her insane. The Elders Health physician recommended that her step-down from valium be postponed until a psychiatric evaluation was obtained. Thereafter, at the recommendation of the psychiatrist, Mrs. O. was gradually stepped-down from her medication. After the treatment group ended, Mrs. O. made a commitment to attend ongoing counselling sessions with a social worker at the Elders Health Program, and the seniors' chemical abuse support group at Lion's Manor.

(iv) **Miss H.** - this woman had been referred to the group by her family physician because of concerns around alcohol and over-the-counter medication abuse. Her attendance at group was sporadic because of ongoing health problems, however, she seemed to enjoy sessions and participated in them with a great deal of energy and insight. She maintained sobriety throughout treatment, and reported that she was becoming more active in her senior citizen's housing unit, organizing weekly bingos for the residents. At the end of treatment, she made a commitment to attend the seniors' chemical abuse after-care group at the Lion's Manor.

(v) **Mrs. S.** - this woman had referred herself to the group, and

regularly attended sessions throughout the treatment cycle. Although she initially expressed a great deal of resentment at being asked to attend group sessions while being stepped-down from her medication, she gradually became more involved in sessions. At one point, she reported to the group that she had begun to recognize that her use of medication stemmed from her inability to cope with life problems. She was able to verbalize a great deal of sadness regarding her husband's death several years earlier, and relate to the other members how this continued to impact on her life. She began to actively work on improving her relationship with her son and reported near the end of treatment that their relationship had in fact improved. She was successfully stepped-down from her anti-depressant medication, and remained adamant in her desire to continue to abstain from the use of any mood-altering medication.

(vi) Mr. S. - this gentleman had been referred to the group by the social worker at the senior citizen's block in which he resided. Although a serious hearing deficit and difficulty with the English language prevented him from participating as spontaneously in group as he might otherwise have, he reported that he enjoyed attending sessions and interacting with other members. He developed a close relationship with one of the peer counsellors during the course of the treatment cycle, and began to attend the seniors' chemical abuse after-care group at Lion's Manor, before the treatment group ended. Initially, Mr. S. was determined to move out of his apartment block because of an ongoing fear that

another resident was going into his suite in his absence. At the encouragement of the peer counsellor, writer, and another Elders Health staff member, he decided to postpone his move and continue to work with his social worker to find out the cause of the problem. Although his level of participation in other activities remained limited because of his reluctance to leave his suite, he continued to maintain sobriety throughout the course of treatment.

2. (a) Empirical results related to group process

An effort to objectively assess the process of the treatment group was made. What follows is a presentation of the results related to group process.

(i) FTAI

A score of sixty was the highest possible score obtainable on the FTAI. Scores on the FTAI, for each individual group session, ranged from 23 - 46. The overall average score was 39.5, indicating that the group accomplished many formative tasks critical to its ability to become a cohesive system.

A review of the FTAI questionnaires showed that several conditions identified with formative task accomplishment were consistently scored higher, that is, were seen as more prevalent than other conditions: (1) item # 1 - group purposes and/or goals are clear to most members, (2) item # 4 - members express verbally or through their behavior their common interest in group's purposes and/or goals, (3) item # 5 - members assume responsibility for tasks important to group's functioning,

(4) item # 6 - members behave in accordance with agreed upon group

norms, rules, or traditions, (5) item # 7 - members express verbally or through their behavior their interest or caring for each other, and (6) item # 12 - members have established patterns of communication, influence and task performance. It appeared that although the treatment group was an open-ended one, and had to deal with members entering and leaving throughout its cycle, it was able to accomplish tasks beyond those often seen in groups which are just beginning.

Conditions associated with formative task accomplishment, which were consistently scored lower, that is, seen as occurring less frequently during sessions, included: (1) item # 2 - members make references to agreed upon group norms, rules, or traditions, (2) item # 10 - members feel free to express different points of view and/or disagree with each other, and

(3) item # 11 - members remind each other to behave in accordance with group norms, rules, or traditions. Speculation as to the possible reasons for these conditions not being observed frequently during sessions, will be made in the next section.

2. (b) Clinical observations related to group process

Ongoing observations of the group's process were made by the writer and her practicuum supervisor(s). A discussion of these observations follows.

(i) Leader's Group Summary Reports

A review of the "group interaction" section on the leader's group summary reports indicated that group members tended to maintain a moderate amount of interaction with one another and that

generally, the group was perceived to be moderately cohesive.

As expected, the group appeared to function as less of a cohesive unit in its early stage, which is when several new members entered simultaneously and members did not know each other. Although member interaction was generally moderate during the initial stage of group development, members tended to focus on relatively superficial issues.

During the first few topic sessions which asked group members to focus on highly emotional issues, interaction and cohesion again was perceived to be somewhat lower. As the group continued to deal with emotionally-laden topics, both interaction and cohesion returned to moderate levels, and appeared to remain stable throughout the balance of the group's existence. With the exception of a few sessions where members appeared to feel particularly close, the writer did not perceive the group as having a high degree of cohesion during most of its cycle.

(ii) **Feedback from supervisor(s)**

Feedback from both the writer's main supervisor, Prof. Ranjan Roy, and her interim supervisor, Prof. Don Fuchs, was provided throughout the group cycle.

Prof. Don Fuchs, who acted as interim supervisor during the first six weeks of the practicuum, identified that the levels of both group interaction and cohesion could be increased. In terms of increasing members' interaction with one another, it was suggested that: (1) the leader validate and reinforce group members' sharing with one another in an effort to establish sharing

as a norm, and (2) the leader become more demanding of group members to "work", by being more directive and actively engaging members to examine relevant issues. With regards to increasing group cohesion, it was suggested that: (1) the leader consistently attempt to link group members by highlighting their commonalities (e.gs. chemical dependency, losses, aging, etc.), and (2) the use of simple exercises to open and close sessions would bring group members together more quickly, and provide a common experience which could serve to increase group cohesiveness.

Prof. Ranjan Roy, who acted as advisor during the remaining eight weeks of the practicuum group, continued to challenge the writer to find ways of increasing group interaction and cohesion. Members' interaction regarding the session's focal topic was often low, particularly in the initial part of the session.

It was suggested that the writer:

(1) introduce session topics in a more natural manner. Rather than simply stating at the outset what the focal topic was, the writer could find ways of weaving the topic into informal discussions which group members initiated at the beginning of the session.

(2) provide group members with weekly schedules of topics. Doing so would assist in stimulating them to think about an upcoming topic ahead of time. This would, in turn, facilitate their sharing of thoughts and ideas during sessions, and assist in keeping them focused.

Because the group had invested a large amount of authority and power to make decisions in the leader, Prof. Roy suggested that

the leader use specific strategies to decrease her power by increasing group members' power. The use of these strategies would increase group cohesion. They included:

(1) openly inviting group members to make decisions about whether to use their session to focus on one particular member's concerns.

(2) encouraging group members to take turns introducing session topics, rather than the leader doing so.

3. (a) Empirical results related to leadership skills

(i) Group Leadership Skills Rating Scale

An examination of the completed questionnaires allowed the writer to identify which leadership skills were strong and which required improvement. Of the 15 leadership skills identified by this instrument, the five which the writer consistently perceived herself as performing better included: (1) item # 1 - active listening, (2) item # 2 - reflecting, (3) item # 6 - questioning, (4) item # 9 - supporting, and (5) item # 13 - facilitating.

The six skills which the writer consistently perceived as being the weakest and most in need of improvement were: (1) item # 3 - clarifying, (2) item # 4 - summarizing, (3) item # 5 - interpreting, (4) item # 8 - confronting, (5) item # 12 - evaluating, and (6) item # 15 - terminating.

Two skills, linking and terminating, were rated as being performed significantly better during the latter half of the treatment cycle than during the first half, indicating that the writer had been able to improve these skills with practice.

3. (b) Clinical observations related to leadership skills

In addition to objectively evaluating leadership skills, clinical observations of these skills were made by the writer's practicuum supervisor(s).

(i) Feedback from supervisor(s)

Suggestions made by the writer's supervisors regarding leadership skills specifically related to increasing group interaction and cohesion, have already been highlighted. Additional feedback regarding group leadership skills was also provided. Prof. Fuchs noted that the writer's body language was often "closed", particularly when a member raised a potentially highly emotional issue. He stressed the need to become more conscious of body positioning. He also challenged the writer to reflect on the source of the apparent discomfort regarding emotionally-laden topics raised by group members. A need to scan the group and observe all the members, rather than focus on the member who was talking, was also identified as a skill which warranted improvement.

Both supervisors identified that the writer appeared to have difficulty being directive during group sessions, and commented that she seemed to feel more comfortable playing a non-directive leadership role. Although the ability to be non-directive had benefits, it also had a disadvantage in that the writer often had difficulty moving members towards the main content of the session.

Prof. Roy identified that at times, group members seemed to be unsure of what the writer was asking them to do or what the

relevance of a topic was, and that there was a need for clarity in these areas. The writer's discomfort with silences was also noted. A suggestion was made that the writer allow silences, and give herself more time to make decisions about what to do with unexpected issues raised by group members, so that significant issues would be dealt with and not overlooked.

DISCUSSION OF RESULTS

1. Clients

A caution regarding the interpretation of data pertaining to clients, must be made. As previously mentioned, the pre-test administration of the instruments used to measure clients' chemical use and functioning was completed as late as three weeks after three of the members entered the group. This may have skewed the results. Secondly only a very small number of group members were involved in the assessment and evaluation efforts, therefore, results are not generalizeable beyond the seniors involved in the practicuum group.

A considerable amount of baseline data was collected. With the exception of chemical use however, overall outcome of the results was equivocal.

With regards to chemical use, five of the seven core group members were able to maintain abstinence from alcohol and other mood-altering substances during the course of the treatment cycle. It seems reasonable to speculate that the group contributed to seniors' sobriety. Firstly, it offered a supportive peer

environment in which seniors could examine their chemical use problems without being judged or made to feel isolated. Secondly, peer counsellors provided "real life" evidence that seniors could indeed recover from a chemical use problem. Finally, the group provided a forum for seniors to discuss common "living and feeling" problems, and share positive coping skills to deal with these problems; this allowed seniors to exchange their chemical use, a previous method of coping, for more positive coping behaviors. Since the primary goal of treatment was to assist seniors to stabilize their chemical use behavior, and five out of seven seniors were able to do so, one can safely assert that the treatment goal was met. Furthermore, it is argued that the delivery of the treatment package, in a group format, contributed to seniors' ability to maintain sobriety.

The writer's clinical evaluation of client change during the course of the treatment cycle pointed to the fact that, notwithstanding the area of chemical use, clients tended to make "small" gains in achieving desired life area changes, rather than "large" ones, particularly in the area of activity levels. Perhaps this serves as a caution against expecting chemically dependent seniors to make major changes within the course of three months.

When seniors were asked for feedback regarding their experience as a group member, they overwhelmingly reported that they had both enjoyed participating in the group, and found it useful. Several of them verbalized that they would miss both the group and other group members.

Empirical measurement of client functioning at the point of treatment entry and again at exit showed that significant improvements in relation to cognitive/motor performance, loneliness, and seniors' connectedness with others, occurred during the treatment period. Although one cannot be certain that clients' participation in the group caused these improvements to occur, an association between participation in the group and the noted improvements is speculated.

Comparisons of the pre- and post-test results of the W.A.I.S. clearly showed that skills related to logical thinking, eye-hand co-ordination, and short-term memory, improved during the course of treatment. Clients' increased performance in these areas was expected. As mentioned in Chapter 1, several researchers found evidence that chemical abuse by seniors had a negative effect on their cognitive and motor functioning. It is argued that abstinence from mood-altering substances contributed to the noted improvements in logical thinking, short-term memory, and eye-hand co-ordination, abilities often subject to change within a short period of time. It is not known why the results of the bicycle drawing test, which also measured eye-hand co-ordination and logical thinking ability, did not show the same pattern and remained stable from the first to the second test period. The results of the vocabulary test component of the W.A.I.S., a measure related to standard IQ testing which was expected to remain stable over time, showed little change from the time of pre-testing to post-testing. This was expected, since individuals' knowledge and

familiarity with the English language was not expected to be negatively effected by chemical use, or alternatively, positively effected by abstinence from chemicals.

A significant decrease in clients' perception of loneliness and an increase in their connectedness with others, at the end of treatment, was also predicted. It seems reasonable to hypothesize that clients' participation in the treatment group contributed to these improvements. Group members formed strong attachments with other members throughout the course of treatment. Some of them began to have contact with one another outside of the group, and actually formed friendships which existed quite separately from the group. The group climate was one which stressed that members were not alone with their problems or their struggles to cope with these problems. A sense of "I am not alone" developed, and no doubt contributed to clients' feeling less lonely and more connected. The one client who continued to report a high degree of loneliness at the end of treatment appeared not to have connected with other group members, nor did she report satisfaction with the contacts she had made in the group.

The treatment group may also have contributed to an improvement in members' relationships with family members and friends. One of the life areas addressed during the course of treatment had to do with relationships in general. One group member identified relationship problems during the treatment period, and began to make active efforts to improve her relationship with her family. At the end of treatment, she

reported that her relationship with her son had improved, and identified him as a source of emotional support, which she previously had not done.

The fact that there was no significant change in seniors' overall life satisfaction during the course of treatment leads one to consider that life satisfaction may be a relatively stable variable that is, one which does not change in the course of three months. Another possibility for the fact that life satisfaction remained stable is that seniors tended to report a fairly high level of life satisfaction to begin with. The life satisfaction measure in large part focused on examining seniors' satisfaction with a number of practical and tangible life areas such as health, housing, finances, etc., with which they indeed seemed satisfied.

A caution with regards to the scoring of the life satisfaction measure must be made. The scoring requirements of the measure resulted in the automatic exclusion of life areas designated as "not applicable". This meant that if a client did not have a spouse of a partner, for example, their level of satisfaction with a partner, or lack of a partner in this case, could not be determined. Although this was necessary from a scoring perspective, it became clear that for several of the clients, the death of their spouse was a major source of dis-satisfaction with their lives. In essence, the life area which for several clients was the most dis-satisfying (the absence of their partner) was not included in their overall life satisfaction score. For these clients, this undoubtedly resulted in scores

score. For these clients, this undoubtedly resulted in scores which reflected a higher overall level of life satisfaction than was actually the case. Had the instrument been able to measure perceived life satisfaction which reflected members' feelings regarding the absence of their partner, scores would likely have been lower.

