INTERPERSONAL SKILL DEVELOPMENT AND SUPPORT GROUP FOR ELDERLY STROKE SURVIVORS AND THEIR SPOUSES

BY

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ABSTRACT

Stroke couples are confronted with social problems related to the illness that drastically changes their lifestyle and interpersonal relationship. A review of the literature revealed that problems in the area of dependence/overprotectiveness, role reversal/role change and social isolation/loneliness are especially troublesome to these couples. This practicum involved the delivery of assertiveness and conflict management training to a group of elderly couples where one spouse had experienced a stroke. Group members assertiveness and conflict management skills were assessed before and after treatment. Upon evaluation and analysis of this intervention, stroke couples were able to benefit from treatment. By applying the skills learned in the group experience, most members were able to make some positive changes towards resolving conflict with their spouse. Recommendations for a similar type of group approach were offered.

DEDICATION

Dedicated in loving memory of my beautiful son, John Edmond Janzen, who lost his life tragically August 2, 1991, in an industrial accident while on his job with Innovative Log Industries, Cochrane, Alberta at the young age of 27.

Dedicated in the hope that our pain will eventually turn to acceptance.

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INTRODUCTION

When a person experiences a stroke, especially if the damage is moderate to severe, a stroke could lead to major changes in a person's lifestyle. These changes could result in strained interpersonal relationships, especially with a spouse.

The problem that the writer addressed in this practicum is that stroke couples are confronted with several problems related to the illness, that drastically change their lifestyle and interpersonal relationship. These problems can be very difficult to cope with and overwhelming at times. After discharge from hospital, the social and emotional problems may be shelved due to the heavy demands of physical care required by the stroke survivors and their spouses. If these problems are not dealt with the couple are not likely to make a good adjustment, life at home would be difficult to tolerate and the survivor might end up institutionalized prematurely. How could we as professional helpers intervene to assist people in this area?

The present literature on stroke rehabilitation, suggests that stroke couples are confronted with several common problems once the survivor returns home from hospital. These problems put strain on the marital relationship. The common problems couples attempt to cope with are dependence/over protectiveness, role change/reversal and social isolation/loneliness. As a result of the stroke, the couple experiences a drastic change in their lifestyle and

interpersonal relationship. The literature suggests that couples need help in adjusting to these lifestyles and relationship changes forced upon them due to the stroke.

This practicum addressed these common problems in a group setting. The interventions utilized in the group were aimed at developing assertiveness and conflict management skills.

OBJECTIVES AND RATIONALE

The overall objectives of this practicum was to implement and evaluate a group intervention aimed at helping stroke couples deal with the problems of dependence/over protectiveness, role change/role reversal and social isolation/loneliness which have changed their lifestyle and caused differences/conflict between them.

The writer assumed that problems which were not dealt with could hinder the rehabilitation process. The type of adjustment the couple made was a determining factor in whether or not the survivor could live at home or require institutionalization in a personal care home or geriatric centre.

The proposed benefits to all clients of the intervention were:

(1) To enhance their social functioning and interaction through assertiveness training. Assertiveness training would assist clients in learning to communicate their thoughts, feelings, needs and wishes openly and directly.

(2) To enhance their conflict management skill development.

(3) To provide mutual support to the clients by developing a safe place such as a group setting that would permit and support expressions of ambivalent and resentful feelings about their problems, losses and offer empathic responses.

(4) To provide an opportunity for clients to ventilate their negative feelings, such as anger, grief, frustration.

(5) To decrease social isolation by providing an opportunity for social contact and encouraging social interaction.

(6) To leave a program in place for the agency to use after the writer's final report has been approved by the MSW committee.

Some of the expected educational benefits to the student were:

(1) To gain first hand knowledge about the problems stroke couples have to cope with in adjusting and adapting to their new lifestyle with the illness.

(2) To learn how to help these clients cope.

(3) To gain experience working with the elderly.

(4) To gain experience establishing a couple's treatment group and learning and applying group leadership skills and the other skills necessary to operate an effective treatment group.

(5) To gain practical experience in applying assertiveness and conflict management skills to enhance the elderly client's ability to cope with illness.

(6) To gain knowledge in evaluating a group intervention and

its results.

This practicum report is organized as follows. Chapter 1 provides a review of the literature pertaining to the problems stroke couples are confronted with and how this affects their interpersonal relationship, disrupts the rehabilitation process and interferes with adjustment to the stroke. Adjusting positively to the changes in their lives is especially important for the elderly as the ill spouse might remain at a lower level of functioning.

It is assumed that by gaining an understanding of how people express their feelings, thoughts, needs and interests regarding pertinent problems that affect their lives and try and resolve differences and alleviate conflict between them, one can see what is needed for them to have a better relationship.

There are interventions that have helped people be expressive and resolve their differences. The writer wanted to try these with stroke couples to see if they could be effective.

The writer saw the social worker's major role as helping the spouse and survivor adjust to living with the stroke at home and in the community at the highest possible functioning level. Another role was to be supportive to the couple as the difficulties of the stroke and its likely consequences were faced.

There are several physical and cognitive problems and

personality changes as a result of stroke which are a source of psychological stress to the couple Binder (1983), Dudas (1986), Gibson and Caplan (1984), Kelly and Winograd (1985) and Ripeckyj and Lazarus (1980). These problems and changes that affect functioning are described in the literature review that follows in Chapter 1. Chapter 1 also describes the usual adjustment process an individual with a chronic illness faces.

Chapter 2 presents a literature review of group work and the stroke survivor and his/her spouse. Also, Chapter 2 presents a review of the literature on Assertiveness Training and Conflict Management. Chapter 3 describes the methods used in this practicum. The couples, their goals and the outcomes are described in Chapter 4. Chapter 5 presents the student's practicum experience in relation to the Stroke Survivor's Group. The beginning, middle and ending phases are included plus a synthesis. Evaluation results are provided in this chapter. Chapter 6 presents the experience in relation to the Spouse's Group. The beginning, middle and ending phases are included plus a synthesis. Evaluation results are provided in this chapter. Chapter 7 contains a discussion of findings of the practicum in relation to the major hypotheses of this practicum. Chapter 8 summarizes the writer's practicum experience and contains recommendations.

CHAPTER 1

THE THREE COMMON PROBLEMS

DEPENDENCE/OVER PROTECTIVENESS

In their article Gibson and Caplan (1984) point out that the goals of rehabilitation for the stroke patient are compensating for the intellectual and physical loss and minimizing the social and financial loss. Compensating for the intellectual and physical loss refers to maximization of the survivor's independence in self-care skills and ambulation and progress in communication skills. Minimizing the social loss concerns reintegration of the survivor into his home and community. Both the survivor's and community's financial resources are conserved if s/he can return and remain living in her/his own home. Hence, a principal rehabilitation goal should be to have stroke survivors discharged home if at all possible.

According to Gibson and Caplan (1984) once in the community, the process of reintegration into the community has its difficulties. Survivors often find themselves dependent on others to meet their transportation needs. Resumption of driving is not always possible due to significant visual or visual-perceptual difficulties and loss of physical functioning. In the writer's opinion, being unable to drive increased the feelings of frustration and isolation the survivor might already have felt. This in turn, might put an additional strain on his/her interpersonal relationships.

According to Ripeckyj and Lazarus (1980), social and psychological factors are critical to the success of rehabilitation efforts. They point out that the survivor has a poor mental state at first. The survivor may have bowel and bladder dysfunction. Having no control over these emotionally charged functions renders him dependent on others. No doubt this dependency affects his self esteem. Loss of mental function, such as the inability to pay attention, speak or remember, are a threat to the stoke survivor's self esteem. All these difficulties have serious effects on the survivor's interpersonal relationships with significant others. He will be socially withdrawn because of the embarrassment of his decreased functioning, and others will withdraw from him. When one looks at how the devastating effects of stroke damages the survivor's self esteem, it is very important in the writer's opinion that the survivor gets assistance, to help him deal with his negative feelings about himself and the pain associated with these feelings. Ripeckyj and Lazarus fail to address this crucial need.

Litman (1966) found that the family had a positive role in rehabilitation. However, Labi, Phillips and Gresham (1980) found that stroke survivors who lived with their families tended to decrease outside socializing more than those who lived alone. The overprotection of family members and the stroke survivor's reliance on the spouse for social interaction deter the survivor from seeking social activities

outside the home. The psychosocial difficulties survivors experience as a result of stroke must be addressed, so that survivors do not become socially isolated. In the writer's opinion it is not enough to say that families tend to overprotect their members who have experienced a stroke. What is needed is some practical strategies to deter family members from overprotecting survivors.

Binder (1983) describes more of the common emotional difficulties patients experience after stroke. Frustration, anxiety and depression, as well as irritability, impulsiveness, impatience, and over-dependence on others are frequently observed in stroke patients. The loss in cognitive, physical and social functioning are great, and patients who confront these may question their self-worth. Cognitive difficulties contribute to emotional difficulties, for example:

> ...brain-damaged patients may jump to conclusions after considering only part of the relevant data. Such behaviour often leads to misinterpretation of the emotions of others and erroneous conclusions. Impaired initiative and lack of empathy can contribute to insensitive, demanding behaviour and a resulting breakdown in interpersonal relationships. (p.17)

Goodstein (1983) talks about some of the commonest disabling responses of the elderly stroke survivors. What was most emotionally upsetting was the unexpected onset of the stroke. Lack of control over their robustness and over what will occur is especially distressing. With this feeling of

lack of control, patients experience fears of losing their physical and sexual abilities and sanity. Loss of dignity and self-esteem is a common response. Anxiety about losing the accustomed relationship with their spouse because of their dependence on others is not unusual. Goodstein states that many elderly stroke survivors do not want to go home after their hospital treatment is terminated because they will have to face their functioning, role and responsibilities there. This frightens them.

Goodell (1975) states that when a formerly healthy person becomes dependent on others this alters his interpersonal relationships, especially at home. Frequently, the breadwinner and financial manager is forced to give up his role to a spouse who is not ready or trained to assume such responsibilities. This sudden role reversal is stressful and difficult to accept.

It was the experience of Mykyta, Bowling, Nelson and Lloyd (1976) who instituted a group for relatives who were caring for day hospital stroke patients, that those relatives having communication difficulties with the survivor found this stressful and lead to open conflict. Secondly, role change was an issue. Relatives, not just wives, felt guilty about taking over the dominant role in the family and their changing to a decision-making role was a problem. They were reluctant to become assertive. Spouses tended to be overprotective because they were fearful that distress would befall their

mate.

> There is much preoccupation about the aetiology of stroke. This is coupled with some guilt feelings where the stroke is related to some physical or emotional stress for which the relative feels responsible. It is also a contributing factor in over-protectiveness. "Will getting him upset cause another stroke?" This causes relatives to protect the patient from normal human emotions and even the most basic decision-making. (p.89-90)

Lowry (1985) states that the majority of adults want to be independent but when illness strikes this desire is in conflict with their wanting to be looked after. It is necessary to know how independent the survivor was prior to the stroke to set realistic goals for his independence that are within his capabilities. Providing supports at home will make his goal a reality. The elderly are especially fearful of becoming unproductive, a burden to others, completely dependent and ending up institutionalized.

> Often a chronically dependent and demanding person will respond to firm realistic limits when they are combined with regular, consistent care and attention that is freely offered before it is requested. This cuts down on the intensity and number of frantic attempts to become inappropriately dependent. (p.192)

Lowry (1985) goes on to say in the case of the survivor who is capable of independent functioning but thinks he is not, or who is not capable but thinks he is, assessing these survivors functional capacity and working through the different versions between the survivor's view of his ability

and real capacities is problematic. It is important that the purpose of caring for the survivor be remembered, namely to assist him to preserve as much mastery over his own life as his potential allows, compensating only where he is incapable. The spouse needs to be subjective and objective simultaneously in her caregiving role and this is difficult. The subjective - "What should I do for my mate? What can I do for my mate?" The objective - "What does my mate need?" What is best for my mate?' What can my mate do for himself?" (p.255) The objective and subjective must be blended. Separating an emotional attachment with your spouse from an objective assessment of his needs is not easy. In the writer's opinion hope and motivation on the part of the survivor are critical if he is to make progress in rehabilitation.

Evans and Miller (1984) stated the following:

> The origin of social dysfunction for stroke patients lies in the discrepancy between what they can do and what is expected by significant others. Attitudinal responses vary from avoidance of the patient to protectiveness. The situation becomes stressful to patients when family and friends fail to alter situational demands, or do not psychologically relieve the patient of the discrepancy. Relationships are strained because of inappropriate expectations and demands from others. (p.247)

Evans and Miller did not take into consideration the survivors readiness to partake in therapy and how insightful the significant others are regarding the survivors capabilities. These are important considerations.

Jarman (1982) interviewed 200 stroke survivors and their

families in their own homes to determine how they had adapted to life after the first year of stroke. Common complaints were that the survivor had become more anxious and irritable, and less vigorous and sociable, which made living with him a burden. Some spouses find this intolerable and pursue a divorce or separation.

According to Jarman these factors cause far greater difficulties and emotional upsets for the family than the difficulties and upsets surrounding the survivor's physical needs. Those with more sedentary pastimes do better. If the spouse makes realistic demands on the survivor, he will progress more quickly toward self-sufficiency.

In M. Holbrook's (1982) study on stroke, she described some of the emotional adjustments that are inevitable in stroke recovery both for the patient and family. She stated:

> Interruptions to the accepted pattern of adjustment are less likely to occur, if the role changes experienced by the family are those that can be taken on without trauma, for it must be remembered that a spouse who has always assumed the dominant role in the marriage will find it very difficult to change from being breadwinner, driver and maker of executive decisions to a more subservient role, and to being dependent upon spouse and children for most activities. Similarly, a dependent spouse may find that taking over the executive role in the household, dealing with all the business and finances, is so worrying that she may need considerable help over a long period of time,for she has also to love and encourage her unhappy spouse. (p.102)

In this same study, Holbrook (1982) asked stroke patients

if they had come to terms with their illness or had adjusted to the stroke. She asked them if the stroke had adverse effects on their relationships, if it had altered their social life, and if they were anxious about their health, finances and ambulation. Fear of having another stroke was common. Problems with frustration, depression, their new life-style, communication, loss of confidence, concentration and independence, being a burden to their spouse, lack of progress and feeling useless were expressed.

Harris (1980) makes a number of important points regarding negative adjustment to stroke. Following the stroke the survivor who is overly dependent usually takes control in the family. The survivor who refuses to do anything on his own makes sure that someone will be there to assist him at all times. Harris (1980) goes on to say this extreme dependency may be encouraged by the spouse who disapproves of the survivor's independent efforts. Where dependency becomes an issue family members feel angry. The extremely dependent survivor can be angry at his mate who remains capable of doing everything on her own. The survivor can control her independence by needing her with him constantly. According to Harris (1980) one spouse had very angry feelings towards the dependent mate due to his incessant orders however would not permit him to try anything on his own. This anger is not always expressed verbally by the spouse but is usually demonstrated non-verbally by her while attending to his

orders. Harris (1980) pointed out that this also applies if the survivor is the wife.

Harris (1980) goes on to say that role reversal can result in over-reaction by the spouse who is forced out of the dependency role. For example, prior to the hospitalization for stroke the survivor made all the decisions throughout their marital relationship. When the survivor is discharged home, the previously dependent spouse takes over new roles and responsibilities and may overreact to the changed relationship and start making all the decisions for the survivor. This controlling behaviour increases the survivor's dependent behaviour and both partners are inclined to feel strong anger toward one another.

Harris stated that the survivor may deter home visits from others and refuse to venture outside the home. This extreme withdrawal is often observed in survivors who are ashamed of their disability. If isolation is a choice by either spouse or survivor it is usually because they are very depressed. These feelings are reinforced by isolation from others. The couple need to express their feelings of depression, anger and discouragement which are essential to the adjustment process. Harris discusses in detail how the stroke affects one's lifestyle but discussion about interventions which will assist people to cope is lacking.

According to Kelly and Winograd (1985) in the chronic phase of stroke care, the goal is to enhance and maintain the

patient's functioning. In the area of mental functioning, depression in the patient can be a serious difficulty in this phase. The burden of caring for the patient, role changes since the stroke, and social isolation can cause conflict in the family, which in turn contributes to depression in the patient.

Social functioning needs to be assessed. Good family support may discourage the patient from involvement in activities in the community. Kelly and Winograd (1985) point out that due to the loss of function, the patient often cannot work or do the homemaking, so role reversal happens. As a result the patient becomes frustrated, sad and angry, which leads to further dependency.

Kelly and Winograd used the medical model but stated that this model does not go far enough so they include some aspects of psychosocial functioning in their framework. They discuss sexual dysfunction but not relationships in general which are an important part of rehabilitation.

Several authors have shown how the survivors' dependency can be a problem for both the survivor and other people. (Gibson and Caplan (1984), Harris (1980), Ripeckyj and Lazarus (1980). Goodstein (1983) points out how survivors fear losing their relationship with their wives because of being dependent on their wives. Goodell (1975) emphasized that survivors' dependency on others alters their interpersonal relationships at home. Lowry (1985) stated that most adults do not like to

be dependent when they are ill and fear becoming a burden on others. Lowry emphasized how important it is to let survivors do things for themselves when they are capable. Jarman (1982) also emphasized how important it is to make realistic demands on survivors so they will become self sufficient more quickly. Holbrook (1983) stated that a person who was independent before the stroke would find it very difficult to be dependent on others. Also, survivors did not want to be a burden on their spouses. Harris (1980) pointed out how angry feelings can develop in both survivor and spouse when dependency on the part of the survivor is a problem.

Ripeckyj and Lazarus (1980) emphasize how dependency affects the survivor's self esteem. Mykyta et al (1976) stated that overprotection is related to the spouses fear of the survivor having another stroke while Labi et al (1980) points out that overprotection on the part of the family members deters survivors from getting re-involved in social activities in the community.

ROLE REVERSAL/ROLE CHANGE

Fengler and Goodrich (1979) assessed the needs and difficulties of elderly wives who looked after their chronically ill husbands at home. Wives with low morale needed outside support if institutionalization of the husband was to be prevented. The wives' median age was 67 and the husbands' 73. Most were working class couples. The sample size was small, thus results can only be suggestive. Morale

was higher when wives saw their income as satisfactory and when they were employed only part time. The degree of the spouse's incapacitation was only significant if he was aphasic.

Support from significant others, i.e. children, contributed to raising morale. Role overload was related to low morale. Working full time and fulfilling the heavy physical care demands of the spouse was exhausting. Townsend (1957) found it to be common for roles to be segregated in working class marriages and remain so after retirement. Role reversal in such marriages is even more burdensome. Also, Townsend, (1957) found that sharing and communication do not occur as frequently in segregated role situations.

Fengler & Goodrich (1979) found that low morale wives did not value their spouses as confidants and companions nearly as much as high morale wives. They confided in friends and relatives instead thus the extra time they spent with their husbands resulted in social isolation and less contact with more significant confidants. Friends drifted away from the couple after the spouse became ill. Low morale wives wanted more time for expressive and personal endeavors.

Fengler and Goodrich (1979) point out that both the low morale husbands and wives wanted to see their close friends more frequently. This loss was greater for the husband. The couples stated, "We would like to see more friends. We always had a lot of company before the stroke. I miss that."

(p.118)

Lowry (1985) stated that functional loss or decline in a spouse's abilities causes marital relationship problems. In some cases the spouse is left without a mate who can participate meaningfully in the activities of life. This disruption means a drastic role change in the long-established way the couple relate to each other and to outsiders. The spouse who assumes the care provider role no longer receives emotional support from the mate and must change their lifestyle to fulfill increased responsibilities. Maintaining contact with social networks and social supports is not possible because of these increased responsibilities.

According to Lowry (1985) anger and depression can result because the caretaker feels burdened. It is a huge adjustment over time to conform to a different lifestyle and learn new skills required to perform roles which the survivor did prior to the illness. Also, the caretaker spouse is required to face uncertainty, a possible deterioration in her mate's condition and accept that she cannot expect from him the kind of support he used to give. Also, she needs to separate her feelings about her mate's condition from her feelings towards him as a mate and person. Lowry (1985) emphasized that it is important that she spend time talking with her mate, sharing experiences and upholding the kind of emotional involvement that was present prior to the illness. The writer concludes that Lowry sees that there is a need for open communication

between the spouses concerning their problems but does not state any specific intervention methods to assist couples in this area of need.

That role reversal/role change is a problem for survivors and their spouses has been well documented by several other authors (Goodell (1975), Harris (1980), Holbrook (1982), Kelly and Winograd (1985) and Mykyta et al (1976).

Fengler and Goodrich (1979) found that wives who were employed full time and caring for their spouses were exhausted. Lowry (1985) basically said the same when he said that due to the drastic role change the caretaking spouse feels burdened.

Goodell (1975) found that the breadwinner is forced to give up his role to a spouse who is not ready or trained to take over these responsibilities. Mykyta et al (1976) found that many wives felt guilty taking over the dominant role and making decisions was a problem for them. Holbrook (1982) pointed out that the female dependent spouse may find taking over the executive role in the household very stressful and may need lots of assistance over a long time period.

Harris (1980) stated that the previously dependent spouse may not only take over new responsibilities but begin to make all the decisions for the survivor. Both spouse and survivor can feel anger towards each other about this. Kelly and Winograd (1985) also stated that conflict can result because of role changes in the home.

SOCIAL ISOLATION/LONELINESS

Coughlan and Humphrey (1982) surveyed 170 spouses of stroke patients who had had their stroke up to eight years earlier. All patients were under 65 years of age. Their findings stated the following:

> A third of all spouses as well as patients had received treatment for depression or tension during the follow-up period. Unhappiness over the loss of their companion in social activities and feelings of being tied to the home with little opportunity to relax were frequently voiced by spouses, of whom one in three considered their enjoyment of life to be much less than previously. (p.121)

Lawrence and Christie (1979) looked at the quality of life after stroke. They examined 45 stroke survivors, 3 years after they were stricken. They examined how the patients were coping and how this related to the extent of their disabilities. The results pointed to the fact that the extent of the patient's rehabilitation was a function not only of his own physical condition, but also of psychological and social factors as well. A person's psychological and social dysfunctioning following stroke is often underestimated, in comparison with this physical dysfunction. They suggest the difficulties in social and psychological adjustment experienced by these patients.

Lawrence and Christie go on to say that one-half of the most severely physically disabled survivors, although previously involved in leisure activities, had withdrawn entirely from such activity. The greatest concern to

survivors was their perception that their interpersonal relationships in their home had deteriorated markedly. One-third of the minimally affected and two-thirds of the severely affected stated that this was the case.

Beaver and Miller (1985) describe a socially isolated individual as deprived of constant and significant interpersonal interaction. When an individual does not have any socially exciting activity and mutually satisfying interpersonal relationships s/he is lonely. Regular, close interaction with significant others is required by the elderly if the consequence of social isolation, namely loneliness, is to be avoided.

The process of resocialization is extremely upsetting for many stroke survivors. According to Gibson and Caplan (1984) it is often self-consciousness related to defective ambulation, speech difficulties and other negative consequences of stroke that hinder survivors from resuming their former social involvements. This self-consciousness also presents a stumbling block to the survivors being reintegrated into the community.

In Dudas's (1986) discussion about resocialization issues concerning stroke survivors, she said:

> Deficits such as gait, speech and facial changes are visible and obvious, often making other people uncomfortable and resulting in isolation for the patient with a stroke. One of the most frustrating situations is coping with emotional liability sometimes present in stroke patients. When patients are unable to

> control their emotions such as laughing or crying inappropriately, an effective intervention to teach the family is to divert the patient's attention to interrupt the patient's behaviour.(p.355)

The most helpful interventions are those related to assisting the survivor to his maximum independence potential and increasing his sense of self-esteem which will affect the resocialization process positively.

Evans and Miller (1984) indicated that it is an expectation that stroke survivors will withdraw from significant others. Alienation might follow due to his withdrawing, however, elements of alienation can be stopped by increasing supports to the family. It is helpful if the social worker interprets this withdrawal to family and friends as limitations and loss of function in the survivor due to his stroke. Evans and Miller do not extend their research far enough in that they do not recommend or address the need for educational and support groups for the families of survivors and for social and recreational groups for the survivors.

According to Hartshorn (1967) if the spouse has good insight and is sure that the survivor's behaviour change is the result of physical change due to his stroke, the spouse is better equipped to fight against the stress and handle her own feelings. Good insight results in good understanding of the survivor's needs. The inability to accept changes in the survivor's condition and abilities for what they are means the inability to adjust one's own responses agreeably. In the

writer's opinion if one cannot accept these changes in their spouse's condition and capabilities and the consequent adjustments one has to make in one's relationship, living together will be a constant struggle.

Shadden (1987) found that stroke families complained of a constant disintegration of their social support network as neighbours and friends slowly decreased the number and quality of social contacts once the survivor is discharged home.

Mailick (1979) emphasizes that the chronically ill individual has a great fear of loneliness. Any form of isolation whether it be his own withdrawal from others or others discontinuing their relationships with him is difficult to have to cope with for the stroke survivor. It is difficult to continue communicating as the ill may be ambivalent, fearing that if they express their anxiety about their illness to people, they may not be accepted. Likewise spouses may not feel comfortable revealing their negative feelings to him.

