

AN ABSTRACT OF THE THESIS OF

ROGER W. EMERSON FOR THE DEGREE OF DOCTOR OF PHILOSOPHY
in Guidance and Counseling presented on July 30, 1979

Title: CHANGES IN DEPRESSION AND SELF-ESTEEM IN SPOUSES OF
STROKE PATIENTS WITH APHASIA AS A RESULT OF GROUP
COUNSELING

Abstract approved: Signature redacted for privacy.
Glenn E. Clark

The primary purpose of this research was to compare posttest scores for changes in depression and self-esteem in spouses of stroke patients with aphasia who received group counseling with those who did not receive group counseling. Depression was measured by the Depressive Adjective Checklist (A-D) and self-esteem by the Tennessee Self-Concept Scale (P-score) (Clinical Research Form).

Eleven spouses of aphasics (8 female and 3 male) were recruited from the Olympia and Tacoma area in the State of Washington. They ranged in age from 46 to 73 years and their aphasic spouse had suffered a CVA within the last two years (1977-1979). A pre and posttest control group design was used that allowed the eleven spouses to volunteer for a treatment or control group. Six spouses (4 female and 2 male) volunteered for the treatment group and five spouses (4 female and 1 male) volunteered for the control group. Both groups were found to be similar in the following characteristics: age; sex; number of children at home; degree of aphasic language difficulty as perceived by the spouse; years of education; months post CVA for aphasics; mobility of aphasic spouse; depression as measured by the DACL (A-D) and self-esteem as measured by the TSCS P-score.

A developmental and personal mastery approach to group counseling reinforced an eclectic nine week treatment program that met 1 1/2 - 2 hours once a week. The program was designed to: facilitate self-exploration; promote improved self-understanding; develop a mutual support system; encourage the setting of personal and meaningful goals and action plans; help the spouse become aware of their own physical and psychological needs; and encourage independence in the spouse as well as in the aphasic.

When comparing the treatment and control groups by pretest data for similarity in levels of depression, an analysis of variance revealed, at the .05 level of confidence, a significant difference in depression between forms A, B, C, and D of the DACL ($F=3.764$). This indicates that possibly forms A, B, C, and D did not equally assess depression in the two groups. Non significant F-values were found between the total means of the treatment and control groups ($F=2.046$); and for interaction between the four forms and the two groups ($F=1.269$). No significant difference was revealed in the pretest comparison of P-scores in measuring self-esteem within the treatment and control groups ($F=.614$).

The posttest means were adjusted for the DACL (A-D) for the treatment and control groups and no significant difference was found in depression between the six spouses who received group counseling when compared to the five who did not receive group counseling. The analysis of covariance revealed non significant F-values in comparing the treatment and control groups ($F=.014$); between forms A, B, C and D of the DACL ($F=2.876$); and for interaction between groups and forms ($F=.804$). However all posttest group mean scores for the four forms decreased for the treatment group when compared to the pretest scores, with changes being the largest for forms A and B.

An analysis of covariance gave no significant changes in posttest TSCS P-scores for the six spouses of aphasics who received group counseling when compared to the changes in the group of five who did not receive group counseling ($F=.167$). The pretest was a significant covariate on posttest scores of the TSCS P-scores ($F=12.816$) but not for the DACL (A-D) posttest scores ($F=.203$).

Although neither null hypothesis was rejected, it was felt that an eclectic treatment program that stresses the developmental and personal mastery approach to group work has strong potential. This is supported by feedback at the end of the treatment program and by individual changes between pre and posttest scores. This evidence suggests, though not empirically verified by group analyses, that spouses of stroke patients with aphasia can benefit from such a program.

© 1979

ROGER WALTER EMERSON

ALL RIGHTS RESERVED

Changes in Depression and Self-Esteem of Spouses of Stroke Patients
With Aphasia As a Result of Group Counseling

by

Roger W. Emerson

A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Doctor of Philosophy

Completed July 1979

Commencement June 1980

APPROVED:

Signature redacted for privacy.

Professor of Counseling and Guidance
in charge of major

Signature redacted for privacy. ~

Dean of the School of Education

Signature redacted for privacy.

Dean of the Graduate School

Date thesis is presented: July 30, 1979

Typed by Lauren Kiolet for Roger Emerson

ACKNOWLEDGEMENTS

I wish to express my deepest gratitude to the many people that have helped and supported me in the pursuit of this accomplishment. I am especially grateful to Dr. Glenn Clark for his patient, firm and valuable guidance while serving as my dissertation advisor throughout my entire doctoral program. I am also extremely grateful to Tom Murphy for his insightful and supportive assistance; Dr. Phil O'Neill for his valuable expertise; and Dr. Margorie McBride for her warm encouragement throughout my doctoral studies. Appreciation is expressed to Dr. Warren Hovland and Dr. Emery Hildebrandt for their valuable and encouraging contributions as the Graduate School Representatives to my committee.

I wish to thank Dr. McKenzie Buck, Director of the Portland Center for Speech and Hearing, for his unique suggestions and personal support during the early stages of my dissertation. His commitment to helping the spouses and families of aphasics was truly an inspiration.

I am also thankful for the support of my fellow graduate students and from Jim Koval, a special friend. Also, I thank my parents, Van and Ada Emerson, for their personal interest and support throughout my graduate program.

Most important, I am indebted to my wife, Sherry, who gave the love, support, and encouragement that made the completion of this goal possible; and to my children Stephen and Michelle for their patience and understanding.

TABLE OF CONTENTS

<u>Chapter</u>	<u>Page</u>
I. INTRODUCTION	1
Context of the Problem	1
Statement of the Problem	3
Definition of Terms	4
Some Assumptions About People Related To This Study	6
Some Assumptions About Testing Instruments Related To This Study	6
II. REVIEW OF LITERATURE	7
The Role and Feelings of the Family in Aphasic Recovery	7
Group Work in Programs for Families of Aphasics	13
Group Counseling as a Modality for Treating Depression and Self-esteem	15
III. PROCEDURES AND METHODOLOGY	19
Selection and Characteristics of Spouses	19
Research Design	20
Hypotheses	24
Data Analysis	24
Independent Variables	25
A Theoretical Group Counseling Model	25
Interrelation of Concepts for the Group Program	26
Content of the Group Program	27
Testing Instruments	30
Tennessee Self Concept Scale	30
Development of P-score	30
Normative Data	31
Validity	32
Reliability	33
Conclusions	34
Depressive Adjective Checklist	34
Development of set I and II	34
Scoring and Normative Data	35
Validity of set I	36
Reliability of set I	37
Conclusions	37
IV. ANALYSIS OF DATA	39
Hypothesis Number One	39
Hypothesis Number Two	45
Feedback at End of the Program	50

<u>Chapter</u>		<u>Page</u>
V.	DISCUSSION, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	53
	Discussion	53
	Summary	63
	Conclusions	
	Results of Statistical Analysis	66
	Content Analysis of Feedback	67
	Recommendations	
	Designs, Variables, and Measurement	
	Recommendations	68
	Clinical Recommendations	70
	SELECTED BIBLIOGRAPHY	71
	APPENDICES	
	Appendix I: Conceptual Definitions of the 29 TSCS Scores	79
	Appendix II: Leadership Intervention Techniques to Facilitate the Group Process	83
	Appendix III: General Information	85
	Appendix IV: Selected Characteristics of Spouses and Aphasic Victims	86
	Appendix V: Reading Material Used with the Group Counseling Program	87
	Appendix VI: Individual Pre and Posttest Scores, Means and Change for the Depressive Adjective Checklist (A-D)	88
	Appendix VII: Individual Pre and Posttest Scores, Percentiles, and Change for the Tennessee Self-Concept Scale (P-score)	89
	Appendix VIII: Feedback	90
	Appendix IX: Dominant Feelings of Six Spouses of Aphasics	91

LIST OF FIGURES

<u>Table</u>		<u>Page</u>
1	Group research design	20
2	Characteristics of spouses in the treatment group after self-selection.	22
3	Characteristics of spouses in the control group after self-selection	22
4	Characteristics of aphasics whose spouses were in the treatment group.	23
5	Characteristics of aphasics whose spouses were in the control group.	23
6	Concept interrelation of treatment program for spouses of aphasics.	27
7	Program content for group counseling with spouses of stroke patients with aphasia.	28
8	Correlations between the total positive score and other personality measures.	32

LIST OF TABLES

<u>Table</u>		<u>Page</u>
1	Pretest means, standard deviations and differences for DACL (A-D) scores.	40
2	An analysis of variance of pretest mean scores of the DACL (A-D) for the treatment and control groups.	41
3	Analysis of covariance of posttest scores of the DACL (A-D) for the treatment and control groups.	42
4	Pre and posttest means, standard deviations, and differences for the DACL (A-D) treatment group scores.	44
5	Pre and posttest means, standard deviations, and differences of the DACL (A-D) for the control group scores.	44
6	Pretest means, percentiles, standard deviations and differences for the pretest of the TSCS P-score.	46
7	An analysis of variance of pretest group means of the TSCS P-score for the treatment and control groups.	46
8	Analysis of covariance of posttest scores of the TSCS P-scores.	47
9	Pre and posttest means, percentiles, standard deviations, and differences of the TSCS P-score for the treatment group.	48
10	Pre and posttest means, percentiles, standard deviations, and differences of the TSCS P-score for the control group.	48
11	Program feedback through open-ended sentences	50
12	Mean change for each spouse in the treatment and control groups for the DACL (A-D) scores.	55
13	Raw scores for each spouse in the treatment and control groups for the TSCS P-score.	57

<u>Table</u>		<u>Page</u>
14	Comparison of change between individual DACL (A-D) means and TSCS P-scores for the treatment group.	60
15	Comparison of change between individual DACL (A-D) means and TSCS P-scores for the control group.	60

CHANGES IN DEPRESSION AND SELF-ESTEEM OF
SPOUSES OF STROKE PATIENTS WITH APHASIA AS A
RESULT OF GROUP COUNSELING

CHAPTER I

INTRODUCTION

Aphasia is a multimodality language disturbance due to a cardiovascular accident (CVA) which causes a language disability that is characterized by various degrees of dysfunction in reading, writing, talking and listening (Keenan and Brassell, 1975). A CVA that results in aphasia can cause complex, traumatic, and conflicting experiences that bring strong pressures to personal and family relations. The result can often be depression and loss of self-esteem for the spouse as well as the stroke patient (Buck, 1957, 1963, 1964, 1968; Dahlberg and Jaffee, 1977; Farrell, 1965; Hall, 1961; Hodgins, 1971; Ritchie, 1961, 1963; Sies and Butler, 1963).

Context of the Problem

In a CVA, or stroke, a portion of the brain is deprived of its blood supply. This deprivation of blood to the brain may be caused by a ruptured vessel due to high blood pressure; a weakness in the wall of the blood vessel; a hardening of the arteries; a blood clot or "plug" made up of bacteria from a distant infection; and/or trauma due to a blow to the head, gunshot wound, or fracture.

As a result of this deprivation certain areas of the brain tissue are damaged or may even die. The location and extent of the damage can

determine, to large extent, the symptoms which will be observed. Usually only one side of the brain is affected by a stroke. The left hemisphere is the dominant hemisphere for speech and language, memory adaptive functioning, and the right side of the body; and the right hemisphere affects judgement, motivation, attention, time and space orientation and the left side of the body (Logue, 1975).

Treatment for aphasia usually involves the stimulation of specific language modalities by auditory, visual, and tactile methods; programmed instruction, and/or group therapy (Darley, 1972). Many programs focus on the patient rather than the family during rehabilitation (Buxbaum, 1967; Buck, 1968; Malone, 1969; Sarno, 1971). However, there are some published programs across the country for families and relatives of adult aphasics (Crewe, 1969; Derman and Manaster, 1967; Overs, 1967; Sarno, 1971). Involving the total family in rehabilitation is more often stressed in theory by speech pathologists and psychologists, than actually implemented (Cobb, 1971; Malone, 1969; Sarno, 1971; and Turnblom and Meyers, 1952).

Feelings of hostility, guilt, shame, impatience, annoyance, loneliness, overprotection, emptiness, and bitterness are some of the emotions expressed by families and spouses of aphasics and reported in the literature (Turnblom and Meyers, 1952; Derman and Manaster, 1967; Buck, 1968; Malone, 1969, 1970; Emerson, 1979). Stroke families often feel they are not given enough information regarding strokes and their effects (Artes, 1967; Haese, 1970; and Overs and Healy, 1971). Empirical evidence exists that indicates that the aphasic's spouse plays an important role in the recovery process. A spouse's perception of his/her spouse's aphasia (Helmick, Watamori, and Palmer, 1967); a wife's own feelings of

nurturance (Buxbaum, 1967); the success in modifying the wife's modification of verbal interaction with their aphasic husband (Goodkin, 1969); and the amount of empathy displayed by families of stroke patients toward the situation (Robertson and Suinn, 1968) all can have an effect on the aphasic's recovery. Several other studies have shown that the spouse can also contribute to the progress in language recovery of the aphasic (Darley, 1967; Harrington, 1975; Keenan and Brassell, 1975; and Flowers, Beukelman, Bottorf, and Kelley, 1979).

No clinical control group research that examines the feelings of a spouse of a stroke patient with aphasia during a group counseling treatment program has been discovered by the writer. Most treatment programs have concentrated on providing educative information and counseling for the spouse in order to help with understanding the changes that take place in the aphasic. Changes that are occurring within the spouse, such as increased depression, loss of self-esteem, guilt, resentment and loneliness are often given only "token" attention. The writer believes the spouse must learn to deal with these stresses and group counseling can be one type of modality that can help deal with these changes. Helping the spouse to understand and cope with their feelings, fears, and anxieties can play a vital role in aphasia rehabilitation.

Statement of the Problem

This research deals specifically with the effect of group counseling as a treatment for creating changes in depression and self-esteem in spouses of stroke patients with aphasia. It will indirectly examine the use of group counseling as a treatment program over a nine week period of time.

Definition of Terms

The following terms are defined from a conceptual and operational perspective. The operational definitions are the independent and dependent variables and are an extension of the conceptual definition.

Depression

Conceptually, depression is a specific alteration in mood characterized by a dejected mood; reduction in gratification; low self-evaluation; negative expectations; self-blame; indecisiveness; loss of positive motivation; withdrawal and suicidal wishes; increased dependency; and loss of appetite, sleep, and interest in sexual activity (Beck, 1967). Operationally it is defined as a psychological reaction due to a loss of something significant in one's environment that leads to a self-report or state, of how you feel now--today (exogenous reaction) (Levitt and Lubin, 1975).

Self-Concept

In a conceptual perspective the self-concept is an organization of perceptions about self that seems to the individual to be who he or she is. It is composed of thousands of perceptions varying in clarity, precision, and importance in the person's peculiar economy. Taken altogether, this organization is the self-concept (Combs, Aliva, and Purkey, 1977). For operational purposes the self-concept is defined as the 29 scores on the Tennessee Self-Concept Scale (Fitts, 1965). See Appendix I for a description of these scores.

Self-Esteem

Conceptually, self-esteem is one dimension of the self-concept. It is the evaluative aspect of all self attitudes and is either an attitude

of approval and/or disapproval that an individual makes in regard to themselves. Operationally it is the P-score on the Tennessee Self-Concept Scale (Fitts, 1965). People with high scores will tend to like themselves and those with low scores will reflect unhappiness and doubtfulness about their own self-worth. See Appendix I for Fitts's description of the P-score.

Aphasia

Conceptually aphasia is a multimodality language disturbance due to brain injury that affects verbal and comprehensive skills, emotional stability and overall health (Buck, 1968). Operationally it is a language disability characterized by various degrees of dysfunction in reading, writing, talking and listening (Keenan and Brassell, 1975).