Finally, clients' level of life satisfaction may not have increased because they were struggling to make a major change in their life: Abstinence from mood-altering substances. One of the variables examined by the life satisfaction index was self-esteem. Although one can argue that clients will feel better about themselves because of their attempts to maintain abstinence, it is also expected that clients, in the initial stage of recovery, might report a lower level of self-esteem because of their struggle to make a major change in their lives. Individuals who are in the early stage of recovery (which can last as long as a year or more) are struggling with new ways of thinking about themselves, and how they have coped with issues in the past. Simultaneously, they are giving up a chemical which frequently serves to medicate their feelings, and have not yet replaced the chemical with alternate methods of coping with feelings and problems. Therefore, it seems reasonable to hypothesize that individuals in the first three months of recovery may not report an increase in self-esteem or other areas measured by a life satisfaction index.

A measurement of clients' level of depression was also made in this study. Unfortunately, because of a scale error, the data

obtained by the instrument could not be included. Based on clinical observations, however, it appeared that although there was some evidence of depressive symptoms in the treatment group population, most clients were not clinically depressed.

As previously mentioned, one of the objectives of the practicuum was to replicate a previous study undertaken by the Elders Health Program. The results of the two studies, pertaining to pre- and post-treatment client functioning, were compared.

With regards to chemical use, the Elders Health Program study found that the majority of group members who completed treatment also stabilized in terms of their chemical use (Tabisz & Jacyk, 1991), similar to the findings of the current study. Because similar positive improvements with regards to chemical use behavior were noted, the argument that there was an association between participation in the treatment program and a stabilization of clients' chemical use, is strengthened.

Similar results pertaining to clients' perception of life satisfaction and loneliness were obtained by the studies. The Elders Health Program found that there were no significant changes in these areas between the time of pre- and post-testing (Tabisz & Jacyk, 1991). Speculation as to why clients did not report increased life satisfaction or a significant decrease in loneliness, has already been made. It would be interesting to see whether other studies would produce similar results.

Pertaining to clients' cognitive/motor functioning, results of the two studies were somewhat different. Although the Elders

Health Program found that there were small improvements noted by two components of the W.A.I.S., these improvements were insignificant (Tabisz & Jacyk, 1991). In contrast, the current study found that clients' cognitive/motor functioning improved significantly as measured by two of the W.A.I.S. components. It is recommended that other studies examine this variable, in order to determine whether similar improvement occurs.

Overall, both studies produced similar results related to client functioning. This lends strength to the assertion that the delivery of the treatment package, in a group format, contributed to the noted improvements in client functioning.

2. Group process

Results of the FTAI clearly provide evidence that open-ended groups can accomplish tasks beyond those of beginning groups. The practicuum group had an advantage, however, in that even though membership changed, a core group of members remained constant throughout the treatment cycle.

It may well be that because the leader did not verbalize group norms or rules beyond the first few sessions, members likewise did not make reference to or remind each other to behave in accordance with group norms or rules. It is unlikely that norms and rules were unclear to group members because they tended to behave according to the norms established at the time of the group's formation.

It is speculated that members' reluctance to freely disagree with one another and express differing opinions may have occurred

in part because the writer did not actively encourage them to do so i.e., verbalizing disagreements was not established as a group norm.

Group cohesion and member interaction remained at moderate levels throughout most of the treatment cycle. Although the group was able to accomplish a great deal of "work", presumably, more could have been accomplished had the group been highly cohesive. Cohesion may have been higher had it not been for membership changes and/or weaknesses on the part of the writer related to "group building" leadership skills. The writer became consciously aware of the importance of actively working to build group cohesion and member interaction.

3. Group leadership

The practicuum experience served to reinforce to the writer the complexity of group leadership. Because the writer had previously facilitated groups for chemically dependent adolescents, she was fairly confident of her leadership skills at the outset of the practicuum. Formal and clinical evaluation of her leadership skills, however, reinforced that although the writer was fairly strong in certain areas of leadership, other skills had previously not been examined and therefore required a conscious effort to build.

The fact that the writer's body language in the early stages of the group was often "closed" when a member began to talk about a highly emotional issue, was not recognized by the writer until it was pointed out to her. It is speculated that there was fear

on her part related to group members dealing with a variety of issues, many of which carried an enormous amount of negative feelings. This fear may have stemmed from the writer's belief that she did not know how to address these issues, or that if she attempted to do so, group members would "fall apart" and she would not have the skill to help "put them together again". Undoubtedly, the fear was an irrational one and once the writer recognized this, she made a conscious effort to watch her body langauge.

The writer's discomfort with being "too directive" in the group also became apparent when her supervisor(s) pointed this out to her. In general, her preference was to be as non-directive in her relationships with clients as possible. Specifically regarding the elderly age group however, the writer also wondered if her discomfort with being directive was related to her having been taught in her family of origin that one should never question or act as if one knew more than someone who was older. Doing so was viewed as a sign of disrespect towards one's elders. Indeed, the writer often found herself thinking that her own life experience was minimal in comparison to the seniors', and wondered how much she could offer them. Another possible explanation for the writer's discomfort with taking a directive role may have been related to her fear of losing clients' approval if she was too directive. The writer recognized that she wanted group members to like her, and may have feared that if she was too directive, she would lose their approval and/or their willingness to continue to participate as a group member.

The enormous value of receiving feedback regarding group process and leadership issues, from individuals who were not personally invested in the group, was reinforced for the writer. Much of the feedback provided by the writer's supervisors served to bring problem areas to the writer's attention, and also, provided her with useful suggestions as to how these problems could be addressed.

The three practicuum objectives, as identified in Chapter 2, were met through the practicuum experience: (1) treatment to chemically dependent seniors was provided in a group format, (2) group members' functioning in various life areas prior to treatment, was compared with their functioning in similar areas at the end of treatment, and (3) a similar study completed by the Elders Health Program was replicated.

The writer's professional learning objectives, also identified in Chapter 2, were met as well: (1) the writer was able to develop and improve groupwork skills related to elder-specific groups, (2) she became more effective at providing social work services to seniors at a group level, and (3)the writer gained knowledge about seniors and the unique issues the elderly age group faced.

Areas of learning related to seniors and the unique issues they face, are discussed in the next chapter. Areas of personal learning, which were for the most part unanticipated, will also be highlighted.

CHAPTER 4 - PERSONAL LEARNING AND CONCLUSIONS

The final chapter of this report highlights and discusses key areas of personal learning which resulted from the execution of the treatment package. Areas of learning are discussed in relation to four broad categories: (1) the treatment package, (2) the group, (3) group leadership, and (4) social work with seniors. Conclusions and recommendations are offered in the hope that they are useful to those practitioners interested in further investigating the use of a groupwork approach in the treatment of chemically dependent seniors.

Although there was a clear agenda for the practicuum regarding the tasks which were to be accomplished during the treatment cycle, many of the issues which arose during the course of the practicuum were not anticipated. These issues simultaneously became a vehicle for learning a great deal about myself, the elderly population, service delivery to seniors in general, and chemically dependent seniors specifically.

1. Treatment Package

It was previously noted that the treatment package delivered to seniors in the practicuum group was identical to the package used in the earlier Elders Health Program study. Two "specific topic" sessions and one "open forum" session formed the basic structure of the package. The topics addressed in the group each week were pre-determined, and a conscious effort was made to adhere to the treatment package agenda. The availability and use of a pre-determined treatment package offered distinct advantages in that: (1) it eliminated the time-consuming process of developing

a treatment program, and (2) the effectiveness of an existing treatment package, previously delivered by only one other professional, could be compared with its effectiveness when delivered by a social worker who was not familiar with the package.

Having delivered the treatment package, it seems advisable that a combination of the two major treatment components, therapy and education, are essential in effectively working with chemically dependent seniors. The initial group sessions which focus primarily on education provide a relatively "low risk" entry for clients, and allow group members to become somewhat comfortable with the group before they are asked to share and discuss more personal issues. After clients reach a level of comfort with the group, they are able to do some of the real work required in examining their "feeling and living" problems.

It is useful to allow the group to determine their own agenda one day per week. Firstly, it reinforces to group members that they have an interest in, and take ownership for, the group's functioning. This serves to increase group cohesiveness. Secondly, it provides group members with autonomy to plan sessions. They seem to appreciate and enjoy the opportunity to examine special interest topics, invite guest speakers to the group, watch a film, or simply visit with one another.

The use of a pre-determined, set treatment package can also be disadvantageous. Many times, there was subtle pressure to focus on a specific topic on a given day simply because of a perceived need to follow the treatment agenda. The result was, at times, a

failure to address in appropriate depth, unexpected but important issues which group members had, for the sake of adhering to the treatment schedule. Certainly, failure to appropriately address these issues was in part due to inexperience. At other times however, it seemed that session topics were presented in a rather "artificial" manner simply because the treatment schedule was being followed. Topics would likely have been of greater interest had they been introduced to coincide with group members current concerns.

It is noted that allowing only two sessions on issues related to identifying and grieving losses, was insufficient. All of the seniors in the group had experienced multiple, significant losses during their lifetime, many of which were unresolved. It was not possible to adequately address in appropriate depth these loss issues and the major impact they continued to have on seniors' lives. For a few of the members, the initial task of identifying losses was not even possible in the time allotted by the treatment schedule.

It would have been useful to allow formal time to address members' issues related to group termination. Because the current treatment cycle was to be a final one, group members did not have the option of continuing on in another group. As a result, regardless of the fact that a few members did not feel ready to terminate treatment, they were required to do so. For these members in particular, dealing with termination was a difficult issue. Although a certain amount of group time was allowed to talk

about termination issues, this time was limited. In retrospect, it would have been useful to have been able to devote more time to these issues, at least for those members who appeared to need additional support. Having adequate time to address these issues would presumably have facilitated members' comfort and sense of control related to the impending termination.

Recommendations

(i) The treatment package which was used with the practicuum group, in its basic format, appeared to be appropriate and effective in the treatment of seniors' chemical dependency problems. Similar to the previous study completed by the Elders Health Program, significant improvements related to clients' chemical use and functioning in various life areas occurred during the treatment period. Although causality was not implied, a tentative assertion that the delivery of the treatment package, in a group format, appears to effect some positive changes in seniors' lives, was made. It is recommended that the treatment package be delivered by other professionals, in an effort to further test its effectiveness. Furthermore, future studies should employ a more rigorous study design, and include a control group if possible. If, under rigorous conditions, delivery of the treatment package results in similar positive client change, the assertion that it is indeed effective, can be strengthened.

(ii) It is recommended that flexibility in terms of which topics and issues are addressed in any given session be built into the treatment model. This would allow the group leader(s) leeway to

decide on a session-by-session basis whether a specific topic is relevant to members' concerns, and thereby facilitate their interest in focal topics.

(iii) Additional sessions which specifically address seniors' loss and grief issues should be incorporated into the treatment package. Doing so will increase seniors' ability to adequately work through these issues.

(iv) In situations where group members do not have the option of participating in all or part of a second treatment cycle, a session devoted specifically to group termination issues should be built into the treatment package.

(2) Group

The benefits of allowing treatment groups for seniors to be open-ended, rather than closed, were summarized in Chapter 2. One of the main benefits noted was that open-ended groups allowed chemically dependent seniors to complete treatment in their own time, that is, seniors could participate in treatment as long as they wished to do so. Again, although the practicuum group was open-ended in the sense that new clients were admitted as late as five weeks into the treatment cycle, the option of participating in another cycle was not available. Members who did not perceive themselves as ready for termination, and those who clearly were not stable in terms of their chemical use, were unable to continue on in a similar type of treatment program. Besides the very real danger of continued chemical abuse on the part of some seniors, or the possibility of relapsing to previous chemical abuse behavior,

there was anxiety and frustration for some clients because they felt they were being deserted.

The effects which premature termination might have on clients, or how these might impact on my own feelings of competency, were not anticipated. In a log which was kept throughout the practicuum, I noted that approximately four weeks before group termination, I became preoccupied with the time remaining to accomplish the group's "work". I began to notice feelings of sadness and anxiety on my part, and guilt related to a belief that I had "not done enough" as a group leader. My difficulty in "letting go" of clients was reinforced when I was confronted with the real lack of treatment resources for seniors, beyond the group at the Elders Health Program. The issue of "letting go" of clients was one which surfaced numerous times in relation to other events which occurred during the practicuum.

Recommendations

(i) Treatment groups for chemically dependent seniors should, wherever possible, be open-ended and allow seniors to continue on in treatment as long as they feel the need to do so. Open-ended groups help to ensure that seniors will terminate treatment when they feel ready to do so. In turn, this may increase the likelihood that clients will be able to maintain ongoing post-treatment sobriety.

(ii) Evaluation of clients' functioning, in open-ended groups, should be completed at scheduled intervals such as once every three months, rather than pre- and post-treatment. The data from

regularly scheduled evaluations can be used to encourage those seniors who are reluctant but perhaps ready to exit group, to do so. Being able to show a senior the improvements and gains which he/she has made can provide the needed incentive for him/her to exit the group and access alternate, more appropriate community resources.

3. Group Leadership

With regards to group leadership, three key learning areas are identified and discussed: (a) co-leadership with a peer counsellor, (b) the dual leadership roles of educator and therapist, and (c) personal learning regarding my role as group leader.

(a) Co-leadership with a peer counsellor

Responsibility for leadership of the treatment group was shared between the peer counsellor and myself. The individual who took on the role of peer counsellor for the practicuum group had previously acted out a similar role with the treatment groups facilitated during the Elders Health Program study. Because this individual was willing to act as a peer counsellor for the practicuum group, and because an attempt to replicate the earlier study was being made, he was invited to assist with group leadership.

The value of the peer counsellor's role was apparent. As a peer counsellor, he served as a role model to group members, and represented tangible hope that recovery from chemical dependency was possible. Group members often looked to him for support and

empathy regarding their own chemical abuse problems, sensing that because he had struggled with similar problems, he could truly understand their struggles as well.

An interesting issue arose with regards to the sharing of group leadership. About midway during the treatment cycle, the peer counsellor and I had a disagreement about whether a particular group member should be referred to a specific self-help group as an additional source of support. This disagreement was never completely resolved. It resulted in ongoing tension between myself and the peer counsellor even though we "agreed to disagree", and made efforts to keep the disagreement separate from the group so that its potential negative impact on the group would be minimized.