Mailick discusses a conceptual model for coping and adaptation and puts the chronically ill within a framework which includes the family and other social networks. She emphasizes how the ill face a series of adaptive tasks forced upon them due to the illness. The first group of tasks are related to the beginning of the illness, second set of tasks are connected to the adaptation of the disabling nature of the illness and final set deals with the termination of the illness.

The social worker's role in the beginning of the illness is described by Mailick (1979) as follows:

> The social worker facilitates the expression of feelings, provides and/or helps the patient and family to seek appropriate information,encourages their active involvement in the diagnostic process, suggests resources that might be useful and helps them to understand and accept the diagnosis. Perhaps most importantly, the social worker encourages the maintenance of the self-esteem and emotional integrity of the patient and the family. (p.122)

In the adaptation stage, Mailick stresses that changes in interpersonal relationships and role expectations that give the survivor the largest degree of self-sufficiency, need to be addressed. The survivors of illness have the task of adapting to pain and loss of physical control and appearance. Family members have to deal with all their feelings related to the survivor's suffering and their sense of powerlessness. The survivor and family have the task of managing role shifts and the survivor has the task of accepting his revised self-image. The task of grieving is associated with the final set of tasks when the illness is terminated.

That social isolation/loneliness is a common problem for stroke couples has been well documented by several other authors Fengler and Goodrich (1979), Harris (1980), Kelly and Winograd (1985), Labi et al (1980) and (Ripeckyj and Lazarus (1980).

Coughlan and Humphrey (1982) found spouses to be grieving over the loss of their companion in social activities. Kelly

and Winograd (1985) found that social isolation can create conflict in the family.

Lawrence and Christie (1979) found that one half of the most severely disabled survivors had withdrawn completely from social activities. Gibson and Caplan (1984) stated that this social withdrawal that Lawrence and Christie talk about is due to the survivor's self consciousness related to his various defects. Similarly, Harris (1980) found that survivors may deter home visits from others and refuse to go out because they are ashamed of this disability. Also, Ripeckyj and Lazarus (1980) stated that survivors become socially withdrawn because of their decreased functioning. Dudas (1986) stated that these defects result in isolation for the survivor because other people feel uncomfortable being in his presence.

Shadden (1987) found survivors' social contacts decreased in quality and number. The findings of Fengler and Goodrich (1979) were the same, friends drifted away from the couple after the spouse became ill.

The preceding literature on stroke rehabilitation suggests that if a spouse has experienced a stroke, the couple struggle with a changed relationship and lifestyle. The literature also illustrated how the stroke has affected the relationship with regards to the three common problems, namely, dependence/overprotectiveness, role reversal/role change and social isolation/loneliness. It was important to the writer, that stroke couples' relationship concerns were

addressed.

INDIVIDUAL ADJUSTMENT TO CHRONIC ILLNESS

Stroke is a chronic illness. Although different illnesses have different physical natures and therefore require dissimilar adaptations, the literature implies there are common elements in the psychological adjustment.

One common element is the need to complete the task of reorganizing the self-image. Schmale (1979) indicated that this reorganization starts with a grief process. The patient experiences a sense of loss in regards to a damaged or changed body part. After the initial shock, the patient gradually develops a personal sense of injury. The grief process is finished with the acceptance that the particular aspect of functioning is permanently lost and will never be like it was before the damage occurred. Engagement in this grief process is viewed as an essential first step before the patient is able to finish the reorganization process. It appears to the writer that the survivor must go through the grief process in order to accept and adjust to his altered state of health and being.

The process persists with attempts to incorporate the new realities and to preserve a feeling of self esteem and optimism. Krupp (1976) stated that this is accomplished through reaching an adaptational compromise. This means striving for the highest functioning and comfort allowed by the illness. This compromise necessarily demands acceptance

of the illness and complete and realistic knowledge of its visibility, prognosis and motivation to be oneself in spite of the limitations. For Krupp letting go of what is lost is essential for the patient to go ahead with rehabilitation. Krupp warns that professional caregivers can fail to recognize the extent of this compromise and can become critical of the patient when he encounters difficulties.

Another common element in the psychological adjustment to chronic illness is the need to learn to live with the uncertainty. There is the uncertainty of the unknown result of the rehabilitation process.

Another common element is the need to move out of the sick role, Parsons (1951). In this role, the patient must give up the responsibilities and obligations of his former roles and must allow himself to be cared for by healthier, more competent people. Finally, he is to give up the role as quickly as he can.

Contrary to Parsons, Mailick (1979) stated that the sick role is not temporary but the patient with a chronic disability must accept a revised self-image and lowered personal aspirations. Professional caregivers can help the patient accept this revision and the reality of the ongoing illness therefore, promoting healthy coping.

Unlike Parsons, Feldman (1974) suggests replacement of the sick role with a "different role". This role is a recognition that a new meaning of life has been formed after

the dissolution of the old one. In the 'different' role the patient can accept the differences imposed by the illness and can preserve a feeling of dignity and worth.

In conclusion, the literature indicated that the onset of a chronic illness triggers a process in which the patient incorporates the changes brought about by the illness. In this chapter, the writer has cited the literature pertaining to the common problems stroke couples face and how these problems affect their relationships and lives. It also described the usual adjustment process an individual with any chronic illness encounters.

CHAPTER 2

OVERVIEW OF THE INTERVENTION STRATEGIES

GROUP WORK WITH THE STROKE SURVIVORS AND THEIR SPOUSES

Field, Cordle and Bowman (1983) found that most of the problems confronting the spouse, family and survivor were related to finding out about the stroke and coping with its consequences. The researchers concluded that the hospital counselling helped the spouse, family and survivors cope with the practical aspects of care, but did nothing to help them cope with the emotional aspects of dealing with the stroke survivor, and with the changed relationships.

The writer's major criticism of Field et al is that they do not provide the reader with any specific interventions to help people cope with their relationship concerns.

Bukowski, Bonavolonta, Keehn and Morgan (1986) see the psychosocial difficulties facing stroke survivors and their families as destructive in the early stage and if not addressed often results in obstacles to adjustment. They stress the need for a psychosocial assessment and the role of the social worker in assisting the survivor and family through the adjustment period. The adjustment process is facilitated by the family and survivor ventilating their feelings and concerns about the stroke. The writer believed this could be accomplished in a group setting.

Harris (1980) stated that for the majority of stroke survivors, returning home is associated with a positive

adjustment to the crisis of stroke. The survivor may protect himself by avoiding activities that are too fatiguing or stressful. Survivors who accept their limitations in terms of energy and time may be more willing to accept the needed help from others, which is a positive adjustment for themselves and their families. Identifying with another person who has had a stroke and is faced with the same difficulties can be a positive adaptation. Getting together with other families who have experienced stroke offers support, and a chance to observe role models which helps the survivor's psychosocial adjustment. To facilitate the psychosocial adjustment of the survivor, Harris suggests to find out from the survivor and his family what their main difficulties and concerns are. Here Harris is suggesting a group approach to assist survivors and family members in coping and adjusting to the after effects of the stroke.

Social workers Miller and Solomon (1980) cite one of the reasons for group work with the elderly is to assist them to exercise greater control over their lives through confronting their difficulties living in the community. They are confident that whatever dilemmas there are in working in groups with the elderly, that the elderly are able to confront, cope with and endure the human relations issues.

D'Afflitti and Weitz (1974) noticed that in their nursing and social work with stroke survivors, these individuals were fearful that any disability meant that they would be unable to

function at home. Relatives often had the same concern but the survivor and his relative were unable to communicate their feelings. Poor communication resulted in a tense relationship between survivor and relative. Good interpersonal relationships with close relatives is essential for successful rehabilitation of the chronically ill.

In order to assist the survivors, D'Afflitti and Weitz set up patient family groups aimed at encouraging communication and the use of community services after discharge. The stroke survivor had to be competent verbally and mentally to be a member. One of his relatives had to be willing to be involved in the group and the plan was for the stroke survivor to be discharged home. Both open and closed groups were tried.

D'Afflitti and Weitz (1974) set up four groups with three to five survivors and their relatives. Relatives included spouses, siblings, children or friends. They trusted that the group process would facilitate communication so that the feelings about the stroke and its consequences could be discussed more easily. Further, they hoped this would result in a more realistic view by the group members of the degree of disability and limitations associated with the stroke. Planning could then fit with these limitations therefore, the closed group was more cohesive and more productive in the work of confronting and living with the losses created by the stroke.

Survivors feared becoming totally dependent and loosing their family as they might see him as a burden. D'Afflitti and Weitz (1974) found that "the family also feared the total loss of a loved one as they had once known him and as he had once functioned in the family." (p.328)

Group members struggled with their grief in the group and D'Afflitti and Weitz pointed out that this struggle could be observed in the framework of Engel's (1964) process of grieving.

1. **Shock and Denial**

Members expressed their doubt and hoped for the loss to go away. D'Afflitti and Weitz (1974) heard comments like:

> Some nights I'm sure when I awaken in the morning it will be gone as quickly as it came, I just can't believe it! I'm getting better every day. Soon I'll be good as new. This arm will be fine if I just exercise it enough. You can do anything with will power, you know. I'll be back working and fishing in a few weeks. (p.328)

2. **Developing Awareness**

According to D'Afflitti and Weitz (1974) anger was expressed by the survivors; "Why did this happen to me? What did I do to deserve it? Hospital staff don't take good care of me. The physical therapists don't tell me how to get this arm moving." (p.328)

Family members were angry at the survivor for having a stroke and being a burden. Guilt over their anger stopped its direct expression. Instead members were frequently

overprotective of the survivor. "I wouldn't think of leaving him at home alone....." "It took me three hours to get him dressed this morning" (D'Afflitti and Weitz, 1974, p.329) (the survivor is capable of dressing himself)

3. **Restitution and Resolution**

Members shared with each other what their life style used to be like. This helped them start to resolve their loses. They talked about the good times they had shared in the past. D'Afflitti and Weitz (1974) found that occasionally this reminiscing proceeded to an effort to reconcile the past and present, for example:

> I know we won't be able to go out as much, but do you think we could go out to dinner sometimes?
> Maybe I can't do my old job, but there are some things around the house I could manage.
> I can't fish anymore, but the boys could put me in the boat and take me with them anyway. (p.329)

Members moved in and out of these phases and feelings of grief over the 3 months the group existed. Engel says successful grieving takes at least a year.

Group members were supported in confronting their problems. The families had the chance to deal with the emotional side of restructuring their lives. Survivors shared the hopeless - helpless feelings they were experiencing. The majority of the group members shared difficult feelings especially about their losses. There was a sense of relief associated with this experience.

According to D'Afflitti and Weitz once communication was open, members started to be more realistic about their expectations. Wives often think their husbands will be more helpless than they really are.

D'Afflitti and Weitz saw the role of the group worker as a support to the members so that, with their empathy and acceptance, members could express their emotions and be worked with toward a more constructive and comfortable emotional condition. D'Afflitti and Weitz (1974) stated:

> Although research needs to be done to evaluate such groups, we feel that the patient-family group described has been a positive force in the rehabilitation of stroke patients and their families toward a more independent and satisfying adjustment. (p.332)

Peterson (1973) recommends the use of elderly couples groups to deal with marital conflict. Peterson states that when people are in conflict intervention required that each other's interests and needs be clearly interpreted to the other and understood by same.

The literature cited on group work with the elderly supports using a group work approach with this population. It indicates that the elderly can and do benefit from being involved in a group situation.

ASSERTIVENESS TRAINING AND CONFLICT MANAGEMENT TRAINING

In the writer's opinion elderly couples can find themselves in conflict over many aspects of marital life. Couples need to resolve the interpersonal conflicts that

distance themselves from each other. Both or one of the spouses may make demands or maintain expectations that cause resentment and/or conflict. For example, a couple may have repeated disagreements about how often to visit friends. Working out a compromise between them is possible sometimes however, some couples are unable to talk honestly and openly to each other about their thoughts and feelings, i.e. disagreements, hurts, etc. Rather than communicating in a clear direct way, they attempt to get what they want by ineffective methods. The couple needs to effectively express their wants and needs to one another. Good communication skills will facilitate their ability to bring about a compatible and gratifying relationship. The writer maintains that assertiveness training will increase their ability to successfully relate to each other.

In the writer's perspective, communication difficulties affect the whole adjustment process negatively. Effective and open communication is important for stroke adjustment and marital harmony not only because of the exchange of information but through the achieving of empathetic understanding. As D'Afflitti and Weitz (1974) have pointed out, some survivors and their relatives cannot express their feelings and concerns to each other. This creates emotional distance between them and prevents their needs from being met.

Keller and Hughston (1981) point out that the elderly person's behaviour can be restricted by conflicts between

himself and others. Independence needs are prevented from being met by the want of social skills for asserting himself when responding to others. With assertiveness development he can cope better in situations that leave him angry, anxious etc. For example, when he feels he cannot express negative feelings to others, his needs are not being taken into consideration, he is irritated by someone else's behaviour. These authors claim that the elderly need assertiveness training to handle difficult interpersonal situations competently.

In support of Keller and Hughston's claim it is the writer's opinion that the elderly need to learn how to act in their own best interests. They need to express their feelings openly with ease, stand up to others, ask favours, make requests, ask questions and readily give their opinions.

According to Carwood (1983) effective assertive communication enriches relationships by building trust and mutual respect with those with whom you interact. Carwood (1983) stated:

> Trust is based partly on the experience of collaborating together and on the ability to manage conflict. Assertive skills contribute to both. You have the courage and competency to initiate activities and work through difficulties with others. (p.21)

Through assertiveness training, the writer believes that interaction is enhanced as one learns to communicate his/her feelings, wants and needs clearly, directly and effectively. The goal of this training is to develop and sustain one's

social skills so one feels more competent in relating to others.

Toseland and Rose (1978) were interested in determining whether or not the social skills of the elderly could be cultivated and advanced. They looked at the effectiveness of three training methods used to advance the social skills of the elderly in interpersonal interactions. Fifty-three elderly people, with a mean age of 69.2, all residing in the community, were divided into three groups, each being trained by one of three methods. A modified audiotaped role-play test based on one of Goldfried and D'Zurilla's models and the Gambrill-Richey Assertion Inventory were administered prior to, after and three months after training. Toseland's group evaluation inventory was administered after training at three months post training to measure outcome. All of the methods increased the elder's ability to handle difficult interpersonal interactions, however,

> ...the study's results suggest that an active role-play approach emphasizing practise is the most effective means of increasing the competence of older adults in handling difficult interpersonal interactions. (p.32)

Fernandez-Ballesteros, Izal, Diaz, Gonzalez and Souto (1988) conducted a conversational skills training program in an institution for the elderly. Sixteen residents with a mean age of 79.4 volunteered for the program. They were randomly assigned to one of three groups. Four residents formed the experimental group; six the attention placebo group and six

the waiting list control group. The sixteen subjects were rated on five conversational skills and were administered the Rathus Assertiveness Schedule, Zung's Self-Rating Depression Scale and the Conflictive Situations in Institutions for the Elderly Inventory. The experimental group participated twice a week in 90 minute sessions. The techniques used in the experimental group were behavior rehearsal, feedback, modelling, discriminative reinforcement verbal instructions and homework. After this training, the experimental group participants were less depressed and increased the frequency of assertive responses to conflictive situations. Their conversational skills also increased. All three groups were given the above tests at pre and post treatment and also three months after the program terminated.

An investigation regarding the effectiveness of assertiveness training for adults over the age of 65 was conducted by Franzke (1987). Participants were 42 upper middle class adults who were attending a national meeting of the American Association of Retired Persons and 42 lower or lower middle class persons attending a nutrition center for the elderly. Their two groups were each divided into an experimental and control group similarly formed in socioeconomic status. Participants were pre and post-tested using the Assertiveness Inventory and the Burger Scale for Expressed Acceptance of Self. The experimental groups completed a six session assertiveness training experience.

Assertiveness training increased positive self-esteem in both experimental groups taken as a whole, largely because of gains by the upper middle class participants. Both social groups improved on the assertiveness measure. Sex and ethnic group difference were not significant.

Engels and Poser (1987) investigated the effectiveness of social skills training in private therapy with women aged 62-70 years old who were living in the community. Clients stated that "practising different ways of handling real-life situations" (P.72) was the most helpful aspect of training. Engels and Poser (1987) found the "brief, structured training in social skills can be beneficial to moderately distressed and isolated elderly clients, and well-received by them." (P.72) While Engels and Poser treated the elderly on an individual basis, they pointed out that using a group approach instead would allow for social facilitation and group support along with abundant opportunities for modelling, role playing and feedback and might be just as effective as individual therapy.

Summarizing the literature reviewed on assertiveness training; Keller and Hughston (1981) claim that the elderly need assertiveness training to handle difficult interpersonal situations competently. In the study conducted by Toseland and Rose (1978) it was found that the social skills of the elderly could be increased. The active role-play approach emphasizing practice was the most effective method to

accomplish this goal. Both Fernandez-Ballesteros et al (1988) and Franzke (1987) like Toseland and Rose (1978) found that the assertiveness responses of the elderly could be increased by training. A study of Engels and Poser (1987) looking at the effectiveness of structured social skills training with elderly women in private therapy also found this training to be beneficial to the participants.

Schulz (1989) proposed an effective assertiveness style which allows one to maintain a good relationship with others when one puts it into regular practice. Schulz's formulae is called the B.E.S.T. method (Behavior, Express, Specify, Tell) (See Appendix L).

Leas (1987) proposed six different conflict management styles; avoiding, persuading, compelling, supporting, collaborating and negotiating. In reviewing these styles the writer has decided that the collaborating and negotiating styles are the most appropriate for use with those who have a fairly high commitment to their relationship and goals. The basis for the writer's decision is that the other four styles are not as committed to both the relationship with the other person and the individual's own personal goals.

Collaboration is seen as mutual problem solving. It is the sharing of the problem by both parties in conflict in an open and fair way. Collaboration as a style means that one party asserts individual goals while at the same time is cooperative; concerned with the goals(s) of another. There is

a discussion about the agreed upon joint problem and their differences are worked through.

Leas (1987) stated that collaboration is useful when:

* There is an assumption that solutions can be found which are mutually satisfying to both parties.
* Stakes are high and the cost of not collaborating greatly exceeds the costs of directly confronting people with whom one initially disagrees.
* Commitment to the relationship is high.
* Both parties are willing to stick to the process.
* Both parties are willing to play by collaborative rules.
* Both parties come to collaborative sessions.

Collaboration is not useful: (Leas 1987)

* When time is limited.
* When issues are dichotomous.
* When resources are not adequate to meet everyone's needs.
* In situations of high conflict where fear and distrust are high.

Leas (1987) suggested how collaboration is to be used. He saw collaboration as useful when the parties in conflict jointly acknowledge the problem, jointly agree on the ground rules and jointly agree on the process for dealing with the problems. Leas stated that the identified interests must be shared jointly. He goes on to say that the parties in

conflict should do the following three things jointly: identify options for mutual gain, agree on criteria for choosing among options and choose an option or options.

Leas (1987) emphasized that the outcomes in the use of collaboration are a feeling of satisfaction by all the parties in their success, people's problem-solving abilities are strengthened and the quality of the decisions are increased. He added that there is a high motivation to comply with the joint decisions.

Leas (1987) referred to the Bargaining or Negotiating style as "splitting the difference". (P.2) Negotiating is similar to collaborating except that expectations of all parties are lower. Both parties get some of what they want. The original demands are reduced - they compromise. The negotiator will give up some of these goals if you will give up some of yours. A middle ground is sought. In this style both parties are assertive and cooperative. Adjustment by both parties leads to a workable solution. Each of the parties must give up something for the good of the whole. Leas (1987) stated that negotiating is useful when:

* There is a willingness to bargain.
* There is a high level of conflict and collaboration won't work.
* Commitment to the relationship is good.
* When the prize is divisible or you can trade items.
* When compelling is inappropriate and collaboration has

been tried and failed or won't work.

Negotiating is not useful: (Leas 1987)

* When positions are dichotomous.
* When compromise is perceived as immoral.
* When there is great power disparity.
* When level of fear of distortion about the other is high.

Leas (1987) suggested how to use the negotiating approach. He stated that the parties in conflict should share only the information which is helpful to their own case and stress the desirability of an agreement. Leas (1987) emphasized starting with easy issues, being specific about one's own position and presenting one's best points last. He added that instead of stressing one's own points to acknowledge the positive points of the other person's argument.

Leas (1987) emphasized that the outcomes in using the negotiating approach are that people need to be reminded of agreements, solutions seem to be sufficient and there is the possible sabotage of decisions to arrive back at points and positions to fulfil our desires.

The No-Lose Problem Solving Model for Negotiating proposed by Adler and Towne (1984) includes eight steps (See Appendix B). Adler and Towne stated that there definitely will be times when a way of meeting everyone's needs is impossible, so negotiating must include compromising.

Research to indicate the effectiveness of this model with elderly couples or any other age group could not be found.[1] Friesen (1990) said that she continues to use Adler and Towne's Model in her workshop, Communicate Effectively.

The elderly's ability to communicate openly is important. Assertiveness training encourages people to communicate openly so they can cope with difficult interpersonal situations more effectively. Assertiveness skills contribute to one's ability to handle conflict. The collaboration and negotiating conflict management styles gives one guidelines for resolving conflict. One needs to assert oneself when one is collaborating or negotiating.

An intervention that has proven effective in increasing the elder's ability to handle difficult interpersonal interactions is assertiveness training using an active role-play approach emphasizing practise (Toseland and Rose, 1978). Schulz's assertiveness style known as the B.E.S.T. method is a useful framework to use to develop assertiveness skills.

Leas (1987) stated that the use of the collaboration conflict management style results in feelings of satisfaction by all parties in success, quality of decision(s) are increased and there is high motivation to comply with the joint decisions. The outcomes of using the negotiating style are similar except that commitment to the decisions are not as

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[1] Lorrie Friesen, (1990), Communicate Effectively Workshop, Continuing Education Department, University of Manitoba.

great and/or lasting. Leas discussed how and when to use each of these two styles and the expected outcomes of their use which is helpful information, however, a major weakness stands out. The weakness in Leas' material is that he has not developed a collaborating and negotiating framework for use when trying to manage conflict.

Adler and Towne (1984) developed a practical model for negotiating which is very helpful when trying to manage conflict. This model has been used extensively in workshops to develop conflict management skills in adults.

In summary, what is apparent in the literature reviewed is that assertiveness training and conflict management training can provide valuable assistance to the couples. The effects of stroke extend well beyond the survivor's functioning to their relationships with others, especially their spouse. Assertiveness training can provide the couples with the tools they need to talk to each other and conflict management training will give them tools to work around their problems however, this does not mean that they will use these tools in their relationships.

The literature cited studies in which assertiveness training provided in a group setting benefitted elderly people. (Fernandez-Ballesteros et al 1988, Franzke 1987 and Toseland and Rose 1978). Two authors (D'Afflitti and Weitz 1974 and Harris 1980) either have used or suggested the use of a group work approach with the stroke survivor and his/her

family.

Looking at the data on the three common problems; namely, dependency/overprotectiveness, role reversal/role change and social isolation/loneliness; it is noted in most of the literature that these problems are a threat to the stability of the marital relationship. Also, they are a threat to the general well-being of the individuals in the marriage relationship.

These findings helped the writer to plan an intervention that would assist the couples in communicating these problems as they can grieve their losses and try and work around these problems. Couples cannot communicate problems if they do not express their thoughts and feelings to each other.

The literature review has provided a theoretical framework for using the experience of stroke couples as they attempt to adjust to the problems caused by the limitations imposed by the stroke. The theory available which concerned the problems and limitations with which stroke couples attempt to cope, assisted the writer in determining the type of intervention that would best meet these couples' needs. The psychological impact of the reality of these limitations continued to be felt as couples faced the on-going struggle of adjusting to these limitations.

The literature cited supports the need for the type of intervention developed in this practicum. It is noted in several articles in the literature review that these common

problems are causing strained relationships for the survivor with other people especially his spouse Goodell (1975), Harris (1980), Jarman (1982), Kelly and Winograd (1985), Lowry (1985), Mailick (1979) and Ripeckyj and Lazarus (1980). In searching the various documents the writer did not find any literature that related to professional intervention with elderly stroke couples.

The writers major criticism of the literature cited is that the authors repeatedly stated that these problems result in a strained relationship between the survivor and his spouse and yet no one has stressed that professional caregivers should intervene through individual treatment or group work. The writer maintains that these problems need to be addressed with stroke couples to ensure that each partner knows how each other is thinking and feeling and to ensure the couples do not become emotionally distant. In the writer's opinion, these couples need to be given the tools to talk to each other and work around these common problems.

The conceptual frameworks that the writer used to guide the practicum interventions were assertiveness and conflict management training frameworks. Specifically, these frameworks were Shultz's assertiveness style formulae and Adler and Towne's No Lose Problem Solving Model for Negotiating (See Appendices A and B). Assertiveness training gives the couple a specific framework to use to express their thoughts, feelings and wishes clearly and directly through I

messages and stating what they want and need. Conflict management training provides a specific framework to use to try and work around these common problems in a non threatening way. These interventions were implemented in a group setting. The group helped the stroke couples feel less alone and isolated and provided an opportunity to learn from each other.