Group Counseling

In a conceptual framework group counseling is a process of using group interaction to facilitate deeper self-understanding and self-acceptance through a climate of mutual respect and acceptance so that individuals can loosen their defenses in order to explore the meaning of behavior and new ways of behaving (Mahler, 1969). Operationally it is defined as a developmental group counseling and personal mastery approach that utilizes the various counselor intervention techniques of active listening, reflection, questioning, restatement, clarifying, supporting, confronting, self-disclosure, semantic corrections, feedback, explanation, suggestion, tacting, silence, blocking, modeling, summarizing, and terminating. These techniques are described in Appendix II.

Some Assumptions About People Related To This Study

The writer believes that people have psychological needs; self-esteem is a component of self-concept; perception is effected by a person's self-concept; and that individuals have the ability to choose one's thoughts, change them, and thus change one's feelings. These beliefs are consistent with a humanistic existentialist view of people and are necessary in order to be effective in operationalizing the concepts just defined.

Some Assumptions About Testing Instruments Related To This Study

The writer assumes that the measurement instruments will sufficiently measure what they are designed to measure; that there is equal distance between choices on the 5-point Likert scale as used in the TSCS; and that there is equal intensity among adjectives on the Depressive Adjective Check List. Also, it will be assumed that the people involved in group counseling come from a population which is normally distributed and is representative of spouses of stroke patients with aphasia only within the Thurston and Pierce counties in the state of Washington.

CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature was concerned with the role and feelings of the family and spouse in aphasic recovery; the role of group work in programs for families of aphasics; and group counseling as a modality in the treatment of depression and self-esteem.

The Role and Feelings of the Family and Spouse in Aphasic Recovery

As early as 1951, Wepman indicated that the family occupied an important role in the language therapy of aphasia. Turnblom and Meyers (1952) claim that the effect of family attitudes on the patient is a key to successful rehabilitation. Biorn-Hansen (1957) observed that the progress in a patient's speech therapy was related to the relief of internal and external pressures and that the family's response was a major factor in the type of emotional response on part of the patient. According to Boone (1967), "there is not a more useful device for understanding aphasia and the patient than family group therapy as part of the total aphasia rehabilitation program" (p. 414).

Buck (1968) described aphasia as a "family illness." He states that there "are real problems which must be faced and talked through but which cannot be talked away" (p. 153). Malone (1969) agreed when he stated:

The family cannot function as positive members of the 'rehabilitation team' until they have been educated to the many and varied problems associated with aphasia and given some help in coping with these problems (p. 510).

The social environment of the patient and his family cannot be ignored. It is a valid concept and necessitates that a counseling program for families become an integral part of the patient's therapy (Malone, 1970). Schuell, Jenkins, and Jiménez-Pabón (1964) advocated "that not to provide such help is to jeopardize all that the best rehabilitation clinics can accomplish" (p. 382).

Feelings and attitudes expressed by families and spouses of aphasics give further support to the need that counseling services should be made available to the spouse and family.

Turnblom and Meyers (1952), when discussing family reactions to aphasia, reported that pity, hostility, shame and guilt were common feelings expressed by families. They described the stroke patient's family as living in an atmosphere of "anxiety and uncertainty."

Derman and Manaster (1967) described extreme frustration as being the most common feeling among relatives of aphasic patients. They observed that family members were not alone in their feelings of guilt, anxiety, frustration, and anger. Bardach (1969) felt that after wives of aphasic patients in their fifties and sixties participated in large group discussions they began to "feel that despite their husband's disabilities, they too were entitled to have and to express feelings of impatience and annoyance" (p. 363).

Malone (1969) had interviews with 25 persons representing the families of 20 persons with aphasia: 12 females, 4 males, and 9 relatives.

They all expressed that role change was the hardest thing to deal with and that it was reacted to in one of two ways: 1: they will fear the new responsibilities or 2: they will enjoy the new authority. Increased feelings of irritability, guilt, social isolation, an altered social life and excessive apprehension dominated the feelings of these family members.

In another study by Malone (1970) he interviewed 30 spouses of aphasics, 10 male and 20 female. Their mean age was 48 years and 100% of the spouses reported feelings of guilt, unrealistic attitudes, rejection, and overprotection. Ninety percent of the subjects agreed with statements indicating a tendency to withdraw from social situations as compared to 33% who indicated that there were certain social activities in which they participated more often.

In a structured group counseling program with three women whose husbands were disabled with aphasia, Emerson (1979) reported that feelings of shock, guilt, loneliness, rejection, bitterness, isolation, and emptiness were common.

Artes (1967) interviewed the wives of 65 stroke patients; Haese (1971) interviewed 20 stroke victims from metropolitan Milwaukee three years after discharge from a hospital; and Overs and Healy (1971) interviewed 88 former patients, with over half of the wives present, and all concluded that stroke families are not given enough information regarding strokes and their effects. Haese (1970) and Overs and Healy (1971) reported the majority of patients felt therapy had helped them. All three researchers reported that the support of the family and friends was a great help in the recovery from the stroke. Artes (1967) concluded that the wives of aphasic victims seemed to experience pessimism and

self-pity to a greater extent than did families of stroke patients where aphasia was not present.

Several studies specifically dealt with the role of the spouse in the rehabilitation of the aphasic patient. Buxbaum (1967) tested the hypothesis that there is a relationship between wives' degree of nurturance (need to give affection and care) and the perception of their husband's speech disabilities. Also, Buxbaum believed that wives with high nurturance would be involved with their husbands more than wives with low nurturance. The 47 middle class white females who participated in the study completed the Edwards Personality Preference Schedule, the Functional Communication Profile (FCP) and an activities questionnaire designed by the New York University Medical Center. Chi-square analysis revealed no significant differences between high-nurturant and low-nurturant groups on the fulfillment of affectional roles. However, the hypothesis that high-nurturant wives more often shared activities with their husbands than did low-nurturant wives was confirmed. "The 'satisfied wife' might feel greater motivation to 'satisfy' her husband" (p. 243). A group counseling program could help the spouses of stroke patients with aphasia to understand their reactions and consequently have less need to devalue their spouse's changed position within the family.

A study by Robertson and Suinn (1968) was concerned with the role of empathy in the recovery process of stroke patients. Twenty stroke patients, all non-aphasics, and their families provided the data by allowing admissions and discharge ratings to be released concerning daily living and mobility. This was summed and divided by the number of days the patient was in the rehabilitation program. A single score representing each patient's rate of rehabilitation was then obtained. A 30-item Q-sort

deck was constructed from the Stages of Psychological Reaction to Disability Scale. This was used to assess levels of empathy by having all patients sort the attitude statements first describing his own attitudes, then sorting them to describe the attitudes he would predict of his family member participating in the study. The family members also described their own attitudes and prediction of the patient's attitudes. The various empathy scores were correlated with the rate of rehabilitation scores. Although there was no statistical significant difference, it was concluded that "the ability of the stroke patient or his family member to predict the attitudes of the other person was significantly associated with a more rapid progress in rehabilitation" (p. 190).

Robertson and Suinn's (1968) study is the only research discovered by the writer that attempts to correlate the attitudes of family members with the stroke patient's recovery rate. It demonstrates that conditions with family members can affect the recovery rate of the stroke patient.

Goodkin (1969) used operant conditioning procedures for modifying three female spouses' verbal interactions with their husbands'. A pre and posttest design was used with no control group. Baseline rates on verbal information were obtained from the aphasic spouse. Each wife underwent a brief individual course in principles of behavior modification and after 15 training sessions, new base rates were obtained in laboratory and home settings and compared with the pretraining data. The data indicated the aphasics' increased general output of sentences and ratio of sentences to words. The wives showed increases in positive feedback and decreased additional questioning. The sample was small and the only criteria used in selecting subjects was that it had been two years since their stroke. No data were reported that attempted to determine

whether the increases were significant.

Helmick, Watamori and Palmer (1976) found that aphasics' communication efforts are not clearly understood by the spouse and that the spouse tends to view communication skills less impaired than they actually are. Six female and five male subjects with a mean age of 57, were assessed through the use of the Porch Index of Communicative Ability (PICA) for the extent of their language skills. The understanding of the aphasic's language problems was measured by rating the aphasic's spouse on the Functional Communication Profile (FCP). The Pearson product-moment correlation coefficient yielded a significant negative correlation coefficient of -0.66 ($p < .05$) which suggests that the spouses tended to assign ratings indicating good communication performance in association with poor PICA scores. The researchers conclude that:

the speech pathologist must counsel the spouse of an aphasic patient in order to increase that spouse's understanding of the aphasic's deficits (p. 241).

Feelings related to dependency, sexual disruptions, and suicidal contemplations were common among families and spouses of aphasics (Buck, 1968). Counseling the spouse and the adult aphasic for sexual adjustment received little attention in the literature. Wiig (1973) believes that references to sexual problems are hidden in the social and emotional aspects of aphasia and in descriptions of general counseling needs. Van Rosen (1963), Buck (1968), Wiig (1973) and Logue (1975) all advocate a definite need for counseling the spouse and aphasics in the area of sexual readjustment.

Spouses also contribute specifically to the progress of the aphasic's language recovery (Darley, 1967; Harrington, 1975; Keenan and Brassell, 1974; Flowers, Beukelman, Bottorf, and Kelley (1979).

In summary, there is strong support for a treatment program that recognizes the psychological adjustments that are being experienced by spouses of stroke patients with aphasia. This writer believes spouses of aphasics often need a professional mental health counselor to help them deal with changes in depression and self-esteem. The acceptance and reduction of guilt, depression, rejection, and overprotection will increase the spouses' morale and self-esteem and help them deal with their situation.

Group Work in Programs for Families of Aphasics

The programs discussed were selected on the basis of being available in the literature. They cover a wide scope of programs offered for spouses and families of stroke patients with aphasia.

A group discussion program for the relatives of aphasic patients was used at the Institute of Physical Medicine and Rehabilitation in New York (Turnblom and Meyers, 1952). This program attempted to help families with emotional adjustments that existed with the family because of a spouse disabled with aphasia. They outlined their program to include an atmosphere for ventilation, reassurance, education and orientation, alleviation of guilt, sharing responsibility, and adapting a constructive outlook. This program has been continued by Sarno (1968) and was reported by Bardach (1969). Holding large group sessions with wives of aphasics was a regular part of the program. They use a large group format in exchanging information, discussing emotional status of the husband, and the spouses' own feelings. It was Bardach's (1969) opinion that over fifteen years of working with groups of spouses of aphasic patients, she was convinced that "rehabilitation centers should broaden their services to include families to a much greater extent than they do now" (p. 365). However, this writer

found no empirical evidence given by Bardach (1969) to support this observation.

The Schwab Rehabilitation Center in Chicago reported in 1967 (Derman and Manaster, 1967) that their group counseling program covers three distinct areas for the spouse and/or family. The program emphasis is on family problems, patient and information and knowledge for the clinicians and hospital patients. Family needs seem to fall into a need for factual information, a need for reassurance, and for ventilation of frustration and guilt. It is concluded that much can be gained through initiating a group counseling program for relatives of the hospital's aphasic patient.

Overs and Belknap (1967) described a medical and para-medical team that worked with the family on problems as they unfold. The two major thrusts of their program were centered around dealing with anxiety reduction, coping with emotional feelings, and teaching the family detailed information about aphasia. Other programs provided a similar educative group session approach (Crewe, 1969; Olsen and May, 1966; Oradei and Waite, 1975; Rolnick, 1969; and Overs and Healy, 1971).

In summary, group counseling programs for families of stroke patients with aphasia have usually placed special emphasis on information sharing, coping strategies, self-help care and future planning. The spouse's feelings of guilt, resentment, fear, loneliness, rejection, bitterness and emptiness need to be dealt with in an accepting atmosphere that not only allows for ventilation but exploration and confrontation of feelings. This writer believes that most programs do not provide, after the first few weeks of hospitalization of the stroke victims, psychological services that give the spouse the opportunity for exploration and confrontation of their feelings. Information is important but the spouse's feelings and

needs should not be overlooked on a short or long term basis. Group counseling is an effective modality for dealing with these feelings and needs.

Group Counseling as a Modality for Treating
Depression and Self-Esteem

Group counseling can be a powerful therapeutic modality. Besides the need of helping many more people at one time, group counseling/therapy can help group members achieve a sense of cohesiveness more quickly, give immediate support to group members, help resolve conflicts, and provide more rapid symptomatic relief (Yalom, 1970; 1975). Yalom (1975) described the value and uniqueness of group counseling as:

1. Imparting of information.
2. Installation of hope.
3. Universality of experience.
4. Altruism.
5. Corrective recapitulation of the primary family group.
6. Development of socializing techniques.
7. Imitative behavior.
8. The corrective emotional experience.
9. The group as a social microcosm.

Ohlsen (1970) believes that commitment, expectations, responsibility, acceptance, attractiveness, security, and tension release are therapeutic factors that exist within a group counseling modality.

Seligman (1977) advocated the use of group counseling with homogenous groups. He stated that for those looking for:

"security, warmth, 'esprit de corps,' spirit of community, and symptomatic relief characteristic of individuals with similar concerns, the homogenous group experience, although presumably not overly intense and not designed for personality restructuring, is of sufficient therapeutic value to warrant consideration as a valuable therapeutic tool for the clinician" (p. 6).

Gazda, Duncan, and Meadows (1967) cited group counseling as facilitating the effective use of peer pressure; making some individuals more amiable to individual counseling; and providing an opportunity for each individual to test reality. Other advantages to group counseling, as reported in the literature and summarized by Gazda (1974) were: 1) that clients discover they are not alone or unique with their problems, 2) they have the opportunity to learn from each other by observing how others solve problems; and 3) they learn to give as well as receive help in the role of co-counselor. Consensual validation, according to Mayadas and O'Brien (1973), "Stands out as perhaps the single most potent variable in mirroring members' behaviors" (p. 108). Individuals will find it difficult to deny particular patterns of behavior if there is consensus within the group regarding that behavior (Asch, 1956). However, these conclusions lacked experimental validation and are supported only by agreement among experts.

Several studies concluded that group counseling helps depressed clients. Miller and Ferone (1966) felt that group therapy allows people to experience the other side of important relations. This was concluded after working with depressed women in an out-patient treatment program. A behavior therapy program for depression based on self-control was conducted against a nonspecific control group. Fuchs and Rehm (1977) found that self-control therapy subjects showed significantly greater reduction in depression on self-report and behavior measures than did the control group.

Snow and Held (1973) advocated group therapy when treating obese adolescent females who complained of depression. They concluded that group therapy promotes "more adequate and independent functioning," and helps in establishing healthier, more satisfying relationships. Levine (1969) identified three stages of group movement in working with depressed agency clients and reported that by using a group treatment approach, clients are less manipulative and less dependent on the counselor.

McLean, Ogston, and Grauer (1973) used a group design for the behavioral treatment of depression. They compared a behavioral treatment with non-specific "contemporary treatments" and found that the behavioral treatment was significantly superior on all measures. The behavioral treatment group showed decreased negative interactions, fewer depressive symptoms, and lower Depressive Adjective Checklist scores. The differences were consistent at 4 weeks, 8 weeks (end of treatment), and at a three month follow up.

Straub (1976) treated 16 persons clinically diagnosed as depressed, by randomly assigning them to a treatment or control group. A t-test was used to analyze the pretest and posttest data. The Mann-Whitney U and the Sign test were used and the results supported the hypothesis that members of the depression group scored significantly less depression on the Beck Depression Inventory and Behavior Change Self-Rating Inventory.