It also became apparent that at times, the peer counsellor's method of interacting with group members differed significantly from mine. The peer counsellor, untrained with regards to therapeutic methods, seemed unsure about the purpose of my therapeutic methods and whether they were beneficial in my attempt to work with the group. In and of itself, this did not necessarily cause problems with regards to working together in group. It seemed however, that there was role confusion on the peer counsellor's part pertaining to who the primary group leader was. This resulted in ongoing tension between us. At times, it felt as if we were operating as a fractured unit, rather than a cohesive one.

My advisor speculated that the tension between myself and the peer counsellor might indeed be related to a vie for control

of the group. Although I did not feel that this was the case, at least initially, I later wondered whether the initial disagreement had indeed stimulated a power struggle between us.

Recommendation

(i) The benefits of using peer counsellors to co-facilitate treatment groups are apparent, and it is recommended that professionals continue to use peer counsellors as much as possible. It is suggested however, that group leaders and peer counsellors discuss their attitudes and beliefs regarding chemical dependency and service delivery, before they make a decision to work together with a group. This will ensure that their differences are identified and discussed beforehand, and will allow them the necessary time to find ways of working together, or alternatively, to make a decision that they will not work together.

(ii) Because a peer counsellor's role concerning group leadership may at times be confusing, it is important that the peer counsellor remains cognizant of his/her role in the group. Individuals who are interested in taking on the role of peer counsellor must have ample opportunity to discuss their role before they begin to work with groups, and on an ongoing basis throughout the group's existence.

(b) Dual leadership roles of educator and therapist

Due to the fact that the treatment package incorporated components of both education and therapy, the group leader was in a position of having to simultaneously fill the roles of educator and therapist. The role of educator required that the leader take

a fairly directive role. In contrast, my therapeutic style leaned more towards playing a non-directive role. The dichotomy between these two roles was confusing and contradictory at times. I frequently found myself having to switch roles during a given group session. Upon reflecting on this, I wondered if group members had also felt confusion as to "which hat I was wearing" at any given moment and if so, what impact this might have had on my effectiveness.

Recommendation

(i) It is recommended that future studies involving the use of a group treatment approach with chemically dependent seniors, examine the effectiveness of having two leaders, appropriately trained, take on primary responsibility for one role. That is, one leader is assigned the role of educator, and the other the role of therapist. Both leaders can be present for all group sessions, and can share the leadership role based on whether education or therapy is the appropriate strategy at any given time.

(c) Personal learning regarding the role of group leader

Because I had previously facilitated treatment groups for chemically dependent adolescents but had not had experience working with the elderly age group, I began the practicuum with a preconceived notion that my role as group leader with seniors would likely be similar to my role with the younger age group. Although the group leadership skills which were required to effectively facilitate the treatment group were similar, I did not anticipate the myriad number of issues with which I would be challenged, as

leader of a seniors' group.

My own discomfort with aging, specifically, the number of losses that group members typically faced due to the fact that they were elderly, became apparent. My discomfort with talking about losses which seniors had experienced, especially in initial group sessions, was unanticipated. As these issues were explored, I became conscious of my need "to fix" group members' problems and relieve their emotional pain, even though I recognized that I was unable to do so. Feelings of helplessness surfaced, which I attempted to alleviate by reminding myself that I was responsible for the process of the group, but not the outcome. At times, I felt guilty because I had not had to deal with the losses which group members had. I wondered if I could cope nearly as well as the seniors if I were dealing with some of the issues they were facing. A number of my own issues as a result of leading a group composed of seniors, thus surfaced, and contributed a great deal to my learning about the elderly age group and myself.

The complexity of leading a group was also reinforced by the practicuum experience. Specific leadership skills which I needed to improve were identified throughout the practicuum experience, and discussed in the previous chapter. My log recording frequently indicated that I felt "there were too many things to remember" in terms of group leadership.

Recommendation

(i) If possible, it would be desirable for professionals who have not had experience working with the elderly age group, to act

as an observer or co-leader of a group before they take on the task of leading a group by themselves. This would allow them the opportunity to at least partially work through their own issues prior to taking primary responsibility for a group, and would minimize the potential negative impact which their personal issues might have on the group.

3. Social Work with Seniors

A summary of my learning related to the provision of social work services to seniors, is presented. Several of the key learning points and suggestions are relevant to social work with seniors in general. Others are relevant to the use of a groupwork approach with seniors, in the treatment a specific problem area.

(a) It is important that groups for seniors are located in a quiet setting. Many elderly individuals are hearing impaired, and any excess noise will exacerbate their ability to hear what is being said.

(b) Written exercises tend not to be welcomed by seniors. Many have difficulty with tasks which require the use of fine eye-hand co-ordination skills. Although they enjoy take-home reading material, often their preference is to talk about experiences rather than write about them.

(c) Because many seniors have limited access to transportation or have difficulty making arrangements to travel, it is preferable that groups meet in central locations. Social workers, where possible, should offer the option of making homevisits for individual assessment and counselling appointments.

(d) Individual counselling should be made available to seniors who are participating in group treatment. Although the use of a groupwork approach has unique benefits, issues often arise which seniors do not wish to discuss in group, or which are best dealt with in an individual setting. One example of an issue which may be best dealt with in an individual setting pertains to unresolved losses, and the grief associated with these losses.

(e) The group leader should be prepared to take a fairly active role in sessions. Often, seniors are reluctant to initiate a group discussion, or may be unsure of what the leader is asking them to do in a given exercise. If the leader participates in group exercises and is willing to initiate discussions, members are more likely to become involved themselves. An active role on the leader's part must be balanced with a willingness to encourage group members to take responsibility for group discussions.

(f) Social workers will often be required to assist seniors to strengthen their assertiveness skills. Particularly in relation to the medical system, seniors are often reluctant to question their physician about diagnoses, methods of treatment and so on. Part of this reluctance may be due to an innate trust in the medical system, however, seniors also appear to be afraid of asking questions for fear that their medical care will be jeopardized if they are seen as being "contrary". Encouraging seniors to be assertive in asking questions, obtaining second opinions, and seeking care from another physician if dis-satisfied, are issues which social workers need to be prepared to deal with.

(g) It is not necessarily the case that in order for social workers to establish credibility with elderly clients, they must themselves be middle-aged or older. My experience was that as a relatively young practitioner, I was not viewed by the seniors as lacking knowledge or understanding of the issues they faced. On the other hand, they appeared to feel free to challenge the validity of my ideas and suggestions when they viewed them as being prejudiced by my age.

(h) Social workers must be prepared to deal with a great many issues revolving around a theme of loss. Loss of health, mobility, independence, friends, and family members are just a few of the losses which the elderly population faces. An awareness of the number of losses which seniors must struggle with and the impact which they have on seniors' lives on an on-going basis, is critical if social workers are to effectively help the elderly age group work through these issues to the best of their ability.

(i) Because many of the issues which elderly clients present in a helping relationship are emotionally-laden, it is important that professionals have access to co-workers with whom they can share some of their own struggles and feelings with. Regular periods of debriefing with co-workers can assist helping professionals to maintain a realistic perspective of their own limits as a caregiver. Co-workers can also be a valuable source of new ideas and suggestions regarding alternate methods of providing service to seniors.

(j) The practicuum experience served to reinforce that the elderly age group is by no means a homogeneous group. For this

reason, it is important that caregivers who are working with seniors use different strategies and therapeutic techniques with individuals, and do not limit themselves to one approach.

The practicuum experience served to test the effectiveness of a group treatment approach with chemically dependent seniors. Beyond this objective, it served to teach me a great deal about myself, my ability to function as a group leader, the unique issues which the elderly age group faces, and the provision of social work services to seniors in general. Thus, it offered a unique learning experience. Hopefully, it encourages others in the helping profession to work with an age group which offers many challenges and rewarding experiences.

Appendix A

Group Treatment Schedule
April - July, 1990

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	Session 2 - BASIC MEDICATION MANAGEMENT
Week 2:	Session 3 - CHEMICALS AND SLEEP
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	Session 5 - PHYSICAL ADJUSTMENT TO CHEMICALS
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	Session 8 - PSYCHOLOGICAL ADJUSTMENT TO CHEMICALS
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	Session 10 - OPEN FORUM
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	Session 13 - OPEN FORUM
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Appendix A

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	Session 19 - OPEN FORUM
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	Session 26 - IDENTIFYING AND MEETING NEEDS
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	Session 29 - STRESS MANAGEMENT
Week 11:	Session 30 - RELAPSE PREVENTION
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Week 12:	Session 33 - COMMUNITY RESOURCES FOR SENIORS
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	Session 35 - TOOLS FOR ONGOING RECOVERY
Week 13:	Session 36 - WRAP-UP/GOODBYES

Appendix B

Session Transcript - Guilt and Shame
May 28, 1990

Leader: Good morning everyone! Number 1 item, piece of business is...Mr. M. you were here...and Mrs. B. was here...for those of you that were here last time--it was a couple of Fridays ago..

Mr. M.: (interrupting): Yes-Mrs. B. was here.

Mrs.S.: (to leader): How's Mrs. B. doing?

Leader: Good. Really good. She's looking chipper every time.

Mrs. S.: Oh!

Peer counsellor: She came to our (AA) club yesterday.

Mrs. S.: Yes? What club was that?

Peer counsellor: Our AA club. She came and she enjoyed herself.

Mrs. S.: That AA is marvellous. My son still goes there and he's very active and he's made so many friends...he goes for lunch with them on Thursdays, and does things for them like when someone at the office was away he did their banking for them... he's very active.

Leader: What I wanted to ask is...you know Lois who works next door? The lady who works with seniors to train them to be peer counsellors? Lois asked if two of the peer counsellors could sit in with this group starting today, twice a week, for two weeks. What they'd be here for is to observe how the group works, and also to participate, just like Albert and Dave participate in this group. They're training to do the same thing Albert and Dave do--peer counselling. So I wanted to check to see if that's okay with you--with the group.

Mrs. S.: (laughing): We've got no secrets here.

Mr. M.: It's okay with me...I mean...

Mrs. S.: What are they training to do?

Leader: They're training to be peer counsellors...they're going to be working in the community with seniors who are having problems with alcohol or medications. You'll get to know them quite well because they'll share...they won't just be sitting back...they'll be participating. Their names are Jocelyn and Jim. They're good people.

Mrs. S.: Are they people who were troubled before?

Leader: You'll have to ask them.

Mrs. S.: No...but I just...

Leader: I don't know.

Mrs. S. Well--how do they get to the group?

Leader: In different ways.

Peer counsellor: Yes...they open up ads in the paper, and if you want to apply, you apply, not necessarily because you've had a problem though.

Mrs. S.: That's nice.

Mr. M.: (to leader): Do you know my son-in-law?

Leader: Yes.

Mr. M.: Bud is very active in it. But he went through it himself...he should know. He hasn't had a drink for about five years.

Leader: That's great.

Mr. M.: He spends a great deal of time with the double A. He

worked for the City of Winnipeg all his life. He was head of the _____ department. He's got a nice pension and everything else.

Leader: (to Mr. S., who is deaf): Mr. S.--is it okay with you if two of the other people in Lois's group come in and join this group? Is that okay?

Mr. S.: I didn't catch you...

Leader: Okay. Two of the people who work with Lois want to come and join the group--our group--for two weeks. Is that okay with you?

Mr. S.: Oh sure--it doesn't matter to me.

Leader: Okay. What I'll do is I'll go and get them right now, and they can participate in today's group. They'll be here on Mondays and Fridays. I'll go and get them. Maybe what we could do is all do an introduction when they come in.

(Leader returns with Jim and Jocelyn. They shake hands with the group members and get coffee).

Mrs. S.: Where's what's his name? (referring to another peer counsellor)

Leader: Dave?

Mrs. S.: Yes.

Leader: Dave's in Minneapolis. He'll be back sometime today and back in group on Wednesday. He went for an AA conference for the weekend.

Mrs. S.: Oh. My son went to one in Brandon a while ago.

Leader: Oh! What I thought we might do for everybody's benefit is spend a few minutes doing introductions. Just so people have

a chance to get to know names, and a little bit about each other. You can feel free to share whatever you want about yourselves. My name is Laura...most of you know that already, and we're about halfway through this group. I've been involved here since April, with this group.

Mrs. S.: We started at the same time.

Leader: Yes. That's right. We're both newcomers. I'm feeling a little tired today, but also hyper as usual, and ready to get going. (To peer counsellors): It's good to have you here, both of you, and I look forward to you being with us. It's good to see everyone here.

Peer counsellor: My name is Albert, and I had trouble with booze. That's the reason I'm here.

Mrs. S.: Talk a little louder Albert.

Peer counsellor: (laughing). Okay Mrs. S. I had trouble with booze, and I went in for peer counselling. Now I go and join the groups for therapy. I really totally enjoy this work. I'm dedicated to it, and enjoy it. I belong to AA.

Mrs. S.: You belong to AA?

Leader: Tell them what you got this weekend Albert.

Peer counsellor: Okay. It was my tenth year in AA.

Mrs. S.: Wow!

Peer counsellor: I got a cake with ten candles on it, and cards and lots of friends that came to visit. Even one of our girls came to visit and totally enjoyed it (referring to another group member). That's it for me.

Appendix B

Leader: Thanks Albert. (To Mr. S.): So you want to introduce yourself?

Mr. S.: Sure. I'm _____. That's it. That was easy.

Mr. M.: My name is _____. I was a so-called social drinker for many many years. In fact, I was a member of _____ for twenty years and I went to all the socials and I could take a drink and that was it. However, it got to the point where I started drinking fairly heavy, and it got to the point where I just couldn't say "no". I wouldn't admit even at that time that I was an alcoholic--it's a difficult thing to admit even to yourself. I realized that's what I was. Unfortunately, I was cleared all up--I attended the program at Sherburn and Portage--unfortunately, my wife went to the Miseracordia Hospital and she was in and out of there for two years and she finally passed away with cancer. When I came home that night--I live too close to the liquor store, but I'm not making excuses for myself--I thought--I'll have one drink--you know--you fellows who have gone through this, I don't need to tell you--one leads to another and so on down the line and that's really why I'm here. Do you know _____? Well, he was the originator of the A.F.M., and at that particular time he was superintendent of _____. He's a personal friend of mine, and he recommended that I come here, and also to others. I don't really belong to AA but I intend to go to some meetings. I feel that I've got the problem beat, and there's only one person that's responsible, and that is me. (To peer counsellor): I didn't meet this young lady.

Appendix B

Jocelyn: My name is Jocelyn.