CHAPTER 3

METHOD

SETTING - MEETING PLACE AND TIME

The agency that served as the context for this practicum was the Lions Place in Winnipeg, Manitoba. The Lions Club of Winnipeg Housing Centres, in co-operation with Manitoba Health Services Commission and Office of Continuing Care, sponsored two Adult Day Programs. These Adult Day Programs were community based day services for frail, aging adults living in their own homes in the community. Day programs were provided for frail seniors who for various health, emotional and social reasons were unable to get out on their own and participate in programs to promote their well-being. These seniors were referred to either Lions Place or the Village Club Day Programs by the Office of Continuing Care. The two clubs offered a supervised and supportive environment.

Lions Place Adult Day Program, 610 Portage Avenue, Winnipeg, Manitoba began in October, 1984. It served seniors in the Inner City, Fort Rouge and River Heights areas. The Village Day Club at Augustine United Church, 444 River Avenue, Winnipeg, Manitoba opened in November 1987. It served seniors in Fort Garry, Fort Richmond and Charleswood areas.

One or more times a week the seniors participated in a variety of therapeutic and developmental activities including physical fitness, recreation, mental stimulation and socialization to meet their special needs and interests. A

nutritious, full-course meal was provided at noon followed by a half hour period of rest and relaxation.

The outcome of the program's physical and psychosocial goals were to prevent premature institutionalization of the elderly by maintaining and/or improving their present level of functioning.

The groups agreed to meet in the board room at Lions Place which was centrally located and afforded privacy. The stroke survivors and the leader decided to meet weekly on Tuesdays from 11:00 a.m. to 1:00 p.m. and the spouses weekly on Wednesdays from 1:00 p.m. to 3:00 p.m. These were the most convenient days for the members as they did not disrupt their other activities. The members contracted for eight sessions.

CLIENTS

The clients who utilized these interventions were, four couples; one partner of each couple had experienced a stroke. One stroke survivor was involved without his partner. Month and year of the occurrence of the stroke and discharge date from hospital varied. This will be discussed further in Chapter 4.

The survivors and their spouses met in two separate groups. The reason for two separate groups was that the survivors were struggling with cognitive, physical and emotional changes in themselves plus the loss of functioning that these changes imposed. The survivor's interpersonal relationships were easily interfered with because of the

amount of emotional energy that was expended in dealing with limitations brought about by these changes. The spouses struggles were different. They struggled with the loss of a spouse as he once was and with the fear that free expression of emotions could upset him and cause a recurrence. Pressure built up because she did not feel free to share problems as she may have done before so managing conflict was more difficult. Both husband and wife did not feel comfortable talking to their spouse about these common problems. Participation in the group/s was on a voluntary basis.

Referrals came from Brenna Shearer, O.T., Director of the Adult Day Programs, Lions Place Club and Village Club. Also, from Ruth Gudgeon, Executive Director of the Stroke Association of Manitoba, Inc.

There was an initial orientation planned for all couples involved so they would know who would be in the group/s. Also, to let them know what the group/s was all about, however, only two couples were able to attend.

RECRUITMENT

This was done from the stroke survivors who were members of the Adult Day Programs at the Lions Place Club and Village Club and the membership of the Stroke Association of Manitoba Inc. One couple from the Lions Place Club and one stroke survivor from the Village Club attended this group. The writer presented this practicum at one of the meetings of the Stroke Association of Manitoba Inc. to determine the interest

of their membership in being involved in this group. Three couples from the Stroke Association of Manitoba Inc. attended this group.

INCLUSION CRITERIA

Members were age 60 and over. One exception was made, one of the spouses was under 60 years of age. Members were competent verbally and mentally, willing to participate and living in their own homes with their spouses. One spouse had to have had a stroke.

THE GROUP WORK MODEL USED IN THIS PRACTICUM

The group intervention model that was used for this practicum was developed by Toseland and Rivas (1984). They conceptualized group work as a series of generic activities and skills carried out by the leader over the existence of the group.

Toseland and Rivas (1984) maintained that the various stages of group development could be broken down into four stages: planning, beginning, middle and end. During the planning phase, the leader considered potential membership and sponsorship and identified the group's purpose. Secondly, the leader composed the group, recruited and orientated members, and prepared for the first session by finding an appropriate room and making other essential arrangements. (Toseland and Rivas 1984)

The beginning phase occured during the first few sessions of the group. As group members began to have face-to-face

interaction, the leader assisted in building relationships by clarifying the group's purpose.

Establishing the group's purpose was one of the most important aspects of the group. A clear statement of group purpose should be established by the leader. (Schwartz 1971) This helped to answer the question, What were we doing here? According to Toseland and Rivas (1984) "a brief statement of the group's purpose includes information on why the group is meeting, how the group might deal with its work and what the extent of individual goals or tasks might be in the group." p.118 The three main group purposes for the stroke couples were education, growth and socialization.

During the beginning stage, the leader assisted members in getting to know each other (Toseland and Rivas (1984). During this beginning stage, the group went through a time of orientation, characterized by a search for structure and goals (Toseland and Rivas, 1984)

In the middle stage, the leader assisted the group in accomplishing its' tasks. The leader maintained and enhanced group dynamics that were conducive to the group's success and altered dynamics that were retarding the group's development. (Toseland and Rivas, 1984)

According to Toseland and Rivas (1984) leaders during this stage were expected to perform four activities. These activities were: "1) preparing for group meetings; 2) structuring the group's work; 3) helping members achieve their

goals; 4) monitoring and evaluating the group's progress." p.192

There were several tasks involved in terminating a group. Leaders assisted the members to admit that the group was actually ending and assisted members with their feelings about the group's termination. The leader also helped in evaluating the group's work and maintaining and generalizing change efforts. (Toseland and Rivas, 1984)

Toseland and Rivas (1984) defined group work as "goal-directed activity with small groups of people aimed at meeting socioemotional needs and accomplishing tasks. This activity is directed to individual members of a group and to a group as a whole within a system of service delivery." p.12

For Toseland and Rivas (1984) the term treatment group was used "to signify a group whose major purpose is to meet members' socioemotional needs." "The purposes for forming treatment groups include meeting members' needs for education, growth, behavior change or socialization." p.15. The reason these authors did not include support and mutual aid was that these purposes were basic to all types of treatment groups.

The term treatment group was used by the writer to define the type of group/s used in the practicum with the stroke couples. The writer decided that in the group/s for stroke couples one of the purposes was to assist members to say what they wanted and needed to say to their spouse and get group support. The group/s were classified by the writer as

treatment group/s because they were assembled to meet the personal needs of their members. Also, because the members were bonded together by their common needs and had common problems and they were expected to disclose their own problems.

In both groups, members were expected to act as resources in helping each other in their adjustment to changes in their lifestyle. Members were asked to assist each other with problem-solving. The groups fostered a high level of self-disclosure because of the homogeneity of the members and the problems they were dealing with. Members learned that they were not unusual in their situation and that other members had similar emotions about having their lifestyle changed by stroke. Roles developed through interaction among the group members. Patterns of communication focused on the needs of members and member-to-member interaction. In the evaluation of the success of the group/s, the leader focused on members' satisfaction with the group experience and whether or not the group had met their needs.

In the writer's opinion, groups like the ones in this practicum for stroke couples could be classified as having educational, growth and socialization goals. Groups with educational goals were aimed at increasing member's information or skills. Groups with growth goals were aimed at developing members' insight and potential. For stroke couples, the educational and growth approach was used by the

writer to help couples deal with the changes. This was accomplished by developing their assertiveness and conflict management skills. The skills were developed by providing information about assertiveness and conflict management and a chance to practise these skills in the groups via structured exercises and role plays. According to Toseland and Rivas (1984), socialization groups were aimed at increasing social skills through role playing and structured exercises which were part of the group work in the stroke couples group/s.

A treatment group approach was used for stroke couples adjusting to a new life style. The group had three primary purposes, education, socialization and growth. This approach was chosen for this practicum because the writer assumed that the needs of the stroke couples would best be met by the social work approach to groups designed by Toseland and Rivas. The writer assumed that stroke couples required an environment that would foster mutual aid and support and provide the opportunity to develop some useful skills to work around their problems (Toseland and Rivas 1984 and Shulman 1985/86).

This practicum was viewed by both the Stroke Association of Manitoba Inc. and the Adult Day Programs for the Frail Elderly living in the community sponsored by the Lions Club of Winnipeg Housing Centres and funded by the Manitoba Health Services Commission as filling in a gap in the social services. The gap namely, helping stroke couples cope with crucial common problems related to their changed lifestyle due

to the stroke. Skills learned through involvement in these groups were transferrable to other problems the couple have not yet dealt with or addressed.

OTHER INTERVENTIONS USED IN THIS PRACTICUM

The assertiveness framework that the writer used in this practicum was that of Schulz (1989) called the B.E.S.T. method. See Appendix A for a description of his formulae.

The conflict management framework that the writer used in this practicum was Adler and Towne's (1984) No-Lose Problem Solving Model for negotiating. A description of their framework includes eight steps which are included in Appendix B.

TREATMENT - GROUP INTERVENTION

The group work practice extended over an eight-week period, with eight, two hour sessions per group. Part of these sessions were spent in assisting the members in developing their assertiveness and conflict management skills. The leader did this by introducing the components of the three interpersonal styles; the passive, aggressive and assertive styles. (See Appendix C). A copy of this was given to the members. Secondly, by providing a relevant, simple example of each style and making the topic; assertiveness style versus aggressive and passive styles relevant to the members. This was done by asking the members, "Can you remember a situation where you acted passively and how you felt about it?" The same procedure followed for the other two styles to make the

topic more meaningful to the members. Thirdly, by introducing members to the legitimate rights (See Appendix D) and stimulating discussion among members about these rights. A copy of these rights was given to the members.

Members were asked to complete an exercise (See Appendix E) either in pairs or as a group to help them distinguish among the three styles and realize how the assertiveness style was the most effective to use. The situations in this exercise were discussed orally. The leader presented Schulz's (1989) assertive style formulae (See Appendix A) to the members and provided a relevant example of how it could be used. Members received this handout (See Appendix A). The members completed another exercise (See Appendix F) where they had to identify the type of response therefore helping them differentiate among the three styles and a discussion followed. Members looked at the benefits of learning to be more assertive and the leader tried to get the members to see when and how they could be more assertive.

Again, the members looked at the assertive style formulae and the leader tried to get the members to see how they could apply it to their own lives and attempted to get them to role-play. The leader explained the purpose of the interaction log (Appendix G), how to complete it, the best time to do it and handed it out to the members with an example copy attached (See Appendix H).

The leader presented and handed out the No Lose Problem

Solving Model for Negotiating (See Appendix B) to the members. Both the goal of this model was explained and how to convince one's spouse that it was in their best interest to work together to try and find a solution that would resolve the differences between them and would satisfy both of them. The leader provided a relevant example of this model's application to the members (See Appendix I). The members were encouraged to think of situations where they wanted to try putting this model to use. The leader encouraged the members to think about how assertiveness and conflict management fit for them at the present time and what it meant for them in their lives. They were asked how they thought they might be able to use it with their spouses. Members role-played with the leader using the model as a guideline. The leader modelled behavior or asked a member of the group to rehearse what he was going to say or do through the role-plays. For example, the leader took the role of the spouse of a member and this member was asked to rehearse how she might approach her husband about his dependence on her to do his chores. The leader then took this member's role and modelled various ways to ask her husband to do his chores. The other members looked on and made comments about the role-plays. The goal here was to further develop the members' assertiveness skills. Members were encouraged to express their feelings while doing the role-plays. Members worked on their own problems and decided which of their conflicts took priority.

RECORDING

Prior to the first group sessions the leader interviewed the couples and completed the necessary questionnaires and the Rathus Assertiveness Schedule (See Appendices J, K, L, and M). This identified the specific problems each couple were coping with and the degree of conflict they were causing. These data were recorded on the questionnaire and kept on file for use in planning the group sessions. The couple's pre-treatment methods of handling conflict and assertiveness scores were recorded and these sheets were kept on file.

Monitoring each group's progress after each session was done by the leader as she recorded the activities and critical incidents that happened. The leader used a summary recording form (Appendix N) for these purposes. The contents of this form were taken from Toseland and Rivas (1984). The only modification made was that meeting or meetings were referred to as session or sessions. This form was completed as soon as possible after each session was finished. Also, each session was video taped which supplied an accurate, unedited record of all sessions.

PROGRESS OF CLIENTS

Clients were asked to record data about their own behavior outside the group sessions. This was optional. Self-monitoring could be accomplished by clients examining their own targeted, specific behaviors and maintaining a record of their efforts of these behaviors on a log (Bloom and Fischer

(1982), (Appendix G). This log was that of Bloom and Fischer (1982). The left side of the log had to be adapted by the leader to fit for the leader's own use with the stroke couples. The writer gave the clients a sample copy of a completed log (See Appendix H) so they could understand how to complete their own log. The targeted behaviors for this practicum were assertion, collaboration and negotiation. The client's progress in the group was automatically recorded by the video tape recorder.

EVALUATION CRITERIA

Evaluation was a way that social workers got feedback and gained knowledge about their work with a group. This practicum used the following evaluation methods to determine the outcome of the intervention.

Four instruments were administered to clients prior to the start of the groups. The Pre-Stroke, Since (Post) Stroke Common Problem Questionnaires (See Appendices J and K) were developed specifically for this practicum by the writer. There was a Pre-Stroke and Since (Post) Stroke Common Questionnaire for the stroke survivor and one for the spouse which covered the three common problems the writer addressed in this practicum. Each questionnaire was one page and the Likert scale was used to measure the amount of conflict between the spouses.

Their development was based on the writer's personal and professional involvement with elderly people who had

experienced a stroke and from general information found in the existing gerontological literature. The writer developed specific questions for these questionnaires by thinking about the literature regarding self care activities, role obligations and social activities in which healthy, elderly people were normally involved. These questions measured dependence/overprotectiveness, role reversal/role change and social isolation/loneliness respectively. The writer conducted a pretest of the questionnaires to develop the face validity of these questionnaires by asking two professionals employed in the geriatric field to complete and comment on the questionnaires.

Since these instruments were unique the writer was unable to comment on their strengths. Since these instruments were simple and very brief they may be limited in amount of information they provided about the extent of the problem the couple was experiencing with dependence, role change and social isolation.

The Conflict Management Questionnaire (see Appendix L) was adapted for use with stroke couples from an instrument used at an assertiveness training workshop given by J. Haid, M.Ed. in the fall of 1988. Several minor modifications were made to suit this practicum. The title of the instrument was changed from How Do You Usually Handle Conflicts? to Conflict Management Questionnaire. A few additions were made at the top of the instrument; a line for the client's name and

interview date, after the introductory, general How Do You Usually Handle Conflicts? with your spouse was added and all the other words except how were in small letters. The scale was changed from frequently, occasionally and rarely to 1. never, 2. rarely, 3. frequently and 4. very frequently. The techniques were changed from the second person to the first person and the verb tenses were changed. The word person in the techniques was changed to spouse where it was appropriate. A sixteenth technique was added, namely, My spouse and I are able to collaborate.

Haid developed this instrument especially for adults of all ages who attended her assertiveness training workshop to assist them in gaining self insight into how they handle conflict and stimulate discussion. Since Haid has not published on her instrument, How Do You Usually Handle Conflict?, it was difficult to assess the validity and reliability although she has used it in several of these workshops and continues to use it.

An existing instrument, The Rathus Assertiveness Schedule (Rathus 1973) (See Appendix M) has been determined to be valid and reliable. It was used in this practicum. The Rathus Assertiveness Schedule has been tested for reliability and validity. Rathus observed the following:

> The schedule is shown to have moderate to high test-retest reliability ($r=.78$; $p<.01$) and split-half reliability ($r=.77$; $p<.01$). Validity in terms of the impressions respondents make on other people ($.33 \leq r's \leq .62$; $p's<.01$) and in terms of their indications of how they would

> behave in specific situations in which assertive, outgoing behavior can be used with profit (r=.70; p<.01) is satisfactory. Item analysis shows that 27 of the 30 items correlate significantly with the total scale score and 19 of 30 correlate significantly with external criteria. (p.398)

The Rathus Assertiveness Schedule was adapted for this practicum in that one-half of the questions were omitted as it was decided that thirty questions were too tiring for the elderly to handle. Only one-half of the questions were used thus the validity of this adapted Rathus Assertivenss Schedule may have been changed somewhat. The higher the positive score one obtained on this schedule the higher his assertiveness level. Rathus has not indicated that his scale was to be used exclusively with any specific age group of adults. In their study, Fernandez-Ballesteros et al (1988) used the Rathus Assertiveness Schedule with the elderly. In the writer's opinion this scale was appropriate for use with all age ranges of adults of normal intelligence.

EVALUATION PROCEDURES

The group leader interviewed the couples individually either in their own home or at the Lions Place Club/Village Club to complete a Pre-Stroke Since (Post) Stroke Common Problem Questionnaire prior to the start of the group work practice. An appropriate amount of time was taken to establish rapport with the client, then under each of the three common problems, the leader asked a few open ended questions. (See Appendices J and K). The leader handled these questionnaires in such a way that the clients did not have

access to the actual instruments. The leader let the client talk and then the leader completed all the questions and scales according to what the client told her.

Also the Conflict Management Questionnaire, (Haid, 1988) (See Appendix L) and one-half of the questions on the Rathus Assertiveness Schedule (Rathus 1973) (See Appendix M) were completed. With regards to the Conflict Management Questionnaire (Haid 1988), the leader asked the open ended question, "How do you usually handle conflict with your spouse?" The leader handled the questionnaire in such a way that the clients did not have access to the actual instrument. The leader wrote a summary of the contents of what the client said on the bottom of this questionnaire and ticked off information on the 16 techniques if he mentioned any of them. The leader used clues by saying to the client, avoid, compromise, fight it out to make it easier for the clients to respond.

In administering the adapted Rathus Assertiveness Schedule the leader read aloud to the clients all fifteen questions in the order which they appeared and completed the scale as they responded. The writer elicited responses from the clients by reading the Likert scale verbatim to the clients. The writer ensured that the clients understood the Likert scaling while in the process of completing this instrument with them. As with the other instruments the clients did not have access to the schedule.

Data collected from these questionnaires determined whether or not there were conflicts related to the three common problems in their relationship since the stroke occurred and how each spouse handled conflict. The Rathus Assertiveness Schedule measured pre-treatment assertiveness.

Within a two to three week period after the group terminated, the leader made a home visit and had the members complete the Conflict Management Questionnaire and the Rathus Assertiveness Schedule. These were administered to members in the same way and in the same order they were administered prior to the group. Scores before and after the intervention were compared to see if there was any change in the member's behavior.

Clients monitored the groups progress by completing an evaluation form (Toseland and Rivas 1984) (Appendix O) at the end of each session which provided feedback as to their level of satisfaction with the group session. This form was that of Toseland and Rivas (1984). The leader had to adapt the first question to fit for the leader's own use with the stroke couples group/s. The leader offered help to clients who were having difficulty completing this form on their own.

A feedback questionnaire was given to the clients at the end of the final group session (See Appendix P). The leader told the members that if they had any difficulty completing it the leader would assist them. This written feedback indicated their overall satisfaction with the group and the leader.

The writer developed this questionnaire by attempting to produce questions that would address important issues. Issues such as strengths and weaknesses of the group, what members found helpful and not so helpful, how the leader could make improvements to meet members needs better, qualities of leadership and the value of the group experience as perceived by the members. Also, the leader's observations at each session and the completed session evaluation forms indicated the members' feelings towards the group.

EVALUATION OF PRACTICE

The monitoring of the leader's work and her skill development was done by using videotaped records of each session and regular meetings with her advisor. The advisor reviewed the tapes and offered suggestions on how the group was developing and analyzed the intervention and the effectiveness of the leader's role.

CHAPTER 4

THE GROUP MEMBERS

COMPOSITION

Ages of the stroke survivors ranged from 61 to 77 years. They were five males who came from middle class backgrounds. The time that elapsed since the stroke ranged from eighteen months to 5 years. All were retired. There was a cultural variety, one survivor was originally from Trinidad.

Ages of the spouses ranged from 47 to 69 years. They were four females who came from middle class backgrounds. Two of the spouses were retired and two were employed.

PRE GROUP INTERVIEWS

At least two personal contacts were made with each couple and individual about the group prior to the pre group interview. These contacts occurred during volunteer work, informal interviews, letters, the meeting at the Stroke Association of Manitoba Inc., the orientation meeting and telephone discussions.

During these interviews, the Pre-Stroke Common Problem Questionnaires and the Since (Post) Stroke Common Problem Questionnaires were administered first, followed by the Rathus Assertiveness Schedule and the Conflict Management Questionnaire. The individuals were invited and encouraged to set a goal related to their own situation and work on achieving it during the group sessions. Individual preferences regarding meeting days and times and means of

transportation to the group were discussed.

INFORMATION ABOUT THE COUPLES

Couple #1

Couple #1 had been married for over 45 years. The husband, Stroke Survivor #1 was 71 and his wife, Spouse #1 was 69 years old. She was self-employed on a part-time basis.

According to Stroke Survivor #1 before the stroke there was no conflict regarding the three common problems. Since the stroke changes had happened. He told the writer of several changes in his marital relationship. Regarding dependence/overprotectiveness, sometimes he demanded his spouse do and get things for him which caused a little conflict. Regarding role change/role reversal his spouse was working and able to earn money teaching piano lessons and he was not. Thus, some conflict existed. He told the writer he resented that she could be productive with her talents and he could no longer repair engines and clocks. Regarding social isolation/loneliness he indicated there was moderate conflict. He said he wanted to be more involved with his friends and especially with his spouse as he felt lonely and that she was not as interested in having visitors over as he was.

According to Spouse #1 before the stroke there was no conflict regarding the three common problems. Since the stroke changes had happened. She reported the following information. There was a little conflict regarding dependence/overprotectiveness as spouse was slow dressing

himself and sometimes he demanded that she get things for him. Some conflict existed over role change/role reversal because her spouse resented all the time she spent playing and teaching piano. She was productive and able to bring in an income and he was not even able to do his hobbies as he did not have the use of his left hand. Her continuation of teaching was very important to her. There was also some conflict with regard to social isolation/loneliness. Her spouse liked a lot of people around but she did not like this so much. Both liked to go to social outings but could not do this so much anymore because she did not drive and he could not. She knew her spouse felt neglected because she was teaching piano lessons.

The source of conflict for the spouses was basically the same. The major source of conflict between them seemed to be related to her ability to work and use her talents to earn a living. Since the stroke he had not been able to use his talents. He felt lonely because of his limited social life with his spouse and significant others.

BIOGRAPHY: Stroke Survivor #1

Prior to Stroke Survivor #1's retirement, he was employed as a rough carpenter and safety inspector. He was a veteran. Stroke Survivor #1 had a right CVA two years ago. Stroke Survivor #1 used a wheelchair but could walk short distances using a

quad cane. He was not able to use his left hand and as a result had difficulty writing.

GOAL: To be more assertive with spouse that I want to spend more time with her and do more things with her.

To try and do some negotiating with her.

OUTCOME:

1. Pre test Score on Rathus Assertiveness Schedule: -9

Post test Score on Rathus Assertiveness Schedule: +5

2.

Pre test Scores on Conflict Management Questionnaire		Post test Scores on Conflict Management Questionnaire
Avoid my spouse	3	3
Try to understand my spouse's point of view	NR*	NR
Give in	3	2
Try to reach a compromise	NR	2
Whine/complain until I get my way	NR	NR
Able to collaborate	2	3

*NR: No response

Stroke Survivor #1's score on the Rathus Assertiveness Schedule increased by 14. His post test scores on the

Conflict Management Questionnaire indicated that he was trying to use more adaptive techniques to handle conflict. Although, he continued to avoid his spouse, he was giving in much less and was able to collaborate more with his spouse about their doing more things and spending more time together. His goal was ongoing.

BIOGRAPHY: Spouse #1

Spouse #1 taught piano lessons on a part time basis in their home. She found this very rewarding and it provided her with extra spending money.

GOAL: To be more assertive with spouse about the fact that it is important to me to play and teach piano. To try to negotiate with him about how we could spend more time together so he does not feel neglected.

OUTCOME:

	1. Pre test Score on Rathus Assertiveness Schedule	Post test Score on Rathus Assertiveness Schedule
	+9	+14
	2. Pre test Scores on Conflict Management Questionnaire	Post test Scores on Conflict Management Questionnaire
Avoid my spouse	4	2

Try to understand my spouse's point of view	NR	NR
Give in	4	3
Try to reach a compromise	NR	3
Whine/complain until I get my way	NR	NR
Able to collaborate	2	3

Spouse #1's score on the Rathus Assertiveness Schedule increased by 5. Post test scores on the Conflict Management Questionnaire indicated that she was not avoiding her spouse as she used to but continued to give in frequently. She told the writer that she was taking some initiative to try and reach a compromise with him so he felt less neglected because of her teaching and she was able to collaborate with him frequently. Both she and her husband were waiting to receive a scooter from Veteran's Affairs so they could go to the City Park together. This was a pastime they both enjoyed prior to his stroke. She was more assertive with her spouse about how important her teaching was to her. Couple #1 were continuing to work on reaching their goals together.