An unpublished dissertation by Street (1976) found that 48 subjects who attended a self-esteem building workshop and 52 subjects who did not attend, showed significant differences in their self-esteem scores as reported by the Tennessee Self-Concept Scale, which is a measure of self-esteem. Other tests were used to assess other variables. Significant correlations were found between self-esteem and dependency (+.78) and

self-esteem and depression (+.69) and dependency and depression (.81).

No significant changes were found in the dependent variables as a result of the workshop experience when compared to the control group.

CHAPTER III

PROCEDURES AND METHODOLOGY

Selection and Characteristics of Spouses

Twelve spouses of stroke patients with aphasia were solicited from the Olympia Speech and Hearing Clinic; Thurston County Sound Home Health Agency; Veteran's Administration Hospitals in Tacoma and Puyallup; Pierce County Stroke Club; Adult Day Services of Olympia; Senior Citizens Center of Olympia; and the local community and private counseling centers. These agencies were contacted by mail and telephone seeking spouses of stroke patients who met the following criteria:

1. Their spouse must be aphasic and have suffered a stroke within the last 2 years.
2. Be 45-75 years of age.
3. Not be under the active care of a psychiatrist, psychologist or mental health counselor during the treatment program.

Upon receiving the name of a possible participant, a letter describing the program was sent and then followed up with a phone call two or three days later that explained the purposes of the research, design, and meeting time. A commitment to the treatment or control group was obtained at this time. Eight out of nine people agreed to participate. Three more subjects agreed to participate after the program was described at a Pierce County Stroke Club meeting in Tacoma.

These eleven spouses, eight female and three male, had a mean age of 61.5 years, with a range of 46 to 73 years of age. Only one spouse of the

eleven spouses had children at home and the average years of education was 12.5. The eleven spouses were asked during the pretesting session to rate their spouses' degree of language difficulty, using the scale shown in number 9 of the general information sheet (Appendix III). This resulted in a mean of 3.5, with a majority of responses being in the profound to severe range.

The eight male and three female aphasic victims whose spouses were in the treatment and control groups, had a mean age of 65 years with a range from 49 to 75 years of age. The time since their last stroke ranged from 1 to 21 months, with a mean of 11 months. Four out of the eleven were confined to a wheel chair. These selected characteristics for the spouses and aphasic victims are shown in Appendix IV.

Research Design

A compromise treatment-control group design was used which allowed the spouses to volunteer for the treatment or control group (Kerlinger, 1973). The volunteer distribution and the design matrix is shown in Figure 1.

Figure 1: Group research design

Spouses of Stroke Patients with Aphasia	Depression and Self-esteem Measures	
	Pretest	Posttest
Treatment Group	n=6	Treatment 9 wks. n=6
Control Group	n=5	n=5

After self-selection, the four women and two men in the treatment group had: 1) a mean age of 58; 2) a mean of 3.17 for perception of

their spouses' language difficulty; 3) 12.4 years of education; and 4) only one spouse had any children at home (Figure 2). The four women and one man in the control group had: 1) a mean age of 65; 2) no children at home; 3) a mean of 4.0 for perception of their spouses' language difficulty; and 4) 12.1 years of education (Figure 3). The characteristics of aphasics whose spouses were in the treatment and control groups are shown in Figures 4 and 5.

Further comparisons between the treatment and control groups were made by using an analysis of variance to determine whether there was any statistical difference in depression and self-esteem between the mean pretest scores on the pretest for Forms A, B, C, D, of the Depressive Adjective Checklist (DACL) and the P-score of the Tennessee Self-Concept Scale (TSCS).

Administration of the pretest and posttest to the treatment group was conducted during the first and last session of the treatment program. Each person was given a packet of materials that included the purposes of the research, permission to video tape, a general information sheet, Forms A, B, C, D of the DACL and a test booklet and answer sheet to the TSCS (clinical and research form). The posttest packet consisted of the DACL and the TSCS materials.

The administration of the pretest and posttest to the control group was conducted through the mail. They received the packet of materials, with a self-addressed return envelope, and a request to return the material within one week.

Figure 2: Characteristics of spouses in the treatment group after self-selection

Age	Sex	Children Home	Perceived Lang. Difficulty of their spouse	Yrs. of Educ.
63	M	0	Severe(3)	12
49	F	1	Moderate(6)	16
63	F	0	Profound(2)	12
73	F	0	Profound(1)	12
54	M	0	Profound(1)	12
46	F	0	Moderate(6)	12
Mean Age: 58			Mean Lang. Diff.: 3.17	

Figure 3: Characteristics of spouses in the control group after self-selection

Age	Sex	Children Home	Perceived Lang. Difficulty of their spouse	Yrs. of Educ.
73	F	0	Severe(3)	12
53	F	0	Mild(9)	14
72	F	0	Moderate(5)	12
53	F	0	Profound(1)	12
72	M	0	Profound(2)	12
Mean Age: 65			Mean Lang. Diff.: 4.0	

Figure 4: Characteristics of aphasics whose spouses were in the treatment group

Age	Sex	Post CVA (Mo.'s)	Confined To A Wheel Chair
74	F	1*	No
51	M	21	No
72	M	9	No
75	M	11	Yes
55	F	10	No
49	M	12	No
Mean: 63		10.6	
*Last of three strokes in last two years.			

Figure 5: Characteristics of aphasics whose spouses were in the control group

Age	Sex	Post CVA (Mo.'s)	Confined To A Wheel Chair
73	M	16	Yes
58	M	10	No
72	M	4	No
53	M	13	Yes
72	F	14	Yes
Mean: 67		11.4	

Hypotheses

This research has conceptually dealt with changes in self-reported feelings of self-esteem and depression in spouses who receive group counseling to those who do not receive group counseling. Operationally this research was concerned with the changes in posttest DACL (A-D) scores and TSCS P-scores between the treatment and control groups. The statistical hypotheses were stated in a null form. Each major hypothesis will be in a general form and followed by an operational hypothesis.

Hypothesis 1: There is no significant change in self-reported feelings of depression for spouses who receive group counseling to those who do not receive group counseling.

H_{1.1}: There will be no significant changes between the treatment and control groups on posttest Depression Adjective Checklist (A-D) scores.

Hypothesis 2: There is no significant change in self-reported feelings of self-esteem for spouses who receive group counseling to those who do not receive group counseling.

H_{2.1}: There will be no significant changes between the treatment and control groups on posttest Tennessee Self-Concept P-scores.

Data Analysis

Parametric statistics were used for this research. They are the most powerful statistics in rejecting the null hypothesis and will allow for the comparison of data with existing literature related to this study. The data gathered was from standardized testing instruments that provided interval level data in measuring depression and self-esteem; and from written feedback from the spouses in the treatment group (Appendix III). Both perspectives provided the framework for the analysis and discussion of the data.

An analysis of variance was used to determine whether significant differences existed in the pretest scores between the treatment and

control groups. A one-way analysis of covariance, using the F statistic, has been used in order to control for the effects of the pretest on the posttest scores; and because of the unequal cell size between the treatment and control groups. The analysis of covariance combines the concepts of analysis of variance and regression to handle situations where this researcher could not completely control all the variables. The results should not be generalized beyond an aphasic population with the described variables.

Independent Variables

A Theoretical Group Counseling Model

A group counseling model based upon developmental stages of group growth was incorporated with a personal mastery (PM) approach to group work. The developmental stages were exploratory, transition, work, and termination (Mahler, 1969; Bonney and Foley, 1969; and Gazda, 1978). The amount, kind, and timing of counselor intervention in these stages was related to the degree of individual and group development. Counselor intervention techniques were designed to facilitate group growth and are reviewed in Appendix II.

Vriend (1978) used Mazlow's essay, "The Characteristics of Self-Actualized Persons" (Mazlow, 1954) as the "rock-bed on which personal mastery counseling is built" (p. 104). Kottler (1978) summarized the PM approach as a "truly integrative and pragmatic approach." (p. 120).

He stated that

It goes beyond a mere eclectic model, which borrows the best from all theories and adds a unifying thread throughout: PM counselors behave in their groups as they would wish all their clients to act in their worlds. Capitalizing on imitative

learning reinforcement processes, an enriched helping atmosphere, and a wide variety of counseling methods, the practitioners can individually design an approach to fit the unique requirements of their personalities, goals, interests, and client needs (p. 120).

Ellis (1978) outlined several superiorities that the personal mastery approach has over other group counseling systems:

- 1) It is clearly cognitive-emotive-behavioral, rather than primarily cognitive or emotive or behavioral.
- 2) it focuses on individual change rather than group process in its own right.
- 3) It stresses responsibility of a group leader.
- 4) It emphasizes quick client change.
- 5) It is rooted in humanistic-existentialist concepts and stresses unconditional acceptance and nondamning of all humans, no matter how self-defeating or antisocial their behaviors may be.
- 6) It encourages individualism and self-determinism.
- 7) It underscores the importance of a group leader's being artistic, charismatic, and scientific.
- 8) It is highly active-directive rather than ineffectively passive or discursive.
- 9) It is specifically homework oriented.
- 10) It is psychoeducational and unashamedly employs many instructional and cognitive methods of psychological treatment.
- 11) It makes good use of pacing and of methodological variety, including the effective use of humor.
- 12) It arranges group processes so that they will best help individuals to achieve personal growth and effectiveness outside the group itself (p. 160-161).

Interrelation of Concepts for the Group Program

The treatment program was 1 1/2 - 2 hours per session for nine continuous sessions. The content of each session varied depending upon the stage of group and individual development. The program was eclectic and based

on ideas and concepts from other programs described in the review of literature, the writer's own past experiences from working with spouses of stroke patients with aphasia, (Emerson, 1979) and consultation with other professionals (see Acknowledgements).

The program content was consistent with the cognitive-emotional-behavioral themes advocated in a personal mastery approach which paralleled the emotional movement and stages of group development. Figure 6 demonstrates the interrelation of these concepts.

Figure 6: Concept interrelation of treatment program for spouses of aphasics

Stages of Group Development:	Exploratory - Transition - Work - Termination			
Sessions of Counseling Program:	1-2	2-5	5-7	8-9
Emotional Movement Of the Group:	Downward and Inward		Upward and Outward	
Personal Mastery Approach:	Cognitive - Emotional - Behavioral			

Content of the Group Program

Figure 7 offers a detailed outline of the program that was used for group counseling with spouses of stroke patients with aphasia. Appendix V describes the reading material that was provided during the treatment program.

Figure 7: Program content for group counseling with spouses of stroke patients with aphasia

Session	General Content
1	Introductions: described their past, present, and future.
2-4	<p>Established an atmosphere of sharing by describing: "One week in the life of a spouse of a stroke patient with aphasia."</p> <ul style="list-style-type: none"> -allowed for ventilation -offered reassurance -found they weren't alone <p>Encouraged the expression of guilt, loneliness, rejection, bitterness, and isolation. Acceptance and the need for expression of these feelings was stressed. Emphasis was on:</p> <ul style="list-style-type: none"> -a realistic expectation of attitudes (Boles, 1959) -feelings are natural -self must be just as important as their spouse
5	<p>Explored: "What keeps you going?" and "How do you cope?"</p> <p>Discussed handouts: B. Horwitz's article, "An Open Letter to the Family of an Adult Aphasic," and M. Buck's book, <u>Dysphasia</u>, the sections on suicidal contemplations and sexual disruptions (p. 50-57).</p> <p>Encouraged expression of need for physical and psychological affection.</p>
6	<p>Reviewed everyone's week.</p> <p>Discussed sexual adjustments, changes in mood, feelings of failure, fear of the unknown, loneliness, impatience, responsibility for spouse's moods, and "super-spouse" syndrome.</p>

Viewed the video tape: "Post discussion with spouses of aphasics" (produced by the writer while at Oregon State University).

7 Reviewed everyone's week.

Continued discussion of video tape and feelings mentioned in the previous sessions.

Discussed handouts: M. Buck's book, Dysphasia, the sections dealing with levels of aspiration and dependency (pp. 147-153).

Discussed financial, medical and legal needs.

8 Viewed and discussed film: Living with Aphasia.

Continued discussion of their spouses' conditions and how they perceived their situation.

Discussed handout: M. Skelly, Aphasia Patients Talk Back.

9 Summarized feelings in relation to being a spouse of a stroke victim who has aphasia. From a large list, each person identified all the feelings they could and then five main feelings were pinpointed. They discussed how they would deal with these feelings in the future.

Played back and discussed video tape of this session.

Farewells and feedback.

Other pamphlets and handouts were made available (Appendix V).

Posttest data gathered.

It must be remembered that the spouses themselves provided the basis for the program. The writer provided the opportunity and structure, through media and counseling techniques, for each spouse to share their personal feelings with other people who have experienced similar but different situations.

Testing Instruments

Tennessee Self-Concept Scale (TSCS)

William H. Fitts began developing the scale in 1955 and by 1965 he felt that he had a highly applicable, well standardized and multi-dimensional scale (Fitts, 1965). The scale consists of 100 self-descriptive statements which the subjects use to portray himself/herself. The statements were classified by seven clinical psychologists into 15 categories with perfect agreement. The items fell into one of 5 general categories: physical self, moral and ethical self, personal self, family self, and social self. Each of these areas was in turn divided into statements of self-identity, self-acceptance, and behavior. Besides these 10 statements, which are evenly balanced for positivity and negativity, there are also 10 items from the Minnesota Multiple Personality Inventory (MMPI).

There are two forms to the TSCS: the counseling form and the clinical and research form (C & R). The C and R form was used in this research because interpretation back to the client was not appropriate (Fitts, 1965). The P-score on the TSCS was the only subscore used for this research.

Development of the P-score

Three primary messages are present in the original 100 statements. They are: Row 1: "What He Is;" Row 2: "How He Accepts Himself;" and Row 3: "How He Acts." The Row scores thus comprise three subscores which, when added, result in the Total Positive or Total P-score (Fitts, 1965).

These row scores vary considerably within themselves. This created new categories which are the five Column Scores on the score sheet:

physical, moral, personal, family, and social self. Thus the entire set of items is divided two ways, vertically into five columns and horizontally into three rows.

The Total P-score reflects the overall level of self-esteem of a person. According to Fitts (1965):

Persons with high scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves (p. 2).

The P-score, or self-esteem score, is only one aspect of the self-concept profile. A complete self-concept profile that describes all 29 scores on the TSCS is described in Appendix I.

Normative Data

The normative data for the P-score (Total Postive) for both forms is reported by Fitts (1965) to be a mean of 345.57 with a standard deviation of 30.70. A reliability coefficient of .92 is given in the manual and based on a test-retest with 60 college students over a two-week period.

The normative data for all major scores were based on a sample of 626 people which included people from all parts of the country; age ranges from 12 to 68 and approximately equal numbers of both sexes, blacks and whites and social and economic backgrounds.

A P-score range of 315 to 421 is given on the profile sheet to indicate a normative range for the Total Postive score. Fitts (1965) reports that when a Total P is above the 95th percentile it indicates that the client reports a very positive view of his/her self.

Validity

As shown in Figure 8 and reported in Fitts (1965), the results are contradictory when the P-score is correlated with other measures of self-regard.

Figure 8: Correlations between total positive score and other personality measures

Other Measures of Self-regard	Total P-score
Taylor Manifest Anxiety Scale	-.70
Cornell Medical Index	-.56
Inventory of Feelings	+.64
California F-scale	-.21
Minnesota Teacher Attitude Inventory	-.53
Izard's Self Rating Positive Affect Scale	+.68
Incomplete Sentence Blank	+.58
Butler Haigh Q-sort (Leake, 1970)	-.61

The correlations with the selected sub-tests on the MMPI and the TSCS (P-score) are: -.52 for depression; -.58 for schizophrenia; and -.64 for social introversion. The P-score correlations with parts of the Edwards Personal Preference Schedule are: achievement -.43; nurturance +.25; and aggression -.22 (Fitts, 1965).