Mr. M.: My name is _____. Now we know each other. I know you meet here Mondays, Wednesdays, and Fridays, but I just pointed out this morning--I had a cataract removed from my right eye and all of my left eye. I don't know how these doctors work, but about two weeks ago, I had to go for laser treatment on my left eye, and the doctor told me to call for another appointment. In fact, it will be two weeks tomorrow. So I phoned this morning, and they have an appointment for me this Friday, so I won't be here this Friday.

Leader: Okay--that's fine. Thanks Mr. M.

Jim: My name is Jim, and I'm an alcoholic. I was a controlled drinker for a little while. Actually, for quite a while I guess. I didn't realize that if I was controlling my drinking that I was in trouble right away. Anyway--I was next door here for the last couple of months. We've taken some training and I find it interesting. I have a similar background to this gentleman here-I never spent any time in my life trying to better myself or help other people--it seemed like I didn't anyway, except for my immediate family, so I have the time now--I'm retired--so I thought I'd try this because the people here know so much more about the technical aspects of it, I think. I know what it causes when I drink and what happens to me and I know about that first drink and some of the things...but I didn't know about some of the pharmacological things that happen to me and things that happen inside my body that causes some of the things that I do. I find my training really interesting. I enjoyed it. Thanks.

Appendix B

Mr. M.: Jim--it sounds as if you and I have gone pretty well down the same road. The only thing that I wouldn't admit to myself was that I was an alcoholic. I wouldn't admit it. And so many of my friends told me that whether I like it or not, I'm only one drink away. By God--I found that out to be true--I'll have just one--and then--that felt pretty good--I'll have another one. And then you finally go to sleep. My trouble with alcohol is that if I drink in excess, I get dizzy too. I don't know about any of the rest of you but I've had two falls strictly due to alcohol.

Leader: That's sort of what Jim was referring to--the physiological effects of alcohol, and what happens inside of your body, and for you, dizziness is probably one of the common effects.

Mr. M.: Plus the fact--with all due respect to the seniors here-I think I'm the senior of the seniors here. I'm 83 years old--I'll be 84 on the 22nd of June.

Mrs. S.: Wow!

Mr. M.: And my good lady--if she'd have survived--she died in January--she'd have been 83 in April. One thing some fellows can blame their wives for, but not me--she wouldn't even take a drink--she wouldn't smoke a cigarette--she was too good to be true, really. We were married for 57 years, so you can imagine how it hit me when she passed away.

Mrs. S.: Yes.

Mr. M.: I'm not asking for sympathy, because there's only one man to blame, and that's me. I realize that now.

Jocelyn: Why am I here? I was married to an alcoholic and I got

divorced because I thought it was better for my children and for myself. At the time I thought that was an easy thing to do--get a divorce, forget, tell the kids "Daddy is sick", put it away, and forget it. We tried to do that and it worked. But I got sick right after the divorce. I was in the hospital for a couple of years with a physical problem--I'm an arthritic. Over the years, I've done alot of time and I say "done time" in hospital because I've been in and out up to two years at a time on very high doses of medication. There is a tendency for people to become dependent on the medication. My last bout was last year, and I was again put on the usual meds, and it started me looking at people and wondering how they managed to survive these "wonderful" things when they went home. Then suddenly it dawned on me that there was a tie-in between the alcohol dependency and...I didn't become hooked on both of them but in some way or other there was a tie-in. Then I heard about this class (peer counselling) and I wanted to find out for myself and for my children how this all worked--what a co-dependent was--you've heard the word co-dependency for those of you who have families. It made me feel guilty. I wanted to take the peer counselling class to find out all about co-dependency and how one tied in to the other. I'm taking the course to feel better about myself.

Mrs. S.: Were you on pills?

Jocelyn: All doctor's prescriptions, which fortunately, I managed to stay on the same dosage all the time. But unfortunately, some people I could see were not doing so, and were falling into the

same trap as what you do with booze and things like that. That's what interested me--it's not an easy road--I've been on alot of medication but I've been very lucky, and that's all you can put that down to. That genetically or somehow or other, I was not inclined towards...(addiction), but I think this has been the biggest thing for me--accepting my own sort of thing, and not putting all the blame on my ex-husband. He is the father of my children, so I'm trying to be fair, in balancing this thing. I came here for selfish reasons, I suppose, because I wanted to learn something more. That about sums it up.

Leader: Thanks Jocelyn.

Mrs. S.: Well--the same old story. I was on a tranquillizer for about 10 years and it wasn't helping me sleep so I wanted to get off. My doctor took me off cold and gave me something else. I was terribly sick for two days, and he said I had to go back on it. And I did, and then I saw a show about this program on T.V., and so I came here, and now I'm getting off this pill. Ten years on the same tranquillizer--that's a long time. I don't drink though. I eat--when I'm upset or I feel rotten, I eat. Like the other night, I couldn't sleep so at 2:30 in the morning, I made a cheese sandwich. I don't know if that's good or not, but I go to food, instead of to drink. And I'm getting off it (the medication)--that's all.

Mr. M.: I might point out that that was my problem too. When I drink I don't eat. I don't want to. I'm not hungry. I found that was a disadvantage too.

Mrs. S.: That's why no one ever believes that I'm sick--because I eat and I never look sick.

Mr. M.: Well, I didn't eat. I'd go for three or four days without anything to eat.

Peer counsellor: That's also an addiction.

Mrs. S.: Yes--that eating in an addiction, and I want to get off that too. I mean, there was a time when I weighed 168 lbs. If I would eat the way I like, I could get that way again within a year.

Peer counsellor: I followed the program that uses the same literature as AA.

Mrs. S.: Yes--I saw Overeaters Anonymous once. My sister-in-law down in the States was on it, and she went right down, and she sticks to it.

Peer counsellor: That's good.

Mrs. S.: But that eating is an addiction for me.

Leader: It certainly can be. Mrs. B. was just talking about it this last week. You (to Mrs. S.) should sit down and chat with her about it because she says she is feeling the same thing--finding herself waking in the night and wanting to eat.

Mrs. S.: Yes? I just did that the other night, on Friday night when I couldn't sleep.

Leader: Okay--our session today is a continuation of what we did on Friday. Friday, we started talking about something called "guilt and shame". The whole reason that we talk about this, and spend two sessions looking at guilt and shame, is because they're common feelings that we all have, at some time or another--all of

us. If you're human, and honest, I think all of us can identify that we sometimes feel guilty, or shame. Shame about ourselves, or something that we've done. With people who are chemically dependent, or addicted to some kind of chemical, guilt and shame are very, very common feelings. For the people who were here on Friday, they were really able to share things that they ended up feeling guilty about--not doing the things that you planned on doing, not following through on the things that you planned on doing, making plans and then not being able to follow through because the drinking or the using interfered. And a whole lot of guilt and shame is usually the end result of that. We spent alot of time talking about that in general on Friday, and what I thought we could do today is move on to the second part, in terms of, how do you resolve feelings of guilt and shame? Those two feelings--if you wallow around in them long enough, they'll pull you down everytime--they just do that. I know for me, guilt is probably one of the most difficult things to deal with. That's probably when I'm most uncomfortable inside myself is if I'm feeling guilty.

Mrs. S.: (to leader): What did you do? Why are you feeling guilty?

Leader: It could be for things that I've done, or not done, or whatever.

Mrs. S.: Oh.

Leader: Guilt is something that... I don't know if some people are more prone to feeling guilty--I don't know you guys. All I know is if you're human, you tend to sort of feel that way. We

tried to sort of distinguish, on Friday, between guilt and shame. I'm not sure we resolved that but really what we came up with is that feeling guilty is often related to things we've done or not done, whereas feeling ashamed is often directed towards ourselves. I may feel guilty about something that I've done, but when I feel ashamed, it's usually about myself as a person so it's more directed at myself. I found a little reading that I thought would be really nice to share. This reading is about shame, and I thought I would read it to you. It really points out how destructive shame can be. If we feel ashamed about ourselves--and we do that sometimes--how destructive that can be. It points out that we need to look at ourselves with a balanced perspective. There are good things about us, and things that are not so good, and that's okay, that's part of being human. We don't need to feel ashamed when we're not perfect, and that's okay. So I'll just read this really quickly. "Shame is a little whip we always carry with us. We can shame ourselves easily. The little whip stings. We often use it to punish our feelings because they evoke the helpless children we were. So we learn to suppress our feelings of fear, or rage, or desire. We would rather not feel at all than feel the sting of shame. Why should we punish our feelings? Everyone feels much the same things. Why should our humanity shame us? Perhaps somewhere, we acquire the notion that it's wrong to be human--that an inhuman perfection is the only proper public image. Love can heal the pain of shame. Self-love, and self-acceptance, can make us strong enough to discard the little whip. We're much more

loveable when we acknowledge our humanity and let go of our shame. We're also better able to love others. Shame shuts us up, whereas love opens us to joy".

Mr. M.: Talking about guilt--I don't know if I've ever felt shame for something that I've done, but I've felt that there are things that I could have done that I didn't do, and that's one and the same thing pretty well. Looking back over the years, I've felt that I could have done this or that which I didn't and I feel guilty on that score.

Mrs. S.: Do you feel guilty for things that you didn't do for yourself, or for somebody else?

Mr. M.: For my wife. Although we've no complaints--as I pointed out earlier, she never took a drink or even a cigarette--but particularly when she was sick, maybe I could have done a little more...although I did what I thought was right. Looking back, maybe I could have done this or that--you know, that sort of thing. It makes me feel guilty. I might point out another thing. We hear a great deal about "like father like son". I have three boys and I'm very happy to say right now that they can take a social drink--not one of the three even smoke. And yet I was a very heavy smoker right up until the Second World War. I could tell you a little story too--it's rather amusing. The job I was in--it was an office job, and I did all the hiring. Everyone that would come in would say, "Have a cigarette". And I always had a package of cigarettes in my shirt pocket, and I got to be a very heavy smoker. And how it affected me was the fact that--I never smoked at home

because my wife didn't smoke--the first thing after breakfast I would light a cigarette. I got to the point where I would lose my breakfast and then I was alright for the rest of the day. So Dr._____ was my doctor at that time, and he said, "Mr. M.--you've got two options--either cut down or quit". I told him I was going to quit. He said, "I don't believe you", but I quit--cold turkey. So I never had another cigarette. It so happened--it was the Second World War--and cigarettes went from 33 cents a pack to 35 cents. I have a brother-in-law--he's gone now--it so happened that we were at a party about two nights later. He said, "Mr. M.--you're not smoking anymore?" I said, "Oh no--I quit". "Well what made you quit?" my brother-in-law asked. I explained it, but then he piped up and said "He's a darn Scotchman and he didn't want to spend that extra two cents." (stops and laughs) Maybe there's some truth in that. It sure has saved me money in forty years, I'll tell you that.

Mrs. S.: Yes.

Leader: Mr. M.--what you shared with the group about guilt in regards to things you haven't done or didn't do, really made me think of something else that is really important, which is looking at what's irrational guilt that we carry around--it's not logical--it's irrational. Guilt can be a positive thing because it tells me when something's not okay. If I'm feeling guilty about something when I go to bed and I look at that--maybe I've done something or said something that I shouldn't have--then that's a positive thing because it tells me where I need to straighten

things out in my life. But there are things that we carry around from the past that aren't rational, because we did the best that we could at the time, and if we're still carrying around guilt because we're telling ourselves things like "I should have" or "I shouldn't have", that's really not fair, and we're not being fair when we do that. Not being fair to ourselves. (To Mr. M): Does that fit in terms of the guilt that you have about your wife--about not doing things? Does that make sense to you that that's not really a rational guilt, probably?

Mr. M.: Well--it effects you to the point--if you think too much about it...of course, it's like alot of other things. I'll tell you one thing that annoyed me--my wife was a very religious woman and forgive me if I say this, but for two long years she really suffered. My God--she prayed to the Lord morning and night and everything else, and I never said this to her, but I thought to myself--and I feel guilty for it--I got to the point where I doubted religion. Here's a good-living woman--why should she have to suffer for two years? And yet there's other people that do everything they shouldn't do and nothing happens to them. I feel a little guilty about even doubting religion. And another thing--something we didn't agree on--I believe in cremation. My wife didn't--she believed in the resurrection--I'm sure many seniors do. I may have made a few remarks to my wife that I regret--you know--I kind of feel guilty. However, she's buried at Chapel Lawn and when the time comes, I'll be buried with her. The family wouldn't go for cremating me--you know, being that my wife's there. Those

are the kind of things that perhaps I should get over. The time's coming when it's going to happen, and you begin to question yourself and say "Should I be thinking this way?" and I may have guilt on this basis. Perhaps some others have the same thing, and perhaps not.

Leader: Let's open that one up.

Peer counsellor: For me, guilt is some things that I did to my children--I really feel guilty about--or my wife. When you look at it, it may not be there at all but I feel a shame for having done it because I know that it wasn't right. That's what I carry on. And yet I really think that I did everything that I could in my power at the time. So it's good to examine guilt and shame because that shame is a killer--it will drag you down like you said. I know that I carried that around for many years. It's starting to feel a little better now because I learned through this program, and the program of AA, that we cannot carry that around. It's good to remember that because then you don't commit the same mistakes but you're better off to "let go and let God". I think my shame will always be there.

Leader: Is it getting more manageable?

Peer counsellor: Definitely! More manageable--that's the word. It is more manageable especially because I attended the 16 week peer counselling course. I was flabbergasted by the education program, especially when you're not too educated. I really enjoyed it. Of course--being in AA, and attending meetings regularly...I think you advance and you grow--slowly.

Appendix B

Leader: Any other comments, from anyone else, on guilt and shame?

Mrs. S.: Well--you're going to laugh, but I don't feel guilty for things I didn't do--I feel guilty for alot of things that I did. For instance, I had a sick auntie and uncle with no children--I did alot of things for them. I had a sick mother with me for ten years too. When I look back, I think it wasn't fair to my husband that I was thinking about them all the time, and doing all these things, and taking away from my children and from him. And I don't know to this day whether I should feel guilty because I had to do these things--they had no one else to do it for them. So I feel guilty for things that I did--not things I didn't do, and it bothers me quite abit sometimes. Why did I have to do all that? It wasn't fair to him. My uncle would phone at night and tell me that auntie had to go to the hospital because of an asthma attack. I'd have to get dressed and go in the ambulance. I mean, I just took too much on myself to help somebody else, and I often wonder whether I should feel good about it or guilty about it. (Laughs, along with a couple of group members). Well, it's true--I can't begin to tell you what I went through. This lady had asthma for 12 years and had attacks in the middle of the night. He had a bad heart and then he died and left her alone and I had to get her into a home, and visit her, and then put my mother into a home after 10 years. I mean, I kept running. It was as if I had to do these things, and sometimes I wonder if I overdid it.