Couple #2

Couple #2 had been married for 8 years. This was the second marriage for both of them. The husband, Stroke Survivor #2 was 62 and his wife, Spouse #2 was 61 years old.

According to Stroke Survivor #2 before the stroke there

was no conflict regarding the three common problems. Since the stroke a change had occurred regarding dependence/overprotectiveness. Stroke Survivor #2 told the writer the following information. He could dress himself but did not like doing it or felt like doing it. He said he was slow with self care activities and this caused moderate conflict because he kept his spouse waiting and late. Not being able to drive was very frustrating for him. He depended on his spouse for transportation. Little or no conflict existed between them regarding role change/role reversal and social isolation/loneliness.

According to Spouse #2 before the stroke there was no conflict regarding the three common problems. In keeping with her spouse, since the stroke a change had occurred regarding dependence/overprotectiveness. She reported the following information. Her spouse was much slower grooming and dressing himself thus he kept her waiting and they were late getting to places. He did not care if he was late. Her spouse would not do things if he could get someone else to do them for him. This caused moderate conflict between them.

This couple reported moderate conflict between them in the area of dependence. The husband's slowness with self care activities, his preference to have others do things for him, and his lack of concern with being punctual caused moderate conflict.

BIOGRAPHY: Stroke Survivor #2

Prior to Stroke Survivor #2's retirement, he was employed as a truck driver. He had a right CVA, two years ago. Stroke Survivor #2 wore a hearing aid and had difficulty expressing himself in writing.

GOAL: To increase assertiveness with spouse when things are bothering me and see how this works.
To increase negotiating skills in planning with spouse.

OUTCOME:

1. Pre test Score on Rathus Assertiveness Schedule: +7
   Post test Score on Rathus Assertiveness Schedule: 0

2. Pre test Scores on Conflict Management Questionnaire / Post test Scores on Conflict Management Questionnaire

Avoid my spouse	NR	NR
Try to understand my spouse's point of view	NR	NR
Give in	4	4
Try to reach a compromise	1	1
Whine/complain until I get my way	2	1
Able to collaborate	1	1

Stroke Survivor #2's score on the Rathus Assertiveness Schedule decreased by 7. His post test scores on the Conflict Management Questionnaire indicated that his techniques for handling conflict basically had not changed. He continued to give in to his spouse very frequently. Stroke Survivor #2 realized that collaborating and negotiating were useful techniques but indicated that he was not using them. The writer cannot be certain why Stroke Survivor #2's, post test score on the Rathus Assertiveness Schedule decreased. The writer speculated that his level of motivation to deal with his difficulties may have deteriorated. He may not have felt confident enough to try and use the adaptive conflict management techniques.

BIOGRAPHY: Spouse #2:

Spouse #2 was a retired bookkeeper.

GOAL: To increase assertiveness with spouse and see how this works.

To increase negotiating skills in planning with spouse.

OUTCOME:

	Pre test Score on Rathus Assertiveness Schedule	Post test Score on Rathus Assertiveness Schedule
1.	+10	+15

2.	Pre test Scores on Conflict Management Questionnaire	Post test Scores on Conflict Management Questionnaire
Avoid my spouse	NR	NR
Try to understand my spouse's point of view	NR	NR
Give in	1	1
Try to reach a compromise	1	2
Whine/complain until I get my way	1	NR
Able to collaborate	NR	NR

Spouse #2's score on the Rathus Assertiveness Schedule increased by 5. Her post test scores on the Conflict Management Questionnaire indicated that her techniques for handling conflict basically had not changed. She claimed that she tried a little to collaborate or negotiate with her spouse but felt it was not going to work. It seemed that the husband was not trying out the adaptive techniques and she was trying to use the adaptive techniques a little but felt they would not work therefore, the goals they were invited to make were not reached. The writer was not optimistic that Couple #2 would try very hard to resolve their differences.

See Appendix Q for information about Couple #3, Couple #4 and Stroke Survivor #5.

In summary, the stroke survivors had become more

assertive. They were using more adaptive techniques for resolving conflict with their spouses. There was an exception in this group (See Appendix R). One survivor's score on the Rathus Assertiveness Schedule decreased and he was not using the adaptive techniques for resolving conflict. The spouses had become more assertive. They were also using more adaptive techniques for resolving conflict with their spouses although, one spouse was trying a little but did not feel the techniques would work with her husband (See Appendix S).

Generally, both the stroke survivors and their spouses had improved their interpersonal skills. The nature of life situations is that people need to use these skills continuously. In the writer's opinion, most of the group members had grasped the skills taught in the group and were making progress.

CHAPTER 5

STROKE SURVIVORS GROUP

BEGINNING PHASE Sessions 1, 2 and 3

The leader's objectives for this phase were 1) establish a sense of trust between the members and between the members and the leader. 2) to encourage social interaction and group building. 3) to identify the group's purpose. 4) to establish norms and 5) attend to the member's emotional concerns and assist members towards achieving their goals. A detailed description of the group process is contained in Appendix T.

The first four objectives of this phase were reached. Attending to the members' emotional concerns and assisting members towards achieving their goal continued to be an objective. Sessions one through three focused on encouraging social interaction, group building and teaching the concept of assertiveness. The group had stabilized in terms of the full and regular attendance of its five members. This small group had clarified its purpose, namely, that it was important to get assistance in saying what you felt, wanted and needed to your spouse and get support from this group. Also, to increase one's assertiveness and conflict management skills so that one was more effective in dealing with one's spouse. Group norms had been established, for example, confidentiality, respect for others (Appendix U).

The leader's role was that of a facilitator, providing direction and a focus. Also, to model interest and caring in

order to encourage members to be supportive of one another as they shared their losses, experiences and emotions.

MIDDLE PHASE Sessions 4, 5 and 6

Each member's emotional concerns were attended to and they were encouraged towards achieving their goals. Sessions four through six focused on assertiveness and conflict management skill development. The concepts of conflict management were taught. Members did some role-playing. The leader modelled behavior, coached and encouraged member efforts and interaction. Attention was focused on the losses and the changed self image members experienced and their expression of emotion. The members had a difficult time talking about their losses and identifying and expressing the feelings associated with these losses. This avoidance was demonstrated by their joking, interrupting and changing the subject. A detailed description of the group process is contained in Appendix T.

The discovery of shared problems boosted self-esteem and fostered group identification. Common problems and concerns expressed by the members included loss of friends, independence, physical functioning and the work role. They realized they were all in the same boat which offered some relief.

Members tried to avoid talking about issues related to conflict with their spouses. Again, the leader observed a lot of interrupting, joking and changing the subject among the

members to avoid discussing their relationship concerns and dealing with the feelings associated with these concerns.

In session six, one member pointed out that stroke victims lose initiative or energy and lack motivation. The leader's assessment was that motivation and energy levels may be too low for members to address their difficulties and needs and act on them. Some members felt depressed at times which could account for their lack of drive. Depending on the degree of depression there could be a tendency towards dependency and passivity in problem solving and decision making. They were already dependent on their wives in many ways and they may have been looking to them to take the initiative in negotiating their differences. Since men do not share their feelings as easily and readily as women, due to being socialized differently, the members may not have shared their feelings and concerns much before. Also, this group experience may have been too threatening for them to reveal themselves any more than they already had. They may not have been open before the stroke. They may have believed that personal matters should be confined to the four walls of their home. Other barriers to furthering self-disclosure might have been fear of rejection and avoidance of responsibility and change.

The leader observed one of the members emerging as the internal leader. He seemed to speak for the other members and no one challenged him. This member seemed to be respected by

the other members and had some influence on them.

In the leader's opinion, this was a cohesive group. The members were attracted to the group, worked well together, were learning some skills and felt a sense of security, stability and belonging. Most of the members were high participators. One member was self-conscious about his slurred speech and accent. His hearing aid was unreliable. These factors were largely responsible for his low participation.

ENDING PHASE Sessions 7 and 8

The men wanted to role-play hypothetical situations using the negotiating model. Members were attentive observors during the role-playing and some members provided feedback to the member who role-played. When brainstorming options, under step seven of the negotiating model members required a lot of assistance from the leader in coming up with ideas. Members talked about group termination and their feelings related to ending. Members were hesitant to raise their concerns at a final joint session with their spouses. A detailed description of the group process is contained in Appendix T.

SYNTHESIS

In the beginning phase a sense of trust between the members and between the leader and members was established and a comfortable atmosphere existed. Initially, risk taking was low however, as members got to know each other; there was some mutual sharing of feelings and members supporting each other.

All members participated on a regular basis and completed the program. There was some feeling of "we-ness". Members felt free to express themselves. There was lots of joking from time to time and members enjoyed the coffee time. Initially, it looked like there maybe a leadership struggle however an internal leader emerged during the middle phase. There was no sub grouping and members worked together co-operatively except for a few tiffs between the same two members. The attention seeking behavior of one of the members annoyed the others otherwise there was not much tension among members. Members laughed to relieve any tension when it did occur. At times interruptions by members decreased group efficiency.

A supportive environment developed in the group. Members struggled with their various losses and changed self-image. They had a difficult time looking at the troubled spots in the relationship with their spouses. In the ending phase, when hypothetical situations were used most of them identified with the situations and one member role-played. Members found this a good learning and practice experience. Even though the men did not do much in the way of role-playing it was the writer's opinion that they had a better idea of how the negotiating model could be applied to their life situations and its usefulness.

During the group several themes emerged: dependency, their social life, caring, decision making and sex with the

increase of mutual support and trust. Socialization was a big issue for the men and it was important to them to have the chance to share their concerns.

RESULTS

PRE AND POST GROUP

The mean score on the Rathus Assertiveness Schedule pre test for the stroke survivor's was -3.0 and the standard deviation was 9.460. The mean score on the Rathus Assertiveness Schedule post test was 4.2 and the standard deviation was 3.962. The post test mean score indicated that the intervention had resulted in effectively increasing the assertiveness scores of the stroke survivors. A t-test was computed. The t score = 2.67, $P<.05$.

The mean scores were calculated for the techniques responded to on the Conflict Management Questionnaire pre test and post test. The results include the mean scores for the five group members (Table 1).

TABLE 1 - Mean scores for the Conflict Management Questionnaire - pre test and post test

TECHNIQUE	OVERALL MEAN		STANDARD DEVIATION	
	PRE TEST	POST TEST	PRE TEST	POST TEST
Avoid my spouse	3.200	2.000	1.304	1.000
Try to understand my spouse's point of view	1.000	1.800	.000	1.095
Give in	3.200	2.600	1.304	1.140
Try to reach a compromise	1.200	2.000	.447	1.000
Whine or complain until I get my way	1.200	1.000	.447	.000
My spouse & I are able to collaborate	1.400	2.200	.548	1.095

Prior to the intervention, the techniques the survivors used most frequently for handling conflict with their spouses were avoiding their spouse and giving in. After the intervention, the techniques the survivors' were using the most frequently for handling conflict were giving in and collaborating so progress had been made. See Appendix R for the pre and post test summaries on the Conflict Management Questionnaire.

In comparing the pre test results with the post test results a difference was found. Overall, the survivors were

using more adaptive techniques to handle conflict with their spouses since the group experience. The post test mean scores increased for the adaptive techniques and decreased for the maladaptive techniques. Both the mean scores and the summaries on the Conflict Management Questionnaire changed in a positive direction.

DURING THE GROUP

After each session, the members completed a session evaluation form (See Appendix O). One member did not complete a form for session 1 because his hearing aid did not work. Responses to this questionnaire by the five members were as follows: Responses to the first question are illustrated in Table 2.

TABLE 2 - Was the information presented about interpersonal skills helpful to you in understanding the concepts of assertive behavior and the collaboration and negotiating conflict management styles?

SESSION	VERY HELPFUL	SOMEWHAT HELPFUL	A LITTLE HELPFUL	NOT AT ALL HELPFUL
1				
2	3	1	1	
3	3	2		
4	4	1		
5	4	1		
6	4	1		
7	3	2		
8	4	1		

The responses indicated that the stroke survivors found most of the information presented to them about interpersonal skills very helpful in understanding the concepts of assertiveness behaviour and the conflict management styles in the eight sessions. These findings assisted the writer in planning for subsequent groups.

The responses to the question: "What information did you find the most helpful?" indicated that the survivors found the explanation of the verbal and non-verbal concepts of the three styles, the rights and the assertiveness style formulae the most helpful. Also, the benefits of being assertive, the exercises, the example using the negotiating model and role-playing (See Appendix V). These findings suggested that the

information and interventions the writer used with the stroke survivors were helpful.

Member's responses to the third question are illustrated in Table 3.

TABLE 3 - Rate the effectiveness of the leader in this group session:

SESSION	VERY HELPFUL	SOMEWHAT HELPFUL	A LITTLE HELPFUL	NOT AT ALL HELPFUL
1	3	1		
2	4	1		
3	3	2		
4	4	1		
5	3	2		
6	4	1		
7	4	1		
8	4	1		

The responses indicated that most of the stroke survivors found the leader very helpful in the eight group sessions.

The responses to the question: "What did you find most helpful about the group during this session?" indicated that the survivors found socializing and sharing, lots of interaction, examples of the three styles helped with understanding more about the differences among the styles, the exercises, shared feelings about losses, being assertive, sharing of similar problems and getting support and good participation the most helpful. Also, seeing how others cope,

the negotiating model was practical, role-playing and the group trying to apply the problem solving model to our real life situations (See Appendix V). These findings indicated that there was a good balance between sharing and learning in the group process.

The responses to the question: "What did you find least helpful?" indicated that the survivors found the steady complaints of one member of the group and his over-emphasis on negative assertions the least helpful about the group. Also, members interrupting and changing the subject too often (See Appendix V). These findings suggested that the leader needed to develop and apply strategies to keep these behaviours under control in the group.

Members responses to the sixth question are illustrated in Table 4.

TABLE 4 - Overall, rate your satisfaction with today's group meeting:

SESSION	VERY SATISFIED	SATISFIED	NEUTRAL	DIS-SATISFIED	VERY DIS-SATISFIED
1	1	3			
2	3	2			
3	3	2			
4	3	2			
5	4	0	1		
6	3	2			
7	4	1			
8	4	1			

The responses to question six indicated that the survivors were either very satisfied or satisfied with the eight sessions they experienced.

The additional comments the survivors made were positive (See Appendix V). Regarding session one, one of the survivors felt the members should be walking more. The leader explained to this survivor that in this particular group working on their physical needs was not one of the group's purposes and this need was better met through contact with other resources, for example, the Stroke Association of Manitoba Inc. The findings indicated that the survivors found the group experience to be educational, growth producing and helpful in meeting some of their emotional needs.

POST GROUP FEEDBACK

A feedback questionnaire (See Appendix P) was distributed at the end of the last meeting, to be filled out by the individual members. The leader provided suggestions and assistance in filling it out.

In summary, the findings indicated that the survivors were satisfied with this group experience and they would strongly recommend this type of group experience to couples who were adjusting to living with a stroke. In comparing the post test scores and summaries on the Conflict Management Questionnaire and the post test scores on the Rathus Assertiveness Schedule as to how the survivors responded to question five, similarities were found. Four of the members

increased their post test scores and four survivors answered moderately, and one, not at all to the question: "Do you find that you are using these skills that you have learned in the group in everyday situations?" The member who answered, not at all, decreased his assertiveness score and is not using the adaptive conflict management techniques since the group experience (See Appendix W).

POST GROUP INTERVIEWS

Some informal discussion occurred about the group experience prior to administering the post tests. How each individual had worked on his pre group goal was discussed.

During this interview, the survivors told the writer that they did not keep a written record of their progress on the interaction log (See Appendix G) because it was too difficult for them to write. They chose to self monitor by recalling their experiences. Two used the example copy as a guide in expressing their feelings, wants and needs to spouse and significant others.

The findings mean that overall the stroke survivors had a positive experience by being involved in this group. Most of them were using or trying to use the skills that they learned in the group sessions. The group met some of their social and emotional needs as well.

CHAPTER 6

SPOUSES GROUP

BEGINNING PHASE: Sessions 1, 2 and 3

The leader's objectives for this phase were 1) establish a sense of trust between the members and between the members and the leader 2) to encourage social interaction and group building 3) to identify the group's purpose 4) to establish norms and 5) attend to the member's emotional concerns and assist members towards achieving goals. A detailed description of the group process is contained in Appendix X.

The first four objectives of this phase were reached. Attending to the member's emotional concerns and assisting members towards achieving their goals continued to be an objective. Sessions one through three focused on encouraging social interaction, group building, teaching the concept of assertiveness and encouraging members to express and share their feelings related to their similar problems. Members related how they dealt with their spouse's crying. The group had stabilized in terms of the full and regular attendance of its four members. This small group had clarified its purpose, namely, that it was important to get assistance in saying what you felt, wanted and needed to your spouse and get support from this group. Also, to increase one's assertiveness and conflict management skills so that one was more effective in dealing with one's spouse. Group norms had been established, for example, confidentiality, respect for others (Appendix U).

The leader's role was that of a facilitator, providing direction and a focus. Also, to model interest and caring in order to encourage members to be supportive of one another as they shared their losses, experiences and emotions.

MIDDLE PHASE: Sessions 4, 5 and 6

Each member's emotional concerns were attended to and they were encouraged towards achieving their goals. Sessions four through six focused on assertiveness and conflict management skill development. The concept of conflict management was taught. Members started to do some role-playing. The leader modelled behavior, coached and encouraged member efforts and interaction. Attention was focused on members' feelings about their caregiver role, how they were coping with their spouse's losses and their own lifestyle changes. Members were encouraged to raise their concerns so we could look at how the group could best meet their needs. A detailed description of the group process is contained in Appendix X.

Mutual aid was a strategy used in this group. Members were encouraged to interact with one another. This group developed in a way that the members needed each other as well as the leader.

Mutual aid assisted the members in helping each other express and discuss uncomfortable feelings. Members were able to relate feelings such as anger, frustration, sadness and helplessness. They were able to share ideas, experiences and

resources which they found helpful in coping with similar problems. Members shared how they dealt with their spouse's demanding assistance from them. Members also provided some emotional support to one another.

The ladies were much more open than the men to talking about personal matters. They seemed to be willing to reveal themselves more than the men. They were less resistant to trying to work around their problems. Their motivation was greater and their avoidance of responsibility and change was less. The men's having had a stroke accounted for some of this difference. The ladies may not have felt so threatened.

The genuine cohesion that existed in the group allowed the members to do some productive work. The members seemed less dependent on the leader than the members in the men's group.

ENDING PHASE: Sessions 7 and 8

Some of the members role-played with the leader using the negotiating model during this phase. Unlike the men, the women did not ask the leader to make up hypothetical situations to role-play but dealt with their concerns directly and were eager to problem solve. The members expressed their feelings about the group ending. Members talked about how it was for them to find themselves more in the dominant role in the marital relationship since the stroke. The ladies were very direct about not wanting to discuss any of their concerns at a final joint session with their spouses. A detailed

description of the group process is contained in Appendix X.

SYNTHESIS

In the beginning phase a sense of trust developed between the members and between the leader and the members and a comfortable atmosphere existed. Risk taking was higher initially in this group and the members opened up much sooner.

All members participated on a regular basis and completed the program. The members concerns were around the various losses their husbands had experienced and how this had affected their lives. Other concerns were related to their husbands' emotional state, their husbands' lack of motivation, their husbands' demanding assistance and how to deal with the conflict related to these concerns.

Early in the group process, Spouse #3 emerged as the internal leader making suggestions and giving a little direction to the way in which the group was going. No alliances formed between members. Conflict between members was minimal however one member remarked to the leader that she felt one of the members was very harsh in her attitude towards her spouse and that another member kept getting off topic.

The homogeneity of the members was such that a cohesive group developed which enabled the sharing of feelings and a number of different experiences, promoting problem solving and support. Since most of the members were motivated, they put some effort into achieving their goals and used the role-playing to practice. Members felt they developed good

awareness of the problems and got some tools to work around these problems.

The focus was on both the individual and on the group as a whole. When the focus was on one member an effort was made to involve the other members in the helping process, which facilitated sharing and support. Several instances have been described to illustrate these dynamics.

On May 7, 1991 both groups met for a joint session. Stroke Survivor #5 did not attend. All group members were reluctant to say much although a few members described very briefly how they felt the group experience had worked for them.

After coffee, the leader asked what they felt they would continue to work on now that the group was over. Stroke Survivor #2 stated that he and his spouse were fighting everyday and that they were still going to keep fighting. This couple directed some accusations at each other. Spouse #3 indicated that they would have to work on boredom. Members exchanged names, addresses and phone numbers.

RESULTS

PRE AND POST GROUP

The mean score on the Rathus Assertiveness Schedule pre test for the spouses was -2.50 and the standard deviation was 13.916. The mean score on the Rathus Assertiveness Schedule post test was 9.0 and the standard deviation was 6.481. The post test mean score indicated that the intervention had

resulted in effectively increasing the assertiveness scores of the spouses. A t-test was computed. The t score = 2.91, $P<.05$.

The mean scores were calculated for the techniques responded to on the Conflict Management Questionnaire pre test and post test. The results include the mean scores for the four group members (Table 5).

TABLE 5 - Mean scores for the Conflict Management Questionnaire - pre test and post test

TECHNIQUE	OVERALL MEAN		STANDARD DEVIATION	
	PRE TEST	POST TEST	PRE TEST	POST TEST
Avoid my spouse	2.250	1.500	1.500	.577
Try to understand my spouse's point of view	1.000	1.000	.000	.000
Give in	3.250	2.250	1.500	.957
Try to reach a compromise	1.250	2.500	.500	.577
Whine or complain until I get my way	1.000	1.000	.000	.000
My spouse & I are able to collaborate	1.250	2.500	.500	1.000

Prior to the intervention, the techniques the spouses used the most frequently for handling conflict with their spouses were giving in and avoiding their spouse. After the

intervention, the techniques the spouses used the most frequently for handling conflict were trying to reach a compromise, collaborating and giving in so progress had been made. See Appendix S for the pre and post test summaries on the Conflict Management Questionnaire.

In comparing the pre test results with the post test results a difference was found. Overall, the spouses were using more adaptive techniques to handle conflict with their husbands since the group experience. The post test mean scores increased for the adaptive techniques and decreased for the maladaptive techniques. Both the mean scores and the summaries on the Conflict Management Questionnaire, post test changed in a positive direction.

DURING THE GROUP

After each session, the members completed a session evaluation form. One member did not complete a form for session #5 because she was absent. Responses to this questionnaire by the four members were as follows:

Responses to the first question are illustrated in Table 6.

TABLE 6 - Was the information presented about interpersonal skills helpful to you in understanding the concepts of assertive behavior and the collaboration and negotiating conflict management styles?

SESSION	VERY HELPFUL	SOMEWHAT HELPFUL	A LITTLE HELPFUL	NOT AT ALL HELPFUL
1				
2	3		1	
3	3	1		
4	3	1		
5	3			
6	1	3		
7	1	3		
8	2	2		

The responses indicated that the spouses found most of the information presented to them about interpersonal skills either very helpful or somewhat helpful in understanding the concepts of assertiveness behaviour and the conflict management styles in the eight sessions.

The responses to the question: "What information did you find the most helpful?" indicated that the spouses found learning how to be assertive, recognizing some of their rights, the exercises, learning the differences among the three styles and learning the models and applying them to their situations by role-playing to be the most helpful (See Appendix Y). These findings suggested that the interventions the writer used with the spouses were helpful.

The member's responses to the third question are illustrated in Table 7:

TABLE 7 - Rate the effectiveness of the leader in this group session:

SESSION	VERY HELPFUL	SOMEWHAT HELPFUL	A LITTLE HELPFUL	NOT AT ALL HELPFUL
1	3	1		
2	3	1		
3	4			
4	3	1		
5	3			
6	2	2		
7	3	1		
8	3	1		

The responses indicated that most of the spouses found the leader very helpful in the eight group sessions.

The responses to the question: "What did you find most helpful about the group during this session?" indicated the spouses found the willingness of the members to share the difficulties encountered with their stroke spouses and how to handle these difficulties, learning the differences among the three styles, role-playing applying the models, exchange of feelings and the friendly atmosphere in the group the most helpful (See Appendix Y). These findings indicated that there was a good balance between sharing and learning in the group process.

The responses to the question: "What did you you find least helpful?" indicated that the spouses found getting off the topic to be the least helpful. One member of the group found part of session four too repetitive. In the spouses group some members needed an additional exercise in order to grasp the differences among the three styles (See Appendix Y). These findings suggested that the leader needed to develop and apply a strategy for re-focusing the members who got off the topic and talked about non related topics.

Member's responses to the sixth question are illustrated in Table 8.

TABLE 8 - Overall, rate your satisfaction with today's group meeting:

SESSION	VERY SATISFIED	SATISFIED	NEUTRAL	DIS-SATISFIED	VERY DIS-SATISFIED
1	2	1	1		
2	1	2	1		
3	2	2			
4	1	3			
5	1	2			
6	1	2	1		
7	1	3			
8	1	3			

The responses to question six indicated that overall the spouses were satisfied with the eighth sessions they experienced.