In discriminate validity, Wylie (1974) criticized the TSCS for its lack of non-independence between the subscores. Many subscores overlap and this can lead to overinterpretation of the profiles. Evidence suggests

that all subscores are not necessary (Gable, LaSalle, and Cook, 1973).

Wylie (1974) stated that:

Suggestive negative evidence comes from Vicchiano and Strauss's (1968) factor analysis of 10 self and 10 lie items which yielded 20 factors. These did not correspond to the three row and five column scale. Only 75 of the 90 self-regard items contributed at all to factor formation (p. 233).

In studies based on assumed validity, Fitts (1965), cited 5 unpublished studies that have found differences between self-regard scores of patients and normals (Congdon, 1958; Fitts, 1965; Piety, 1958; Havener, 1961; Wayne, 1963). Lower self-regard scores have been reported, when compared to normals, by alcoholics (Vanderpool, 1969; Gross and Adler, 1970); delinquents (Atchison, 1958; and Lefebber, 1964); lower reading and math achievers (Williams and Cole, 1968).

However, Wylie (1974) offered evidence contradictory to the above by reporting that:

Havener and Izard (1962) predicted and found that paranoid schizophrenic subjects Self-Acceptance scores (Row 1 minus Row 2) were significantly more favorable than normal control subjects (p. 233).

Wylie (1974) accounted for these positive results by the concept of "random responding as a determinant of low self-regard scores" (p. 234).

Reliability

Test-retest reliability of the total positive score for 60 college students over two weeks was +.92, with test-retest reliability of various subscores ranging from +.70 to +.90 (Fitts, 1965).

Data on internal consistency was not reported. Known group reliability estimates for delinquents, neuropsychiatric patients, and school aged children were not available.

Conclusions

For the purposes of this research the TSCS is very appropriate because it offers a total self-esteem score, a wide range profile of self-regard, strong standardization and norm group data, and a popularity among social science researchers. New information is constantly being accumulated about the scale. Robinson and Shaver (1976) rank the TSCS and the Piers-Harris scales as the best scales available for overall quality when testing for changes in self-concept.

The TSCS is lacking known-group reliability data, poor discriminate validity, reading level information, and norms that deal only with ages between 12 and 68. Wylie (1974), the scale's strongest critic, believes that the test has been over used and misinterpreted, especially when dealing with the independence between subscores.

Depressive Adjective Checklist (DACL)

The DACL is an empirically derived test that began with using 171 adjectives that appeared to represent depression or its absence (Lubin, 1967). There are seven forms (A-G) that are divided into set I (A-D) and set II (E-G). The item pool was submitted to two item analyses.

Development of set I and II. The first item analysis involved 48 female psychiatric patients who had been rated as either "moderate" or "severely" depressed on a four-part scale after interview and to 179 normal females. The results yielded 120 adjectives which significantly differentiated the 2 criterion groups. These differentiating adjectives, balanced for discriminating power and equal number and placement of positive (checked more frequently by depressed group) and negative (checked more frequently by normals) adjectives, made up form A-D. Consequently, each list in

set I contained 22 positive and 10 negative adjectives. Forms A-D also made possible the computation of split-half reliabilities, for each list was divided into 2 sets of items, each contained 11 positive and 5 negative adjectives.

A second item-analysis was conducted which resulted in the construction of set II. This involved 47 male psychiatric patients as "marked" or "severely" depressed after interview and 100 normals. Of the 102 adjectives that were statistically found to discriminate these two criterion groups, 72 were positive adjectives and 36 were negative. The differentiating adjectives separated the groups at the 1% level. These 102 adjectives were assigned to three lists (E, F, G) consisting of 34 adjectives each. Each list has 22 positive and 12 negative adjectives.

The norm group was 95 neuropsychiatric patients who had been rated as either "moderate" or "severely" depressed and 279 normals which had been matched on the basis of age and education (Lubin, 1967). Both females (591) and males (265); senior citizens (61); and adolescent delinquents (78) served as normals. Psychiatric patient samples consisted of 31 depressed and 48 non-depressed males; and 136 depressed and 119 non-depressed females.

Scoring and Normative Data. The DACL produces interval level data. The score for each list consists of the total number of positive (+) adjectives checked and minus (o) adjectives not checked. Low scores indicate less depression and the raw scores range from 0 to 32. Lubin (1967) offers the following means and standard deviation for non-psychiatric patient samples for forms A, B, C, and D of the DACL:

Means and Standard Deviations for Non-Psychiatric Patient Samples (p.6)

Sample	Sex	FORM				
			A	B	C	D
High-school, College, and Graduate School Students	M	N	265	265	265	265
		Mean	8.53	8.02	8.63	8.71
		S.D.	4.91	5.10	4.77	4.97
	F	N	591	591	591	591
		Mean	7.78	7.32	7.87	7.82
		S.D.	5.39	5.48	5.33	4.96
Senior Citizens	F	N	61	61	60	61
		Mean	6.21	6.34	7.07	7.08
		S.D.	3.94	3.24	3.42	3.72
Adolescent Delinquents	F	N	78	78	78	78
		Mean	12.38	11.94	12.69	13.33
		S.D.	7.74	7.25	6.59	7.86

Validity for set I. The manual gives consistent correlations between set I of the DACL and the Beck Inventory of Depression (Form A: +.38; B: +.47; C: +.50; D: +.49); Zung's Self-Rating Depression Scale (Form A: +.27; B: +.38; C: +.32; D: +.34); and Global Rating of Depression (Form A: +.36; B: +.38; C: +.35; D: +.32). All correlations except between list A and the Zung Depression Scale are significant at or beyond the .05 level of significance (Lubin, 1967).

Lubin (1967) reported strong correlations between set I of the DACL and the Multiple Affect Adjective Check List (MAACL): A: +.80; B: +.85; C: +.76; D: +.78. Mildly strong correlations were given for set I with the MMPI-Depression Scale: A: +.47; B: +.32; C: +.42; D: +.37 (Lubin, 1967).

In studies based on assumed validity, depressed patients obtained significantly higher scores on the DACL than do other psychiatric disorders (Lubin, 1967). Fogel, Curtos, and Kordasz (1966) reported a correlation of $+0.79$ between the ratings of a psychiatrist and the DACL scores: a $+0.59$ between the pooled ratings of 2 psychiatrists and DACL scores and a $+0.95$ between the patients self-rating and DACL scores.

Reliability for set I. The internal consistency of the DACL (Set I) was computed from a two-way analysis of variance. 156 female subjects provided the following correlations of reliability: A: $+0.86$; B: $+0.87$; C: $+0.88$; D: $+0.85$; and 105 male subjects produced: A: $+0.81$; B: $+0.81$; C: $+0.88$; D: $+0.81$ (Lubin, 1967). The effect of the order of taking the forms in set I was found insignificant (Lubin, 1967).

Split-half reliabilities for each form in set I had a combined coefficient of $+0.92$. Lubin (1967) summarizes:

Overall, the reliabilities ranges between $+0.82$ and $+0.93$ for normals, and between $+0.86$ and $+0.93$ for patients. For the normal groups there is a consistent tendency for reliabilities to be higher for the sex on which the original item-analysis was conducted, e.g. 11 females are higher on E, F, and G. The same tendency can be seen in the patient group for lists A, B, C, and D, but there is a reversal of the trend for lists E, F, and G. For the patient groups, females have higher reliabilities on all lists (p. 5).

Conclusions The forms A-D in set I were selected for use in this research for a variety of reasons. First, the item analysis and norming data of these forms have made extensive use of female subjects. The majority of the spouses of stroke patients with aphasia are females. However, the norming data does seem to ignore the middle age years.

Second, the statistical procedures are sound and the majority of correlations reported for internal consistency, intercorrelations, cross

validations, correlations with other clinical depression scales, and split-half coefficients, are strong and significant at either .01 or .05.

Third, Bernard Lubin is constantly gathering data and cites over 50 references where the DACL has been used in clinical research (Lubin, 1977). Form E of the DACL has been used in a national survey to sample the proneness of depression in the general population (Levitt and Lubin, 1975). The DACL is receiving national use for research into depression as well as clinical uses.

Overall, the DACL was summarized by Goodstein (1972):

It should be clear that the DACL has been successful in meeting the author's intention of providing a brief, reliable, and valid self-report measure of depression...the DACL is the most psychometrically sound of the several brief, self-report measures of depression now available...(p. 65).

CHAPTER IV

ANALYSIS OF DATA

The primary purpose of this research was to compare posttest scores for changes in depression and self-esteem in spouses of stroke patients with aphasia who received group counseling with those who did not receive group counseling. In researching this purpose, the data gathered was from two types: 1) standardized testing instruments for measuring depression and self-esteem; and 2) written feedback at the end of the treatment program from spouses in the treatment group. Both perspectives will provide the framework for the analysis and discussion of the data.

An analysis of variance was used to determine whether significant differences existed in the pretest scores between the two groups and the analysis of covariance was used to test the two null hypotheses. The .05 level of confidence was selected as the acceptable level of significance. Analyses were computed by the Oregon State University Computer Center.

Hypothesis Number One

There is no significant difference in self-reported feelings of depression for spouses of aphasics who received group counseling to those who did not receive group counseling.

Analysis of hypothesis 1.1:

There will be no significant change between the treatment and control groups on posttest Depression Adjective Checklist scores, using forms A-D.

Table 1. Pretest means, standard deviations and differences for the DACL (A-D) scores

Form	<u>Treatment</u>		<u>Control</u>		<u>Difference*</u>	
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.
A	10.66	4.58	8.0	4.74	+2.66	.16
B	9.83	5.23	5.0	5.14	+4.83	.09
C	10.83	4.87	7.4	4.82	+3.43	.05
D	11.16	5.63	6.8	4.43	+4.36	1.2
Total \bar{X} :	10.63	5.8	6.8	4.78	+3.82	1.18

*Low scores indicate less depression
 DACL norms: (see page 36)

Table 1 shows the pretest means, standard deviations, and differences between the treatment and control groups for the DACL (A-D). The total mean for all the forms between the two groups ranges from 10.63 for the treatment group to 6.8 for the control group, for a total mean difference of 3.82. A difference exists between all the treatment and control group means, ranging from 4.83 (form B) to 2.66 (form A). The differences in the group means indicated a lower amount of depression in the control group than in the treatment group on all four forms of the DACL. This raises the question of equivalence of the groups on this dependent variable and necessitates additional analysis. The question of equivalence was addressed statistically by employing the analysis of variance to all pretest scores. The results of this analysis is presented in Table 2.

Table 2. An analysis of variance of pretest mean scores of the DACL (A-D) for the treatment and control groups

Sources of variation	df	SS	MS	F
Between groups (G)	1	189.225	189.225	2.046
Error (st/G)	9	832.075	92.452	---
Between forms (F)	3	23.944	7.981	3.764*
Interaction (GxF)	3	7.875	2.625	1.269
Error (FxST/G)	27	55.83	2.067	---

Tabular F (1,9) = 5.12, (3, 27) = 2.96, $p < .05$

*significant difference

The non-significant F-value ($F=2.046$) for the between groups comparison indicates that when compared on the overall average of the four forms, the groups score essentially the same. However, the between groups comparison does yield a significant F-value ($F=3.764$) suggesting that in some manner the various forms of the test do not yield consistent assessments of depression for the groups. This may be reflecting non-equality of the four forms in assessing this variable. At any rate, the differences do suggest that additional caution be applied in any comparison of posttest scores.

Since analysis of posttest scores will constitute the major basis for the test of Hypothesis one and given the indication of non equivalence in assessment among the four forms of the DACL (A-D) on the pretest, the decision was made to use the analysis of covariance for the hypothesis test.

The use of this analysis allows the pretest scores for each individual to be used as the covariate in assessing their "true" posttest score. In this manner it provides a statistical "control" for the fact that some initial differences existed in the group on the pretest and it provides adjustments in the posttest scores commensurate with these initial differences. Thus it ensures a more rigorous test of the Hypothesis. A summary of this analysis is presented in Table 3.

Table 3. Analysis of covariance of posttest scores of the DACL (A-D) for the treatment and control groups

Sources of Variation	df	SS	MS	F
Pretest (covariate)	1	.563	.563	.203
Between Groups (G)	1	1.141	1.141	.014
Error (St/G)	9	717.675	79.741	---
Between Forms (F)	3	27.338	9.113	2.876
Interaction (GxF)	3	7.645	2.548	.804
Error (FxSt/G)	26	82.371	3.168	---

Tabular F (1,9) = 5.12, (3, 26) = 2.97, $p < .05$

The analysis of covariance reported here reveals no significant difference in posttest depression adjective checklist scores among the six spouses of stroke patients with aphasia who received group counseling to the five who did not receive group counseling. The posttest means of the treatment and control groups, for the four forms, were adjusted in relation to the pretest mean scores which revealed non significant F values between the treatment and control groups ($F = .014$); forms A, B, C, and

D of the DACL ($F = 2.876$); and interaction between groups and forms ($F = .804$). The pretest mean scores were used as a covariate which indicates that the pretest had no significant influence on the posttest scores ($F = .203$).

On the basis of the data, the null hypothesis cannot be rejected and one must conclude that following group counseling sessions the treatment group scored no differently than the control group.

It is interesting to note however, that the F-value ($F = 2.876$) for the between forms comparison does approach significance reflecting the fact that even with statistical adjustments applied to the data, the assessment yielded by the various forms maintains substantial differences.

The source of this inconsistency is revealed somewhat in the comparison of pre and posttest means and standard deviations presented for the treatment group in Table 4 and for the control group in Table 5.

Table 4 shows the pre and posttest DACL (A-D) group means, standard deviations and differences for the treatment group scores. All the posttest group mean scores for the four forms of the DACL decreased (less depression) when compared to the pretest scores. The differences ranged from 2.84 (form A) to .5 (form B). The total group mean for all four forms changed from 10.63 to 9.29 for a decrease of 1.34. The amount of change decreased and the standard deviations increased as the forms progressed from A to D, indicating a possible lack of equivalency between forms, which is contrary to what is published in the manual (Lubin, 1967) and Chapter III of this research.

In Table 5, the control groups pre and posttest group means, standard deviations, and differences for the DACL, show an increase (more depression) in means for three out of the four forms. The differences in

Table 4. Pre and posttest means, standard deviations and differences for the DACL (A-D) treatment group scores*

Form	<u>Treatment Group</u>					
	<u>Pre</u>		<u>Post</u>		<u>Difference (Po-Pr)</u>	
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.
A	10.66	4.58	7.82	4.62	-2.84	.04
B	9.83	5.23	8.16	4.35	-1.67	.88
C	10.83	4.87	10.5	3.78	- .33	1.09
D	11.16	5.63	10.66	9.36	- .5	3.73
Total \bar{X} :	10.63	5.08	9.29	5.53	-1.34	2.64

*Low scores indicate less depression

DACL (A-D) norms: (see page 36)

Table 5. Pre and posttest means, standard deviations and differences of the DACL (A-D) for the control group scores*

Form	<u>Control Group</u>					
	<u>Pre</u>		<u>Post</u>		<u>Difference (Po-Pr)</u>	
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.
A	8.0	4.74	7.8	7.32	- .2	2.58
B	5.0	5.14	6.6	6.50	+1.6	1.36
C	7.4	4.82	8.0	5.24	+ .6	.42
D	6.8	4.43	7.8	5.18	+1.0	1.62
Total \bar{X} :	6.8	4.78	7.55	6.06	+ .75	1.5

*Lower scores indicate less depression

posttest scores ranged from 1.6 (form B) to .6 (form C). Form A had a difference in posttest mean of .2, indicating only a slight decrease in depression between the pre and posttest means. The change in the total group posttest mean for all four forms of the DACL was an increase of .75, with a range of 6.8 for the pretest and 7.55 for the posttest. Appendix VI shows a comparison of individual pre and posttest scores of the DACL for the treatment and control groups.