Leader: I sounds like you were doing some good things, so when you're thinking about feeling guilty about it, where is that guilt

coming from?

Mrs. S.: Well, first of all I don't think it was fair to my husband that I had to take on all these other problems because in his family, his mother was a wonderful lady, and there were no problems with her, you see. So it was just on my side that all this was going on. I don't think it was so fair to him that I had to assume all this responsibility.

Leader: Did he say things that would make you feel guilty about it or...

Mrs. S.: No--he didn't.

Jim: Maybe he admired you for doing it.

Mrs. S.: (laughing): I don't know--I don't know. See there was no one in his family that he had to take responsibility for. Even though he lost his father and my mother-in-law died at 92--but she was a marvellous woman, a very religious woman you know. She didn't believe in being angry at anyone, or things like that. But I don't know...to this day, I don't even know how I did it.

Leader: It reminds me of me feeling guilty sometimes about things that I haven't done for someone else, or things that I have done, or whatever...and I end up feeling badly about it, and when I end up talking to them about it, they didn't even notice.

Mrs. S.: (laughing): They didn't notice.

Leader: I thought of that when Jim said to you "Maybe he admired you for what you did". It's quite possible here that you're carrying some guilt that isn't yours to carry.

Mrs. S.: Yes, I am.

Appendix B

Jim: I had the same types of problems as Albert did. Because I drank, and spent alot of money. And I had alot of ambition and I had alot of insecurity. And if you add ambition and insecurity together, you get an overachiever and you get a guy that wants to work all the time, and you get a guy that wants to make money and have "the good life". So what this caused in my family--I thought anyway--I wasn't there for my wife or my children, I was away. If somebody said overtime, I'd work. You know, I wanted to make more money...I wanted to have more things. I bought a farm, I had two jobs all the time--that type of thing. So I carried around guilt, and you know, I think guilt is healthy--a little bit of it--some of it. But I carried that around until I finally talked to them about it. And they said: "It wasn't a big deal Dad--we knew the way you were. That's the way you are, isn't it?" So they accepted me the way I was--they accepted me just the way I was. I found that people are very much like that. Like Albert said something about step programs, and something about steps eight and nine where you go and talk to people and try and explain some of these feelings that you have, and talk about how to work through them, and ask their opinion, and that's what I do. And I did go overboard, but they accepted me because I was their dad, and I'm a human being, and I made a mistake--big deal, you know? One thing it did do--by talking about it--it made our relationship closer--communication was better. "Shame" I call a master emotion, for myself, because it makes me feel that I'm basically flawed as a person--there's something definitely out of touch and out of whack

with Jim. With guilt, I feel badly, I feel "if only"...". If I say "if only" about something, I'm feeling guilty, but if I feel ashamed, I feel that I'm out of touch and out of step with the rest of the people in the world, that I don't fit in, that I'm not a part of, and for me, that's very bad. Like if I felt I couldn't talk in this group--if I felt that I was locked up and closed, I would feel uncomfortable. I'm fortunate that I don't feel this way right now. I don't always feel comfortable, but right now I do. If I feel shame, then I don't feel this way.

Mrs. S.: Well, I'm not ashamed, but I guess because sometimes I feel that I overdid things, that I'm not doing enough now for other people. Sometimes someone will say to me at the club, "Come on and do the work with the tag day", and I say "No--I did enough all these years", which I did. I don't want to do it anymore, and then I say to myself, "Gee--you're getting to be a spoil sport".

Jocelyn: That sounds wonderful--being able to say "no".

Mrs. S.: Yes--I'm learning to say "no" to some things. Yes, I'm learning to say "no".

Leader: That can also be a sign of health.

Mrs. S.: Is it good or bad...I don't know.

Jim: "No" is a very positive word.

Mrs. S.: Is it? Because I never used to say "no", you see. But I'm having to say "no".

Leader: And that can be a very positive thing, Mrs. S. But if you're not used to it, maybe it will take a while to get used to it.

Jocelyn: It's scary. I think saying "no" can be scary. The first time that you get enough guts to say "no" can be really scary.

Mrs. S.: Yes.

Jocelyn: Until you get used to it, and then it's easier.

Mrs. S.: Well--sometimes you have to learn to say "no".

Mr. M.: What I learned very early in life was the fact that, particularly when I got involved in politics, was "Say what you think--don't think what you're going to say". If you say what you think, you can never forget it, but if you think what you're going to say, a year from now you may not remember. And I've found that to my advantage, believe me. People say, "That's what he means, because that's what he says". That's nothing to do with guilt. It's just that I learned it very early in life.

Leader: (to Jim): I like what you said about shame, the way you explained it, and I can't even remember the exact words you used, but that made it very clear. I used the word "heavier" on Friday because I couldn't think of a better word. Shame is "heavier" for me than guilt. Guilt is more manageable, whereas shame is something that is very difficult for me to deal with.

Jocelyn: (to Jim): When you talked about it, what it meant to me was that guilt was something you could learn to communicate about, but shame was something that you did not communicate to other people. Shame was a thing that you held inside, and yet guilt was something that you made advancements on, when you learned to communicate it.

Leader: Shame often makes us want to hide. Shame makes us want

to stay in our house and not see anyone, and not want to answer the door, and not want to answer the telephone, and just withdraw. That's what shame feels like--like there's something wrong with me, so I don't want to be around people, because they're going to see what's wrong with me. They're going to notice it, and I don't want anyone to see it, so I'm just going to hide. That to me is what shame feels like.

Jim: I think if I feel shame--if I'm a victim of shame--and someone says to me: "You really look good today, Jim. I like your shirt and tie", then I look down to see if my fly is open. (Group members laugh) I don't trust what other people tell me. If they tell me that I'm a good person, then I say "Uh-huh" but in my mind I'm thinking, "Is that true?"

Mr. M. (chuckling): Jim--you don't give them a quarter for telling you that, do you?

Leader: Anybody want a refill of coffee? We'll take five minutes. (Group members break for a few minutes and then return)

Mrs. S.: I have a habit of saying to my grandchildren that I'm not feeling good, and my granddaughter bawled me out the other day. Now I don't know if I should feel guilty, or give her hell. Sometimes, you just tell people, you know. I told her, "I'm not feeling well. I'm full of pain, and I'm getting off this pill so I feel kind of woozy". "Oh Baba", she said. "You're always complaining that you're sick, and you're always telling everybody that you're sick". How do you get over that?

Leader: You mean you? You personally?

Appendix B

Mrs. S.: Yes--me. I mean, just not tell anybody. From now one, I'm not going to say a word to her. And I think that's wrong. I know I listen to a lot of people that are telling me their physical ailments and I don't tell them to quit complaining.

Leader: Throw that one out. Throw that one out to the group. How do you handle that?

Mrs. S.: (angrily): I don't tell them to quit complaining.

Peer counsellor: For me, it's an age gap. Of course, you talk about pains with people who are about in the same fix as you, because that little girl has no idea. She doesn't like to hear it.

Mrs. S.: Yes--she doesn't like to hear it.

Peer counsellor: So...you say it to those who don't mind hearing it.

Mrs. S.: But I think it was wrong of her to bawl me out.

Peer counsellor: Well, not really....

Mrs. S.: After all, I'm older than her.

Peer counsellor: She's voicing her opinion...

Mrs. S: (interrupting): These young people--they don't understand how we feel when we're older.

Peer counsellor: Well--that's what I'm saying...

Mrs. S.: See--I listened to my mother complain all my life.

Peer counsellor: Oh yes, but that's changed.

Mrs. S.: I listened to her, and I never said, "Oh quit complaining". I tried to do something...so I'm used to listening to people like that.

Mr. M.: But you must remember--you and I came through the thirties. You can't make comparisons between what happened in your young days with what's happening today. I quit that a long time ago, because the children may not even believe what you tell them. And yet, on the other side of the coin...I know I even worked for 25 cents an hour--I don't know about you other fellows--and you know what the wages are today. But also at that particular time, you could go and buy a loaf of bread for three cents, which the children can't understand. Eaton's basement bakery used to have bread for three cents a loaf--unsliced. So I quit that completely now. I don't make comparisons anymore.

Mrs. S.: Yes--it's a different world.

Peer counsellor: Yes.

Mr. M.: We're in a different environment today. My God--the minimum wage--see what it is today. Same with the seniors--when the first seniors' pensions came out it was 25 dollars a month and we thought that was a godsend.

Mrs. S.: Fifteen--my mother got 15 dollars a month.

Mr. M.: Oh--I never remembered that.

Mrs. S.: I do--my mother got 15 dollars a month, and she lived with me. She used to spend it on drugs--on medicines--because she was a sickly woman. There was no medicare then.

Mr. M.: She wouldn't get much for that now.

Mrs. S.: Yes.

Leader: So--along with those kind of other changes you're talking about--(to Mr. M.)--you're talking about not making comparisons in

general because it doesn't work--and Albert is talking about this being a different age--and I think also what's in there is a difference in attitude on the part of young people now, versus when you were young.

Mrs. S.: Oh yes.

Leader: That there are different attitudes and values now.

Peer counsellor: Definitely.

Mrs. S.: Well--we knew we had to take care of our parents--they don't.

Jim: I don't think that means that you don't have anybody to tell.

Mrs. S.: What?

Jim: You need to talk about things.

Mrs. S.: Well, people don't like to hear. I'm not going to say a word from now on.

Jim: You need supportive and safe people to talk to.

Mrs. S.: Well...when I'm sick I'll go to the doctor--I'm not going to complain to them.

Jim: You could come here and say that you had a headache last night, and nobody would shoot you down, I don't think.

Leader: No.

Mr. M.: No. I've got no problem--don't get me wrong--my relationship with my family couldn't be better, really. It's ideal. Everyone of them seem to look after me, and appreciate what we've done over the years. But don't start telling them what happened in 1932, or...

Mrs. S.: No--I don't tell them that...

Mr. M.: ...because there's no comparison.

Jocelyn: But there is some comparison with some things. I know I've had my disease for 25 years, and I suffer from chronic pain, and my children have listened for 25 years to pain...they've listened...it's the same as though I were 80-something or other. Twenty-five years is 25 years of pain. And so I've had to come to terms with pain, and how to talk about it to people, where it's safe to talk about it, and where I can still keep up a balance that's good for me inside, so that I feel good myself even if I'm in pain.

Mrs. S.: Yes.

Jocelyn: And for that young person coming around--sometimes it would be okay--if I'm having a very bad day--to say, "Hey--today I can't do this because I'm having so much pain". And other days, not mention it--maybe take it out somewhere else. For all of us, it's a learning thing...I don't know--I think that's the way it works for me. I've run afoul of it--sometimes I do too much, and sometimes I do too little, so it's like walking a tightrope to sort of figure out when you should say...

Mrs. S.: But if you complain to them that you're not well, how do they take it?

Jocelyn: I guess I would voice it not as a complaint, but I would make it a plain statement of fact: "Today is a bad day--I'm having a hard day today, and I need help pouring coffee". I have to ask for help...

Mrs. S.: I don't get help--I do it. I have them over--they don't

have me.

Jocelyn: I find that I get a good response. Well, my son gets a bit indifferent...but they respond to calls...

Peer counsellor: You see, lots of times--we have a word in AA--we go on the "pitypot".

Mrs. S.: The what?

Peer counsellor: The pitypot.

Mrs S.: Oh...yes--that's a good one.

Peer counsellor: The thing is to line up all your faults--write them down on a sheet--not only in your head, and then put the good things about yourself, and you'd be amazed at the good things you have.

Mrs. S.: Of course.

Peer counsellor: So maybe with that little girl, you could talk about the good things you have.

Mrs. S.: Oh no--she's not selfish or anything--she's good to me. I mean she calls me everyday but...(laughing) she didn't like it the other day--I was having a bad day.

Mr. M.: I haven't heard that word for years--pity.

Mrs. S.: I wasn't looking for pity. I used that word pity in my upbringing.

Mr. M.: I didn't.

Mrs. S.: I did. I mean--I felt sorry for them when they needed help, and I did it. I did pity them.

Mr. M.: Oh, but you didn't ask for it for yourself.

Mrs. S.: No.

Mr. M.: There's a difference, I mean, whether you're giving it or asking for it.

Mrs S.: Who wants their pity? What good does pity do? It doesn't do any good.

Jocelyn: Sometimes I enjoy it.

Leader: Sometimes I do too.

Mrs S.: Yes?

Jocelyn: Sometimes I enjoy a good old-fashioned "pity-thing", and then carry on with the rest of my life. But boy--I have a good time.

Mr. M.: Well--that's wonderful.

(Mrs. S. chuckles)

Peer counsellor: Well--it's not healthy, to tell you the truth, to have self-pity.

Leader: I think that as long as we're human, there are going to be times where we're going to feel sorry for ourselves.

Mrs. S.: Well sure.

Leader: ...and it's not going to become destructive if we don't allow ourselves to wallow in it. When I'm feeling sorry for myself, I have to work on getting myself out of it.

Peer counsellor: But if you feel self pity at quarter to ten in the morning, then you'll find that you're anxious for that time, so that you can get into that self-pity. That's why I say that it's dangerous...to get into it.

Leader: Okay.

Jocelyn: I never looked at it that way. To me, when I do a self-

pity routine, I can work it so that I do it so much to myself that I can almost end up giggling, and get myself out of it that way, and then it goes away and I can get a good laugh at it. And I don't know...that works for me.

Mrs. S.: You can laugh at yourself?

Jocelyn: I can laugh at myself.

Mrs. S.: I find it hard to laugh sometimes...I don't know...

Jim: Do you miss him (referring to Mrs S.'s husband) that much?

Mrs. S.: Sure--everybody does. It's hard--being on your own--it's very hard.

Peer counsellor: It's not easy...but you try that once--mark all the bad things in and on the other side, mark all the good things, and you'd be surprised at all the good things you find...

Mrs. S.: Uh-huh.