The additional comments the spouses made were positive however, one spouse commented that more emphasis needed to be placed on sticking to the topics (See Appendix Y). This is the same comment made to the question: "What did you find least helpful about the group?" Overall, the findings indicated that the spouses found the group experience beneficial.

POST GROUP FEEDBACK

A Feedback Questionnaire was distributed at the end of the last session, to be filled out by the individual members. The leader provided suggestions and assistance in filling it out.

In summary, the findings indicated that the spouses were satisfied with this group experience and they would recommend this type of group experience to couples who were adjusting to living with a stroke. One spouse pointed out "The group was excellent in showing concern and were anxious to assist in methods of coping and/or practising assertiveness." (See Appendix Z).

In comparing the post test scores and summaries on the Conflict Management Questionnaire and the post test scores on the Rathus Assertiveness Schedule as to how the spouses responded to question five, some differences were found. Question five asked, do you find that you are using these skills that you have learned in the group in everyday situations. Spouse #2 answered moderately. Her assertiveness score increased by 5 however, she rarely tried to compromise

with her spouse. The explanation for the difference may be that she was trying to use the adaptive techniques with other people. Spouse #3 answered, somewhat, which is a lower self-rating than her increase of 21 on the Rathus Assertiveness Schedule suggested. Her ability to collaborate with her spouse more frequently, at least when she needed to, suggested that she was using the skills learned in the group as she reported.

POST GROUP INTERVIEWS

Some informal discussions occurred about the group experience prior to the administration of the post tests. How individuals had worked on his/her pre group goal was discussed.

During this interview, the spouses told the writer that they did not monitor their progress on the interaction log but one mentioned the examples were useful and encouraged her to practice the skills.

The findings suggested that overall being involved in this group had been a positive experience for the spouses. They were using or trying to use the skills they learned in this group. The group experience met some of their emotional and social needs too.

Analysis of the measures revealed a considerable amount of similarity between the stroke survivors and the spouses groups. The findings indicated that the interventions, information, exercises and techniques the writer used to help

the members of the groups reach their goal were useful and effective.

In both groups, members reported being satisfied with their involvement in the group and found the leader helpful. Members found the sharing of similar problems and feelings and trying to apply the negotiating model to their situations by role-playing helpful.

Both groups indicated that getting off the topic was least helpful about the group. The survivors also mentioned that interruptions were least helpful and one spouse mentioned that a second exercise similar to the exercise in the previous session made part of the present session too repetitious. Both groups said they would recommend this type of group to couples who are adjusting to living with a stroke.

CHAPTER 7

PRACTICUM HYPOTHESES AND FINDINGS

There were implicit hypotheses in the design which warrant examination.

Were there gender differences in assertiveness and use of conflict management techniques at pre test between the group of stroke survivors (males) and the group of spouses (females)? A one way analysis of variance with gender as an independent variable and the pre test scores as the dependent variable was used. The results indicated no significant effect. Overall, the findings suggested that the males and females were similar in their level of assertiveness and the types of techniques they were using to handle conflict prior to the group intervention.

Were there gender differences in assertiveness and use of conflict management techniques at post test between the group of stroke survivors (males) and the group of spouses (females)? A one way analysis of variance with gender as the independent variable and the post test scores as the dependent variable was used. The results indicated no significant effect. Overall, the findings suggested that the males and females were similar in their level of assertiveness and the type of techniques they were using to handle conflict after the group intervention.

Were there pre-post differences in assertiveness and was this different for the stroke survivors (males) than for the

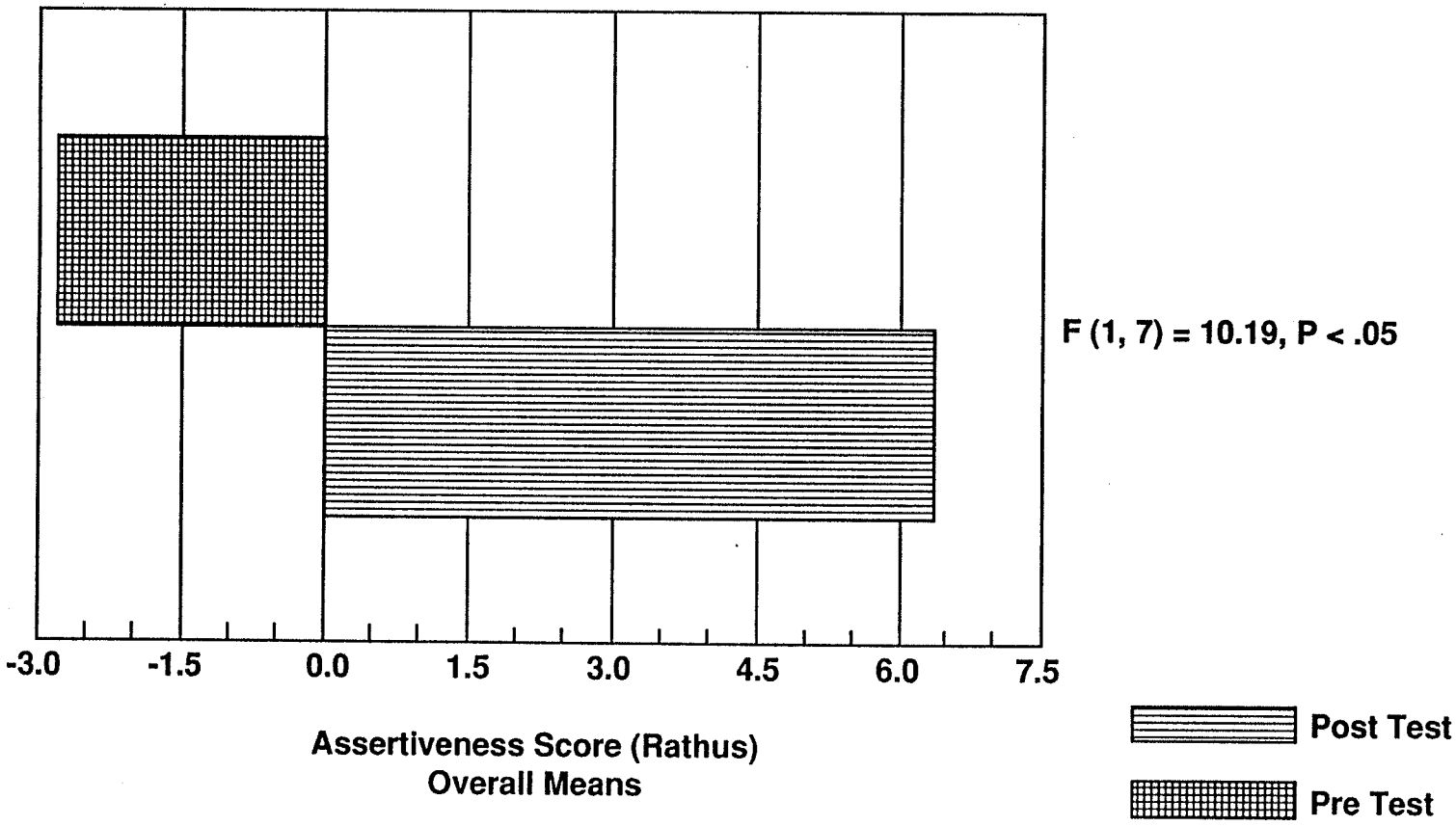
spouses (females)? A one between (gender) and one within (Pre Post) analysis of variance was used. There was a significant pre post effect on the Rathus Assertiveness Schedule regardless of gender. $F(1,7) = 10.19$, $P < .05$ What this means is that both the male and the female scores from pre test to post test on the Rathus Assertiveness Schedule changed similarly. Both the male and female scores increased. There was a significant difference from pre test to post test on the Rathus Assertiveness Schedule for the nine members of the group/s. The genders were not done separately because the number of cases would have been too small, five and four respectively, to detect any effect. There was no significant difference between males and females on the Rathus Assertiveness Schedule from pre test to post test (See Figure 1 on the following page). The findings suggested that the members of both groups benefitted from the intervention to much the same extent.

Was there an increase in scores from pre test to post test on the Rathus Assertiveness Schedule for the group of stroke survivors (males)? Comparing the mean on the pre test -3.0 with the mean on the post test 4.2 there was a change, an increase of 7.2.

Was there an increase in scores from pre test to post test on the Rathus Assertiveness Schedule for the group of spouses (females)? Comparing the mean on the pre test -2.50 with the mean on the post test 9.0 there was a change, an

FIGURE 1.

Change in Assertiveness from Pre Test to Post Test (before and after group therapy) in Stroke-Affected Couples



increase of 11.50.

Were there pre-post differences on the Conflict Management Questionnaire?

A multi-variate analysis of variance was used to look at all the techniques responded to, taken together at first and evaluated as to whether there were changes from pre test to post test. There were no significant repeated measures effect among these techniques. This means that the responses to the pre and post conflict management techniques were the same.

While normally one would not examine univariate effects where the multi variate effects were not significant, in this case because some of the variables measured adaptive changes and some maladaptive changes the repeated measures effect may have been obscured. In fact on three of the five variables that could be tested, significant repeated measures effects were found.

These were conflict management technique; avoid spouse

$F(1,8) = 11.26, P<.05$

Try to understand my spouse's point of view

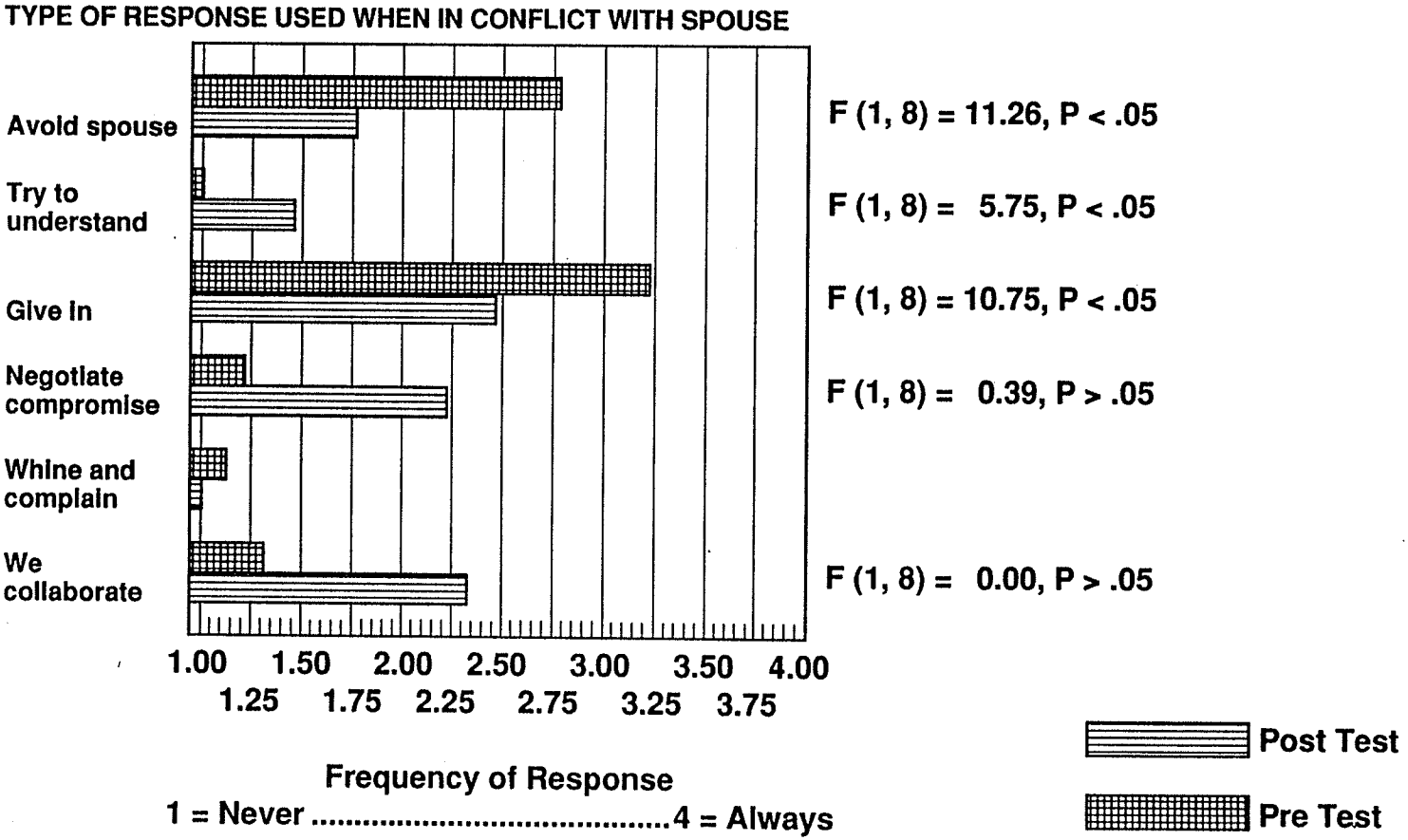
$F(1,8) = 5.75, P<.05$

Give in

$F(1,8) = 10.75, P<.05$ (See Figure 2 on the following page) Two variables were not significant. These were, try to reach a compromise and able to collaborate. One variable, whine/complain until I get my way could not be tested because the pre and post measures were too highly

FIGURE 2.

Change in Use of Responses from Pre Test to Post Test (before and after group therapy) in Stroke-Affected Couples



correlated for the analysis to proceed.

In fact the analysis evaluating the differences among the conflict management techniques was significant confirming that there were differences among the responses. This means the maladaptive and adaptive techniques did not agree.

$$F(5,40) = 8.28 \quad P<.05$$

Also, there was a significant interaction between the responses and the repeated measures effect. The way the responses changed from pre test to post test depended on which question or conflict management technique was asked. Adaptive techniques went up from pre test to post test and maladaptive techniques went down from pre test to post test.

$$F(5,40) = 8.57 \quad P<.05$$

Was there an increase in the scores from pre test to post test on the adaptive techniques on the Conflict Management Questionnaire for the group of stroke survivors (males)?

Comparing the means of the adaptive techniques on the pre test, try to understand my spouse's point of view 1.000, try to reach a compromise 1.200 and my spouse and I are able to collaborate 1.400 with the means on the post test, 1.800, 2.000 and 2.200 respectively, there was a change, an increase of .800 for all three techniques. The means on all the maladaptive techniques decreased. The findings suggested that there was a significant change from pre test to post test.

Was there an increase in the scores from pre test to post test on the adaptive techniques on the Conflict Management

Questionnaire for the group of spouses (females)?

Comparing the means of the adaptive techniques on the pre test, try to understand my spouse's point of view 1.000, try to reach a compromise 1.250 and my spouse and I are able to collaborate 1.250 with the means on the post test, 1.000, 2.500 and 2.500 respectively, there was a change an increase of .250 on two of the adaptive techniques. The means on two of the maladaptive techniques decreased and one remained constant. The findings suggested that there was a significant change from pre test to post test.

On the severity of the sources of conflict, Dependence/Overprotectiveness, Role Change/Role Reversal and Social Isolation/Loneliness, since the stroke were there differences due to gender? A Multivariate Analysis of Variance was used to determine if there were any differences in the severity of conflict on these three measures between the males and females. This was not significant.

SUMMARY

There was no difference between the males and females on the pre test measure of assertiveness and conflict management techniques. There was no difference between the males and the females on the post test measure of assertiveness and conflict management techniques.

The treatment had an effect on assertiveness. There were changes in the group of stroke survivors (males) from pre test to post test on the Rathus Assertiveness Schedule as the mean

score increased. There were changes in the group of spouses (females) from pre test to post test on the Rathus Assertiveness Schedule as the mean score increased.

There were changes in the group of stroke survivors (males) from pre test to post test on the Conflict Management Questionnaire as the mean scores on all the adaptive techniques increased. There were changes in the group of spouses (females) from pre test to post test on the Conflict Management Questionnaire as the mean scores on two of the adaptive techniques increased.

The lack of a multi variate effect may be attributable to the fact that some of the variables assessed changes in an adaptive direction and some in a maladaptive direction.

Since the group experience, members were handling conflict in a more effective way, part of which required talking about ones' feelings in an assertive manner. The highest possible score a member could get on the Rathus Assertiveness Schedule was +45 and the mean pre test score for the nine group members was -2.78. The writer's assessment of these couples was that they needed to learn adaptive techniques to handle conflict, part of which was to increase their level of assertiveness. The writer speculated that the stroke survivors may have been more assertive prior to their having experienced a stroke. Most of the members have increased their assertive responses since their involvement in this group/s.

The research findings supported Keller and Hughston's (1981) claim that the elderly need assertiveness training to handle difficult interpersonal situations competently. The mean pre test score on the Rathus Assertiveness Schedule was -2.78 which was quite low. Like Fernandez-Ballesteros et al (1988), Franzke (1987) and Toseland and Rose (1978), the writer found that the assertiveness responses of the elderly could be increased by training. This research suggested that assertiveness training and conflict management training with the elderly in a group setting, using an active role-play approach emphasizing practice was an effective intervention.

CHAPTER 8

CONCLUSIONS

A treatment group approach was an effective method of intervention for stroke couples since they were all dealing with losses and changes in their life style and relationship. There was an need for these couples to receive help with identifying and coping with their emotions. Also, there was a need for the couples to receive help in opening up and communicating about dependency issues, roles, their social life, decision making, sex and caring. They required support to accomplish these tasks.

Mutual aid and support facilitated the sharing of common emotions, problems and losses therefore, disburdening some of the isolation these couples frequently experience. Members were able to receive and give support to each other related to identifying and coping with their emotions.

The literature review helped direct and predict the needs of these couples. The knowledge that these couples often have common problems, losses and difficulties in dealing with life style changes helped in developing the interventions used with them in this practicum.

The benefits of using a group intervention with the elderly were numerous. Loss was a common theme for this population and social isolation and loneliness were common concerns for many elderly people therefore, a therapist could attend to the needs of several clients at once which was more

economical and time saving than individual therapy. The elderly had an opportunity for peer involvement which decreased social isolation. Generally, the elderly were good at providing social stimulation among themselves. Listening to how others had coped with their losses could inspire clients towards better adjustment. In a group setting the elderly began to realize they were not alone in experiencing problems. Also, to learn that others had the same feelings and experiences could be very reassuring.

There were some weaknesses in using a group approach. The elderly experienced problems getting to the group sessions on time because of their dependency on public transportation which was not always reliable. It was important to include all members in the sessions. Various sensory losses required exquisite handling by the leader as elderly people with such losses withdrew from the group if the leader did not draw them into the process.

A member in one of the groups was accusing and belittling. It was suggested to the couple to have some individual counselling. The leader agreed to have a separate session with this couple or make a referral. Another member tended to go on and on a lot and get off topic. The leader needed a strategy to cut her off. A hearing impaired person was a problem in the group, he withdrew into himself and the leader needed to keep bringing him into the group.

Although, members did learn from their exposure to the

assertive and negotiating skills some more than others, basic communication skills appeared to be lacking especially in the stroke survivor's group. Some members had difficulty replying to the open ended questions, What does that mean for you?, What does that mean for your life? The spouses would have liked longer group sessions. The stroke survivors did not and two said they would have liked shorter sessions.

Due to the above factors, the writer would recommend the groups run for a longer period of time with the initial emphasize on basic communication skills. If some members feel the group was not covering much ground in just dealing with basic communication skills, the leader would have to be flexible and take individual skill levels into consideration in determining when to move forward to more advanced skills. The stroke survivors could meet twice a week for one and one-half hours. The spouses could meet once a week for three hours. Once these basic skills had been developed sufficiently in the members, the leader could move forward in assisting them with assertiveness and conflict management skill development.

In the writer's opinion, a couple are two unique individuals who have to learn to negotiate their differences and the model used in this practicum was very practical. To be good at using this model took lots of practice, effort and time and in fact was ongoing.

All members benefitted from the interventions in several

ways. Most couples had made an effort and continue working towards reaching their goal. This also applied to the stroke survivor who attended without his spouse. One couple was either not using the skills much to resolve their differences or felt they would not work. Putting these skills into use when needed was ongoing for all people.

Members did share their common problems and received support in their efforts to work around some of the changes they needed to deal with. Some members practised skills by exercises, role-playing and received feedback from others. Mutual aid and support in the group setting allowed the sharing of negative feelings about their problems and losses. Members benefitted from ventilating their emotions. Members appreciated the social contact with others who were dealing with similar problems and some meaningful relationships between members developed.

This has been a very significant task for the writer to develop this practicum and see it to its completion. Designing the study and several questionnaires plus adapting a few questionnaires specifically for the study was a challenging experience for the writer. To find appropriate and helpful conceptual frameworks for the intervention was time consuming. Finding a suitable setting to do the study and then enough participants was difficult and very time consuming for the writer.

The writer had benefitted from this whole practicum

process in several ways. The implementation of this practicum had allowed the writer to experience in practice most of the theory in the literature review. It had given the writer a very broad, clinical experience by working with both the disabled and non disabled elderly, males and females, couples and caregivers. All this had been a new and challenging experience for the writer.

Since this was the writers first experience organizing and establishing a treatment group, the writer was able to learn and apply group leadership and other skills necessary to operate an effective treatment group.

Some of the specific skills, the writer gained from running the groups were invaluable. Linking group members by pointing out shared losses, feelings and experiences assisted members in seeing their common concerns, which facilitated identification between members and established social interaction. Secondly, the writer learned how important it was to attend to scanning the whole group to see where the various members were at, so that they did not tune out. Thirdly, the writer learned how important it was to develop strategies to get members re-focused who got off the topic. In addition, early in the life of the group the writer changed her style of role-playing with the members thus she felt more comfortable and as a result the members benefitted to a greater extent.

The writer learned how to help these couple's cope,

ventilate their feelings and apply skills to enhance their ability to cope with the stroke and their changed relationship.

This practicum experience had been a positive and meaningful experience for both the group members and the writer.

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Appendix A

AN ASSERTIVE STYLE
B.E.S.T. METHOD

Formulae:

When you .....
Nonjudgmental description of the other person's behaviour

I feel .....
Describe your feelings about the other person's behaviour

What I would like .....
Your request

What I will do .....
Your intention - If you are willing to give some help, you can tell the other person what you are prepared to do

Source: Schulz, W. (1989). Making Friends, Peguis Publishers Limited, Winnipeg, Manitoba. 51.

Appendix B

NO-LOSE PROBLEM SOLVING MODEL FOR NEGOTIATING

An Assertive Style
B.E.S.T. Method

Formulae:

I feel .....
Describe your feelings about the other person's behaviour

when you .....
Nonjudgmental description of the other person's behaviour

What I would like .....
Your request

What I will do .....
Your intention

A No-Lose problem solving model for Negotiating
Eight steps are involved:

1. Identify the problem and what I want

2. Select an appropriate time and place to speak to the other person

3. Using an assertive style describe the problem and your needs to the other person

4. Ask for feedback to make sure the other person knows what you are saying. This ensures that they understand you.

5. Ask the other person, "What do you want or need?"

6. Let them know what you have heard to be sure you understand their need.

7. Negotiating a solution

   a) identify and define both person's problem and needs

   b) brainstorm solutions/options and do not judge them

   c) evaluate these solutions/options

   d) choose one which is workable

8. Follow-up the solution

   Think about how well the solution/option chosen turned out.

Source: Schulz, W. (1989). Making Friends, Peguis Publishers Limited, Winnipeg, Manitoba. 51.

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Appendix C VERBAL AND NON-VERBAL COMPONENTS OF BEHAVIOURS

	NON-ASSERTIVE	ASSERTIVE	AGGRESSIVE
-VERBAL	Apologetic words Veiled meanings Hedging; failure to come to point Rambling; disconnected At loss for words. Failure to say what you really mean. "I mean, "You know."	Statement of wants. Honest statement of feelings. Objective words. Direct statements, which say what you mean. "I" -- messages.	"Loaded" words. Accusations. Descriptive, subjective terms Imperious, superior words "You" -- messages, that blame or label.
I. NON-VERBAL GENERAL	Actions instead of words, hoping someone will guess what you want. Looking as if you don't mean what you say.	Attentive listening behaviour General assured manner, communicating caring and strength.	Exaggerated show of strength Flippant, sarcastic style Air of superiority.
Specific 1. Voice	Weak, hesitant, soft sometimes wavering	firm, warm, well-modulated, relaxed.	Tense, shrill, loud, shaky cold, "deadly quiet"; demanding, superior, authoritarian.
2. Eyes	Averted; downcast; teary pleading	Open, frank, direct, Eye-contact, but not staring	Expressionless; narrowed; cold; staring; not really "seeing" you.
3. Stance and posture	Lean for support; stooped; excessive head nodding	Well-balanced; straight-on; erect, relaxed	Hands on hips; feet apart Stiff & rigid; rude imperious
4. Hands	Fidgety, fluttery, clammy	Relaxed motions	Clenched; abrupt gestures; finger-pointing; fist pounding.

