

“The Finishing Touches”: A Women’s Group at the End of Lengthy
Community ABI Treatment as a Tool to Address Residual Issues of Social Isolation,
Socialization and Continuing Social Support
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Introduction

Thank you for the opportunity to share with you some of our work, work which we feel may have some relevance to you. This Women’s Group intervention was relatively simple, inexpensive, had significant impact and was a pleasurable and profound experience for the group members and us. The women call the group the “La La Group”.

Lynn Sansom and I are members of the Acquired Brain Injury Resource Team of the Peterborough Community Access Centre. We work with a caseload of about 35 brain injured clients out of the 3000 clients that the Access Centre serves in the Peterborough County population of 180,000 citizens. Lynn is an Occupational Therapist and I am a Social Worker. We have been working as a team since 1995.

When fully staffed our ABI Team provides quite a full set of services to these clients including Occupational Therapy, Individual and family counselling, Physiotherapy, Speech Language Pathology, Behaviour Therapy and Nursing services. We do groups occasionally when in our small population base we have the right combination of clients with similar needs and availability. We have for instance facilitated an anger management group. We have a proposal in for a Men’s Exercise Group combining a conditioning program and a talk group.

Our ABI population and our services we described in detail in our paper “Poor Man’s Rehab” presented to the IterUrban ABI Conference in 2001. Since we are a publicly funded community health program, those who do not have insurance coverage or who have run through their resources dominate our population. Our client population has a distinct demographic and clinical profile. They are older, 80% are between 30 and 58 years of age. 30% presented at least 5 years post illness or injury. Only 60% have trauma as cause of their injury. Many have had cancer or other tumours, CVA,s, anoxia, aneurysm, or medical misadventures. 70% are receiving social benefits or pensions on admission. They are often a neglected population for rehabilitation. Members of this group had a similar profile.

Perceived Need

In 2003 we had a number of women at, or close to discharge who, despite many years of successful rehabilitation and the development of numerous coping skills, continued to report significant social isolation and related problems with social skills and self esteem. We met with these women and shared our observations and together with them designed a brief 10 session group experience that we hoped would consolidate and build social skills, utilize for each other their rich resource of strategies and accommodations, and perhaps provide an ongoing support network beyond the end of our formal services.

Group Goals

We as staff originally envisaged the group as having the following goals:

- Increase client's confidence in extra family social situation
- Reduce social isolation
- Increase knowledge of and range of compensations
- Enhance communication skills

We speculated that the group would:

- Have fun
- Form relationships outside the group
- Provide some support for clients at discharge

At the first meeting of the Group they formed their own goal statements which were:

- Share challenges and compensations
- Provide mutual support
- Reduce social isolation
- Have fun

Who are they?

Women

Age

- Range – 42 to 57
- Mean – 50

Marital Status

- 1 widow
- 1 separated
- 4 married

Children

- 3 have between 1 and 3 children under 18

- 3 have raised one or 2 children now over 18 and living away from home

Employment Status

- All currently unemployed
- Some volunteering

Education (highest achieved)

- 4 university
- 1 technical/college
- 1 highschool

Pre injury vocation

- Hairdresser
- Writer/reporter
- Teacher
- Botanist
- Court reporter
- Veterinarian Technician/homemaker

Nature of brain injury or illness

Source

- 2 MVA
- 1 gunshot/MVA
- 3 tumour/ cancer and surgery
- 1 aneurysm

Area of brain impacted

- Frontal lobe
- Right parietal
- Minor diffused
- Bilateral posterior
- Communicating arteries
- Temporal lobe

Primary challenges

Cognitive

- Memory -5
- Organization – 4
- Attention – 1
- Initiation – 1
- Processing speed – 1
- Naming – 1

- Aphasia – 1
- Face recognition
- Anticipatory awareness

Physical

- Fatigue – 6
- Severe visual field cut (left) – 1
- Pain – 2
- Hyperaesthetic syndrome – 1
- Motor coordination – 1

Emotional/Behavioural Changes

- Persistent depression – 2
- Anxiety - 4
- Suicidal thoughts - 4
- Disinhibition – 1

Time Since Injury – Range 5 to 32 years

- 3 between 5 and 10 years
- 2 between 10 and 15 years
- 1 between 15 and 20 years
- 1 over 30 years

Years in Treatment

- Range 2 to 7 years
- Mean 5

In summary, this was a group of middle-aged women who had significant brain injuries and have been receiving a variety of individual treatments over many years from our team. When the group was planned, many were deemed ready for discharge from our services. While all are currently unemployed and receiving government benefits, all have raised or are raising families, are relatively well educated and have been employed in significant jobs and professions both before and after their injuries. Some still have active volunteer roles. They have, in many cases after many years of problems, actively engaged in a slow stream rehabilitation process. This group was precipitated by their identified need for better social skills and supports.