Several trends are worth noting. For example, the direction of change for the treatment group is consistently toward lower scores, indicating a decrease in depression. With one exception, (Form A) and it is slight, the reverse is true for the control group, that is, they tended to report higher amounts of depression on the posttest.

In addition, comparisons of the amount of change for the group documents that Forms A and B were measuring the largest differences between pre and posttesting for the treatment group. Possibly a significant difference would have been achieved if only Forms A and B would have been used to assess changes in depression.

Hypothesis Number Two

There are no significant differences in self-reported feelings of self-esteem for spouses of aphasics who receive group counseling to those who do not receive group counseling.

Analysis of hypothesis 2.1:

There will be no significant change between the treatment and control groups on posttest TSCS P-scores.

Table 6 presents the pretest means, percentiles, standard deviations and differences for the TSCS P-score between the treatment and control groups. The mean P-score for the total treatment group was 332.5 and a control group P-score of 349.8 for an increase of 17.3 between the two

groups. The treatment groups mean was at the 29th percentile when compared to the normative data given in the manual (Fitts, 1965). Compared to the control group percentile of 50, the 21 percentile difference between the two groups indicates that there was some difference in self-esteem between the treatment and control groups.

Table 6. Pretest means, percentiles, standard deviations, and differences for the pretest of the TSCS P-score*

<u>Treatment</u>			<u>Control</u>			<u>Difference</u>		
\bar{X}	%	S.D.	\bar{X}	%	S.D.	\bar{X}	%	S.D.
332.5	29	37.1	349.8	50	35.6	+17.3	21	1.5

*The higher the score the more self-esteem.
TSCS norms: \bar{X} = 345.57, S.D. = 30.70

The results of the analysis of variance of the pretest scores are presented in Table 7.

Table 7. An analysis of variance of pretest group means of the TSCS P-score for the treatment and control groups

Source of Variation	df	SS	MS	F
Between Groups	1	816.245	816.245	.614
Within Groups (Error)	9	11960.300	1328.922	

Tabular F (1, 9) = 5.12, $p < .05$.

However, Table 7 reveals that the difference was not statistically significant when comparing pretest scores for self-esteem between the treatment and control groups ($F=.614$).

An analysis of posttest scores by the use of the analysis of covariance, in order to "control" for some of the initial differences that existed in the group during the pretest, is summarized in Table 8.

Table 8. Analysis of covariance of posttest scores of the TSCS P-scores for the treatment and control groups

Sources of Variation	df	SS	MS	F
Pretest (covariate)	1	5336.331	5336.331	12.816*
Between Groups	1	69.629	69.629	.167
Error	8	3331.002	416.379	---

Tabular $F(1, 8) = 5.32$, $p < .05$

*Significant difference

Using the pretest as a covariate, Table 8 indicates that the correct statistical tool was utilized in the study because the pretest appears to have a significant influence on the posttest scores ($F=12.816$). Therefore, the higher the pretest score for an individual the higher the score on the posttest.

Also shown in Table 8, an analysis of covariance reveals that there are no significant differences in posttest Tennessee Self-Concept Scale P-scores among the six spouses of stroke patients with aphasia who received group counseling to the five who did not receive group counseling.

Therefore, Hypothesis 2.1 cannot be rejected and it must be concluded that after group counseling sessions the treatment group scored no differently than the control group.

The pre and posttest means, percentiles, standard deviations and differences of the TSCS P-scores for the treatment and control groups are presented in Tables 9 and 10.

Table 9. Pre and posttest means, percentiles, standard deviations, and differences of the TSCS P-score for the treatment group

<u>Treatment Group</u>								
<u>Pre</u>			<u>Post</u>			<u>Difference (Po-Pr)</u>		
\bar{X}	%	S.D.	\bar{X}	%	S.D.	\bar{X}	%	S.D.
332.5	30	371	340.7	40	29.6	+8.2	10	7.5

The higher the score the more self-esteem.
TSCS norms: \bar{X} = 345.47, S.D. = 30.70

Table 10. Pre and posttest means, percentiles, standard deviations, and differences of the TSCS P-score for the control group

<u>Control Group</u>								
<u>Pre</u>			<u>Post</u>			<u>Difference (Po-Pr)</u>		
\bar{X}	%	S.D.	\bar{X}	%	S.D.	\bar{X}	%	S.D.
349.8	51	35.6	347	49	30.8	-2.8	2	4.8

The higher the score the more self-esteem.
TSCS norms: \bar{X} = 345.57, S.D. = 30.70

Table 9 gives the pre and posttest means, percentiles, standard deviations and differences of the TSCS P-scores for the treatment group. The posttest means score was 340.7 (40th percentile), which shows an increase score of 8.2 when compared to the pretest of 332.5 (30th percentile). The change of 10 percentile points in rank is evident and suggests that change may have been occurring within the treatment group. Possibly a longer period of time for the treatment group would have allowed enough time for changes in self-esteem to occur.

Table 10 shows the pre and posttest means, percentiles, standard deviations and differences of the TSCS P-score for the control group. The posttest mean was 347.0 (49th percentile) and when compared to the pretest mean of 349.8 (50th percentile), reveals a change, or decrease, of 2.8 or 2 percentiles. This seems to indicate that little or no change in self-esteem was occurring within the control group.

Summary

The analysis of variance revealed that there was no significant difference between the treatment and control groups in depression and self-esteem. However, a significant difference between the four forms of the DACL was evident between the two groups.

An analysis of covariance was used to analyze the changes in posttest scores in depression and self-esteem, as measured by the DACL (A-D) and the TSCS P-score. Posttest scores for six spouses of stroke patients with aphasia who received group counseling were compared to the posttest scores of five spouses who did not receive group counseling. Although analysis of the data indicated change may have been taking place, no significant changes were found in posttest scores for the measures of

depression or self-esteem. The pretest scores were used as covariates and only the P-score for the TSCS revealed a significant F-value.

Feedback at End of the Program

At the end of the nine week treatment program for the treatment group, the six spouses responded to an evaluation of their experience by filling out a "feedback" evaluation form (Appendix VIII). This form uses six open-ended sentences and two questions that ask for specific comments as a basis for evaluating the program. Table 11 shows all the comments that were given in response to the open-ended sentences. Not everyone completed all of the sentences.

Table 11. Program feedback through open-ended sentences

I learned that I....

- am not alone.
- wasn't alone and other people are worse off than I am.
- am not alone in my reactions to the stroke situation.
- am not the only one with troubles.
- am not alone and I am able to cope with the situation.

I was surprised that I....

- was the only one in the group whose spouse had more than one stroke.
- have been able to handle my situation as well as I have. I have more confidence in myself.
- could feel more comfortable with my spouse when we are out in company.
- our group became as close as it did since it has such a wide range of ages and our spouses' conditions were so varied.

I was saddened that I....

- realized I was blaming my husband for his many illnesses as well as his stroke. I am working my way through this.

I never knew that I....

- would share so many feelings with a group.
- could get so angry at my spouse's brother and niece.

I found it hard to believe that I....

- could talk about my spouse's threat of suicide to someone else.

I plan to change....

- my attitude toward my husband--to show more affection. It has already brought some easing of tension and he seems to feel better.
- our will.
- hopefully my working habits and maybe get out socially more.

The following responses were made to the statement: "Please make any suggestions that you feel would be helpful to me as the counselor or ideas you might have concerning our group."

- "Glad you're going to include some more legal information next time around. You might want to develop a check-list for stroke families to have as an aid to services available or items to think about. Especially information about stroke clubs."

- "Counselor and group could not be improved."

- "Possibly expand the length of time and open the sessions up to include a social worker or health nurse. This could offer a different viewpoint."

The second specific comment asked, "Do you feel these group meetings have been helpful? The following answers were given:

- "They have helped me more than I can express."

- "Most assuredly. To meet with lovely people who share common problems, to help each other with them, has helped me to ease my burden. I hate to see the sessions end."

- "Definitely Yes! I felt I learned a great deal. The feeling of support from the others is a tremendously strengthening force."

- "Definitely."

- "Yes, and would like to know more about the resources available."

- "Very much so."

One specific comment was received from a group member after the nine week program was completed. It came in the form of a thank you note, which read:

"Thanks again for the past 9 Wednesday evenings. I know that my outlook on life has changed during that time. I felt gladness when I filled out the other survey Wed. night while I felt sadness doing it before."

These responses and comments offer support that changes in depression and self-esteem, though not statistically significant, were taking place within people receiving counseling during the nine week treatment program.

CHAPTER V
DISCUSSION, SUMMARY, CONCLUSIONS
AND RECOMMENDATIONS

In this study assumptions have been made by the investigator about the importance of recognizing the feelings that are being experienced by spouses of stroke patients with aphasia and the effectiveness of a group counseling model in dealing with these feelings. A review of the literature has been made, which dealt with the feelings expressed by families and spouses of aphasics, the role of group work in aphasic rehabilitation programs, and group counseling as a modality in treating depression and self-esteem. An experimental project was designed to test the assumptions. The results of this study have tentatively inferred that the assumptions have some validity.

Discussion

In comparing the treatment and control group by pretest data for similarity in levels of depression, an analysis of variance revealed at the .05 level of confidence, a significant difference in depression between forms A, B, C, and D of the DACL. Non-significant F-values were found between the total means of the treatment and control groups and for interaction between the forms as responded to by the two groups.

This raises a question to whether the forms in set I of the DACL are equivalent as advocated in the manual (Lubin, 1965) and discussed in Chapter three of this research. In reviewing Table 1, the difference may

be in form B, which yields a mean difference of 4.83 between the treatment and control groups. Form D has a mean difference of 4.36 and together with B, could be contributing to the significant F-value of 3.764 shown in Table 2.

Form A and/or B could have assessed depression between the groups with more reliability than all four forms, especially in light of Table 3 which shows the mean difference between the pre and posttests of the treatment group decreasing in strength as the forms progressed from A to D.

In adjusting the posttest scores of the DACL for the treatment and control groups, no significant difference was found in depression between the six spouses who received group counseling compared to the five who did not receive group counseling. An analysis of covariance revealed no significant F-values, in comparing the treatment and control groups ($F=.014$); between forms A, B, C, and D of the DACL ($F=2.876$); or for interaction between groups and forms ($F=.804$). However, all posttest group mean scores for the four forms decreased (less depression) for the treatment group when compared to the pretest scores, with change being the largest for forms A and B as shown in Table 3. Depression scores within the control group seem to be rather constant as shown in Table 4. An individual analysis of the spouses' DACL scores might reveal some individuals in the treatment group responding very positively to the treatment program.

Appendix VI has the individual pre and posttest scores for the DACL (A-D) with the amount of mean change for the six spouses in the treatment group and the five in the control group. Table 12 gives the amount of mean change for all forms for each spouse in the treatment and control groups. After pre and posttesting, three out of six spouses in the treat-

ment group indicated less depression, with scores ranging from 13.5 to 1.25. Scores of the two spouses indicated more depression after post-testing and one spouse did not have any change in mean depression scores for the four forms (11.5 to 11.5).

Only one spouse in the control group had less depression on the posttest when compared to the pretest. Increases in depression scores for the three other spouses was very slight, leaving only one spouse with any notable increase (more depression) in depression scores (13.0 to 16.25). This seems to indicate that the level of depression for the control group was remaining fairly constant while the treatment group was experiencing greater decreases in depression. Even though the change was not statistically significant, change appeared to be taking place for some members of the treatment group.

Table 12. Mean change for each spouse in the treatment and control groups for the DACL (A-D) scores

<u>Treatment (n=6)</u>	<u>Control (n=5)</u>
+ 5.25	+3.25
- 1.25	+ .5
+ .5	+ .75
-13.5	-1.0
- 2.5	+2.5
0	
<hr/>	
(-) = decrease in depression scores	
(+) = increase in depression scores	

It is possible that considering the situation of each person in both groups, a certain amount of depression is to be expected that will be evident in a spouse whose partner is a victim of a CVA that has resulted in aphasia. The spouses in the treatment group were also in an age range that developmentally can cause excess stress and sometimes personal crisis. In Figure 1, the mean age of the spouses in the treatment group was 58, with a range from 46 to 73. This age range is receiving some attention lately as a time of mid-life crisis. The mean age for the control group was 65, with a range from 53 to 73. Three out of these five spouses were in their early seventies. This could possibly account for the stability of the control group's depression scores, unless one is of the belief that aging is related to a loss of self-esteem. This is not supported by the high self-esteem P-scores in the control group. It was very difficult for the researcher to determine whether the DACL (A-D) is measuring developmental depression or depression that is a result of being with a stroke patient with aphasia. In either case, treatment programs for spouses of stroke patients with aphasia might need to emphasize methods of coping with mood changes rather than attempting to reduce or eliminate depression altogether. Program components should be examined for their relevancy to the developmental stage of the group members.

The inability of any instrument to measure changes within a nine week period may also account for the lack of measurable change in depression. The DACL was chosen as the most sensitive to measurement of change.

In dealing with differences in self-esteem between the treatment and control groups, an analysis of variance revealed no significant differences in pretest scores between the two groups when measured by the TSCS P-scores ($F=.614$). An analysis of covariance gave no significant changes

in posttest TSCS P-scores among the six spouses of aphasics who received group counseling compared to the five who did not receive group counseling ($F=.167$). The posttest mean score of 340.7 is at the 40th percentile according to the normative data given in the manual (Fitts, 1965). This is a mean difference of 8.2 in raw score points or 10 points in percentile rank.

However, as shown in Appendix VII and Table 13, the inference is toward positive change in self-esteem taking place from some spouses in the treatment group. Table 13 gives the pre and posttest raw P-scores for each spouse in the treatment and control groups. For the treatment group, higher posttest P-scores are evident for four out of six spouses with the other two spouses having lower scores on the posttest than on the pretest. Two out of the five spouses in the control group had increases in their posttest scores with the other three showing a decrease. This may imply that negative feelings toward self were increasing, or at least staying the same, despite the possible effect of the pretest.

Table 13. Raw scores for each spouse in the treatment and control groups for the TSCS P-score

<u>Treatment</u>		<u>Control</u>	
<u>Pretest</u>	<u>Posttest</u>	<u>Pretest</u>	<u>Posttest</u>
378	323	294	304
327	304	375	373
289	323	361	327
333	365	337	356
296	315	382	375
372	354	382	375

The researcher feels that the treatment program had a positive influence especially on some spouses of the treatment group. This is supported by two indicators, 1) the increase in posttest P-scores; and 2) by statements of the spouses in the treatment group expressed at the end of the program evaluation, which indicated they were not alone in their situation. Discovering they are not alone with their problems was very important in building self-confidence, reducing depression and understanding that feelings (i.e. loneliness, guilt, resentment, rejection, and exhaustion) are a natural result of experiencing the effect of a CVA that results in aphasia.

Two people in the treatment group had pretest P-scores below 315.0, a P-score value that is used by the TSCS clinical and research form, to indicate a person who would possibly be experiencing low feelings about themselves. As noted in Table 12, one person's score increased 34 pts. and the other increased 19 pts. to achieve the 315 score. The one person in the control group who had a P-score below 315.0 changed only six points, from 298 to 304. This change could be attributed to the pretest effect on the posttest. All the other P-scores for the treatment and control group were near or above the 345.47 normative mean given by Fitts (1965). Spouses who had P-scores of 375 or above, remained high over the nine week period, and probably were not in need of some aspects of the program. Particular types of programs for spouses of stroke patients with aphasia should be designed according to the level of self-esteem indicated by a standardized test such as the TSCS. For example, those spouses who scored low in self-esteem are in need of self-esteem building experiences with emphasis on the emotional component of the program, identified as contributing to negative feelings toward self. Spouses with high

self-esteem P-scores could be on a different level of awareness and hence more in need of cognitive and behavioral ideas for helping themselves and their spouses.