Source: Bloom, L.Z., Cobur, K. and Pearlman, J. (1975) The New Assertive Women

Appendix D

YOUR LEGITIMATE RIGHTS

You did not have much choice about which traditional assumptions you were taught as a child. Now, however, you have the option of deciding whether to continue behaving according to assumptions that keep you from being an assertive adult. Each of these mistaken assumptions violates one of your legitimate rights as an adult:

Mistaken Traditional Assumptions	Your Legitimate Rights
1. It is selfish to put your needs before others' needs.	You have a right to put yourself first, sometimes.
2. It is shameful to make mistakes. You should have an appropriate response for every occasion.	You have a right to make mistakes.
3. If you can't convince others that your feelings are reasonable, then they must be wrong, or maybe you are going crazy.	You have a right to be the final judge of your feelings and accept them as legitimate.
4. You should respect the views of others, especially if they are in a position of authority. Keep you differences of opinion to yourself. Listen and learn.	You have a right to have your own opinions and convictions.
5. You should always try to be logical and consistent.	You have a right to change your mind or decide on a different course of action.
6. You should be flexible and adjust. Others have good reasons for their actions and it's not polite to question them.	You have a right to protest unfair treatment or criticism.
7. You should never interrupt people. Asking questions reveals your stupidity to others.	You have a right to interrupt in order to ask for clarification.
8. Things could get even worse, don't rock the boat.	You have a right to negotiate for change.
9. You shouldn't take up others' valuable time with your problems.	You have a right to ask for help or emotional support.
10. People don't want to hear that you feel bad, so keep it to yourself.	You have a right to feel and express pain.
11. When someone takes the time to give you advice, you should take it very seriously. They are often right.	You have a right to ignore the advice of others.

12. Knowing that you did something well is its own reward. People don't like show-offs. Successful people are secretly disliked and envied. Be modest when complimented.	You have a right to receive formal recognition for your work and achievements.
13. You should always try to accommodate others. If you don't they won't be there when you need them.	You have a right to say "no".
14. Don't be anti-social. People are going to think you don't like them if you say you'd rather be alone instead of with them.	You have a right to be alone, even if others would prefer your company.
15. You should always have a good reason for what you feel and do.	You have a right not to have to justify yourself to others.
16. When someone is in trouble, you should help them.	You have a right not to take responsibility for someone else's problem.
17. You should be sensitive to the needs and wishes of others, even when they are unable to tell you what they want.	You have a right not to have to anticipate others' needs and wishes.
18. It's always a good policy to stay on people's good side.	You have a right not to always worry about the goodwill of others.
19. It's not nice to put people off. If questioned, give an answer.	You have a right to choose not to respond to a situation.

Keep in mind that assertiveness communication is based on the assumption that you are the best judge of your thoughts, feelings, wants and behaviours. Nobody is better informed than you regarding how your heredity, history and current circumstances have shaped you into an unique human being, therefore, you are the best advocate for expressing your position on important issues. Because of your uniqueness, there are many times when you differ with significant people in your life. Rather than overpower the meek or give in to the aggressive, you have the right to express your position and try to negotiate your differences.

Source: Davis, M. Eshelman, E.R. and McKay, M. (1988). The Relaxation and Stress Reduction Workbook. Third Edition New Harbinger Publications. 133-134.

Appendix E

3 "OPTIONS" EXERCISE

Hi, I would like to ask a favor. Since you are going out of town for a week, I wonder if I could borrow your car? (This person is a close friend and you know plenty about his or her driving habits.)

PASSIVE.....

AGGRESSIVE.....

ASSERTIVE.....

You are in the midst of eating dinner. The telephone rings. It is your sister who starts the conversation with: "I know this is a bad time to call you, but I have an important decision to make soon and I just have to talk it over with someone.

PASSIVE.....

AGGRESSIVE.....

ASSERTIVE.....

You are standing in a long line at a movie theatre. When you are near the front of the line, a man approaches you and asks you to buy tickets for him. You reply:

PASSIVE.....

AGGRESSIVE.....

ASSERTIVE.....

You have had the interior of your home painted. As you begin moving the furniture back into place you notice that there is paint splattered all over the floor. You are angry. You decide to call the painter.

PASSIVE.....

AGGRESSIVE.....

ASSERTIVE.....

You are sitting in a movie theatre. The person next to you is smoking and you find this very annoying and distracting. Your reply:

PASSIVE.....

AGGRESSIVE.....

ASSERTIVE.....

Source: Unknown

Appendix F

DISCRIMINATION: ASSERTIVE, AGGRESSIVE, PASSIVE BEHAVIOUR

A a P

Situation:	Response:
1. You have set aside 4-5:00 for things you want or need to do. Someone asks you at that time to visit with you. You say:	Well, eh, I can see you at that time. It is 4:00 Monday then. Are you sure that is a good time for you?
2. A women gets silent instead of saying what is on her mind. You say:	Here it comes. The big silent treatment. Would it kill you to spit it out just once?
3. Your partner has criticized your appearance in front of friends, you say:	I really feel hurt when you criticize my appearance in front of people. If you have something to say, please say it at home before we leave.
4. A friend has often borrowed small amount of money and does not return as asked. She again asks for a small loan which you would rather not give her. You say:	I only have enough money to pay for my lunch today.
5. A neighbour has been constantly borrowing your vacuum. The last time she broke it. When she asks for it again, you say:	I am sorry, but I do not want to lend my vacuum anymore. The last time I loaned it, it was returned broken.
6. A woman is being interviewed for a job, in the process of which the interviewer looks at her leeringly and say "I'm sure you have all the qualifications for the job". She responds:	I am sure I am quite capable of doing the work here.
7. Your mate wants to go out for a late night snack. You are too tired and say:	I really do not feel like going out tonight. I am too tired. But I will go.
8. You are walking to the copy machine when a fellow employee, who always asks you to do his copying, asks you where you are going. You respond:	I am going to the Celtics ball game. Where does it look like I am going?
9. A parent is talking with married child on the telephone and would like the child to come for a visit. The parent says:	I had a funny dream last night. I dreamt that the grandchildren came to visit me.

Source: North Island Women's Society (1984). Working Together for Change Copywright 1984, 70

Appendix G

INTERACTION LOG (ADAPTED)

CLIENT NAME:_____ DAY AND DATE:_____

TIME	PLACE	WHO WAS THERE?	WHAT I SAID	WHAT SPOUSE SAID	WHAT I SAID	WAS YOUR BEHAVIOR ASSERTIVE? DID YOU COLLABORATE OR NEGOTIATE?
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____
		_____	_____	_____	_____	_____
			_____			
			_____			
			_____			
			_____			
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____
		_____	_____	_____	_____	_____
			_____			
			_____			
			_____			

Source: Bloom, M & Fischer, J. (1982) Evaluating Practice: Guidelines for the Accountable Professional Prentice-Hall Inc. Englewood Cliffs, New Jersey. 190

Appendix H
Example Copy

INTERACTION LOG

CLIENT NAME:_____ DAY AND DATE:_____

TIME	PLACE	WHO WAS THERE?	WHAT I SAID	WHAT SPOUSE SAID	WHAT I SAID	WAS YOUR BEHAVIOR ASSERTIVE? DID YOU COLLABORATE OR NEGOTIATE?
1991 Mar 29	at home	My wife and I or husband and I	When you are continually late I feel irritated and angry. I would like you to be ready when we have to leave to go somewhere. I will tell you 1½ hours before we have to leave so you can be on time.	My lateness really bothers you.	Yes, are you willing to try and be on time?	Yes. Collaborated as wife/husband agreed to this plan.
Apr. 4	at home	My wife and I or my husband and I	When you go out to movies with your friends and do not include me, I feel left out. I would like you to include me sometimes. I will tell you when this bothers me.	I did not realize you were feeling left out when I go to the movies with my friends. Let's go to a movie together sometime this week.	Yes, I would like to do that.	Yes Collaborated.

Source: Janzen, C.G. (1990)

Appendix I

APPLICATION OF THE NO LOSE PROBLEM SOLVING MODEL FOR NEGOTIATING

An example of a common problem for a stroke couple and how these frameworks are applicable: The spouse wants to go out to concerts, movies, sports events, and restaurants but the survivor wants to restrict their social life to having friends and relatives visit in the home.

B.E.S.T. Method: Survivor says to spouse:
When you insist that I go out to movies, concerts, and other community activities, I feel annoyed because I am uncomfortable being out in public. I would like us to have friends and relatives over more often for meals, barbecues, birthdays, special occasions, games, etc. I'll try and let you know when this annoys me. I am open to suggestions about our social life.

No-Lose Problem Solving Model for Negotiating:]

1. Problems and needs
Survivor and spouse have unfulfilled social needs. The survivor needs a large portion of his social activities restricted to the home. The spouse needs to get out more to concerts, movies, for lunch and other activities in the community.

2. They select a time when they are both available and have their privacy at home. The timing is convenient for both and they both have the inclination to talk about the problem at hand and are not tired.

3. Using an assertive style describe the problem and your needs to the other person. Survivor says to spouse.
When you insist that I go out to movies, concerts and other community activities,
I feel annoyed because I am uncomfortable being out in public. I would like us to have friends and relatives over more often for meals, barbecues, birthdays, special occasions, games, etc. I'll try and let you know when this annoys me. I am open to suggestions about our social life.

4. The survivor asks his spouse to tell him what he has just said so he is sure she understands his needs. The spouse says "You need to be involved in social activities at home and want more company over."

5. The survivor asks his spouse "What do you need?" The spouse says "I need to socialize more in the community."

6. The survivor paraphrases her response to make sure that he has understood her need. "You need to get out more and be involved in activities in the community."
If both people's needs can be met at this point; by the couple knowing each others needs and agreeing on a plan very easily they have collaborated therefore, the seventh step of negotiating is not necessary.

7. Negotiating a solution:
   a) Both people have unfulfilled social needs. The survivor needs a large portion of his social activities restricted to the home. The spouse needs to get out more to be involved in community activities.

   b) Brainstorm solutions/options:
   Rent movies and watch sports events on TV together at home.
   Order in restaurant meals and have them delivered.
   Have more people in for meals, parties and barbecues and play cribbage and other games.
   Survivor attends restaurant with spouse for every time she hosts a party or barbecue at home.
   Survivor and spouse find some activities in the community which they both enjoy so they can get out together more often.
   Spouse will go to concerts and lunch twice a week with friends if survivor will agree. Spouse will arrange to have more people over.

   c) The couple evaluate the solutions from b.

   d) The couple choose the last solution because they feel it may be workable.

8. Follow-up the solutions
   The couple will apply their chosen solution and think about how well their choice turned out.

Problems such as the above were role-played in both the survivor's group and the spouse's group.

Appendix J

COMMON PROBLEM QUESTIONNAIRE
PRE STROKE

FOR STROKE SURVIVOR CLIENT'S NAME _____

INTERVIEW DATE _____

This questionnaire is designed to measure what life was like with your spouse, prior to your stroke.

Dependence/Overprotectiveness

Would you tell me how you managed to get these self care activities done?

Bathing:
Grooming:
Dressing:

How much conflict do you feel this caused between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Role Change/Role Reversal

How was the family income earned?

How were the bills paid and the budget balanced?

How were the household repairs handled?

How were the car repairs looked after?

How was the cooking and shopping done?

How much conflict do you feel this caused between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Social Isolation/Loneliness

How was your social life, your visits with friends, neighbours and relatives and getting out to social gatherings?

How much conflict do you feel this caused between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Source: Janzen, C.G. (1990)

Appendix J

COMMON PROBLEM QUESTIONNAIRE
PRE STROKE

FOR SPOUSE CLIENT'S NAME _____

INTERVIEW DATE _____

This questionnaire is designed to measure what life was like with your spouse, prior to his stroke.

Dependence/Overprotectiveness

Would you tell me how your spouse managed to get these self care activities done?

Bathing:
Grooming:
Dressing:

How much conflict do you feel this caused between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Role Change/Role Reversal

How was the family income earned?

How were the bills paid and the budget balanced?

How were the household repairs handled?

How were the car repairs looked after?

How was the cooking and shopping done?

How much conflict do you feel this caused between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Social Isolation/Loneliness

How was your social life, your visits with friends, neighbours and relatives and getting out to social gatherings?

How much conflict do you feel this caused between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Source: Janzen, C.G. (1990)

Appendix K

COMMON PROBLEM QUESTIONNAIRE
SINCE STROKE

FOR STROKE SURVIVOR CLIENT'S NAME _____

INTERVIEW DATE _____

This questionnaire is designed to measure what life was like with your spouse, since your stroke.

Dependence/Overprotectiveness

Would you tell me how you are managing to get these self care activities done?

Bathing:
Grooming:
Dressing:

How much conflict do you feel this causes between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Role Change/Role Reversal

How is the family income earned?

How are the bills paid and the budget balanced?

How are the household repairs handled?

How are the car repairs looked after?

How is the cooking and shopping done?

How much conflict do you feel this causes between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Social Isolation/Loneliness

How is your social life, your visits with friends, neighbours and relatives and getting out to social gatherings?

How much conflict do you feel this causes between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Source: Janzen, C.G. (1990)

Appendix K

COMMON PROBLEM QUESTIONNAIRE
SINCE STROKE

FOR SPOUSE

CLIENT'S NAME _____

INTERVIEW DATE _____

This questionnaire is designed to measure what life was like with your spouse, since your stroke.

Dependence/Overprotectiveness

Would you tell me how your spouse is managing to get these self care activities done?

Bathing:
Grooming:
Dressing:

How much conflict do you feel this causes between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Role Change/Role Reversal

How is the family income earned?

How are the bills paid and the budget balanced?

How are the household repairs handled?

How are the car repairs looked after?

How is the cooking and shopping done?

How much conflict do you feel this causes between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Social Isolation/Loneliness

How is your social life, your visits with friends, neighbours and relatives and getting out to social gatherings?

How much conflict do you feel this causes between you and your husband/wife?

1	2	3	4
Little or no conflict	Some conflict	Moderate conflict	Strong conflict

Source: Janzen, C.G. (1990)

Appendix L

CONFLICT MANAGEMENT QUESTIONNAIRE (ADAPTED)

Client's Name:_____
Interview Date:_____

How do you usually handle conflicts with your spouse?

After each of the following techniques, indicate whether you use it.

1. Never
2. Rarely
3. Frequently
4. Very frequently

NR: No reponse

1. Avoid my spouse _____
2. Change the subject _____
3. Try to understand my spouse's point of view _____
4. Try to turn the conflict into a joke _____
5. Admit that I was wrong even if I do not believe I am _____
6. Give in _____
7. Apologize _____
8. Try to find out specifically what we agree on and disagree on to narrow down the conflict _____
9. Try to reach a compromise _____
10. Pretend to agree _____
11. Get another person to decide who is right _____
12. Threaten my spouse _____
13. Fight it out physically _____
14. Play the martyr, give in, but let my spouse know how much I am suffering _____
15. Whine or complain until I get my way _____
16. My spouse and I are able to collaborate _____

Source: Haid, J (1988) Assertiveness Training Workshop

Appendix M

RATHUS ASSERTIVENESS SCHEDULE (ADAPTED)

Indicate how characteristic or descriptive each of the following statement is of you by using the code given below.

+3 very characteristic of me, extremely descriptive
+2 rather characteristic of me, quite descriptive
+1 somewhat characteristic of me, slightly descriptive
-1 somewhat uncharacteristic of me, slightly nondescriptive
-2 rather uncharacteristic of me, quite nondescriptive
-3 very uncharacteristic of me, extremely nondescriptive

_____1. When the food served at a restaurant is not done to my satisfaction, I complain about it to the waiter or waitress.

_____2. If a salesman has gone to considerable trouble to show me merchandise which is not quite suitable, I have a difficult time in saying "No".*

_____3. To be honest, people often take advantage of me.*

_____4. I enjoy starting conversations with new acquaintances and strangers.

_____5. I will hesitate to make phone calls to business establishments and institutions.*

_____6. I find it embarrassing to return merchandise.*

_____7. If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance.*

_____8. I have avoided asking questions for fear of sounding stupid.*

_____9. During an argument I am sometimes afraid that I will get so upset that I will shake all over.*

____10. When I have done something important or worthwhile, I manage to let others know about it.

____11. I am open and frank about my feelings.

____12. I often have a hard time saying "No".*

____13. I tend to bottle up my emotions rather than make a scene.*

____14. If a couple near me in a theatre or a lecture were conversing rather loudly, I would ask them to be quiet or to take their conversation elsewhere.

____15. I am quick to express an opinion.

a Total score obtained ny adding numerical responses to each item, after changing the signs of reversed items.

* Reversed items.

Source: Rathus, S.A. (1973) A 30 item schedule for assessing assertive behavior Behavior Therapy, 4, 399-400.

Appendix N

SUMMARY RECORDING FORM FOR GROUP SESSIONS

Group Name:_____Beginning Date:_____

Social Worker's Name:_____Termination Date:_____

Session Number:_____ Date of Session:_____

Members Present: _____

_____

Members Absent: _____

Purpose of the Group: _____

_____

Goals for this session: _____

_____

Activities to meet these goals: _____

_____

_____

Social worker's analysis of the session: _____

_____

_____

_____

_____

_____

_____

_____

Plans for future sessions:_____

_____

Source: Toseland, R.W. & Rivas, R.E. (1984) An Introduction to Groups Work Practice. MacMillan Publishing Company. 310

Appendix O

CLIENT'S SESSION EVALUATION FORM

1. Was the information presented about interpersonal skills helpful to you in understanding the concepts of assertive behavior and the collaboration and negotiating conflict management styles?

1	2	3	4
very helpful	somewhat helpful	a little helpful	not at all helpful

2. What information did you find the most helpful?_____

_____

3. Rate the effectiveness of the leader in this group session:

1	2	3	4
very helpful	somewhat helpful	a little helpful	not at all helpful

4. What did you find most helpful about the group during this session?_____

_____

_____

5. What did you find least helpful about the group?_____

_____

_____

6. Overall, rate your satisfaction with today's group meeting:

1	2	3	4	5
very satisfied	satisfied	neutral	dissatisfied	very dissatisfied

7. Additional comments:_____

_____

_____

Source: Toseland, R.W. & Rivas, R.F. (1984) An Introduction To Group Work Practice. MacMillan Publishing Company. 314

Appendix P

FEEDBACK QUESTIONNAIRE

Your feedback and candid evaluation of the group you just experienced will assist me in making future improvements.

1. To what extent were your expectations of the group met? (circle one)

not at all		moderately		completely
1	2	3	4	5

2. Which aspects of the group fell short of your expectations?

_____

_____

_____

3. Which aspects of the group exceeded your expectations?

_____

_____

_____

4. To what extent do you perceive a change in your assertiveness and conflict management skills as a result of your participation in the groups? (Circle one)

not at all		moderately		completely
1	2	3	4	5

5. Do you find that you are using these skills that you learned in the group in everyday situations? (Circle one)

not at all		moderately		completely
1	2	3	4	5

6. Rate the helpfulness of the leader. (Circle one)

not at all helpful	a little helpful	somewhat helpful	very helpful
1	2	3	4

7. What did you find most helpful about the group? What made the group successful?

_____

8. What did you find least helpful about the group? How could this group be improved?

_____

_____

_____

9. Overall, rate your satisfaction with the group.

very dissatisfied	dissatisfied	neutral	satisfied	very satisfied
1	2	3	4	5

10. I would recommend this type of group to couples who are adjusting to living with a stroke.

strongly disagree	disagree	agree	strongly agree
1	2	3	4

Source: Janzen, C.G. (1990)

Appendix Q

INFORMATION ABOUT THE COUPLES

Couple #3

Couple #3 had been married 3 years. This was a second marriage for the husband and a first marriage for the wife. The husband, Stroke Survivor #3 was 63 and his wife, Spouse #3 was 47 years old. She was employed part time.

According to Stroke Survivor #3 before the stroke there was no conflict regarding the three common problems. Some changes had occurred since the stroke. There was some conflict with regards to dependence/overprotectiveness. Stroke Survivor #3 told the writer the following information. He was bored in the house, liked to get out but could not drive. He did not like depending on his spouse to drive him around. Also, there was moderate conflict with social isolation/loneliness. Some of his friends had stopped calling and visiting because they did not know how to handle his disability and he had been hurt by this neglect. He did not like going to church, large gatherings, bowling banquets or visiting his wife's mother weekly but his wife liked going to all these things. He felt uncomfortable seen in public using a cane because his wife was young.

According to Spouse #3 before the stroke there was no conflict regarding the three common problems. Changes that had occurred since the stroke were: there was some conflict with regards to dependence/overprotectiveness. Spouse #3 reported the following information. Her spouse was dependent on her to drive him around. He did not like to use Handi Transit that much because it was inconvenient. He was bored. This worried her the most. There was moderate conflict with regards to social isolation/loneliness. She liked to go out socially and felt uncomfortable going to church alone. Sometimes her spouse had pain and he did not want to go out. He felt she would be ashamed or embarrassed being with him because he used a cane as she was a young wife.

The source and intensity of the conflict was basically the same for both spouses. Both experienced some conflict in the area of dependence/overprotectiveness and moderate conflict in the area of social isolation/loneliness. He was bored and this worried his spouse. It appeared that she thought he should be finding things to do on his own and using Handi Transit when she worked rather than depending on her. She felt badly that some of his old friends had dropped him. She wanted to see him more active socially in things that were of interest to her or both of them.

BIOGRAPHY: Stroke Survivor #3:

Prior to Stroke Survivor #3's retirement, he was employed in several occupations as a teacher, real estate agent and administrator. He had a right CVA, eighteen months ago. He walked with a cane and could see on the right side only.

GOAL: To be more assertive regarding my social needs and dissatisfaction with large gatherings.
To try and negotiate with spouse so both of us get most of our social needs met.

OUTCOME:

1. Pre test Score on Rathus Assertiveness Schedule: -16
   Post test Score on Rathus Assertiveness Schedule: +1

2. Pre test Scores on Conflict Management Questionnaire / Post test Scores on Conflict Management Questionnaire

Avoid my spouse	4	1
Try to understand my spouse's point of view	NR	3
Give in	4	3
Try to reach a compromise	NR	NR
Whine/complain until I get my way	NR	NR
Able to collaborate	NR	3

Stroke Survivor #3's score on the Rathus Assertiveness Schedule increased by 17. His post test scores on the Conflict Management Questionnaire indicated that he did not avoid his spouse but he still gave in frequently. He tried to understand his spouse's point of view frequently and was able

to collaborate with his spouse. Stroke Survivor #3 indicated to the writer that since the group he was attempting to collaborate with his spouse when he saw it as needed and it went well. His goal was ongoing and the writer believed he would continue to work at accomplishing it.

BIOGRAPHY: Spouse #3:

Spouse #3 was employed part time as a nurse.

GOAL: To be more assertive regarding my social needs. To try and do some negotiating with spouse so both of us get most of our social needs met.

OUTCOME:

1. Pre test Score on Rathus Assertiveness Schedule: -16

Post test Score on Rathus Assertiveness Schedule: +5

2. Pre test Scores on Conflict Management Questionnaire / Post test Scores on Conflict Management Questionnaire

Avoid my spouse	NR	NR
Try to understand my spouse's point of view	NR	NR
Give in	4	3
Try to reach a compromise	2	2
Whine/complain until I get my way	NR	NR
Able to collaborate	NR	3

Spouse #3's score on the Rathus Assertiveness Schedule increased by 21. Her post test scores on the Conflict Management Questionnaire indicated that she gave in less frequently and was able to collaborate with her spouse.

Spouse #3 indicated to the writer that she did collaborate when something was important to her and it went well however, that she and her spouse had not needed to collaborate or negotiate much. Couple #3 were working on their goals which were ongoing. Both had increased their assertiveness dramatically and were doing more social activities together.

Couple #4

Couple #4 had been married over 30 years. This was a second marriage for the husband and a first marriage for the wife. The husband, Stroke Survivor #4 was 77 and his wife, Spouse #4 was 61 years old.

According to Stroke Survivor #4 before the stroke there was no conflict regarding the three common problems. Since the stroke the only source of conflict was related to dependence/overprotectiveness. He said there was some conflict in this area because he was a lot slower doing his self care activities and getting around. He indicated that his spouse did not like it when he demanded she get him things he could get himself and was unco-operative.

According to Spouse #4 before the stroke there was no conflict regarding the three common problems. Since the stroke the only source of conflict was related to dependence/overprotectiveness and there was moderate conflict in this area. She said her spouse demanded she help him when he could do things and get things for himself.

The source of conflict for the spouses was basically the same although, she saw the intensity of the conflict as more severe than he did. Both realized that his demanding behavior put a strain on their relationship.

BIOGRAPHY: Stroke Survivor #4

Prior to Stroke Survivor #4's retirement, he was employed as a machinist. He had a left CVA five years ago. Stroke Survivor #4 walked with a quad cane. He could not use his right hand therefore, he had a great deal of difficulty writing. Stroke Survivor #4 was hearing impaired and wore a hearing aid in his right ear. He had slurred speech and spoke with an accent.

GOAL: To try and negotiate with spouse when she is upset with my demands or wants my co-operation.

OUTCOME:

1. Pre test Score on Rathus Assertiveness Schedule

-1

Post test Score on Rathus Assertiveness Schedule

+5

2. Pre test Scores on Conflict Management Questionnaire

Post test Scores on Conflict Management Questionnaire

Avoid my spouse	4	3
Try to understand my spouse's point of view	NR	NR
Give in	4	3
Try to reach a compromise	2	3
Whine/complain until I get my way	NR	NR
Able to collaborate	2	3

Stroke Survivor #4's score on the Rathus Assertiveness Schedule increased by 6. His post test scores on the Conflict Management Questionnaire indicated that he was avoiding his spouse and giving in less frequently and was trying to compromise and was able to collaborate. He told the writer that he tried to negotiate and did not fly off the handle at his spouse as much as he used to. He tried to think more about what his spouse needed and wanted.