Leader: You know, I really like that exercise--also for guilt and shame, what we're talking about today. For sure, if we walk around all day thinking in our head about..."Laura, you know, you're stubborn, and you said that stupid thing, and you tried to do this and you knew you shouldn't take it on, and..." --you know all those negative messages. If we carry around those things all day, we're going to end up feeling--me anyway--pretty guilty, or ashamed. And as long as I'm feeling that way, forget about that positive stuff. I wouldn't see the positive things about me if someone put it in front of my face, if I'm feeling guilty or ashamed. You could write all those wonderful things on the board and I would say, "Who are you talking about?" Right? So that for

me, in that negative thinking, there sure isn't a whole lot of room left for positive, and that's why it's really important to look at the guilt and the shame, and decide what's realistic here. What's rational guilt, and what's irrational? What are you going to keep, and if you can, make amends for, and what are you going to let go? Because carrying it around--the more I carry it around, the more destructive it gets, and the worse it gets.

Jocelyn: Does that mean when you let it go it's gone forever, or does it come back again--have you got it back another time?

Leader: No. For me, it's what Albert was talking about. It gets more manageable--it becomes more manageable over time, but I have to work at it. It doesn't happen automatically: "Well, I'm going to let go of this guilt and shame", and it's gone forever. I shared this on Friday, and I'll share it with this group as well. Probably one of the hardest things that I've had to deal with is a separation. I was separated from my husband three years ago, and one of the hardest things that I had to deal with was the shame. What I did was--I had a lot of thoughts like, "What's wrong with me, first of all, that this had to happen?" Secondly, what I was doing was saying "What's wrong with me that I got into that situation in the first place?" So I was really doing alot of self-blaming, and certainly part of that was good because I learned alot, but it was a two-way street. To really take all the responsibility on was not fair--not fair to myself--it was a 50 - 50 thing. In the three years...I don't feel the same kind of shame that I did two years ago, or six months after the separation. I

don't feel that shame anymore. What I feel now, occasionally, is a little nagging feeling that says, "How come?" And then I really have to stop myself--this is just my way of coping--I have to stop myself and say: "Okay Laura, you weren't the same person eight years ago, or even three years ago, that you are now. You did the best that you could at the time. And I know that that's true. And I believe that that fits for all of us. We all do the best we can, at any given time, with what we have. And so kicking ourselves for things we've done in the past is absolutely unfair, and useless. Because it's easy to see--down the road--some of the things that we've done or not done, when we've become more experienced...

Mr. M.: Well, that's where the word "guilt" comes in. I mean, do you feel guilty, or don't you feel guilty, that sort of thing. Or are you just partly guilty? I'm speaking about your personal problem right now.

Leader: For me, guilt was definitely part of it, but it was the other bigger thing--what's wrong with me as a person--so there was definitely shame in it. There was both. And what I'm saying to you, I guess, is that it definitely has not completely gone away but I'm not carrying it around like a big load on my shoulders anymore either, just because I realize that that's not fair to myself, and that it's not going to help me.

Mr. M.: Right.

Leader: As long as I carry that around, it's extra baggage. I learned alot of things out of the whole experience, that I hope I don't forget, you know? That will help me with other things in

the future.

Jim: (to Mrs. S.): Were you going to say something?

Mrs. S.: Me? No--I'm just listening.

Jim: Oh. Well, when I was drinking, I did alot of things I wasn't particularly proud of. And that caused alot of shame. When I sobered up, I saw some of the things that happened. And I asked myself "Why?" I had alot of guilt over that, and alot of shame. And I think I had to be with others. I had to join a fellowship--that's just what helped me more than anything. And with me, that fellowship just happened to be Alcoholics Anonymous.

Mr. M.: Do you belong to the Fellowship Club? (thinks Jim is talking about another club).

Jim: Yes.

Mr. M.: I do too, and I've belonged for many many years.

Jim: I need other people around me, with the same kind of problem, that can get my problem into focus a little easier. Sometimes I can't solve shame by myself--I have to have other people involved. Just about all the time I have to have other people involved. When I drink, I tend to withdraw--when I withdraw, I get lonely--when I get lonely, I get on the "pitypot", and I race around the track, just like this round table. And I drink a little bit more because I'm a little more lonely and then I get more withdrawn when I'm more lonely--around in a circle.

Leader: A vicious circle?

Jim: Yes. To break that is difficult, but it's sure worthwhile. I found it worthwhile.

Mr. M.: Jim--I'll tell you something--you don't know the party anyway--but this fellow Jim _____--the last time, he said, "Mr. M.--I'm going to put you in the hospital as a place where you can go." You're not in there for more than two or three days, normally, and when you're in there, you can go and walk around--you're not confined. So last time I was there, there was one chap, and it was a Thursday, and I asked, "When did you get in?" "Oh, just today", he said. And yet he knew everybody in there. I said "My God--it didn't take you long to get to know everyone". "Well", he said, "I've been here 15 times".

Mrs. S.: Wow!

Mr. M.: Now--what can you do with that sort of thing? And he was proud of the fact that he'd been in 15 times.

Mrs. S.: And it didn't help?

Mr. M.: No--that's what I wondered. He knew everybody in there by their first name, and rightly he should have, and there was no shame as far as he was concerned. "Oh--I've been here 15 times!" I didn't think that they allowed that.

Peer counsellor: That's very common, because we have one in our group that's been 22 years in our group. He's no more than two weeks dry at a time, so it's a common thing.

Mrs. S.: Well--some of them can't.

Peer counsellor: Some of them can't.

Mr. M.: There was another case where this young chap had been in trouble, apparently with the law, and they had a security officer who stayed there 24 hours a day, and all they did was to assure

that this young fellow didn't escape, or whatever it was.

Peer counsellor: What they do now--you know you're not allowed to go that many times anymore.

Mr. M.: Well that's what I thought. You know, I was surprised. They certainly don't give up easy--15 times!

Leader: You've got to give somebody credit, for hanging in and trying again.

Peer counsellor: Yes--22 years.

Mrs. S.: Maybe he wasn't really trying. It was just a lark to him.

Mr. M.: And another thing--there was a lady that came up to talk to me--her husband and her were both there, and there were two couples, and each one blamed the other. In other words, the husband blamed the wife, and the wife blamed the husband for being there.

Leader: That's common too.

Mrs. S.: Yes.

Mr. M.: Well, have you ever been in there Jim?

Jim: No.

Mr. M.: Well, it's certainly worth seeing, you know? What goes on...

Mrs. S.: Talking about drinking, what do you think of this murder? Like my son says that that's alcohol related--the guy must have been drunk when he killed his wife because they were out drinking, and he says he came home drunk...

Mr. M.: (interrupting): Well unfortunately, 75% of...

Mrs. S.: ...he came home drunk, beat her up, and that was it...it's alcohol related.

Mr. M.: It must be. That last one that happened where the husband was never charged--I'm quite sure...

Mrs. S.: That's the one I mean...

Mr. M.: There had to be liquor involved.

Mrs. S.: Of course--they were drinking! And she stayed on, you see? Alot of the murders that are happening are alcohol related.

Mr. M.: But this one wife, she gave me the whole story, and she said that her husband used to buy beer by the case. And he'd bring a case of beer home and say, "Marjorie--have a beer". And she'd say "That's all". "Oh no"--"have another one", because he was having another one. And she said the only one person to blame for her being there (in the hospital) was him. And I was surprised that they don't separate the males and females in this particular case. I could be sleeping in this bed, and you could be sleeping in the next, and so on down the line. I thought they'd be separated, but not there...that's at the general hospital.

Mrs. S.: Really?

Jim: Oh--you were at the general hospital?

Mr. M.: Yes. Jim_____ put me in there for three days, just to...

Leader: Mr. M., I was going to ask you--you were nodding when Jim was talking about the cycle of feeling guilty and then getting withdrawn, and then feeling lonely and drinking to try and ease that--you were nodding.

Mr. M.: Yes.

Leader: That fits for you? Those feelings going along with being withdrawn and then drinking...

Mr. M.: That's correct. But it's surprising--really surprising, when you get around and know as many people as I do--that many young people are really involved. I feel bad about it because even the younger women too--18, 19, 20 and 21 years old--they have their whole life ahead of them, and unless they can control it now...

Leader: Some people will argue that for younger people, the advantage is that if someone can offer them and get them to accept help earlier, recovery occurs a little bit more quickly for younger people. But yes--I know what you mean in terms of the concern about younger people...

Mr. M.: Well--I'm sure you noticed in the paper the other day where these two or three young fellows under the bridge, where they were gone...that's a tragedy.

Leader: It sure is.

Mrs. S.: Of course.

Mr. M.: It shouldn't have to happen, but it does. What can you do?

Jim: Education.

Mr. M.: They need alot of education, and yet they're at the age where they should be taught pretty well--you know, 18-20 years in particular--he's reached about as far as where the normal education can go. He may go further by going into a profession-university--that sort of thing...but I'm very proud of every one of my three

sons--although I didn't make a great deal of money, everyone of them got degrees--university, and I'm very happy about that.

Jim: I don't know whether that's particularly the type of education that's really required, though.

Mr.M.: You're talking about the type of education they get at home?

Jim: No--well in my home, my mother and father didn't drink. Why did I end up an alcoholic? You know--I asked myself that question lots of times--why me? Then I had to look into things a little bit deeper, and I found out that my grandfather was an alcoholic, my uncle was an alcoholic, my brother was an alcoholic, I'm an alcoholic, you know...

Mrs. S.: Not in my family.

Jim: And then I added this all together with what I listened to in all these other places, like Alcoholics Anonymous, and I added that all up and I thought that it makes sense now. It makes sense--there's something different in my enzymes, or in my cells, or in my DNA or whatever you want to call it, that is maybe a contributing factor to this. So I've told all my children now, and all my grandchildren. I've told every one of them--you know-"I'm sorry, but I may have passed on this rotten little deal to you, and be aware--be aware of it for sure".

Leader: Yes.

Peer counsellor: Now they're going as far as saying that it could be something that's in the genes, so that's something you can't help, even if you...

Leader: No--and it doesn't mean though, that you're going to become chemically dependent.

Peer counsellor: No--it doesn't.

Mr. M.: I never really got to know my father, because he was killed in 1916. I was only 10 years old at the time. Then I left home when I was 20--and my mother was still quite a young woman--and I never saw her since I left home although I've been over there, but she died pretty young.

Leader: So you're not really aware of your family history?

Mr. M.: No--I can't blame anyone.

Peer counsellor: Well--there's no blame either.

Leader: No.

Mr. M.: No, I know--but what Jim said--it just runs in the family--it's not necessary--it could be.

Peer counsellor: It could be.

Mr. M.: Because as I said, my sons know I'm an alcoholic--I didn't try to hide the fact--and yet none of them...they'll take a drink, you know, but I hope none of them become alcoholics because I am.

Leader: They're not going to because you are. It just means that if people are aware--like Jim says, he told his kids just to make them aware--because they may be at slightly higher risk than somebody else.

Mr. M.: Well--that's what Jim said. It had been in the family--grandfather and grandson, and so on down the line...

Leader: Yes.

Jocelyn: And they're raising children who become aware at a

younger age. We talk about 16 year olds--their education starts far before 16--not an academic thing, but more of a ...I look at my six month old grandchild and we know--my daughter and I--that her grandfathers, both sides of the family...and now that we're coming up front and talking about it--before we didn't talk about it--now it's talked about, and everything else. The talking is healthy--the communicating is...and not making it seem like an awful deal--taking the stigma out of it, and treating it like an everyday thing, I think is alot healthier for our family. Hopefully, I think my grandchildren stand a better chance of fighting things like that because it's been looked at in a more normal way, both from pills or whatever it is, earlier on in life.

Leader: (to Mrs. S.): Do you know of any history in your family?

Mrs. S.: No.

Leader: Or in your husband's family?

Mrs. S.: No.

Peer counsellor: Is there a history of sugar diabetes in your family?

Mrs. S.: No.

Peer counsellor: Or a history of heart problems?

Mrs. S.: Well, my father-in-law died of a heart condition. My husband...

Peer counsellor: Because there is no difference between the illness of alcoholism and the illness of sugar diabetes.

Mrs. S.: No--no sugar diabetes.

Peer counsellor: And yet we feel sorry for the sugar diabetes

guy because the guy's got an illness that he's got no control over.

Mrs. S.: If sugar diabetes came from eating sweets, I should have it, because I was such a sweet lover--pastry and rich things--I was eating it all the time. Even now, I like it, but I try to keep away from it.

Peer counsellor: It's usually cholesterol.

Mrs. S. That's what I have--high cholesterol.

Mr. M.: Well--I'm the same as you. I have rolled oats for breakfast every morning but I've got to have sugar in it.

Mrs. S.: Yes.

Mr. M.: I don't like it if it doesn't have sugar.

Mrs. S.: Use the Sweet 'n Low.

Mr. M.: The cup of coffee I've got here has two helpings of sugar.

Mrs. S.: Use the Sweet 'n Low. When I have tea with lemon, I take a Sweet 'n Low, otherwise, I don't take anything.

Mr. M.: Well--it doesn't seem to have hurt me too much. I like sugar.

Leader: I've got an exercise here that we're not going to have time to do today, but I'm just going to go through it, and encourage everybody to do, if you haven't already done it--you may have already done this, because I know AA does something very similar to this--but it's a very simple exercise in terms of it simply asks you to write down or list actions in the past that you believe you were responsible for, or regret, or believe that you have done wrong. So things that you've done--or not done--because that fit for a number of us--things that you've done or

not done--that you regret, or that you believe you're responsible for, or that you think you've done wrong by doing or not doing. You can just write a word for each thing you think of. Some of you might have one or two things, some of you might have nine or ten things--I don't know, it depends. It depends on how many things you've been adding up in your head, I guess, and keeping track of. When you're done with the list, take a look at it and go through each item, one by one, and decide if it's a rational guilt or not. Decide if there's something--in other words--that you really did wrong, and if you didn't, make a mental note to yourself to try and work on letting it go--not carrying around the guilt anymore. Like I said, it's not that easy in terms of it's not going to happen overnight, but you can start to get rid of some of the extra baggage by telling yourself that you're going to get rid of it, and by starting to work on it.

Mrs. S.: Yes--but I'm sick of thinking about the past, and all the things that I probably did wrong. I mean--at this age--why should we have to be thinking about what we did wrong?...

Leader: Okay, the key here, Mrs. S., is I don't want you to list everything you've done wrong. My God--if I had to do that I'd be sitting there for days, and I can't.

Mrs. S.: (laughing): Yes.

Leader: And I don't want to think about those things either.

Mrs. S.: Yes.