In analyzing the individual scores even further, Table 14 offers a non-statistical comparison of individual changes between the DACL (A-D) and TSCS P-scores for the treatment group in an effort to examine the relationship between depression and self-esteem. Three out of the six spouses in the treatment group show a decrease in depression and an increase in self-esteem which is indicated by a minus in the DACL column and a plus in the P-score column. Two spouses in the treatment group had an increase in depression and a decrease in self-esteem. However, one of those spouses had only a .5 increase in the DACL posttest score compared to a decrease of 23 on the P-score. Another spouse had no change in the mean difference between pre and posttesting. This was a comparatively high score (11.5) and with a loss of 18 on the P-score this indicates that self-esteem was decreasing despite the treatment group. There is a strong relationship for spouses in the treatment group between depression and self-esteem, but the scores of the two people in the treatment group do not reflect that the treatment was helpful to them. Self-esteem is only one aspect of reducing depression and it is possible that treatment programs dealing with these two variables will need to offer a wide variety of experiences in order to touch upon the many symptoms of depression, such as need deprivation, indecisiveness, increased dependency and negative expectations. It was not possible to compare the instruments (DACL and TSCS) with personal statements regarding the treatment experience, as participants were not asked to identify themselves when they made their statements. Such identification could be enlightening.

Table 14. Comparison of change between individual
DACL (A-D) means and TSCS P-scores for
the treatment group

<u>DACL (\bar{X}) *</u>	<u>P-scores</u>	<u>Relationship</u>
+ 5.25	378-383	dep. up/s. est. up
- 1.25	289-323	dep. down/s. est. up
+ .50 (3.75-4.25)	327-304	dep. up/s. est. down
-13.5	333-365	dep. down/s. est. up
- 2.5	296-315	dep. down/s. est. up
0 (11.5-11.5)	372-354	no change/s. est. down

*minus = decrease in depression
plus = increase in depression

Table 15 provides a comparison of change between individual DACL (A-D) means and the raw P-scores achieved by the spouses with the relationship between depression and self-esteem scores made evident. Only one spouse in the control group had a minus in the DACL column (depression) and a plus in the P-score column (self-esteem). Three other spouses had a plus-minus relationship but the changes were all small.

Table 15. Comparison of change between
individual DACL (A-D) and TSCS
P-scores for the control group

<u>DACL (\bar{X}) *</u>	<u>P-scores</u>	<u>Relationship</u>
+3.25	294-304	dep. up/s. est. up
+ .50	375-373	dep. up/s. est. down
+ .75	361-327	dep. up/s. est. down
-1.0	337-356	dep. down/s. est. up
+2.5	382-375	dep. up/s. est. down

*minus = decrease in depression
plus = increase in depression

The relationships between depression and self-esteem are much weaker for the control group when compared to the treatment group.

Many variables seem to affect a spouse's ability to deal with their feelings of self-esteem and depression. A reality for the six participants in the treatment program was "exhaustion, tiredness, and fatigue" while trying to cope with their situations at home (Appendix IX). This exhaustion apparently left little energy to cope with mood changes experienced by their aphasic spouse, and other problems mentioned below, let alone changes in their own feelings. Consequently, researchers using programs for spouses of stroke victims with aphasia can expect to have difficulty controlling some factors that can affect the level of self-esteem and depression. Factors such as: 1) the aphasic's mood changes; 2) a reoccurring stroke; 3) degree of language progress of the aphasic; 4) degree of support from significant others; 5) financial burdens; 6) the dependency relationship between the couple; 7) the degree of nurturance of the spouse; and 8) other medical complications are just a few of the factors that this writer noted during the treatment program which seemed to affect a spouse's mood. How well a person felt they had control of these factors also seemed, according to statements made during treatment, to be related to how long it had been since the stroke had occurred.

In examining the design of the research, it must be remembered that the eleven participants who volunteered for the research, also volunteered for the treatment or control group. Subjects were not randomly assigned. The volunteer to the treatment group might have felt a need for such a group and therefore could have responded to the treatment program with more willingness. In the pretest, the group mean of the P-score for the TSCS was lower (less self-esteem) but not significantly lower, for the

treatment group than for the control group. The means for the four forms of the DACL show a significantly higher (more depression) for the treatment group than for the control group. This could indicate that the selection process influenced the way members of each group responded. Kerlinger (1974) points out, that programs may be effective because of selection or self-selection. However, this writer believes that the treatment and control groups were very similar in their characteristics. All the characteristics in which these groups appear to be similar were: 1) age range of the spouse and the aphasic; 2) sex; 3) perceived language difficulty of the aphasic spouse; 4) years of education obtained by the spouse; 5) number of children at home; 6) post CVA time in months; 7) mobility of the aphasic; and 8) level of self-esteem and depression.

The treatment program stressed the developmental stages of group growth and a personal mastery approach to group work. It offered a cognitive, emotional and behavioral atmosphere where common problems and feelings were shared, confronted and explored. A realistic expectation of attitudes toward their situation, the importance of accepting their feelings as natural consequences of their situation and that their self was just as important as their spouse's self was a constant underlying theme throughout the nine weeks. Use of selected media, including a film, video tape, and reading material, as well as the organization of the group sessions were all important ingredients in making the most effective use of the personal mastery counseling skills. This researcher felt the treatment program was helpful. This was supported by: 1) careful examination of the data gathered as it applied to individuals within the group; 2) by the direction of movement of the treatment group toward higher self-esteem and less depression (though not significant in the nine

week period); and 3) by feedback at the end of the program in which all six spouses in the treatment group made statements indicating the program had been very helpful.

Both of the standardized testing instruments have advantages and disadvantages that were extensively reviewed earlier. Every attempt was made by the writer to standardize the administration of the pre and posttest procedures. It can only be assumed that the instruments will sufficiently measure what they are designed to measure, although nine weeks may not have been long enough to measure changes in depression or self-esteem. Both the TSCS and the DACL have been used extensively in clinical research and it was felt by the researcher that they were the best tests available for measuring the assumptions of this research.

Perhaps no instrument yet developed has the power to measure discriminately such highly sensitive constructs such as self-esteem and depression.

Extreme caution is urged in generalizing the results of this research beyond the small sample ($n=11$). The researcher's belief is that in any area of the country a similar group counseling program, which stresses the developmental group counseling approach, can provide the type of atmosphere that will help spouses of stroke patients deal with changes in their self-esteem and depression.

Summary

Damage to the left hemisphere of the brain from a cardiovascular accident (CVA) usually results in aphasia, a multimodality language disturbance that affects verbal and comprehensive skills, emotional strength and overall mental and physical health of the victim. It also can cause

complex and conflicting feelings for the spouse of the stroke victim with aphasia. These feelings, such as guilt, resentment, loneliness and emptiness, and bitterness, to name a few, often result in depression and loss of self-esteem for the spouse. This brings strong pressures to personal and family relations.

Most family treatment programs for aphasia concentrate on providing educative and consultive services for the spouse in order to help with understanding the changes that take place in their spouse's aphasia. Feelings that are being experienced by spouses of aphasics usually are given a secondary emphasis in such programs. Spouses need a treatment program that recognizes the psychological changes that they are experiencing. The acceptance and reduction of depression will increase self-esteem and help spouses deal with their daily challenges.

The inherent factors in group counseling make it a powerful modality in helping people with common problems, such as aphasia. The literature indicates that especially in treating depression and self-esteem, group counseling has served successfully as a treatment method.

To compare changes in posttest scores in depression and self-esteem for spouses of stroke patients with aphasia during a group counseling treatment program, eleven spouses of aphasics (8 female and 3 male) were recruited from the Olympia and Tacoma area in the State of Washington. A pre and posttest control group design was used in which the spouses volunteered to be in a treatment or control group. Depression was measured by changes in the DACL (A-D) posttest scores and self-esteem was measured by the changes in the TSCS posttest P-scores. The six spouses in the treatment group were exposed to a nine week (1 1/2 to 2 hour

session once a week) treatment program, while the other five volunteered as a control group. Both groups were found to be similar in background characteristics. The treatment program was eclectic and stressed the developmental stages of group growth. A personal mastery approach to group counseling offered a cognitive-emotional- and behavioral atmosphere where feelings were shared, confronted and explored. The program content concentrated on the feelings and needs of the aphasic spouse.

Pretest scores of the DACL (A-D) and the TSCS (P-score) were used as another means of comparing the treatment and control groups for differences in depression and self-esteem. A significant difference was found between forms A, B, C, and D of the DACL and the level of depression between the two groups. This raised some question as to the equality of the four forms. However, no significant difference was revealed in the pretest comparison of P-scores between the treatment and control groups.

The treatment program was unable to affect a significant statistical change in depression and self-esteem. The comparison of adjusted posttest scores revealed no significant differences between the treatment and control groups for either depression or self-esteem. The pretest was a significant covariate on posttest scores of the TSCS P-scores but not for the DACL (A-D) posttest scores. However, at the end of the program, written feedback revealed that five of the six spouses in the treatment group learned that they were not alone in their situation. All six spouses expressed that the treatment program had been beneficial. An individual analysis of raw scores seems to indicate that change was taking place for some spouses in the treatment group when compared to the control group. A mild relationship between increases in self-esteem and decreases in depression was evident within the two groups.

Although neither of the two null hypotheses could be rejected, it was felt that an eclectic treatment program that stresses the developmental and personal mastery approach to group work has strong potential. This is supported by end of the program feedback by participants and by observation of individual changes between pre and posttest scores. This evidence suggests, but is not empirically verified by group analyses, that spouses of stroke patients with aphasia can benefit from such a program.

Conclusions

The following conclusions stem from: 1) a statistical analysis and visual inspection of the data; and 2) results obtained by content analysis of the feedback obtained at the end of the program from the treatment group.

Results of Statistical Analysis

1. There was a significant difference in pretest mean scores between forms A, B, C and D of the Depression Adjective Checklist when comparing depression scores within the treatment and control groups. This suggests instability in the various forms of the instrument in this sample.
2. There was no significant change in DACL (A-D) posttest scores in depression between the six spouses of stroke patients with aphasia who received group counseling when compared to the five spouses who did not receive group counseling.
3. The pretest DACL (A-D) scores were not a significant influence on posttest DACL scores.
4. There was no significant difference in pretest TSCS P-scores between the treatment and control groups.

5. There was no significant change in TSCS posttest P-scores between the six spouses of stroke patients with aphasia who received group counseling when compared to the five who did not receive group counseling.

6. The pretest TSCS P-scores were a significant influence on the posttest scores of the treatment and control groups.

Content Analysis of Feedback

1. Five out of six spouses of aphasics in the treatment group reported that it was significant for them to become aware that they were not alone in their situation and all six reported that they felt the program had been beneficial. An individual analysis of raw scores indicates a mild relationship between increases in P-scores and decreases in DACL (A-D) scores between the two groups. Therefore changes in self-esteem and depression were occurring for many of the spouses in the treatment group. Comparisons with the control group participants could not be made since similar data were not collected.

2. An eclectic treatment program that stresses developmental stages to group work and a personal mastery approach to personal counseling can bring positive changes in levels of depression and self-esteem for spouses of stroke patients with aphasia.

3. Possibly group work is not the most appropriate modality for dealing with depression and self-esteem in spouses of stroke patients with aphasia. Everyone has a different style and degree of coping and an individual approach to the situation could be utilized.

4. Spouses of stroke patients with aphasia may be experiencing a different type of depression than was being assessed by the DACL (A-D). Therefore, treatment programs need to be aware of the time that has

elapsed since the last stroke; level of fatigue being experienced by the spouse; and actual conditions of the aphasic spouse.

5. As observed by this researcher, the factors affecting a spouse's mood were: 1) the aphasic's mood; 2) a reoccurring stroke; 3) degree of language progress of the aphasic; 4) amount of support from significant others; 5) financial burdens; 6) the dependency relationship between the couple; 7) the degree of nurturance of the spouse; and 8) their own physical well-being.

Recommendations

The recommendations are of two types: 1) suggestions for alternative research designs and other measureable variables; and 2) recommendations related to the clinical setting for spouses and families of aphasics.

Designs, Variables and Measurement Recommendations

1. Use a pre and posttest control group design and randomly assign the participants to the treatment and control group.

2. Establish an equivalent time series design project for pre and posttesting over a period of time. This would allow for the control of some of the internal validity problems that occur within the nine weeks. This type of design could provide basic data that would look at the developmental progression and fluctuations of feelings for spouses of stroke patients with aphasia. Then different treatment programs could be developed that would correlate with the needs created by the time since the onset of the last stroke.

3. Measure changes in attitudes, in a pre and posttest control group design, to examine the effectiveness of a program in treating the

unrealistic attitudes that have been reported by relatives and families of aphasics.

4. Measure changes in nurturance and dependency in using a pre and posttest control group design with a similar treatment program.

5. Design a project that would use sex, income, and occupation as variables within the sample population.

6. In light of pre and posttest changes in scores, it might be beneficial to extend the treatment program to see if differences are significant between the treatment and control groups.

7. Incorporate components into treatment programs for spouses of stroke patients with aphasia that specifically relate to their psychological and social needs.

8. Design a similar research project that would only deal with changes in individual posttest scores.

9. Using a similar treatment program, assess changes with only form A and/or B of the DACL, or a combined score, in order to avoid interpretation difficulties arising from differences in what different forms may be measuring.

10. In a similar design, assess changes in depression and self-esteem by posttesting after a period of time has elapsed since the program was completed.

11. Correlate the degree of language disability as perceived by the spouse with how it has been assessed by the speech pathologist.

12. Match scores with statements made by group members in feedback that evaluates the treatment program.

Clinical Recommendations

1. Stroke and aphasic rehabilitation services should provide group counseling programs as part of their total rehabilitation services.
2. In order to meet individual needs different rehabilitation programs for aphasics and their families could possibly be developed and implemented at various times since the last stroke.
3. Any type of clinic, public or private, that is related to better mental health, should provide adequate physical space for group work.

SELECTED BIBLIOGRAPHY

- Artes, R. H. "A Study of Family Problems as Identified and Evaluated by the Wives of Stroke Patients." Dissertation Abstracts International, 1967, 28, 1B, 347.
- Asch, S. E. "Studies of Independence and Conformity: A Minority of One Against a Unanimous Majority," Psychological Monographs, 1956, 70.
- Atchison, C. O. "Comparative study of the self-concept of behavior problem and non-behavior problem high school boys." Unpublished doctoral dissertation, Indiana University, Ann Arbor, Michigan: University Microfilms, 1958. No. 58-5196. Cited in: Fitts, W. Manual: Tennessee Self-Concept Scale. Nashville: Counselor Recordings and Tests, 1965.
- Bardach, J. L. "Group Sessions with Wives of Aphasic Patients." International Journal of Group Psychotherapy, 1969, 19, 3, 361-365.
- Beck, A. T. Depression, Clinical, Experimental and Theoretical Aspects. New York: Harper and Row Publishers, Inc., 1967.
- Benjamin, A. The Helping Interview. Boston: Houghton-Mifflin, 1974.
- Biorn-Hansen, V. "Social and Emotional Aspects of Aphasia." Journal of Speech and Hearing Disorders, 1957, 22, 1, 53-59.
- Blackham, G. Counseling: Theory, Process and Practice. Belmont, California: Wadsworth, 1977.
- Boles, G. "Personality factors in mother's of cerebral palsied children." Genet. Psychological Monographs, 1959, 59, 159.
- Boone, R. "A Plan for Rehabilitation of Aphasic Patients." Archives of Physical Medicine and Rehabilitation, 1967, 48, 410-414.
- Bonney, W. C. and Foley, W. J. "The transition Stage In Group Counseling In Terms of Congruity Theory." Journal of Counseling Psychology, 1963, 10, 136-138.
- Brammer, J. and Shostrum, E. Therapeutic Counseling: Fundamentals of Counseling and Psychotherapy. Englewood Cliffs, N.J.: Prentice-Hall, 1977.
- Buck, "Adjustments During Recovery from Stroke." American Journal of Nursing, 1964, 64, 10, 69-75.
- Buck, M. Dysphasia: Professional Guidance for Family and Patient. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1968.
- Buck, M. "Life with a Stroke," Crippled Children, 1957, 35, 4, 24-25.