BIOGRAPHY: Spouse #4:

Spouse #4 was a housewife.

GOAL: To be more assertive when spouse is demanding and unco-operative and attempt to do some negotiating.

OUTCOME:	1. Pre test Score on Rathus Assertiveness Schedule	Post test Score on Rathus Assertiveness Schedule
	-13	+2
	2. Pre test Scores on Conflict Management Questionnaire	Post test Scores on Conflict Management Questionnaire
Avoid my spouse	3	2
Try to understand my spouse's point of view	NR	NR
Give in	4	2
Try to reach a compromise	1	3
Whine/complain until I get my way	NR	NR
Able to collaborate	NR	3

Spouse #4's score on the Rathus Assertiveness Schedule increased by 15. Her post test scores on the Conflict Management Questionnaire indicated that she did not avoid and give in to her spouse nearly as much. She had tried to reach a compromise and was able to collaborate frequently. Spouse #4 reported to the writer that it was easier for her to negotiate and she took time to look at her spouse's point of view. She said there was less arguing between them and her spouse was more considerate. This couple had improved their relationship and it appeared they would continue working on their ongoing goals.

Stroke Survivor #5

Stroke Survivor #5 had been married for over 30 years. He was 61 years old.

According to Stroke Survivor #5 before the stroke there was no conflict regarding the three common problems. Since the stroke the only source of conflict was related to social isolation/loneliness. He reported that there was some conflict because his spouse would like them to be doing more

activities together and he did not feel up to it at times. The major conflict between Stroke Survivor #5 and his spouse was their decrease in joint social activities.

BIOGRAPHY: Stroke Survivor #5

Prior to Stoke Survivor #5's retirement, he was employed as a machinist. He had a right CVA three years ago and as a result he used a wheelchair to ambulate. Stroke Survivor #5 was able to walk short distances using a quad cane. He could not use his left hand. Stroke Survivor #5 was a diabetic who took seizures and spoke with an accent.

GOAL: To be more assertive when something is bothering me and attempt to collaborate/negotiate with spouse especially related to doing more things together.

OUTCOME:

1. Pre test Score on Rathus Assertiveness Schedule: +4
   Post test Score on Rathus Assertiveness Schedule: +10

2. Pre test Scores on Conflict Management Questionnaire / Post test Scores on Conflict Management Questionnaire

Avoid my spouse	4	2
Try to understand my spouse's point of view	NR	3
Give in	NR	NR
Try to reach a compromise	NR	3
Whine/complain until I get my way	NR	NR
Able to collaborate	NR	NR

Stroke Survivor #5's score on the Rathus Assertiveness Schedule increased by 6. His post test scores on the Conflict Management Questionnaire indicated that he no longer avoided his spouse but tried to understand her point of view and reach a compromise about their social life. He reported to the writer that he talked more to his spouse about his wants and needs regarding their social life. Stroke Survivor #5's spouse confirmed this and said he was making more decisions. His goal was ongoing and the writer believed he would continue to work at accomplishing it.

Appendix R

THE STROKE SURVIVORS' PRE AND POST TEST SUMMARIES ON THE CONFLICT MANAGEMENT QUESTIONNAIRE

Pre test summaries for Stroke Survivor #1, #2, #3, #4 and #5 respectively:

Gave in a lot, got angry and avoided the situation and said nothing.

Did not try to compromise, collaborate or negotiate differences.

Gave in a lot; did not attempt to collaborate, compromise or negotiate.

We raised our voices very loudly and then it was all over.

Avoided things when they did not see eye to eye.

Post test summaries for Stroke Survivior #1, #2, #3, #4 and #5 respectively:

Spouse initiated some problem solving but he did not. He thought it was good that she did this as they were able to collaborate sometimes.

Realized that collaborating or negotiating were useful techniques but he did not use them. He claimed his spouse was not so fiery, had cooled down a bit.

Attempted to collaborate with spouse when needed and it went well however, not needed very often.

Tried to negotiate if needed using handout from the group. He did not fly off the handle at spouse as much. He thought more about what she needed and wanted.

Talked more to spouse about his wants and needs regarding their social life and tried to compromise with her. Spouse confirmed this and said he was making more decisions.

Appendix S

THE SPOUSES' PRE AND POST TEST SUMMARIES ON THE CONFLICT MANAGEMENT QUESTIONNAIRE

Pre test summaries for Spouse #1, #2, #3 and #4 respectively:

If something was important enough she spoke up about it but issues did not always get resolved.

Did not feel she should have to compromise, collaborate or negotiate. She described herself as pigheaded, stubborn and obstinate.

We gave in a lot of the time rather that compromising, negotiating or collaborating.

We argued a lot, when spouse was demanding and insisted I help him when he was able to do things for himself, for example get his own jacket.

Post test summaries for Spouse #1, #2, #3 and #4 respectively:

Attempted to collaborate and negotiate. She said she took some initiative.

Tried a little to collaborate and negotiate with spouse but felt it was not going to work.

Had not needed to collaborate or negotiate much but had collaborated when something was important to her and it went well.

Easier for her to negotiate, took time to look at spouse's point of view too. Had been less argumentative and more collaborating and negotiating. Spouse was more considerate.

Appendix T DESCRIPTION OF THE GROUP PROCESS, STROKE SURVIVORS GROUP

BEGINNING PHASE March 5 - 19, 1991

Session 1: The first session was attended by five members. The leader began by welcoming them to the group, introducing them to one another, telling them what to expect regarding coffee breaks, washroom facilities etc. Members were given a handout with norms (See Appendix U) and we went over these as a group. These norms were taken from Toseland and Rivas's (1984) treatment group contract and modified. The writer called it Tips for Good Group Membership and did not sign this as an agreement or ask members to do so. Some wording was changed, left out or added to the statements so they were not patronizing and fit the specific needs of the group and the leader. An additional statement "allow each member to speak without interruption" was included with the member's norms and the last statement was omitted from the leader's norms. Next, the purpose of our group sessions, how we would deal with our work, the function of the leader and how the leader would assist them to meet their goals was discussed.

In order to help members to get to know each other on a more personal level, to encourage social interaction and to build the group, members were asked to get into pairs. Members were asked to tell their partner their strengths, good qualities and what they liked about themselves and were good at. Members were informed that after they finished talking to their partner they would be asked to introduce their partner to the whole group.

The members shared with each other their life's work, hobbies and Stroke Survivor #2 his feelings of anger and frustration over loosing his driver's licence. He was legitimately angry and this was validated by the leader.

Session 2: The second group session was attended by five members. The atmosphere was congenial. The leader introduced the components of the three interpersonal styles (See Appendix C) using a flipchart. After each style was reviewed; an example of a wife relating to her husband in that specific style was provided. Members were asked "Can you remember a situation where you acted passively and how you felt about it?" This same procedure followed for the other two styles in order to make the topic relevant to the members. Stroke Survivor #3 recalled his passiveness in his not wanting to go out and do things. Stroke Survivor #5 talked about his inability to build basements, an ability he used to possess. The leader acknowledged his loss. Members did not offer any situations where they acted aggressively or assertively. The

theme of loss had emerged.

The leader introduced members to the legitimate rights (See Appendix D) explained why it was important for the group to become familiar with them and asked if members felt these would help them feel more comfortable asserting themselves. These rights stimulated some discussion. Several members asked questions. Stroke Survivor #3 commented "that people do not want to hear about your pain." Stroke Survivor #1 told about an experience he had recently. He called a neighbor for help and was turned down but realized his neighbor had the right to say No. Stroke Survivor #2 saw this neighbor as exercising right #16. Stroke Survivor #5 expressed "That sometimes he wanted to be alone; did not want to go to socials." He saw this as exercising right #14.

There was a lot of interaction among members throughout this session. Members did not give each other feedback or ask for it. There was a lot a sharing going on and members supporting each other.

Session 3: All five members attended. The three interpersonal styles were reviewed briefly by using the printed material on the flipchart. Members were encouraged to complete an exercise (See Appendix E) orally which did help them differentiate among the three styles. Members were asked how they felt this exercise fit in with the three styles and the legitimate rights we talked about. Replies were: "Makes sense, fits in well, the exercises are good, I find this deep".

The leader presented the assertive style formulae (See Appendix A) and applied this formulae using the following situation: When a person has had a stroke it was not unusual for friends to stop calling and visiting. This generated a lot of the member's emotional concerns over the loss of their former friends and relative contact since their stroke and other losses. The leader attended to the emotional concerns by getting the members to express their frustration, hurt, anger and other relevant emotions regarding their losses.

Stroke Survivor #5 who had expressed the loss of his ability to build basements seemed to have completed the grieving process. He said this was "past tense." Stroke Survivor #1 expressed his hurt and disappointment about loosing his driver's licence and not being able to work on his motor and clock repairs. He said "Greater loss than I want to admit, feel downhearted, terrible."

Stroke Survivor #2 had difficulty saying directly that he was angry about not being able to get his driver's licence back but finally said he was angry at the system. Stroke Survivor #4 seemed to have completed the grieving process

related to the loss of the use of his right hand and had accepted the change, "Main thing is that I can manage so OK. I can handle chairs so that is good enough for me." Stroke Survivor #2 expressed his concern about the loss of love between he and his spouse, "loving went out the window" When asked "How do you find that?" He answered "It does not bother me, I do my own thing. It's her way or the highway. I have no choice." The leader said pointing to the assertive style on the flipchart "This style will certainly help you with that."

The members shared concerns and feelings and a supportive atmosphere developed among the members. The leader praised them for being open about their personal situations. One member gave feedback to two of the members. He told one that he was passive and the other that he was too aggressive. At this point, there seemed to be a leadership struggle between two members.

MIDDLE PHASE (March 26 - April 9, 1991)

Session 4: During this phase the leader encouraged members towards achieving their goals and establishing supportive interaction. The three interpersonal styles were reviewed briefly by using the printed material on the flipchart. Members got into pairs to complete an exercise (See Appendix F). After its completion the members reassembled and we discussed these situations in the exercise orally. This exercise stimulated a fair amount of discussion especially around loaning tools to friends which lead into how members felt about saying No and the risk of loosing a friend. The members felt this exercise gave them an even better idea of the differences in the three styles. Expressions of affection were observed between several of the members.

Members talked at length about their loss in the area of physical abilities and acknowledged that it was hard to deal with these changes. Stroke Survivor #3 compared the symptoms of having a stroke to when a spouse dies, you wonder why and he said "It's almost like a death." Stroke Survivor #2 and Stroke Survivor # 5 said "Why me?" Stroke Survivor #1 interrupted and changed the subject twice and said how he loved puttering in the garage and would like to be back to where he was. The leader validated that it was hard to have to deal with changes in our lives especially when they have something to do with loss and that it took quite a while to get over the hurt and sadness. Stroke Survivor #1 said he felt like gardening but quickly changed the subject and joked. The leader asked "What is it like for you to think of having to give up gardening?" Stroke Survivor #2 told a joke and Stroke Survivor #1 did likewise which interfered with Stroke

Survivor #1's expressing his loss and the feelings that go with it. The members were uncomfortable talking about their losses and how this had been for them.

The leader tried to stimulate discussion about the benefits of learning to be more assertive and to get the members to see how and when they could be more assertive. Stroke Survivor #3 was experiencing difficulty telling his spouse that he was in pain and did not want to go out. The leader tried to get him interested in role playing but he denied this was a problem. Stroke Survivor #5 did a role play with the leader regarding his difficulty telling his spouse and others that he did not want to go out to social events.

Stroke Survivor #2 acted in a very aggressive manner during this session. His attention seeking behavior was demonstrated by put downs, answering for and interrupting and teasing other members. This behavior annoyed the other members.

The leader handed out the interaction log with an example copy (See Appendix G and H) so they would understand how to complete it and explained the purpose and the best time to do it. This was an optional exercise to monitor their own progress.

Role that developed through interaction among the group members were:

Stroke Survivor #1	Opinion Giver Tension Reliever
Stroke Survivor #2	Information Seeker Opinion Giver Tension Reliever Trust Builder
Stroke Survivor #3	Communication Helper Information Seeker and Giver Opinion Giver
Stroke Survivor #4	Opinion Giver
Stroke Survivor #5	Opinion Giver Information Seeker and Giver

Session: 5 The leader encouraged the members to express their feelings about their changed self-image and tell the group how they were coping with their losses and changed life style. Members were encouraged to open up. The idea here was to provide support for the members as they heard how their cohorts had coped and what survival strategies they had used.

Stroke Survivor #3 described himself as recovering from slurred speech and swearing. The change in his social life, long time friends dropping him, which he never expected had been the hardest to bear. He said "this has been difficult but I have to get adjusted to it." The leader tried to get him to express his feelings about this but he just nodded when the leader commented, "I sense you are very disappointed because friends have dropped you."

Stroke Survivor #1 was able to say "I feel so useless, cannot get up and do anything. I have a couple of hobbies, cannot do either of them, need both hands to do it, cannot fix a clock or motor with one hand." Stroke Survivor #1 talked about his neighbor helping him. The leader asked "Are you saying you feel rather dependent on other people?" He said "Yes." When asked "What has that meant for your life generally?" He replied "Gives me a little contact with the outside world."

Stroke Survivor #2 said "No use complaining nobody listens anyway." Stroke Survivor #3 showed support for him when he said "look, we are all listening when you talk. We are all in the same boat." The leader reassured Stroke Survivor #2 that he was cared for and about by our group.

The leader inquired "How have things been for you since your stroke, Stroke Survivor #4?" He indicated "Not to bad, things I did before I cannot do now otherwise, things are OK" and he went on to say that he had accepted this.

Stroke Survivor #5 said he felt, "Just useless, cannot do what I have done, I am just useless." The leader asked him "What does all that mean for your life right now?" He replied "I try doing things on my own. I can handle steps." Stroke Survivor #2 said that the stroke was shattering because he could not work anymore. He missed working and all he did now was watch TV.

Several members mentioned that they struggled with depression. Stroke Survivor #3 did not like his wife working part time but he did not want to tell her this was hard on him. He found this lonely and difficult to adjust to but denied role reversal was a source of conflict. The self image question received much attention during session four.

The leader attended to the member's emotional concerns by trying to get them to express their sadness, anger, frustration and disappointment. This was done by a direct question, "Are any of you angry because you had a stroke?" Stroke Survivor #2 admitted that he was bitter about it and Stroke Survivor #3 said he was more frustrated than angry. Stroke Survivor #5 denied his feelings and Stroke Survivor #1

and #4 were silent.

The leader said to Stroke Survivor #1, "Last week you mentioned that you would like to be doing what you were doing before. You used to enjoy puttering in the garage." Stroke Survivor #1 expressed how he felt about not being able to drive anymore. He indicated that it was quite a blow when he first heard he had lost his licence.

The leader presented the No Lose Problem-Solving Model for Negotiating (see Appendix B) and explained it's goal to the members and provided a relevant example (See Appendix I) of it's application and explained how couples could use this model. Stroke Survivor #2 claimed that his spouse was alright as long as she was the boss all the time. He expressed his anger and frustration about his stormy relationship with his spouse indirectly. Stroke Survivor #3 was supportive and said that he understood Stroke Survivor #2's frustrations. Several members agreed to this model's usefulness. Stroke Survivor #2 joked a lot and said he was in a no win situation.

Session 6: We started off looking at assertiveness and negotiating and determining how these fitted into the members own lives and how they might want to use these skills in their relationship with their spouses. Stroke Survivor #1 indicated that he was not doing as many things with his spouse as he would like to because he cannot do some of the things he used to. He missed going for walks to the park with his spouse. The leader suggested that he and his spouse could use the negotiating model to think of options that both of them might want to look at.

Stroke Survivor #2 arrived late. There was lots of joking and members were avoiding talking about the relationship concerns they had with their spouses. After coffee, the leader left the topic open. Stroke Survivor #2 suggested a taboo subject, sex and expressed his frustration indirectly. Stroke Survivor #2 was asked how he would like things to be different and he did not know. Stroke Survivor #3 talked about being bored and Stroke Survivor #4 suggested he join the Adult Day Program at Lions Place.

The leader checked out with the members what their thoughts were about what they could do next session and where they were at in terms of applying assertiveness and negotiating to their own life situations. Stroke Survivor #3 was emerging as the internal leader. He suggested that the leader make up some hypothetical situations for discussion and application because members did not want to discuss their personal lives. No one objected to Stroke Survivor's #3 suggestion. Stroke Survivor #2 indicated that this was too deep for most of them however, no one challenged this. Some

of the others may not have agreed but may not be all that motivated to try.

ENDING PHASE (April 16 - April 23, 1991)

Session 7: Stroke Survivor #2 came in ten minutes late and attention was focused on a fight he had with his spouse. The leader did some role-playing with Stroke Survivor #2 around their disagreement about her driving habits. Stroke Survivor #2 was aggressive in this interaction but did not seem concerned about the manner in which he related to his spouse.

The leader referred to the negotiating model and introduced a hypothetical situation and asked members to try and use the model. The situation was: 70 year old Peter with multiple sclerosis, who cannot use his left hand and was confined to a wheelchair. His wife, Peg tutored high school students eight hours per week. Peter and Peg used to do a lot of things together and lots of these things he cannot do anymore or with difficulty. He missed these joint activities and so did she. They both needed time to be alone.

The leader coached and encouraged the members to try by asking questions such as "What do you gentlemen see as the problem?", How do you think Peter could tell his wife, using the assertive style how he felt about their not doing things together as much as they used to? and Can you think of another option that Peter and Peg might look at for something to do together?" The leader modelled how Peter might use the assertive style and coached by making comments such as "The idea here is to brainstorm options because there maybe things they can do together but you have to think of new activities.

Stroke Survivor #1 strongly identified with Peter's situation. When looking at the options that Peter and Peg might consider he said "I saw something at Oakview: a game, tick-tack-toe. I can play it. I can sit in my wheelchair and do it with one hand. This game would take my spouse away from her knitting."

A second hypothetical situation was looked at which follows: 60 year old Jack with arthritis had retired recently. He missed working. Jack's driver's licence was suspended three months ago due to impaired driving. Because of his arthritis he had some pain and discomfort in his joints but gets around using the public transportation system. Jill, his wife worked in a bakery. He had a lot of time on his hands and was lost for things to do. Jill was upset because Jack did not have enough to do and felt down.

The leader used the same techniques as in the first situation to help the members apply the negotiating model to

Jack's situation. Stroke Survivor #2 identified with Jack's situation when he said "I don't have enough to do and even if I had something to do I wouldn't do it." I don't like it." The leader indicated that what Jack was really saying is that he wanted to get more things in his life to keep him busy. Stroke Survivor #2 indicated that he found time long on his hands since he retired. Stroke Survivor #4 mentioned a number of ways he kept himself busy. He was a good model for the members as he had adjusted well to the stroke. When the members brainstormed options to keep Jack busy they needed a lot of assistance from the leader in coming up with ideas. The leader and members talked about the group ending next week, our social and our feelings about ending.

Session 8: The last session started with lots of joking and laughing. Stroke Survivor #1 and #2 arrived late. The following hypothetical situation was role-played: 60 year old Bill felt too dependent on his wife, Elizabeth and felt badly about this. Bill was in a car accident and broke his left arm and leg. He used a quad cane to ambulate and his left arm was in a sling. His balance was very good. Elizabeth would like to see him try and become more independent.

Stroke Survivor #2 was Bill and the leader was Elizabeth. Stroke Survivor #2 identified with Bill's situation and he was really himself in the role-play. Stroke Survivor #3 gave feedback as to how the role play was going and suggested we needed a mediator and assumed this role.

When asked what they thought they learned from this group experience the comments were: "I have learned to be a little more tolerant. I have changed, not that I wanted to", "I think it was too deep for most us", I think we have learned how to communicate in new situations because since the stroke it has changed so we have to learn to communicate in a new situation", I learned something I did not know before, very good" and "I have learned a lot. I do much more around the house, making more decision."

When asked what do each one of you think you are taking away with you the comments were: "friendship", "We learned a lot of things" and We learned how others are coping. We do not feel alone in it."

The leader introduced the idea of having one joint session with their spouses to discuss what the group experience had meant for each one of them. The members were agreeable but one member did not think they should raise any concerns and no one said they disagreed with him.

Part of this session was used for completing the Feedback Questionnaire with the assistance of the leader. We

celebrated with lunch at the Lions Place Restaurant with their spouses and a special cake decorated with the wording "Congratulation to a Great Group".

Appendix U

TIPS FOR GOOD GROUP MEMBERSHIP

Tips for Members:

1. Try to attend each group session or call on day prior to the group meeting to let me know you will be absent.

2. Try to arrive on time for each group session.

3. Not talk about anything that occurs in the group to anyone outside the group, unless it applies only to myself and no other group member.

4. Complete the interaction log between group sessions.

5. Allow each member to speak without interruption.

6. Participate in exercises, role plays and other simulations conducted during group sessions.

Tips for the leader:

1. Be prepared for each group session.

2. Try to begin and end all group sessions on time.

3. Provide refreshments and program material needed for each session.

4. Discuss the group only with my MSW Committee associated with the University of Manitoba and Brenna Shearer, at work and not outside of the educational/work context.

5. Evaluate each group session to ensure that the group is meeting the expectations and is personally satisfying to all group members.

Source: Toseland, R. & Rivas, R.F. (1984) An Introduction to Group Work Practice. MacMillan Publishing Company. 133.

Appendix V

RESPONSES OF THE STROKE SURVIVORS TO THE SESSION EVALUTATION FORM

The following are the responses to: What information did you find the most helpful?

Session 1: not answered because it was not relevant to this session.

Session 2: explanation of the verbal and non-verbal concepts of the 3 styles and the rights.

Session 3: assertiveness style formulae, review of differences between the 3 styles.

Session 4: exchange of ideas, benefits of being assertive, the exercise.

Session 5: exchange of ideas, example using the negotiating model.

Session 6: talking about changes and how we have coped, information on problem - solving which applied to my problem.

Session 7: hypothetical situations and how one can problem solve, talking about feelings etc. about ending, general discussion, using hypothetical situations was helpful.

Session 8: Bill and Liz role-play, talking about what we have learned from this group experience, role-playing Bill helped apply the skills we are trying to learn.

The following are the responses to: What did you find most helpful about the group during this session?

Session 1: Socializing and sharing, getting to know the others in the group and the leader.

Session 2: Lots of interaction, each had a chance to say how he feels, examples of the three styles helped me understand more about the difference among the styles, to be more assertive, learning about the 3 styles and their differences.

Session 3: Shared feelings regarding losses, the exercise, group discussion and exercise, talking about losses, good to express feelings.

Session 4: Being assertive, talking to one another, sharing of similar problems and getting support, the exercise, liked the way most members participated and the way the leader

encouraged the low participants to get involved.

Session 5: Being open to suggestions, the negotiating model is very useful and the example helped me to understand it, support I received from all, talking about our changed self esteem and how we have been coping, don't feel so alone, good participation by everyone, talking about how each coped with their changed self image, negotiating model is practical.

Session 6: Being with other stroke survivors and a leader that understands me, see how others cope, looking at a way to problem solve, they were very open, helped me to get stuff off my chest, seeing how I can resolve a problem.

Session 7: Program was very good, sharing experiences, full participation of the group, dealing with Peter and Peg's situation got me thinking about using the model in my own marital relationship, group trying to apply the problem solving model to our real life situations.

Session 8: Sharing of opinions about what we learned from being in the group, the role-play with Bill and Liz, role-playing using the negotiating skills, being together, talking about all kinds of things, doing the role-playing, sharing each others feelings about our group experience and role-playing.

The following are the responses to: What did you find least helpful about the group?

Session 1: Immobility, that we are all at a big disadvantage after the stroke.

Session 2: Nothing.

Session 3: Steady complaints of one member of the group and his over-emphasis on negative assertions.

Session 4, 5, 6: Nothing.

Session 7: Interruptions, members changing the subject for discussion too often, coffee was not strong enough.

Session 8: Loss of efficiency of each group member in coping

There were additional comments for sessions 1,3,4,5,7 and 8.

In session 1, the comments were: I feel we should be walking more than we are. By walking more it would improve our mobility and reach our goal better and faster. Its' good for us to see others, how they cope, some are worse off etc. and I think the session went very well. Session 3 was helpful for

attitudes, the exercise is educational and helped me learn to communicate my feelings and needs to other people. The comments about Session 4 & 5 were: the leader addressed our feelings quite well, the negotiating model is very practical, our leader is very patient and very good at explaining the different situations to us. For Session 7 & 8 I have found our leader very good and most satisfactory, role-play was satisfactory and helpful and the leader has given a lot of caring and help in problem solving.

Appendix W RESULTS OF THE FEEDBACK QUESTIONNAIRE FOR THE STROKE SURVIVORS

The results are as follows:

1. To what extent were your expectations of the group met? Two answered moderately and three, completely.

2. Which aspects of the group fell short of your expectation? Of the two members who answered moderately to the first questions answered lack of mobility and communication skills are lacking among stroke members.