The Intervention

This group was designed as a short term goal directed support group. The group was designed to run for 10 sessions but only ran for 9 due to resource issues. We met every two weeks. The setting and process was customized to meet the needs and challenges of these clients. Despite the customization we speculate that this intervention with

modifications could be repeated and reconfigured to meet the needs of other clients with brain injuries, either our own or yours. Some of these particular features of this group and the related challenges are as follows:

Use of Visual Aids – We used a large flip chart at every session. At every session we displayed and read and reviewed the goals of the group. At the end of each session the main points discussed were summarized on the flip chart and at the beginning of the next group session this was reviewed following the Group Goals.

Challenges addressed: memory, verbal vs. visual memory strengths, organization.

Setting – the group was held in our offices in the same internal room (no windows) each session. The lighting was adjustable and kept quite low. The room was quiet (we did disturb some of the administration with our noise!). Lighting and sound control was particularly important for the client with hyperaesthetic syndrome. Seating was carefully arranged in the same circular pattern for each session and each person sat in the same seat. Seating position accommodated the visual field deficits of each client. Positioning was particularly important for one client who had no face recognition ability and an 80% left visual field deficit.

Challenges addressed: sensitivity to noise and light, memory and face recognition, visual field deficits.

Time – Every group started on time with encouragement for clients to arrive 15 minutes early. The group was always started on time and finished after one hour including the summarization. We noted that even though the women were encouraged to arrive early to socialize, that this plan deteriorated over time and they arrived only in time for the group itself.

Challenges addressed: organization, fatigue, attention, and initiation.

Group Process Interventions –The group process interventions we used were more direct, concrete and structured than one might use for a non brain injured group. It was non productive to make a broad and subtle intervention such as “ what is happening” in an expectation that group members would, for instance, pick up on the fact a particular group member was not participating. It was more productive for the therapist to model with an intervention such as saying “I notice that ---- has not said much today”. In a similar vein, turn taking interventions such as going around the room were very productive. A good deal of the time it was not necessary to intervene, except to note that another group member might have something to say, once a group member had shared a problem or asked for assistance. The group was very sympathetic to each other and generous with sharing both support and strategies.

It is interesting to note that when group members attempted to continue to meet on their own that they identified their main problems as: the uncertainty and instability of changing locations and rooms; turn taking; staying on topic; continuity; handling members who were in crisis or overbearing in session. One could speculate that these difficulties might have been the result of their original cognitive difficulties and/or that because our interventions were directive there was little learning as to how to manage in

the group. The worker speculates that if our goal was to help the group continue meeting as a group that we would have had to undertake some explicit teaching and perhaps help the group identify group leaders. The group has in fact continued to meet except for a summer break and they have just identified and coerced a group member into helping with timing and turn taking.

Again we speculate that given the familiar set of cognitive problems these clients have that many of the practical tools and simple interventions that we used in this group would likely be useful in any similar group.

The Impact

Generally the group was a very positive experience for the members and fulfilled all of their and our goals. As therapists we were pleased, impressed and moved by the experience. We were flabbergasted that all the clients were fully aware of their challenges and needed accommodations and could explain them to other group members with amazing sophistication. The richness and depth of the material and emotions shared were impressive including the experience of at least one client sharing for the first time outside of therapy her experience of her head injury as a survivor of a very violent domestic incident. There was much sympathy, crying and laughter. Social skills were clearly learned and firm friendships were made and have lasted.

We had a skilled interviewer follow up at three months and six months post the end of the group to determine what the impact of the group had been for each member. Audiotapes were made of each interview and the results summarized for each member and the group. We asked the following questions:

Interview 3 month follow-up – Women’s Group June, 2004

Open ended questions:

1. What has been the impact of the Women’s Group Experience on you?
2. Did your confidence in social situations improve or not? If improved, by how much?
3. Are you getting out of the house more or less often?
4. Did you learn anything about how you communicate?
5. Did you learn any new strategies or compensations to help you deal with the challenges of your brain injury?
6. Was the group experience a rewarding experience? Why?

7. Did you form relationships with other group members outside of the group?
8. Does the group provide support?
9. Did you have fun?
10. Would you change anything in the group?

Analysis – three month’s follow-up

General Impact

- Very positive
- All were extremely grateful for the opportunity to meet other women who could relate to the unique challenges of a brain injury.
- Friendship – all referred to other group members as friends, care for each other.