- Buck, M. "The Language Disorder: A Personal and Professional Account of Aphasia." Journal of Rehabilitation, 1963, 29, 6, 37-38.
- Buros, O. The Seventh Mental Measurements Yearbook. Highland Park, N.J.: The Grypho Press, 1972.
- Buxbaum, J. "Effect of Nurturance on Wives: Appraisals of their Marital Satisfaction and the Degree of Their Husbands Aphasia." Journal of Consulting Psychology, 1967, 31, 3, 240-243.
- Cobb, B. A. Medical and Psychological Aspects of Disability. Springfield: Charles C. Thomas, 1975.
- Combs, A. W., Avila, D. L. and Purkey, W. W. Helping Relationships. 2nd edition. Boston: Allyn and Bacon, Inc., 1978.
- Congdon, C. S. Self Theory and Chlorpromazine Treatment. Unpublished Doctoral Dissertation, Vanderbilt University, 1958. Cited in: Fitts, W. Manual: Tennessee Self-Concept Scale. Nashville: Counselor Recordings and Tests, 1964.
- Corey, G. and Corey, M. Groups: Process and Practice. Monterey: Brooks and Cole, 1977.
- Crewe, M. "Training Course: Stroke In Your Family." Rehabilitation Record, January-February 1969, 32-34.
- Dahlberg, C. C. and Jaffee, J. Stroke: A Doctor's Personal Story of His Recovery. New York: W. W. Norton and Co., 1977.
- Darley, F. L. "Impairment of communication ability in patients with cerebrovascular accidents." Mayo Clinic Procedure, 1967, 42, 648-652.
- Darley, F. L. "The Efficacy of Language Rehabilitation in Aphasia." Journal of Speech and Hearing Disorder, 1972, 37, 1, 3-21.
- Delaney, D. and Eisenberg, S. The Counseling Process. Chicago: Rand McNally, 1972.
- Derman, S. and Manaster, A. "Family Counseling with Relatives of Aphasic Patients at Schwab Rehabilitation Hospitals." ASHA, 1970, 9, 5, 111-113.
- Douglas, E. "Diagnostic Classification and Re-education in Aphasia." Canadian Medical Association Journal, 1953, 69, 376-381.
- Ellis, A. Growth Through Reason. Hollywood: Wilshire Publishing Co., 1971.
- Ellis, A. "Critical Reaction To Personal Mastery Group Counseling." The Journal For Specialist In Group Work, 1978, 3, 3, 160-164.
- Emerson, R. W. "A Summary of Feelings and Adjustments of Three Women with Spouses Disabled with Aphasia." Journal of the Oregon Speech and Hearing Association, 1979, 17, 2, 10-11.

- Farrell, B. "The Gallant Fight of Pat Neal." Life, 1965, 59, 92-120.
- Fitts, W. Manual: Tennessee Self-Concept Scale. Nashville: Counselor Recordings and Tests, 1965.
- Flowers, C. R., Beukelman, D. R., Bottorff, L. E., and Kelley, R. A. "Family Members' Predictions of Aphasic Test Performance." Aphasia-Apraxia-Agnosia; 1, 1, 1979.
- Fogel, M. L., Curtos, G. C., Kordasz, F. and Smith, W. G. "Judges ratings, self-ratings and checklist report of affect." Psychological Reports, 1966, 19, 299.
- Fuchs, C. Z. and Rehm, L. P. "A self-control behavior therapy program for depression." Journal of Consulting and Clinical Psychology, 1977, 45, 2, 206-215.
- Gable, R., LaSalle, A., and Cook, K. "Dimensionality of Self Perception: Tennessee Self-Concept Scale." Perceptual Motor Skills, 1973, 36, 551-560.
- Gazda, G. M. Basic Approaches to Group Psychotherapy and Group Counseling. 2nd edition. Springfield: Charles C. Thomas, 1974.
- Gazda, G. M., Duncan, J. A. and Meadows, M. D. "Group Counseling and Group Procedures--Report of a Survey." Counselor Education and Supervision, 1967, 6, 305-310.
- Gazda, G. M. Group Counseling: A Developmental Approach. Boston: Allyn and Bacon, Inc., 1978.
- Glass, S. The Practical Handbook To Group Counseling. Baltimore: BCS Publishing, 1972.
- Goodkin, R. "Procedure for Training Spouses to Improve the Functional Speech of Aphasic Patients." Paper presented Annual Meeting, American Psychological Association. Washington D.C., September 1969.
- Goodstein, L. D. Cited in Buros, O. The Seventh Mental Measurements Yearbook, Highland Park, N.J.: The Grypho Press, 1972.
- Gordon, T. Parent Effectiveness Training. New York: Wyden, 1970.
- Gross, W. F. and Adler, L. O. "Aspects of alcoholics' self-concepts as measured by the Tennessee Self Concept Scale." Psychological Reports, 1970, 27, 431-434. Cited in: Wylie, R. The Self Concept: A Review of Methodological Considerations and Measuring Instruments, Vol. 1. Lincoln: University of Nebraska Press, 1974.
- Haese, J. B., "Attitudes of stroke patients toward rehabilitation and recovery." American Journal of Occupational Therapy, 1970, 24, 4. Cited in: Cobb, B. A. Medical and Psychological Aspects of Disability. Springfield: Charles C. Thomas, 1975.

- Hall, W. A. "The Return from Silence: A Personal Experience." Journal of Speech and Hearing Disorders, 1961, 26, 174-177.
- Harrington, R. "Communication for the aphasic stroke patient." Journal of American Geriatric Society, 1975, 23, 254-257.
- Havener, P. H. "Distortions in the perception of self and others by persons using paranoid defenses." (Doctoral dissertation, Vanderbilt University) Ann Arbor, Mich.: University Microfilms, 1961. No. 61-2316. Cited in: Fitts, W. Manual: Tennessee Self Concept Scale. Nashville: Counselor Recording and Tests, 1965.
- Havener, P. H. and Izard, D. E. "Unrealistic Self-enhancement in Paranoid Schizophrenics." Journal of Consulting Psychology, 1962, 26, 65-68. Considerations and Measuring Instruments, Volume 1. Lincoln: University of Nebraska Press, 1974.
- Herbert, D. J. "Reading Comprehension as a Function of Self-Concept." Perceptual and Motor Skills, 1968, 27, 78.
- Helmick, J. W., Watamori, T. S. and Palmer, J. M. "Spouses Understanding of the Communication Disabilities of Aphasic Patients." Journal of Speech and Hearing Disorder, 1976, 41, 238-243.
- Hodgins, E. "Listen: The Patient." New England Journal of Medicine, 1966, 274, 657-661.
- Jourard, S. The Transparent Self. New York: Van Nostrand, 1971.
- Keenan, J. S. and Brassell, E. G. Aphasia Language Performance Scales: Manual 1975.
- Keenan, J. S. and Brassell, E. G. "A study of factors related to prognosis for individual aphasic patients." Journal of Speech and Hearing Disorders, 1974, 39, 257-269.
- Kerlinger, N. Foundations of Behavioral Research. New York: Holt, Rinehart, and Winston, 1973.
- Kottler, J. A. "How the Effective Group Counselor Functions." The Journal For Specialists in Group Work, 1978, 3, 3, 113-121.
- Leake, D. "The measurement of self-esteem." Unpublished Masters Thesis, Ohio State University, 1970. Cited in Robinson and Shaver, Measures of Social Psychological Attitudes. Ann Arbor: University of Michigan, Institute of Social Research, 1976.
- Lefebber, J. "The delinquent's self-perception." (Doctoral dissertation, University of Southern California), Ann Arbor, Mich.: University Microfilms, 1964. No. 65-10,094. Cited in: Fitts, W. Manual: Tennessee Self-Concept Scale. Nashville: Counselor Recordings and Tests, 1965.

- Levine, B. and Schild, J. "Group treatment of depression," Social Work, 1969, 14, 4, 46-52.
- Levitt, E. E. and Lubin, B. Depression: Concepts, Controversies, and Some New Facts, New York: Springer Publishing Company, Inc. 1975.
- Lewinsohn, P. M., and Weinstein, M. S. and Alper, T. "A behavioral Approach to the Group Treatment of Depression (ed) Persons: A methodological contribution." Journal of Clinical Psychology, 1970, 26, 4, 525-532.
- Logue, P. E. Understanding and Living With Brain Damage. Springfield: Charles C. Thomas, 1975.
- Lubin, B. Bibliography for the Depression Adjective Checklist. San Diego: Educational and Industrial Testing Service, 1977.
- Lubin, B. Manual for the Depression Adjective Checklist. San Diego: Educational and Industrial Testing Service, 1967.
- Mackeen, B. A. and Herman, A. "Effects of Group Counseling on Self-Esteem," Journal of Counseling Psychology, 1974, 21, 3, 210-214.
- Mahler, C. A. Group Counseling in the Schools. New York: Houghton Mifflin, 1969.
- Malone, R. L. "Attitudes Expressed by Families of Aphasics," British Journal of Disorders of Communication, 1970, 5, 2, 174-179.
- Malone, R. L. "Expressed Attitudes of Families of Aphasics." Journal of Speech and Hearing Disorder, 1969, 34, 2, 146-151.
- Mayadas, N. S. and O'Brien, D. E. "The Use of Videotape In Group Psychotherapy." Group Psychotherapy and Psychodrama, 1973, 26, 1-2, 107-119.
- Mazlow, A. Motivation and Personality. New York: Harper and Row, 1954.
- McLean, P. D., Ogston, K. and Grauer, L. A. "A behavioral approach to the treatment of depression." Journal of Behavior Therapy and Experimental Psychiatry. 1973, 4, 323-330.
- Miller, P. R. and Ferone, L. "Group Psychotherapy with Depressed Women," American Journal of Psychiatry, 1966, 123, 6, 701-703.
- Nolan, E. J. "Leadership Interventions for Promoting Personal Mastery." The Journal for Specialists in Group Work, 1978, 3, 3, 132-138.
- Ohlsen, M. M. Group Counseling. New York: Holt, Rinehart and Winston, 1970.
- Olsen, J. Z. and May, B. J. "Family Education: Necessary Adjunct to Total Stroke Rehabilitation." American Journal of Occupational Therapy, 1966, 20, 2, 88-90.

- Oradei, D. M. and Waite, N. S. "Admissions Conferences for Families of Stroke Patients." Social Casework, 1975, 56, 1, 21-26.
- Overs, R. P. and Belknap, E. L. Educating Stroke Patient Families, Journal of Chronic Disease, 1967, 20, 45, 45-51.
- Overs, R. P. and Healy, J. Education Stroke Patient Families, Vol. I, II, III. Milwaukee: Research Department, DePaul Rehabilitation Hospital, 1971.
- Piety, K. R. "The role of defense in reporting on the self concept." Unpublished doctoral dissertation, Vanderbilt University, 1958.
Cited in: Fitts, W. Manual, Tennessee Self Concept Scale, Counselor Recordings and Tests, 1965.
- Ritchie, D. Stroke. Garden City, N.Y.: Doubleday, 1961.
- Ritchie, D. "The patient's feelings-A personal account of a stroke." Journal of Rehabilitation, 1963, 29, 50-53.
- Robertson, E. D. and Suinn, R. M. "The Determination of Rate of Progress of Stroke Patients Through Empathy Measures of Patient and Family." Journal of Psychosomatic Research, 1968, 12, 3, 189-191.
- Robinson, J. P. and Shaver, P. R. Measures of Social Psychological Attitudes. Ann Arbor: University of Michigan, Institute of Social Research, 1976.
- Rolnick, M. I. "Speech Pathology Services in a Home Health Agency: the Visiting Nurse Association of Detroit." ASHA, 1969, 11, 10, 462-463.
- Sarno, M. T. "Role of the Family in Aphasia." In Gerber, S., "The Family as Supportive Personnel in Speech and Hearing Remediation. Available from Social and Rehabilitation Service (DHEW), Washington, D.C. Rehabilitation Services Administration, U.S. Government Printing Office. 1971, 74-84.
- Schuell, H., Jenkins, J. J. and Jiménez-Pabón, E. Aphasia in Adults. New York: Harper and Row Publishers, 1964.
- Sies, L. F., and Butler, B. "A Personal Account of Dysphasia." Journal of Speech and Hearing Disorders, 1963, 28, 261-66.
- Seligman, M. Group Counseling and Group Psychotherapy With Rehabilitation Clients. Springfield: Charles C. Thomas, 1977.
- Snow, D. L. and Held, M. L. "Group psychotherapy with obese adolescent females." Adolescence, 1973, 8, 31, 407-414.
- Straub, J. H. "Multimodality counseling groups as an adjunct to the treatment of depression." Dissertation Abstracts International, 1976, 37, 3B, 1452.

- Street, C. P. "Changes in self-esteem in a self-esteem building workshop." Dissertation Abstracts International, 1976, 37, 3B, 1418-1419.
- Trotzer, J. The Counselor and the Group: Integrating Theory, Training and Practice. Monterey: Brooks and Cole, 1977.
- Turnblom, M. L. and Meyers, J. S. "A Group Discussion Program with the Families of Aphasic Patients." Journal of Speech and Hearing Disorders, 1952, 17, 4, 393-396.
- Turner, R. S., Ward, M. F., and Turner, D. J. "Behavioral Treatment For Depression: An Evaluation of Therapeutic Components." Journal of Clinical Psychology, 1979, 35, 1, 166-175.
- Vanderpool, J. A. "Alcoholism and the Self-Concept." Quarterly Journal of Studies on Alcohol, 1969, 30, 59-77. Cited in: Wylie, R. The Self Concept: A Review of Methodological Considerations and Measuring Instruments, Volume 1. Lincoln: University of Nebraska Press, 1974.
- Vicchiano, R. R., Strauss, P. S. and Schiffman, D. C. "Personality correlates of dogmatism." Journal of Consulting and Clinical Psychology, 1968, 32, 83-85. Cited in Wylie, R. The Self Concept: A Review of Methodological Considerations and Measuring Instruments, Volume 1. Lincoln: University of Nebraska, 1974.
- Vincent, J. "An Exploratory Factor Analysis Relating to the Construct Validity of Self Concept Labels." Educational and Psychological Measurement, 1968, 28, 9, 915-921.
- Vriend, J. "What Personal Master Counseling in Groups Is All About: Background and Rationale." The Journal for Specialists in Group Work, 1978, 3, 3, 104-112.
- Wayne, S. R. "The relation of self-esteem to indices of perceived and behavioral hostility." Unpublished doctoral dissertation, Vanderbilt University, 1963. Cited in: Fitts, W. Manual: Tennessee Self Concept Scale. Nashville, Counselor Recordings and Tests, 1965.
- Wepman, J. M. Recovery from Aphasia. New York: Ronald Press, 1951.
- Wiig, E. H. "Counseling the Adult Aphasic for Sexual Readjustment." Rehabilitation Counseling Bulletin, December, 1973, 110-119.
- Williams, R. L. and Cole, S. "Self-concept and school adjustment." Personnel and Guidance Journal, 1968, 46, 478-481.
- Wylie, R. The Self Concept: A Review of Methodological Considerations and Measuring Instruments, Volume 1. Lincoln: University of Nebraska Press, 1974.