Leader: I'm not asking you to list everything that you think you ever did wrong. What I'm asking you to do is to list things that

you're carrying around and feeling guilty about--things that you think you did wrong--that you're still carrying around guilt for. Things you did or didn't do, that you're carrying around in your head, and feeling guilty about. Because if you're still carrying them around in your head, then you're spending alot of energy and time thinking about them.

Mrs. S.: Yes.

Leader: So--just those kinds of things. I don't want you to dig underneath the surface. You know, and all of us know, what's up in our heads and what we're carrying around on a day-to-day basis, that we still feel badly about. We know, without thinking about it for too long. And then just take a look at each thing on the list, whatever number there are, and decide if it's a realistic guilt, or if it's something you can even do anything about, you know, if it's time to let it go, instead of continuing to feel guilty for it. There may be some things on the list that you decide--"Yes--I'm still feeling badly that I said such-and-such to that person, and that person is still around, so maybe I can go back to that person and make amends". There's nothing that gets rid of guilt quicker than being able to make amends. Sometimes we can't--sometimes we can, by saying we're sorry, or by just correcting whatever it was, it just depends. But sometimes we can't, and those are the ones where we really have to look at "Is it doing anybody any good anymore for me to feel guilty about this, or for me to hurt myself and feel ashamed?" Does that make sense?

Mr. M.: Yes.

Peer counsellor: Yes, it makes good sense. You see, in AA, of course we have such a thing as a daily inventory. That covers pretty well that ground. And I don't think you'll find that there's many days--at least for me--that there's not something that you could have done better. In that case, well, you try and do better the next day, and that's not necessarily so, but at least you realize...for me, it's a great exercise.

Leader: So what happens then, if you're going to sleep, and you've got this nagging guilt feeling, but you can't identify it-you can't figure out what it is. Let's say it's an irrational guilt--it's not a rational one--it's irrational. What do you do with that? You sit down and you think "I don't know why I feel guilty--I can't think of one specific thing that happened today, or why I'm feeling guilty". So you decide, "This isn't very logical--I don't know where this is coming from."

Jim: I have a little shelf.

Leader: A little shelf?

Jim: A little shelf.

Mrs. S.: You put it on the shelf?

Jim: I don't know what to do with it. It's a vague kind of thing--is that what you're talking about?

Leader: Yes.

Jim: It's a vague kind of thing that you can't put your name on? I have a little deal up there--it's called a shelf--and I just mentally put it over on that shelf.

Leader: And leave it there?

Jim: And leave it there. And if it's worthwhile, it always comes back. And if it isn't worthwhile...they told me that in AA, and I thought "What a stupid system". I'm a pretty practical person--"What a stupid thing to do--how does this work?" This thing that I had going at that particular time, it had long since past and wasn't even worthwhile thinking about anymore, but at that time, it was very important to me. And a guy said, "Well--if you just put it on the shelf..." and I said "What shelf?" He meant to put it on the mental shelf, and leave it alone. And I did.

Mrs. S.: That's a good idea.

Jim: And it worked--it worked beautifully. And it's such a simple thing, and it never occurred to me to do it until this guy told me. I had alot of trouble sleeping, and I found that if I drank a few beer, some wine or some whiskey, or whatever was available, I could sleep.

Mr. M.: How long does alcohol stay in your system?

Jim: Long enough for me, if I drink it for the right reasons.

Mr. M.: No, but does anybody have any idea how long it actually stays?

Leader: You mean physically? How long it really stays inside your system?

Mr. M.: In your system.

Leader: It takes, for most people, of average size and of average height--your body can get rid of about one ounce per hour. So if you sit down and you drink a 26 ouncer, it's going to take your body--for most people--roughly 26 hours to get rid of all the

alcohol.

Mr. M.: I've heard discussions where they say it can stay in you system for six weeks.

Leader: Not the alcohol itself. The effects of alcohol can certainly stay for six weeks.

Jim: For six months even.

Leader: Yes, six months.

Peer counsellor: Just like smoking. You experienced it too, Mr. M. The effects can stay for a long time.

Mr. M.: That's a funny thing. When I quit smoking, I quit like that, and it didn't bother me. In fact, I've gone as far as to-when somebody's in the car with me--even light a cigarette for them, and hand it to them, and it didn't bother me. And yet, I was addicted to smoking, believe me. I used to smoke at least a minimum of a package a day.

Peer counsellor: (to leader): The irrational thing that you were talking about, that Jim was saying to put on the shelf, isn't it a real example, in your case, about your separation or divorce--the divorce is still there--it didn't change--it'll be there forever--but your way of looking at it is different. So anything that's irrational today, might become almost rational because the problem never really goes away.

Leader: The event--yes--I can't change the event. The only thing I can change is how I look at it, and how I'm going to deal with things in future.

Mrs. S.: That's a good way..how you look at things. See,

different people look at things differently. They'll look at what a person is doing and say that he's a bad person. Another person will look at some things and say that he's a good person, or "He's doing wrong", or "He's doing right". And I think that I look at alot of things the wrong way.

Peer counsellor: You're not unique.

Leader: No.

Mrs. S.: I try not to criticize people and I try not to dislike people--when I was younger, I was a holy terror. If somebody was mean or didn't do the right thing, I would let them have it, and tell them...I don't do that anymore.

Peer counsellor: That's good.

Mrs. S.: No--you can't be too critical. There are some people that are always criticizing everybody.

Leader: You're changing...you know, recognizing where we don't always have the attitude that we want to have, is good. We're never going to be perfect--nobody is.

Mrs. S.: I don't want to be perfect--why should I? It's too hard. (laughs)

Leader: No--I don't either. And it would also be kind of boring.

Mrs. S.: And it's too hard to be perfect.

Leader: And wouldn't it be a boring world if everybody was perfect? We'd know exactly what everybody was going to do all the time.

Mrs. S.: Yes.

Peer counsellor: It's impossible.

Leader: And no fun. I guess we can try but...I'm kind of glad I'm never going to be.

Peer counsellor: Anyway, just on a little note of humour--Jim is in the program--he should know this--does anybody here know why an Al-anon never smiles when she's making love to an alcoholic? It's because she can't stand to see an alcoholic have a good time. (group members laugh).

Leader: Okay, so I'd encourage everybody to do the exercise, sometime within the next week, and next week, when we have the same members back, we'll talk about it. People can share things if they want to...but you don't have to.

Peer counsellor: Thanks for the session. It was good.

Mrs. S.: Well, I just want to make a remark--this group--what I'm learning isn't just how to get off alcohol or pills--it's how to behave--it's more about human behavior.

Leader: Human feelings--and coping.

Mrs. S.: And coping with life. But you tie it in with alcohol and pills. Well, it's true. How did I get on that tranquillizer 10 years ago? I had terrible pains in my legs--I used to wake up crying at six o'clock in the morning, and none of the doctors could find out...they sent me to a haematologist, I had all the tests, and the doctor said I'd have to go to my psychiatrist. And he gave me those pills. Because I was having problems then--divorces, drinking--not me--and that's how I got on the pills, because I couldn't cope. So the moral of the story is, you have to learn to cope.

Leader: So does it fit for you then, why those things are being tied together?

Mrs. S.: Yes. Of course, I don't drink, but that's how I got on the tranquillizer, and I was taking valium before that. Well, the doctors gave it to you then.

Peer counsellor: Just another addiction. And these pills, and alcohol, are but a symptom. It's just a symptom of your problem. After you get rid of the alcohol, you still have the same problem, so it's only a symptom. It's because I wanted to cover up my problem.

Leader: That's why we spend so much time in this group looking at feelings, and coping, and problems--because we all have them and the thing is, you can't just get rid of the chemical--you can't just throw the booze away, or the pills away. The problem and the feelings are still there, so we have to find another way of coping with them without using a chemical, or without drinking.

Mrs. S.: Because I don't want a sleeping pill now, and I'm sure not sleeping, but I'm not going to take a sleeping pill--no way.

Jim: It's not life threatening--if you don't sleep well.

Mrs. S.: Yes--but it's nerve-racking. Like I got up at 2:30 and made a sandwich.

Mr. M.: But I'll tell you about my better half. The doctor put her on sleeping pills but then he finally had to take her off because she was getting addicted to them--she couldn't get along without them. She quit them just like that and she never had any more. But she couldn't go to sleep without those darn sleeping

pills. And the doctor told her that she was addicted, and he refused to give her any. Well, I've got to go. My daughter will be waiting.

(Group members say good-bye to each other, and begin to leave)

Appendix C

Hôpital Général - St. Boniface - General Hospital
409 Tache Avenue,
WINNIPEG, MANITOBA R2H 2A6
(204) 233-8563

CONSENT FORM II

I hereby agree to participate in this project being conducted by the Department of Social Work, St. Boniface General Hospital. The objectives of this project were explained to me and I understand that I can withdraw from the project at any time without compromising my future medical care.

June 4/90

Date

Signature

Witness

Appendix D

C.A.G.E.

1. Have you ever felt the need to cut down on drinking?

   Yes or No

2. Have you ever felt annoyed by criticism of your drinking?

   Yes or No

3. Have you ever had guilty feelings about your drinking?

   Yes or No

4. Have you ever taken a morning eye opener?

   Yes or No

SCORING: Number of questions answered "Yes" _____

4

Appendix E

BRIEF MICHIGAN ALCOHOLISM SCREENING TEST

		Yes	No
1.	Do you feel that you are a normal drinker?	0	2
2.	Do friends think that you are a normal drinker?	0	2
3.	Have you ever attended a meeting of AA?	5	0
4.	Have you ever lost friends, girl/boyfriend because of drinking?	2	0
5.	Have you ever gotten into trouble at work due to drinking?	2	0
6.	Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	2	0
7.	Have you ever had delirium tremens, heard voices, or seen things that were not there after heavy drinking?	2	0
8.	Have you ever gone to anyone to help stop your drinking?	5	0
9.	Have you ever been in a hospital because of drinking?	5	0
10.	Have you ever been arrested for drunk driving or driving after drinking?	2	0

Appendix F

MANITOBA DRUG DEPENDENCY SCREEN

1. What drugs are you currently taking? (Put Info on Chart)
2. Are you taking any other medication to help you sleep?

   NO YES----------(Ask Information on Chart)
3. Are you taking any other medication to help with your nerves?

   NO YES----------(Ask Information on Chart)
4. Are you taking any other medication for pain?

   NO YES----------(Ask Information on Chart)
5. Do you find that any of your medications no longer work as well as they used to? NO YES

   (IF YES) Which ones?_____

   _____

   _____

   (Ask Information on Chart for any Drug not listed previously)
6. Are you taking any medications you would like to do without?

   NO YES

   (IF YES) Which ones?_____

   _____

   _____

   (Ask Information on Chart for any Drug not listed previously)
7. Do you receive prescriptions from more than one doctor?

   NO YES
8. Do you get all your medications from the same pharmacy?

   NO YES

Appendix F

	Drug_____	Drug_____	Drug_____
	_____	_____	_____
(CIRCLE ONE---)	O B N	O B N	O B N

Why are you taking it?

_____

How often do you take it?

_____

How much do you take at one time?

_____

How long have you been taking it?

_____

Was it prescribed by a doctor?

_____

How often do the directions say to take it?

_____

How much do the directions say to take at one time?

_____

Could you do without this medication?

_____

(IF NO) WHY?

_____

Appendix G

Hôpital Général - St. Boniface - General Hospital
409 Tache Avenue,
WINNIPEG, MANITOBA R2H 2A6
(204) 233-8563

July 25, 1990

Dr. Bill Jacyk
Mr. Mark Badger
Mrs. Ellen Tabisz
Elders Health Program
403 - 400 Tache Avenue
Winnipeg, Manitoba
R2H 3C3

Dear Elders Health Program Staff:

I am writing to you regarding an instrument entitled the "Manitoba Drug Dependency Screen." I would like written permission to use this instrument to diagnose drug dependency in seniors.

Thank you in advance for your co-operation.

Yours truly,

Laura A. Morris (B.S.W.)

Appendix H

SCORING INSTRUCTIONS FOR BICYCLE DRAWING TEST

One point is scored for each of the following items included in the drawing:

1. Two wheels
2. Spokes on wheels
3. Wheels approximately same size (smaller wheel must be at least three-fifths the size of the larger one)
4. Wheel size in proportion to bike
5. Front wheel shaft connected to handle bars
6. Rear wheel shaft connected to seat or seat shaft
7. Handlebars
8. Seat
9. Pedals connected to frame at rear
10. Pedals connected to frame at front
11. Seat in workable relation to pedals (not too far ahead or behind)
12. Two pedals (one-half point for one pedal)
13. Pedals properly placed relative to turning mechanism or gears
14. Gears indicated (i.e., chain wheel and sprocket; one-half point if only one present)
15. Top supporting bar properly placed
16. Drive chain
17. Drive chain properly attached
18. Two fenders (one-half point for one fender; when handlebars point down, always give credit for two fenders)
19. Lines properly connected
20. No transparencies

Appendix I

LIFE SATISFACTION SCALE

We would like you to consider your life as it is right now. Pick the number that best describes your own life as it is now.

INSTRUCTIONS: Put the appropriate number from the following choices on the blank space before each item.

(1)	TERRIBLE	(2)	VERY DISSATISFYING
(3)	DISSATISFYING	(4)	MIXED
(5)	SATISFYING	(6)	VERY SATISFYING
(7)	DELIGHTFUL		

___ Health (The present state of your general, overall health)

___ Finances (Your income and assets)

___ Family Relations (Kind of contact and frequency of contact you have with your family members, including personal contact, phone calls, and letters)

___ Paid Employment (Any work for wages, salaries, or fees - NOTE: If you are not currently receiving wages, put an 8 on the blank)

___ Friendships (Kind of contact and frequency of contact you have had with your friends, including personal contact, phone calls, and letters)

___ Housing (The present type, atmosphere, and state of your home)

___ Living Partner (Includes spouse, common-law partner - NOTE: If you are not living with a partner, put an 8 on the blank)

___ Recreation Activity (Personal recreation activites you engage in for pure pleasure when you are not doing normal daily living chores or some type of work)

___ Religion (Your spiritual fulfillment - NOTE: If you are not religious, put an 8 on the blank)

___ Self-esteem (How you feel about yourself)

___ Transportation (Public and private, including convenience and expense)

___ Using the same scale, how do you feel about your life as a whole right now?

Appendix J

November 26, 1990

Frank M. Andrews
Stephen B. Withey
Institute for Social Research
University of Michigan
Ann Arbor, Michigan
48106

Dear Mr. Andrews and Mr. Withey:

Re: Life Satisfaction Scale

I am currently facilitating a treatment group for chemically dependent seniors as part of a practicuum towards a graduate degree in Social Work. I would like to use the Life Satisfaction Scale to determine whether there is a change in seniors' life satisfaction after their chemical use has stabilized.