3. Which aspects of the group exceeded you expectations? Friendship and openness of the group members, appreciation for each other, chance to learn new skills and be with other stroke people and to see they have the same feelings is reassuring, expressing feelings, good to share with others loss of your physical capacities and role plays using the skills and expressing your feelings.

4. To what extent do you perceive a change in your assertiveness and conflict management skills as a result of your participation in the groups? One answered somewhat; two moderately and two completely.

5. Do you find that you are using these skills that you learned in the group in everyday situations? One answer, not at all, and four moderately.

6. Rate the helpfulness of the leader. Two found her very helpful, three found her somewhat helpful.

7. What did you find most helpful about the group? What made the group successful? Discussions about losses and how to problem solve, small group and the leader was most helpful, understanding and sensitive to our feelings and needs. Appreciation of the group's growth in friendship, a small number of people is good and the handouts were useful, a small number of participants, flipchart and handouts were useful because my hearing is poor, learned some useful skills, members and leaders openness to discuss problems. Role-plays were very useful and helped me learn good skills.

8. What did you find least helpful about the group? How could this group be improved? Meetings were too long could be 15 minutes shorter, Be more specific in topic discussions, more examples of role plays, and session could be one hour instead of two.

9. Overall, rate you satisfaction with the group. Three were very satisfied and two were satisfied.

10. I would recommend this type of group to couples who are adjusting to living with a stroke. Four strongly agreed and one agreed.

Appendix X DESCRIPTION OF THE GROUP PROCESS, SPOUSES GROUP

BEGINNING PHASE (March 6 - 20, 1991)

Session 1: The first session was attended by four members. The leader began by welcoming them to the group, introducing them to one another, telling them what to expect regarding coffee breaks, washroom facilities, etc. Members were given a handout with norms (See Appendix U) and we went over these as a group. Next, the purpose of our group sessions, how we would deal with our work, the function of the leader and how the leader would assist them to meet their goals was discussed.

In order to help members to get to know each other on a more personal level, to encourage social interaction and to build the group, members were asked to get into pairs. Members were asked to tell their partner their strengths, good qualities and what they liked about themselves and were good at. Members were informed that after they finished talking to their partner they would be asked to introduce their partner to the whole group.

Spouse #1 shared her sadness with regards to her husband's loosing his ability to be affectionate. This seemed to trigger Spouse #2 into expressing her frustration and anger about her husband's lack of affection, his blaming her for all his problems and his laziness. She also expressed that sometimes she felt "like packing it in". Spouse #1 showed her support by saying sometimes "I feel like you, like walking out, my spouse does absolutely nothing".

Session 2: This session was attended by four members. The atmosphere was relaxed, congenial and friendly. The ladies shared a lot about their feelings associated with their husband's doing a lot of crying since the stroke. The leader sensed that it was very important to let each one of them share this experience that they had encountered with their spouse.

The leader introduced the components of the three interpersonal styles (See Appendix C) using a flipchart. After each style was reviewed; an example of a wife relating to her husband in that specific style was provided. Members were asked "Can you remember a situation where you acted passively and how you felt about it?" This same procedure followed for the other two styles in order to make the topic relevant to the members. Spouse #2 and Spouse #3 gave meaningful examples. Spouse #1 had difficulty identifying herself using these styles and tended to get off topic and

carried away. Spouse #4 was an active listener.

The leader introduced members to the legitimate rights (See Appendix D) explained why it was important for the group to become familiar with them and asked if members felt these would have helped them feel more comfortable asserting themselves. These rights stimulated some discussion and members appeared to understand this connection.

Session 3: All four members attended. Members got into pairs to complete an exercise (See Appendix E) to help them differentiate among the three styles then reassembled for discussion. There was excellent participation and discussion by all members about the assertive style's effectiveness.

The assertive style formulae was presented to the members and applied using the following situation: When one's spouse has had a stroke, one could find her spouse became very demanding and expected her to do things for him that he could do for himself.

The leader raised the concern members had about their husbands crying a lot since the stroke. Spouse #2 used to talk to the doctor about this and he told her to ignore the crying. When asked if she ever felt a sense of helplessness, she said, "No, it does not upset me." Spouses #1 was asked how it was for her when her husband cried and how did she feel. She remembered her husband being at his sister's place and crying because he could not dance and went on to say if it had been any other time I would have cried with him. I knew I had to keep on going. Spouse #4 responded to the same questions by saying "At first I felt sorry for him because he was always strong. Now, I am used to it."

Spouse #1's concern about her husband's inability to be affectionate was explored. With assistance from the leader she was able to get in touch with her feelings and said "I find it hard to throw off. It really hurts." Spouse #1 told the group about when her husband was hospitalized he spent time in the company of a female patient even when she was there to visit him. She said "I was so hurt I just about died" I think this was what made me sick, just the end of the straw." Spouse #1 seemed to be struggling with her suspicion that her husband was unfaithful. Also, she appeared frustrated and angry that her husband gave her a real hard time when she was teaching piano and indicated that she would not be telling anyone else about it. The leader mentioned to her that she had told the group that she felt like walking out

and was asked why she had never walked out. She replied "I have too much to loose." Spouse #2 tried to be supportive but at the same time she was diagnosing and telling Spouse #1 what to do. Spouse #1 took a big risk in telling the group about the tensions in her marital relationship.

Spouse #2's concern about her husband's lack of motivation and her frustration over him not getting his driver's licence back and her feelings about packing it in were explored. Her frustration and anger were centred around her husband's procrastination and laziness. She vented her anger. It came out in her tone of voice and statements like, "I don't care if he stays in bed all day and rots. He wants everything done for him. He depends totally on me."

Spouse #3's feelings about her husband being easily hurt, sensitive and suspicious were dealt with. She said "I cannot change that, with time I think he heals. We both cried. I encourage him to cry."

No leadership struggle emerged. Two of the members expressed their anger and hurt over their burden of caregiving and the deterioration in the marital relationship. Spouse #1 tried to dominate by keeping the group focused on her concerns. At this point, there appeared to be an alliance forming between Spouse #1 and #2. The members benefitted one another by sharing.

MIDDLE PHASE (March 27 - April 10, 1991)

Session 4: During this phase the leader encouraged members towards achieving their goals and establishing supportive interaction. Members got into pairs to complete an exercise (See Appendix F). Two of the members had difficulty differentiating among the three styles and asked the leader several questions. After the members completed the exercise they reassembled. There was excellent participation in the exercise and it stimulated a lot of discussion. In going over the benefits of learning to be more assertive, the leader tried to stimulate discussion by asking the members open ended questions. There was a high level of participation in this discussion.

In looking at the assertive style formulae and how one could use it in their own life, the leader asked "Does anyone have a recent situation were they think they would like to be assertive?" With Spouse #4 the leader made the comment "So if your spouse asks for things he can get for himself do you

think you could use this formulae at all?" The leader showed Spouse #4 how she might use it by running through the formulae applying it specifically to her situation. Modelling was used to help the members see where and how they might use this formulae.

Spouse #1 stated that her spouse could be very demanding and when asked how was that for you when he was like that, she replied "I have found it hard. He reminded me once that it was my duty and I realize it is my duty and that he was not demanding things he could do for himself."

Spouse #2 found it very frustrating when she wanted to go somewhere and her spouse was not ready. The leader tried to get her to see how she could use the assertive style formulae here and tried to get a role-play going, however, she felt it was no use trying to be assertive with her spouse as he is too stubborn. She also found that he did not care how others felt and it did not bother him to be late. The leader modelled how she could use the formulae with her spouse. Spouse #2 stated "You have to do everything, I am so used to doing everything without a husband so nothing has changed." The leader inquired "What does that mean for your life, all that burden you are carrying, you are carrying the full weight now?" She claimed that neither she nor her spouse worried. It was difficult for her to get in touch with how she felt.

The leader handed out the interaction log with an example copy so they would understand how to complete it and explained the purpose and the best time to do it. This was an optional exercise to monitor their own progress.

Spouse #1 and #4 felt the pace at which the group was moving was right for them. Spouse #2 felt we were not covering much ground. Spouse #3 felt the group needed to be more sympathetic towards their spouses. Members felt we kept on track better this session.

Roles that developed through interaction among the group members were:

Spouse #1	Trust Builder
	Opinion Giver
	Information Seeker
Spouse #2	Trust Builder
	Opinion Giver
	Information Seeker
	Tension Reliever

Spouse #3	Opinion Giver Trust Builder
Spouse #4	Opinion Giver Information Seeker and Giver

Session 5: The leader encouraged the members to express their feelings regarding the losses their husbands had experienced and tell the group how they were coping with these losses and life style changes. Each member talked freely about how she had coped with the losses her husband had experienced due to the stroke.

Spouse #3 relayed that she felt gyped because she thought one should have at least ten years of marriage without health problems. In the beginning she felt "Like a bird in a cage." The leader asked "How does that feel?" Spouse #3 said "Like you want out and there is no way out." The leader said "That must be very difficult. How do you feel about that?" Spouse #3 replied "I cry a lot, I do not want to go out and meet people. Sympathy is the last thing you want and that is all I need to start the tears again. You see that you are better off than a lot of people." Spouse #3 admitted that she thinks she felt very angry. She said "It's just like a death." The leader asked her if it was hard for her to deal with her feelings. She replied "For me there was no choice for getting out of this. He is so good to me. There is so much companionship and the love factor has not changed. Friends have asked how is it sexually?" When asked what has it meant for you life, your husband's having had a stroke, she indicated that her husband did not like going out to social functions or to relatives and she missed the socializing. He did not like her seeing her single male friends in the Single's Club because he was afraid of the competition. She had to reassure her husband that she would still choose him. She admitted that she wore a mask a lot of the time but was not always hurting.

When, Spouse #2 was asked how it had been for her, dealing with all the losses her spouse had experienced, first she indicated that it did not bother her that much as she had already lost a husband and that the stroke was hard on her spouse. He was the one going through the anger of why me. Secondly, for me this minor stroke was nothing. I don't feel it was any worse than if my spouse had to have a hernia operation, you cope, you had to.

Spouse #1 told the group how her spouse had a heart attack and then three strokes. When asked how it was for her going through all these experiences, she said "I think I was prepared for this all these years because my spouse had had a heart attack years before the strokes." The leader asked her

"How has this affected your life?" Spouse #1 said "I just felt he was always still here, he was not dead, still something to live for." She went on to tell the group about her spouse being angry because he had to go upstairs when she was teaching piano. She said "The problem is me, I have not been able to take him out. I don't drive." The leader indicated that the No Lose Problem Solving Model we were going to look at would be good to use to handle this situation that was bothering her.

The leader presented the No Lose Problem Solving Model for Negotiating, explained its goals to the members and provided a relevant example (See Appendix I) of its application and explained how they could use it in their own lives. Spouse #1 was able to see how one could help themselves by using this model. Spouse #3 claimed she and her spouse were already using this model.

Spouse #2 told the group that her spouse had low self esteem which had been magnified since the stroke. She claimed that he wanted to become more dependent and this was like having a kid again. Spouse #2 thought her spouse felt that she was going to leave him. She complained about her spouse's lateness. The leader suggested to Spouse #2 that we could do some role-playing using the negotiating model next week. Also, the leader encouraged the members to think of situations where they wanted to try putting this model into practice.

Session 6: The leader encouraged the members to think about how assertiveness and conflict management fitted for them right now and what it meant for them in their lives. Also, to think about how they might be able to use assertiveness and conflict management with their spouses. The leader encouraged them to raise any other concerns or indicate what their greatest concerns were at present as it would be good if we talked about that and how this group might be able to meet any of their unmet needs.

Spouse #3 said "Where do we go from here, this group is something my spouse looks forward to each week. What else can we start? He gets bored so easily." There was a lot of discussion about the various activities available to seniors in the community.

The leader asked "Am I hearing you correctly that one of your greatest concerns is that your husbands are bored?" Spouse #3 said "Yes, I think so, hard to motivate him." Spouse #1 and #2 nodded their heads up and down. Spouse #4 was asked directly, "what about you, do you find your spouse is bored or are his days quite full"? She indicated to the group that her spouse read and played chess all day.

The leader asked if there were any other concerns that they felt where really important and invited feedback as to how the members were thinking and feeling. After a minutes silence, the leader asked directly "Is there anything you would like to talk about, something you think is important?" Members had difficulty deciding. One member told the group she would like a maid. Everyone laughed. This lead into a discussion about how little their spouses did and how each had a supportive network to turn to for help.

Spouse #1 volunteered to role-play using the negotiating model as a guide. Her spouse did not like her teaching piano lessons as he resented the time she spent at it because he felt neglected. Teaching was very important to her. The leader was Spouse #1's husband in the role-play.

One of the members gave some direction to Spouse #1 as she attempted to role-play. The leader stimulated discussion by asking the members if they could think of something this couple might be able to do together that would cut down on the resentment. We looked at options together. Members gave positive feedback regarding the usefulness of the role-playing.

Spouse #2 talked about her spouse's lack of initiative and how he would not do a thing if he could get others to do it for him and that he would not even try. It was suggested that she might want to role-play next session to help her deal with her situation.

ENDING PHASE (April 17 - April 24, 1991)

Session 7: The leader and some of the members expressed their feelings freely about the group ending next week, then we did some role-playing. Spouse #2 raised her concern about her spouse not having respect for time and her frustration in trying to deal with this situation. She said she did not think it was possible to negotiate with him because he did not care if she disliked his lateness. We talked about how important it was in negotiating that both people cared about the other person's feelings and were considerate of their point of view. Spouse #2 role-played with the leader and the other members suggested options to help problem solve.

Again, Spouse #2 expressed her concern that her spouse did not show much initiative in arranging his own activities. The leader pointed out that last week the greatest concern that all of them had mentioned, Spouse #4 being an exception, was that their spouses were really bored and they felt they were not showing much initiative to get involved in activities and other things. The leader indicated that in the men's group the husbands had expressed these same concerns and we

had looked at a couple of situations related to these concerns and went through the model. The leader went further and said that one of the things we did look at were activities that your husbands could do, various activities they could get involved in if they chose, in the community and a number of options came up.

Spouse #1 talked about how she and her spouse had a loving relationship and how he had lost his sexual capacity and that he took this out on her. The leader said "That must be very difficult." She went on to say that she told her spouse that sex was not the last thing in the world but he saw things differently. She indicated that her spouse could be nasty with his words and gave an example, "Anything I do is no good. Anything I say is no good." The leader asked her "Are you saying that your spouse is blaming you for a lot of things because some of his abilities have deteriorated?" She answered "He likes to think I am going to go under too. I said I got mixed up between Wednesday and Thursday and he said to our daughter, your mother is always getting mixed up in the days." Spouse #1 complained that her spouse does not know what to say or how to be nice to her to take the place of sex. She cannot understand why a man who can recite poetry and has such knowledge with words cannot say a kind something to her sometimes. The leader validated her loss by saying "Big loss to you." and Spouse #1 acknowledged her disappointment. The leaded asked "He is bitter about loosing his sexual capacity isn't he?" She indicated that the doctor told her that was the case. When asked how does that affect your life, she said "I just go out of my mind, what else can I do." The leader continued "That he is taking his frustrations out on you and that is hurtful?" She replied "Yes, no good getting angry about it." The leader asked her "Have you ever said when he is nasty to you that you really feel hurt? Have you ever been able to say that to him?" Spouse #1 indicated that No she did not think so. The leader modelled if you say to him _____, "when you talk to me like that I feel hurt". She said "I will just go to Oakview Home. He knows that hurts me." The leader asked how is that for you? Spouse #1 said "I just don't answer because it does hurt me." Spouse #3 said to her "You wear masks a lot too." Spouse #3 agreed. The leader tried to get Spouse #1 to express her feelings about the burdens she shared with us but she continued focusing on her grandparents.

Spouse # 3 talked about her spouse asking to go with her to her bowling banquet. This was a break through because he had not liked going to socials with her since his stroke and she loved going out but not alone.

Spouse #4 and the leader role-played a situation that caused tension between she and her spouse. Her spouse did not co-operate when she tried to vacuum. Members offered some options to Spouse #4.

Spouse #1 opened up and revealed more of herself than the other members and had been quite willing to risk talking about areas of her life that were very difficult to talk about. She did have difficulty identifying and expressing most of her feelings. There was much less joking, interrupting and changing the subject in this group. The ladies were more willing to look at their concerns, deal with their emotions and try and problem solve.

Session 8: This session began with Spouse #2 and the leader role-playing regarding Spouse #2's concern that her husband was too dependent. Spouse #2 and the leader reversed roles on one of the member's suggestion and Spouse #2's agreement. One member commented that stoke victims had a common denominator, that was, they lack ambition. The leader validated this statement. Another member got off topic several times and the leader had to get the group re-focused.

Spouse #2 mentioned that she had to handle both jobs since her first husband's death. At this point, the leader commented "Since your husbands have had the stroke, you probably have found yourselves more in the dominant role and I am wondering how that has been for you. How have you found that, have you found it a burden and stressful?" Spouse #2 said No, because her first husband died young and left her with four children to raise and that was stressful but with her present husband's stroke, she did not find it hard, he was responsible for himself. Spouse #3 said she had assumed the dominant role and it was not that difficult to adjust to. She was single and independent for many years and it was a break to have someone else responsible for her for a year but when the stroke occurred she could pick up the dominant role right away. She had to make all the decisions but she consulted with her husband even though he had appointed her interim manager. She found this overwhelming at first, as she did not expect it that soon after she married. Spouse #4 indicated that before the stroke she made the little decisions herself and consulted with her husband about the big decisions. For her nothing had changed, she was driving and making the payments. Spouse #1 had to do everything after her husband's third stroke and at first she found this really hard. Neighbors and relatives did things for her and when she felt overwhelmed she just dids the best she could.

When asked what they thought they learned from this group experience, comments were: "That people have worse problems than me and that my life has changed", "I am in agreement with

what people say being a common problem support group is helpful", "The group just reinforced my own feelings that I don't have to become a slave to this guy just because he had a stroke" and "Learned more understanding of stroke and how it affects people and how others cope. I think I spoiled my spouse, I think he can do more, I do things for him and he expects me to do it. I should let him struggle a bit."

When asked what do each one of you think you are taking away with you comments were: "It has helped me identify my feelings", "That it could be worse, the circumstances could be worse, yes the stroke", "Just this kind of sharing" and "More understanding of stroke and how it affects people and how others cope".

The leader introduced the idea of having one joint session with their spouse to discuss what the group experience had meant for each one of them. One member did not like the idea because she was afraid the men might find out what they had said about them, and she indicated that she would not open up at all. Another said she would not open up and did not want to discuss anything because she only felt comfortable talking about her husband to women. Another member said she would not say anything. The ladies made it very clear that they did not want to discuss any of their concerns at this session, however, they agreed to a joint session on May 7, 1991.

Part of this session was used for completing the Feedback Questionnaire with the assistance of the leader.

Appendix Y RESPONSES OF THE SPOUSES TO THE SESSION EVALUATION FORM

The following are the responses to: What information did you find the most helpful?

SESSION 1: not answered because it was not relevant to this session.

SESSION 2: finding out what assertiveness consisted of and how to be that way, aggressiveness is wanting to order everyone around, and recognizing some of my legitimate rights.

SESSION 3: exercises to learn the differences between and among the 3 styles, how to use the assertiveness approach rather than passive or aggressive, examples of the 3 styles used were very much what you meet in daily living and easy to relate to, and the formulae showing us how to be assertive.

SESSION 4: knowing the assertive style formulae that one can apply to any difficult situation with her spouse, Assertiveness exercise, I need some repetition in order to have this information about Assertiveness stick in my mind, differentiating between passive and assertive and the benefits of assertiveness.

SESSION 5: getting the other person to give feedback, that others have really more problems than my own, the method to use when negotiating a solution to problems.

SESSION 6: sharing Spouse #1's problems, negotiating model helps you understand the other person well, doing the role-play that applied the negotiating model to my situation.

SESSION 7: role-playing, the role-playing, our problems are mutual and listening to the other member's concerns.

SESSION 8: role-playing, how to accomplish the assertive role, that other people have problems too, sharing others feelings and finding they are very similar.

The following are the responses to:
What did you find most helpful about the group during this session?

Session 1: willingness to share experiences with spouses, the freedom to express a common concern, very friendly, talking about problems and feelings.

Session 2: learning the distinction between the 3 styles was useful, they are friendly and easy to talk to, the open sharing of difficulties encountered with stroke spouses, willingness to share experiences relating to behavior.

Session 3: leader listened to my feelings without being judgemental and is interested in how I am coping, the sharing of other spouses of stroke victims of their problems and how to handle same, co-operation, learning the difference between non-assertive, assertive and aggressive and how to express our feelings and needs to our spouse in an assertive manner so we can improve the relationship.

Session 4: discussion about the answers to the exercise, learning about the benefits which can help us want to be more assertive, very personal about their problems, exchange of personal feelings, the common sharing as we compare what strokes have done to our partners.

Session 5: personal situations make relating easier, the personal feelings of others and how it has affected their lives, the sharing with others on coping with spouses handicap.

Session 6: role-playing, Spouse #1's willingness to role-play, everyone is very understanding and friendly and takes time to listen.

Session 7: role-plays are helpful, they are sympathetic and listen, role-plays that apply the assertiveness and negotiating, learn other people's problems are much like my own, the common sharing of a common concern in regards to stroke.

Session 8: role-playing, each person told what the sessions meant for them and also the role-play, the role-playing model, willingness to listen to others problems.

The following are the responses to:
What did you find least helpful about the group?

Session 1: Drawing out the past in a total stranger.

Session 2: Too much time spent talking about non-related topics, getting away from the subject matter, nothing.

Session 3: No complaints find the rest of group interesting, nothing.

Session 4: Too repetitive.

Session 5: We are hesitant to open up.

Session 6: Filling out this form is difficult, none.

Session 7: ---

Session 8: Nothing, straying from the topic, agreeing on date for next meeting.

Their additional comments were:

Session 1: Interesting to meet other people with the same problems:

Session 2: I feel the time has been spent very well. It has been worthwhile coming out, more emphasis placed on sticking to the topics.

Session 3: ---

Session 4: The company has helped me a great deal.

Session 5: I enjoy the company of the other ladies.

Session 6: I have appreciated the opportunity to be in such a group.

Session 7: Everybody spoke and told of their problems and we discussed overcoming them.

Session 8: Discussion about bringing the two groups together was useful.

Appendix Z RESULTS OF THE FEEDBACK QUESTIONNAIRE FOR THE SPOUSES

The results were as follows:

1. To what extent were your expectations of the group met? Two answered moderately and two quite a bit.

2. Which aspects of the group fell short of your expectations? Too short in length of session, maybe longer session and less weeks. The sessions were rushed so there was not enough time to listen to the whole problem or concern. Longer sessions, three hours would have given more time to problem solve. Nothing.

3. Which aspects of the group exceeded your expectations? People's willingness to share their personal lives and problems. Understanding of the three personalities by acting the roles. The group was excellent in showing concern and were anxious to assist in methods of coping and/or practising assertiveness. I found it reassuring to learn that others had the same feelings and experiences I have and some have more problems. Good to unload my burdens, express my feelings, support I received from the leader and members in coping, learning assertiveness and negotiating skills of value, role plays were especially helpful.

4. To what extent do you perceive a change in your assertiveness and conflict management skills as a result of your participation in the groups? One answered somewhat; two moderately and one quite a bit.

5. Do you find that you are using these skills that you learned in the group in everyday situations? One answered somewhat, two moderately and one quite a bit.

6. Rate the helpfulness of the leader. All four members found her very helpful.

7. What did you find most helpful about the group? What made the group successful? The ability to share experiences, emotions, etc. Learned useful skills, the group was small, attending once a week was good, kindness towards each other, regular attendance of members, nice room with good lighting and air conditioning, the time of year and day time was good, group small in number, everyone could say what was on their heart and mind, very comfortable, preferred the winter, one session a week was good, small group size was excellent, flipchart was very good and so were the handouts, good air conditioning and lighting.

8. What did you find least helpful about the group? How could this group be improved? Set up subject to be discussed with a time limit and better parking facilities. Sessions could be three hours instead of two hours. The group leader did all she could. The sessions could be lengthened to three or four hours in the morning.

9. Overall, rate your satisfaction with the group. All four members were satisfied.

10. I would recommend this type of group to couples who are adjusting to living with a stroke. One strongly agreed and three agreed.

Appendix a PERMISSION FOR OBSERVATION

In utilizing the services of Carolyn Janzen, B.S.W. group members are participating in the Practicum Research Project of a Masters of Social Work student at the University of Manitoba.

1) That information obtained from initial interviews, questionnaires, the orientation meeting, evaluation forms and group sessions, or follow-up questionnaires may be shared with Carolyn's clinical supervisor and with her MSW Committee members during meetings;

2) That information, whether on paper or computer record, is shared solely for the purposes of aiding treatment, contributing to student training, and University of Manitoba administration and research;

3) That all information is kept under strict conditions of professional confidentiality;

4) That observation and/or audiotaping or videotaping of a group session/s may be required. The tapes will be used by myself and my supervisor only.

Read and agreed to:
Name of Member(s):

_____

Signature of Member(s):

_____

_____ Date _____

Signature of Student Social Worker
or Other Witness

_____ Date _____