Yalom, I. D. The Theory and Practice of Group Psychotherapy. New York:
Basic Books, 1970.

Yalom, I. D. The Theory and Practice of Group Psychotherapy, 2nd ed.
New York: Basic Books, 1975.

APPENDIX I

CONCEPTUAL DEFINITIONS
OF THE 29 TSCS SCORES

The following TSCS score definitions were noted by Fitts (1965):

- 1) Self Criticism (SC) Score: This scale is composed of ten (10) items. These are all mildly derogatory statements that most people admit as being true for them. Individuals who deny most of these statements most often are being true for them and are being defensive and making a deliberate effort to present a favorable picture of themselves. High scores generally indicate a normal, healthy openness and capacity for self-criticism. Low scores indicate defensiveness, and suggest that the Positive Scores are probably artificially elevated by this defensiveness.
- 2) The True-False Ratio (T/F): This is a measure of response set or response bias, an indication of whether the subject's approach to the task involves any strong tendency to agree or disagree... High T/F scores indicate the individual is achieving self definition or self description by focusing on what he is and is relatively unable to accomplish the same thing by eliminating or rejecting what he is not. Low T/F scores would mean the exact opposite, and scores in the middle ranges would indicate that the subject achieves self definition by a more balanced employment of both tendencies--affirming what is self and eliminating what is not self.
- 3) Net Conflict Scores: These scores are highly correlated with the T/F Score. More directly, however, they measure the extent to which an individual's responses to positive items differ from, or conflict with, his responses to negative items in the same area of self perception. Thus this is a limited and purely operational definition and application of the term "conflict".
- 4) Total Conflict Scores: High scores indicate confusion, contradiction, and general conflict in self perception. Low scores have the opposite interpretation.
- 5) Total Positive (P) Score: This is the most important score on the Counseling Form. It reflects the overall level of self esteem. Persons with high scores tend to like themselves,

feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful of their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves. If the SC Score is low, high P Scores become suspect and are probably the result of defensive distortion.

- 6) Row 1 P Score - Identity: These are the "what I am" items. Here the individual is describing his basic identity - what he is as he sees himself.
- 7) Row 2 P Score - Self Satisfaction: This score comes from those items where the individual describes how he feels about the self he perceives. In general this score reflects the level of self satisfaction or self acceptance. An individual may have very high scores on Row 1 and Row 3 yet still score low on Row 2 because of very high standards and expectations for himself. Or vice versa, he may have a low opinion of himself as indicated by the Row 1 and Row 3 Scores yet still have a high Self Satisfaction Score on Row 2.
- 8) Row 3 P Score - Behavior: This score comes from those items that say "this is what I do, or this is the way I act." Thus this score measures the individual's perception of his own behavior or the way he functions.
- 9) Column A - Physical Self: Here the individual is presenting his view of his body, his state of health, his physical appearance, skills, and sexuality.
- 10) Column B - Moral-Ethical Self: This score describes the self from a moral-ethical frame of reference--moral worth, relationship to God, feelings of being a "good" or "bad" person, and satisfaction with one's religion or lack of it.
- 11) Column C - Personal Self: This score reflects the individual's sense of personal worth, his feeling of adequacy as a person and his evaluation of his personality apart from his body or his relationships to others.
- 12) Column D - Family Self: This score reflects one's feelings of adequacy, worth, and value as a family member. It refers to the individual's perception of self in reference to his closest and most immediate circle of associates.
- 13) Column E - Social Self: This is another "self as perceived in relation to others" category but pertains to "others" in a more general way. It reflects the person's sense of adequacy and worth in his social interaction with other people in general.

- 14) Total Variability (V) Score: This score represents the total amount of variability for the entire record. High scores mean that the person's self concept is so variable from one area to another as to reflect little unity or integration. High scoring persons tend to compartmentalize certain areas of self and view these areas quite apart from the remainder of self. Well integrated people generally score below the mean on these scores but above the first percentile.
- 15) Column Total V Score: This score measures and summarizes the variations within the columns.
- 16) Row Total V Score: This score is the sum of the variation across the rows.
- 17) Total Distribution (D) Score: This score is a summary score of the way one distributes his answers across the five available choices in responding to the items of the scale. It is also interpreted as a measure of still another aspect of self perception: certainty about the way one sees himself. High scores indicate that the subject is very definite and certain in what he says about himself while low scores mean just the opposite. Low scores are found also at times with people being defensive and guarded. They hedge and avoid really committing themselves by employing "3" responses on the Answer sheet.
- 18) D Sub-Score 5: This score is simply a count of the number of 5 responses.
- 19) D Sub-Score 4: This score is simply a count of the number of 4 responses.
- 20) D Sub-Score 3: This score is simply a count of the number of 3 responses.
- 21) D Sub-Score 2: This score is simply a count of the number of 2 responses.
- 22) D Sub-Score 1: This score is simply a count of the number of 1 responses.
- 23) Defensive Positive (DP) Score: This is a more subtle measure of defensiveness than the SC score. One might think of SC as an obvious defensiveness score and DP as a subtle defensiveness score. The DP score stems from a basic hypothesis of self theory: that individuals with established psychiatric difficulties do have negative self concepts at some level of awareness, regardless of how positively they describe themselves on an instrument of this type. A high DP score indicates a positive self description stemming from defensive distortion.

- 24) General Maladjustment (GM) Score: This score is composed of 24 items which differentiate psychiatric patients from non-patients but do not differentiate one patient group from another. Thus it serves as a general index of adjustment-maladjustment but provides no clues as to the nature of the pathology. Note that this is an inverse score on the Profile Sheet. Low raw scores result in high T-Scores, and vice versa.
- 25) Psychosis (psy) Score: The Psy score is based on 23 items which best differentiate psychotic patients from other groups.
- 26) Personality Disorder (PD) Score: The 27 items of this scale are those that differentiate this broad diagnostic category from the other groups. This category pertains to people with basic personality defects and weaknesses in contrast to psychotic states or the various neurotic reactions. The PD score is again an inverse one.
- 27) Neurosis (N) Score: This is an inverse score composed of 27 items. As with the other inverse scores, high T-Scores on the Profile Sheet still mean high similarity to the group from which the scale was derived--in this case neurotic patients.
- 28) Personality Integration (PI) Score: This score consists of the 25 items that differentiate the PI Group from other groups. This group was composed of 75 people who, by a variety of criteria, were judged as average or better in terms of level of adjustment or degree of personality integration.
- 29) Number of Deviant Signs (NDS) Score: The NDS score is a purely empirical measure, and is simply a count of the number of deviant features on all other scores. This score is based upon the theoretical position of Berg (1957) as stated in his "deviation hypothesis". This hypothesis states that individuals who deviate sharply from the norm in minor behaviors are likely to be deviant in more major aspects of behavior. The findings with the NDS score substantiate this hypothesis. Disturbed persons often obtain extreme scores on either end of the continuum. Consequently, a system which sets appropriate cut-off points (above 10 or below 0) for the NDS score will identify disturbed persons with considerable accuracy.

APPENDIX II

Leadership Intervention Techniques to Facilitate the Group Process
 (Nolan, 1978)

<u>Intervention</u>	<u>Description</u>
Active listening (Gordon 1970)	Attending without interrupting.
Reflecting feelings (Carkhuff 1969)	Communicating understanding of affective content.
Questioning (Trotzer 1977)	Probes and open-ended questions.
Restatement (Benjamin 1974)	Mirroring or rephrasing client's statements.
Clarifying (Blackham 1977)	Simplifying client statements through translation into common meaning.
Supporting (Delaney & Eisenberg 1972)	Verbal reinforcement of desired behavior
Confronting (Trotzer 1977)	Identifying the existence of conflicting behavior or information.
Self-disclosure (Jourard 1971)	Revealing of personal information.
Semantic corrections (Ellis 1971)	Altering client phraseology into correct usage
Feedback (Mahler 1969)	Honest, concrete, and explicit opinions, impressions, and clinician's observations of client's behavior.
Explanation (Benjamin 1974)	Neutral descriptive statement to answer a client's behavior
Suggestion (Blackham 1977)	Mild form of advice
Tacting (Delaney & Eisenberg 1972)	A request for a specific example

Intervention

Silence
(Brammer & Shostrom 1977)

Blocking
(Corey & Corey 1977)

Modeling
(Corey & Corey 1977)

Summarizing
(Glass 1972)

Terminating
(Corey & Corey 1977)

Description

Absence of verbal interaction

A protective intervention on behalf of a group member or members

Demonstration of appropriate behavior

Pulling together cogent aspects of a discussion or group session in abbreviated form.

Preparation to finalize and disband

APPENDIX III

GENERAL INFORMATION

DIRECTION: Please fill-out the following information before you complete the two inventories that are enclosed.

1. Name _____
2. Address _____
3. Male _____ Female _____
4. Age _____ Age of Spouse _____
5. Date of spouse's last stroke _____
6. Is your spouse confined to a wheelchair or bed?

Yes _____ No _____

7. If any children at home, please list:

Names: _____ Age _____

8. Have you been satisfied with the programs available to spouses and families of stroke patients?

Yes _____ No _____

Please feel free to comment.

9. On a scale of 1 to 10, would you rate the degree of language difficulty of your spouse.

	1	2	3	4	5	6	7	8	9	10	
	/	/	/	/	/	/	/	/	/	/	
Cannot											Like before
speak											the stroke
	Profound	Severe		Moderate		Mild					

APPENDIX IV

"Selected Characteristics of Spouses And
Aphasic Victims"

Age	Sex	Children Home	Perceived Lang. diff. of their spouse	Yrs. of Educ.	Post CVA (Mo.'s)	Confined To Wheel Chair
Spouses						
63	M	0	Severe(3)	12		
49	F	1	Moderate(6)	16		
63	F	0	Profound(2)	12		
73	F	0	Profound(1)	12		
54	M	0	Profound(1)	12		
46	F	0	Moderate(6)	12		
73	F	0	Severe(3)	12		
53	F	0	Mild(9)	14		
72	F	0	Moderate(5)	12		
53	F	0	Profound(1)	12		
72	M	0	Profound(2)	12		
Mean: Age: 61.5 3.5 12.5						

Aphasics						
74	F				1*	No
51	M				21	No
72	M				9	No
75	M				11	Yes
55	F				10	No
49	M				12	No
73	M				16	Yes
58	M				10	No
72	M				4	No
53	M				13	Yes
72	F				14	Yes
Mean: Age: 65						

*Last of three strokes in last two years.

APPENDIX V

Reading material used directly during the group counseling program:

- Buck, M. Dysphasia: Professional Guidance for Family and Patient. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1968, 50-57, 147-153.
- Eisenson, J. Adult Aphasia: Assessment and Treatment. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1973.
Appendix IV: "The Family and the Recovering Aphasic;"
Appendix V: "Selected Annotated Bibliography of Books and Materials for Families and Friends of Aphasics."
- Emerson, R. "Referrals for Stroke Patients and their Families: Thurston and Pierce Counties." March, 1979.
- Horwitz, B. "An Open Letter to the Family of an Adult Patient with Aphasia," Rehabilitation Literature, 1962, 23, 5, 141-144.
- Boles, G. "Personality factors in mothers of cerebral palsied children," Genetic Psychological Monograph, 1959, 59, 159.
Cited in: Malone, R. L. "Attitudes Expressed by Families of Aphasics," British Journal of Disorders of Communication. 1970, 5, 2, 174-179.
- Skelly, M. "Aphasic Patients Talk Back," American Journal of Nursing, 1975, 75, 7, 1140-1142.

Reading material used indirectly with the group counseling program:

-American Heart Association Publications:

<u>Pamphlet</u>	<u>No.</u>
<u>Aphasia and the Family</u>	#50-002A
<u>Strokes: A Guide for the Family</u>	#50-025
<u>Stand Up To Stroke</u>	#50-033A
<u>Stroke: Why Do They Behave That Way</u>	#50-035A
<u>7 Hopeful Facts About Stroke</u>	#51-016A
<u>Road To Recovery (Directory of Services Available to Stroke Persons)</u>	AHA-W
<u>Stroke Clubs</u>	AHA-W

- Taylor, M. L. Understanding Aphasia: A Guide for Family and Friends. The Institute of Rehabilitation Medicine, New York University Medical Center, 1958.

APPENDIX VI

Individual pre and posttest scores, means and change for the
Depressive Adjective Checklist (A-D)*

<u>Treatment Group</u>											
Form:	A		B		C		D		<u>Mean</u>		<u>Change</u>
	<u>Pre</u>	<u>Post</u>	<u>Pre</u>	<u>Post</u>	<u>Pre</u>	<u>Post</u>	<u>Pre</u>	<u>Post</u>	<u>Pre</u>	<u>Post</u>	
	7	13	5	13	8	11	11	15	7.75	13.0	+ 5.25
	13	12	13	11	13	12	15	14	13.50	12.25	- 1.25
	5	4	4	2	4	7	2	4	3.75	4.25	+ .5
	16	1	17	4	18	5	18	5	17.25	3.75	-13.5
	15	9	13	8	13	13	13	14	13.50	11.0	- 2.5
	8	8	7	11	9	15	8	12	11.5	11.5	0
Mean:	10.66	7.82	9.83	8.16	10.83	10.5	11.16	10.66	10.63	9.29	3.83
<u>Control Group</u>											
	14	18	13	17	14	15	11	15	13.0	16.25	+ 3.25
	8	3	2	3	3	8	4	5	4.25	4.75	+ .50
	11	13	7	8	11	11	12	12	10.25	11.0	+ .75
	2	1	0	0	4	2	2	1	2.0	1.0	- 1.0
	5	4	3	5	5	4	5	6	4.5	4.75	+ .25
Mean:	8.0	7.8	5.0	6.6	7.4	8.0	6.8	7.8	6.8	7.55	1.15

*lower scores indicate less depression
change = Posttest minus Pretest

APPENDIX VII

Individual Pre and Posttest Scores, Percentiles, and Change for
the Tennessee Self-Concept Scale (P-score).

<u>Treatment Group</u>				
<u>Pretest</u>	<u>Percentile</u>	<u>Posttest</u>	<u>Percentile</u>	<u>Change</u>
378	82	383	91	+ 9
289	4	323	21	+17
327	26	304	9	-17
333	30	365	70	+40
296	7	315	15	+ 8
372	73	354	59	-14
Mean: 332.5	37.0	340.7	37.5	
S.D.: 37.1		31.2		
<u>Control Group</u>				
294	6	304	8	+ 2
375	79	373	76	- 3
361	66	327	26	-40
337	32	356	61	+29
382	90	375	80	-10
Mean: 349.8	54.6	347.0	50.2	
S.D.: 35.6		30.78		

APPENDIX VIII

FEEDBACK

Please consider the following sentence beginnings and complete them where you feel it is appropriate.

I learned that I....

I was surprised that I....

I was saddened that I....

I never knew that I....

I found it hard to believe that I....

I plan to change....

Comments:

Please make any comments that you feel would be helpful to me as the counselor or ideas you might have concerning our group.

Do you feel these group meetings have been helpful? Please comment.

APPENDIX IX

"Dominant Feelings of Six Spouses of Aphasics"

The following are the strongest and most dominant feelings that are a result of being a spouse of a stroke patient with aphasia, as identified by six spouses in the treatment group (9th session).

exhausted*	tired
frustrated	burdened
grief	imposed upon
mad	isolated
sad	helpless
pressured	determined
lonely	ignored
longing	infuriated
tempted	pressured
anxious	sympathetic
confused	confused
disturbed	

*Exhausted was listed five times.