I am requesting from you, written permission to use your scale. Thank-you for your consideration.

Yours truly,

Laura A. Morris
265 Campbell St.
Winnipeg, Manitoba
R3N 1B4
Canada

28 Nov 1990

By this note, you hereby have permission for the use requested above. Please cite the source of the scale if you publish results derived from its use. Good luck with your work!

Appendix K

BRIEF UCLA LONELINESS SCALE

The following statements express the way that most people feel sometimes.

==========

INSTRUCTIONS: Pick the appropriate number from the following choices that expresses how often you feel the statement describes your feelings. Put the number on the blank space before each item.

==========

(1) NEVER (2) RARELY (3) SOMETIMES (4) OFTEN

___ I lack companionship

___ There is no one I can turn to

___ I am an outgoing person

___ There are people I feel close to

___ I feel left out

___ I feel isolated from others

___ I can find companionship when I want it

___ I am unhappy being so withdrawn

___ People are around me but not with me

There is a difference between saying "I'm ready to die", and "I want to die". Which of the following phrases would you say best represents how you feel? (Check one response)

___ Ready to die ___ Want to die ___ Both ___ Neither

Appendix L

THE UNIVERSITY OF BRITISH COLUMBIA

School of Family and
Nutritional Sciences
2205 East Mall
Vancouver, B.C. Canada V6T 1W5

Office of the Director

BITNET: USERHDP@UBCMTSG
Fax: (604) 228-5143

December 15, 1990

Laura Morris

Dear Laura,

Your letter of November 26th has recently reached me. I am very pleased of your interest in doing loneliness research. The UCLA scale was developed for research purposes (rather than for clinical use), and therefore the items are in the public domain. They were published in Russell et al.'s 1980 ***Journal of Personality and Social Psychology*** article. A copy is enclosed for your use. I would be interested in your findings when they are available.

Sincerely,

Daniel Perlman

Appendix M

SOCIAL NETWORK SCREENING QUESTIONAIRE

1. Is there anyone who helps you with things like shopping, housework, preparing meals, or going to appointments?

   1 - NO

   2 - YES

   (IF YES) WHO? (LIST ALL RESPONSES)_____

_____

2. Do you have anyone who you confide in, talk to about yourself, your concerns, etc.? That is, do you receive emotional support from anyone or not?

   1 - NO

   2 - YES

   (IF YES) WHO? (LIST ALL RESPONSES)_____

_____

3. Who provides companionship to you most often? (LIST ALL RESPONSES)_____

_____

4. If you were admitted to the hospital, is there anyone who would visit you?

   1 - NO

   2 - YES

   (IF YES) WHO? (LIST ALL RESPONSES)_____

_____

5. Is there anyone close to you who has a problem with alcohol, prescription medication, or any other drugs?

   1 - NO

   2 - YES

   (IF YES) WHO? (LIST ALL RESPONSES)_____

_____

Appendix N

Hôpital Général - St. Boniface - General Hospital
409 Tache Avenue,
WINNIPEG, MANITOBA R2H 2A6
(204) 233-8563

January 31, 1991

Dr. Bill Jacyk
Elders Health Program
403 - 400 Tache Avenue
Winnipeg, Manitoba
R2H 3C3

Dear Dr. Jacyk:

I understand that you were involved in the development of the questionaire entitled "Social Network Screening Questionaire". I am requesting permission to use this questionaire in my social work practicuum, which involves the facilitation of a treatment group for chemically dependent seniors.

Thank-you for your consideration.

Yours truly,

Laura A. Morris (B.S.W.)

Dear Laura:
Please feel free to use any of the instruments, including the Social Network Screening Questionaire, which you became familiar with in the Elders Program.
Good luck & keep in touch please

Appendix O

FORMATIVE TASK ACCOMPLISHMENT INSTRUMENT

How often have you clearly observed the following conditions among the members present in your group?

==========

(1) NEVER/ALMOST NEVER (2) SOMEWHAT LESS THAN HALF THE TIME

(3) ABOUT HALF THE TIME (4) SOMEWHAT MORE THAN HALF THE TIME

(5) ALWAYS/ALMOST ALWAYS

==========

___ Group purposes and/or goals are clear to most members

___ Members make references to agreed upon group norms, rules, or traditions

___ Members talk as much or more to each other as they do to the group worker(s) or leader(s)

___ Members express verbally or through their behavior their common interest in group's purposes and/or goals

___ Members assume responsibility for tasks important to group's functioning

___ Members behave in accordance with agreed upon group norms, rules, or traditions

___ Members express verbally or through their behavior their interest or caring for each other

___ Members quickly become involved in discussion or activity

___ Members agree quickly on the focus of discussion or choice of activity for a session

___ Members feel free to express different points of view and/or disagree with each other

___ Members remind each other to behave in accordance with group norms, rules, or traditions

___ Members have established patterns of communication, influence and task performance

Appendix P

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

School of Social Work

The University of North Carolina at Chapel Hill
CB# 3550, 223 E. Franklin St.
Chapel Hill, N.C. 27599-3550
Tel. (919) 962-1225

August 22, 1990

Laura A. Morris, BSW
Elders Health Program
403-400 Tache Avenue
WINNIPEG, MANITOBA R2H 3C3

Dear Ms. Morris:

Dr. Galinsky and I would be pleased to consent to your use of our "Formative Task Accomplishment" instrument to assess your open-ended group. Any reports of your findings should include an appropriate citation. You may be interested to know the report of our research using the earlier version of the instrument will be published in the Fall issue of Small Group Research. We are enclosing the most recent version which we presented in Montreal last fall.

We hope you find this to be a useful assessment tool and would appreciate feedback on your experience in using it.

Sincerely,

Janice H. Schopler, Ph.D.
Associate Professor

Maeda J. Galinsky, Ph.D.
Professor

JHS:bhs

Enclosure

Appendix Q

LEADER'S GROUP SUMMARY REPORT

DATE:

TOPIC OF MEETING:

MEMBERS PRESENT/ABSENT:

GROUP INTERACTION:

INDIVIDUAL PROGRESS:

SUMMARY:

PLAN FOR NEXT MEETING:

Appendix R

GROUP LEADERSHIP SKILLS RATING SCALE

==========

Rate each item on a scale of 1 to 7.

1 = I am very poor at this
7 = I am very good at this

==========

___ 1. Active Listening: I am able to hear and understand both direct and subtle messages.

___ 2. Reflecting: I can mirror what another says, without being mechanical.

___ 3. Clarifying: I can focus on underlying issues and assist others to get a clearer picture of some of their conflicting feelings.

___ 4. Summarizing: When I function as a group leader, I'm able to identify key elements of a session and to present them as a summary of the proceedings.

___ 5. Interpreting: I can present a hunch to someone concerning the reasons for his or her behavior without dogmatically telling what the behavior means.

___ 6. Questioning: I avoid bombarding people with questions about their behavior.

___ 7. Linking: I find ways of relating what one person is doing or saying to the concerns of other members.

___ 8. Confronting: When I confront another, the confrontation usually has the effect of getting that person to look at his or her behavior in a nondefensive manner.

___ 9. Supporting: I'm usually able to tell when supporting another will be productive and when it will be counterproductive.

___ 10. Blocking: I'm able to intervene successfully, without seeming to be attacking, to stop counterproductive behaviors (such as gossiping, storytelling, and intellectualizing) in group.

___ 11. Diagnosing: I can generally get a sense of what specific problems people have, without feeling the need to label people.

___ 12. Evaluating: I appraise outcomes when I'm in a group, and I make some comments concerning the ongoing process of any group I'm in.

___ 13. Facilitating: In a group, I'm able to help others openly express themselves and work through barriers to communication.

___ 14. Empathizing: I can intuitively sense the subjective world of others in a group, and I have the capacity to understand much of what others are experiencing.

___ 15. Terminating: At the end of group sessions, I'm able to create a climate that will foster a willingness in others to continue working after the session.

Appendix S

November 26, 1990

Brooks/Cole Publishing Co.
Monterey, California
93940

Dear Madam or Sir:

Re: "Group Leadership Skills Rating Scale" - developed by Gerald Corey and Marianne Schneider Corey, and published in Groups: Process and Practice (1977)

I am attempting to contact Gerald Corey and/or Marianne Schneider Corey in an effort to obtain written permission to use the "Group Leadership Skills Rating Scale" developed in 1977.

I am currently facilitating a treatment group for chemically dependent seniors as part of a practicuum towards a graduate degree in Social Work. I would like to use the Group Leadership Skills Rating Scale in order to rate my own leadership skills.

I would greatly appreciate written permission to use the above-named scale.

Thank-you for your consideration.

Yours truly,

Laura A. Morris

12/19/90

You have our permission to use the
Rating Scale in your practicuum.
If you wish to reproduce the scales in
published form, you will need a separate permission.
Please use the following credit line:
From Groups: Process and Practice, 3rd Edition
by Marianne S. Corey and Gerald Corey. Copyright (c)
1987, 1982, 1977 by Wadsworth, Inc. Reprinted by permission
of Brooks/Cole Publishing Company, Pacific Grove, CA 93950.

Carline Haga
Permissions Manager

Appendix T

Case Summary - Mrs. L.

Mrs. L. self-referred to the treatment group after having seen a television documentary about the Elders Health Program. She reported that she had been using two prescription medications sporadically for many years, and regularly for the last four years: (1)alprazolam - .5 mg., one to two times daily (anti-anxiety medication), and (2)triazolam - .25 mg., one to one and a half tablets at bedtime (sleeping medication). Mrs. L. felt that her use of medications was causing frequent mood swings, in particular, unexplained periods of sadness and an inability to do even routine household activities. She reported that if she did not take the anti-anxiety medication by mid-afternoon, she experienced headaches and dizziness, and she was unable to fall asleep without the aid of sleeping medication. Initially, she connected the onset of regular medication use with her inability to return to full-time employment as a homemaker, after having had surgery to remove her gall bladder in 1986. Since her surgery, she had experienced chronic stomach pain. Her doctor advised that she would be unlikely to be able to work full-time again. Mrs. L. felt that since the loss of her job, she had "too much free time" to worry about her family.

Mrs. L. presented as soft-spoken, somewhat shy, and as someone who had a very low opinion of herself. Clinical observations suggested the possibility of depression. Because she consistently identified that her headaches and stomach pain occurred during the times when she was alone and anxious, it

was suspected that her physical discomfort was largely psychosomatic.

Mrs. L. began attending two group sessions per week, on April 18, 1990, with a plan to slowly reduce her use of medications under the supervision of the Elders Health physician.

She stated that she did not feel comfortable talking to her family physician about medical concerns. When she had broached the subject of wanting to discontinue her use of mood-altering medications, her physician had become annoyed with her, and told her that "they (the medications) weren't hurting her". Mrs L. was encouraged to consider seeing a different family physician. She expressed interest in seeing a doctor whom she had seen regularly prior to her gall bladder surgery, but said that she was reluctant to call him because she was afraid he would be angry with her for having discontinued her involvement with him four years earlier. When an offer was made to contact him on her behalf, she seemed relieved. Arrangements were in fact made for her to see her old physician again, and he became actively involved in planning her step-down from the medications.

Mrs. L. initially preferred to listen to group discussions, rather than participate. The writer noticed that during discussions in which other members verbalized feelings sadness or grief, she became very withdrawn. During one session, she suddenly left the group room. When she was asked what was wrong, she said that she had developed a very bad headache and felt she had to leave. An attempt was made to connect her physical discomfort with

her own anxiety and feelings of sadness, and normalize her feelings in the context of the losses she had experienced in her life. Mrs. L. had previously shared that two of her siblings had died within the previous four years, and that she frequently thought of them during the times when she was feeling depressed and immobilized. Mrs. L. was encouraged to talk about her siblings and her feelings of sadness, but she seemed unable to do so within group sessions. On a one-to-one basis however, she appeared to be more comfortable talking about these issues.

As the time to begin her step-down program drew nearer, Mrs. L. expressed an increasing amount of anxiety and fear about her ability to successfully reduce her use of medications. She felt that if she was home alone and feeling down, it would be too difficult for her to resist self-medicating. Although she was encourged her to take things slowly, and try the step-down plan, she continued to worry. During a home visit on May 8, 1990, Mrs. L. asked that arrangements be made for her to enter a residential treatment program. She felt that in a structured setting, with the support of other patients and professionals 24 hours a day, her chances of a successful step-down would be higher. Mrs. L. was referred for an assessment at the Alcoholism Foundation of Manitoba, and requested that she be admitted. On May 23, 1990, at the recommendation of the A.F.M. psychologist, she was admitted to the primary care unit at A.F.M.. By June 1, 1990, she had discontinued all use of mood-altering medications, and verbalized a great deal of self-satisfaction with her success. Although she

was to remain at A.F.M. to complete the treatment cycle, she chose to leave on June 11, 1990, saying that she felt she could return home without jeopardizing her abstinence from medications. She wished to continue to attend the group at Elders Health, and did so until the end of the treatment cycle.

During the latter half of the treatment cycle, Mrs. L. began to participate more actively in group sessions. She made connections, for the first time, between her use of mood-altering medications and the loss of her siblings. She also verbalized a desire to become more active again so that she would not be at home alone every day. She began to look into volunteer opportunities, and arts and crafts classes. At the encouragement of her physician, she agreed to go for a series of tests to try and determine the cause of other medical problems. Mrs. L. had been postponing these tests for some time because of fear of the procedure and possible results. Although she experienced a great deal of anxiety as the time of testing drew closer, she was able to verbalize her fears and complete the testing. She stated, with a great deal of pride, that she had been able to ask the doctor direct questions about the testing procedures and recommended surgery, something which she had never before been able to do. At the point of post-treatment assessment, Mrs. L. no longer displayed symptoms of depression. Although she was still struggling with periods of insomnia, she was able to cope in a healthier way by accepting her inability to sleep and making attempts to use these periods constructively, rather than becoming more agitated. She

reported that her short-term memory and ability to concentrate had improved considerably, and that her family had noticed and commented on these improvements. She continued to abstain from all use of mood-altering medications and verbalized a desire to maintain her abstinence. She planned to attend the after-care group for seniors at Lion's Manor, and take courses in craftwork in the fall.

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