Trends

- If confidence in social situations was a problem before, then it improved with the group. Many group members learned that it is OK to tell someone you have a brain injury, it is not shameful to ask other people to adjust their communication skills so women can understand.
- Less isolation – between meetings and phone calls during the day all the women seemed to have more social contact outside the family. Most expressed happiness at having friends for the first time in many years.
- Communication skills improved because they listen to the feedback of other group members without hostility. Learned what they need to work on, what bugs other people.
- Group helped them to take the strategies learned in home visits with OT/SW and actually apply them in real life situations. The women found the strategies easier to apply because they seemed less overwhelmed when they learned how other group members had used them. All spoke of the importance of a routine.
- All were very supportive of each other. Make a conscious effort to help each other, express sympathy and help with difficult situations. For many, they are the first friends, outside the family that they’ve had in a very long time.

At six months

At six months the generally positive impacts described at three months persisted. The group continued to meet formally every few weeks. All but one group member reported that the group continued to play a pivotal role in their lives.

When asked to rate the impact of the group on a scale from 1 to 10, with 10 being a significant life event, 5 of 6 clients rated the experience at 7 or higher.

Group members identified particular experiences as having added to the richness and depth of the experience.

- The ritual hello and good bye hug the members initiated among themselves.
- Sharing - “we’ve lived through it and have come out the other side and we want to enjoy life.”
- All group members can relate to each others near death experiences.

Conclusion

It is clear to us that for this particular group of woman clients the group was a success and that nearly all gained as much or more that they had hoped for. Did we luck out or did we intervene in a way that resulted in this outcome? It is difficult if not arrogant to suggest that from a sample of one group that we can draw any definitive conclusions. We do suggest that there are features that we feel contributed to the success. Some may be unique to our service and others might be generalized to other settings and groups of similar clients.

In our small service, the therapists for the group were also the therapists for these clients elsewhere in the program. We were their Occupational Therapist and Social Worker. We both had group therapy training. Because of our long therapeutic role relationship with individuals in the group, we were able to customize the group design from the start to meet what we judged to be their challenges, needs and necessary accommodations. Not only did this mean that we properly configured aspects like the setting, lighting and seating, but in doing so we saved a great deal of time and effort for the group that they could direct to their goals. It might be argued that discovering these needs and associated accommodations in the group process would have enriched group members learning but our resources (time) were limited and so was their energy. This feature might be duplicated in another setting with a good clinical assessment of each potential group member.

We chose our group members carefully. Clients had reasonably good verbal skills. We chose clients who were at similar stages in their rehabilitation. They were generally not in crisis at the beginning of the group. They were self identified as struggling with less critical needs for improved social skills that would support them on discharge from our service, and would also help them establish ongoing community social supports.

There are a number of less service specific, more generic tools we found effective.

- We limited the group sessions to 10.
- We kept the actual group therapy time each session to one hour.
- We insisted on being goal directed.
- We used visual aids (flip charts).
- We always summarized the group process in writing on the flip chart.
- We were more directive than one might be in a non-brain injury process group. (turn taking).

We would likely use these same tools in any future group. They would likely be useful in any group therapy experience for brain injured clients. Customizing by paying attention to lighting, seating and using a quiet, distraction free setting is the fine tuning.

In our follow-up there were few suggestions for improvements to the group. The most significant recommendation was one we anticipated when we realized that the group intended to continue meeting formally. One member said they could have used some instructions as to how to maintain the group and handle selection of group leaders.

Post Script

We made no recommendations as to the group about what they might or might not do following the finish of the group. Eight months later they are still meeting. At this time many group members are expressing a wish to expand the group from a more formal format to a more social experience. Setting is a problem with some members expressing reservations about sharing personal information in a public setting like a restaurant. Some are uncomfortable with the group meeting in each other's homes where their relative wealth or lack of organization might be noted. This latter reservation seems to have been overcome and become fodder for group discussion.

Most continued to see the group as "boosting" each other. Positive benefits continue to be experienced with members noting that having "come out" in the group they have become more at ease with themselves and found more acceptance in their family.

One group member has introduced a few others to groups run by another agency and they have participated in a Self Esteem Group and an Assertiveness Group. A few have joined some group learning activities run by a local convent.

What have we created? Is the group rigidly holding on to the formal group because they need the organization and structure? Is there such a thing as group perseveration?

We conclude that if we ran a group like this again we would pay much more attention to our termination process. We would actively discuss options that members might consider for continuing socialization. We would educate as to how to maintain the group and handle common problems. We would explore a wide variety of community services that might meet their social needs.

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