THE ROLE OF RESILIENCE IN FACILITATING FAMILY ADJUSTMENT TO TRAUMATIC INJURY

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ACKNOWLEDGEMENTS

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S2S Development project

TBI
Liverpool BIRU, Royal Rehab, Westmead
BIU, Illawarra BI Service, Mid West BI
Service, BIU Princess Alexandra

SCI
Royal Rehab SIU and SOS, Prince of Wales
Family resilience after traumatic injury

- Established 1976
- 1st specialist TBI unit in Australia
- Co-located at the major trauma hospital for Sydney South West (lower socio-economic area)
- One of 15 units of the NSW Brain Injury Rehabilitation Program

16 bed IP ward
4 bed Transitional living unit
Vocational Rehab service
Community Rehabilitation team
Residential respite unit
Research team

LBIRU
LIVERPOOL HOSPITAL

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INGHAM INSTITUTE

- Not-for-profit medical research organisation for Sydney’s South West
- Medical research that addresses the needs of the local population and wider Australia.
- Unique collaboration between the SWSLHD, UWS and UNSW.
- 7 research streams: Injury & Rehabilitation (including BIRRG), Cancer, Clinical Science, Community & Population Health, Early Years/Childhood Health, Mental Health
AIMS

1. Context for resilience
2. Defining resilience
3. Role of resilience in family adjustment to traumatic injury
4. Building family resilience
1. CONTEXT FOR FAMILY RESILIENCE
High levels of depression and anxiety (Anderson et al 2013; Anderson et al 2009; Gervasio and Kreutzer, 1997)

Subjective burden and increased help-seeking behaviours (Ponsford et al 2003; Hall et al.1994)

Feeling overwhelmed (Douglas & Spellacy 2000)

Changes in family functioning including reduced levels of communication, affective involvement, general functioning and role change (Anderson et al 2013; Anderson et al 2009; Kreutzer et al. 1994).
Family members who become caregivers find that the caregiving role impacts upon their interpersonal relations, roles, social and leisure activity, employment, psychological well-being, and health-related quality of life (HR-QOL)

15.7% major depression <1yr post-SCI (Dreer et al 2007)
18.4% sig depression and 26.3% sig anxiety (Manigandan et al 2000)

Rates of caregiver burden at 25% (13y post-SCI) (Post et al 2005), 16.2% (moderate to severe burden, 12y post-SCI (Arango-Lasprilla et al 2010)
POLICY, PLANNING AND SERVICE DELIVERY PERSPECTIVE

Value of informal care
- $40 billion per annum in Australia (Access Economics 2010)
- $450 billion per annum in USA (Feinberg et al 2011)

Resilience is associated with
- reduced levels of morbidity (e.g., anxiety, depression)
- positive wellbeing
- sustainability of informal care

(White et al 2008; Godwin et al 2015)
EMERGENCE OF THE POSITIVE PSYCHOLOGY MOVEMENT

• scientific study of positive emotion, character and institutions (Seligman et al 2005)

• seeks to understand factors associated with happiness, well being and optimal functioning (Lee et al 2005)

• one application of PP has been to investigate recovery from traumatic injury and the concepts of resilience and post traumatic growth
2. DEFINING RESILIENCE
PEARLIN’ S STRESS PROCESS MODEL (1990) FOR CAREGIVERS

- Background variables
- Primary stressors
- Secondary stressors
  (Role change, intrapsychic)
- Mediating factors
- Stress outcomes
Family resilience after traumatic injury

STRESS PROCESS MODEL

• Caregiving may imperialistically expand to the point where it occupies virtually the entirety of the relationship
• Reciprocities and give and take that existed fade into the past
• Some caregivers (the exception) found some inner enrichment and growth even as they contend with mounting burdens
• Relentless and progressively expanding demands of caregiving are capable of diminishing positive elements of self
A PARADIGM SHIFT IN REHABILITATION?

...demanding and stressful experiences do not inevitably lead to vulnerability, failure to adapt, and psychopathology (Saleebey, 2006, p.13)

Within neurorehabilitation, the paradigm shift is away from a deficits-based to a strengths-based approach

(White et al 2008, Godwin & Kreutzer 2013)
Resilience is the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaption and ‘bouncing back’ in the face of adversity. Across the life course, the experience of resilience will vary” (Windle and the Resilience Network 2010)

“... a dynamic process encompassing positive adaptation within the context of significant adversity.” (Luthar et al., 2000, p.543)

Resilience is a multi-dimensional construct
Comprises a mix of personal skills and attributes, social competence and spirituality
Not just a personality type but a skill that can be acquired (White et al 2008)
POST TRAUMATIC GROWTH

• Tedeschi & Calhoun *Trauma and Transformation* (1995)
• Self-perceived PTG is referring to an objective complex cognitive, behavioural and emotional outcome of successful accommodation to the traumatic event (McGrath 2011)

• Identified benefits reported in the aftermath of trauma included:
  (i) a greater appreciation of life,
  (ii) improved quality of relationships with those going through the same thing, or who have been there to help
  (iii) discovery of unexpected personal strengths
  (iv) Opening up of unforeseen life options
  (v) A deepened ‘spirituality’
Family resilience after traumatic injury

POST TRAUMATIC GROWTH

- PTG not the struggle with the trauma per se but the appraisal or meaning
- Fit within existing schema
- Reframe but not change schema
- Denial or minimise trauma
- Changing of life priorities (true PTG)
- PTG can involve a spiritual dimension
- Critique of resilience as returning to homeostasis

FIGURE 1
Schematic representation of a range of possible psychological responses to adverse events.
FIRST WAVE (Richardson 2002)
What characteristics mark a resilient person?

Being female
Robust
Humour
Good self-esteem
Positive outlook
Internal locus of control
Self-mastery
Self-efficacy
Sense of purpose/making meaning

Caregiving environment inside/outside family
Warm, close, personal r’ship with an adult
Supportive family environment and an external support system
SECOND WAVE
How resilient qualities are acquired?

Stressors
Adversity
Life events

Protective factors

Bio-psycho-spiritual
Homeostasis

Disruption
Reintegration

Resilient Reintegration
Reintegration back to
Homeostasis
Reintegration with loss
Dysfunctional
Reintegration

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**GEORGE A BONANNO**

**Recovery:** trajectory in which normal functioning temporarily gives way to threshold or sub-threshold psychopathology.

**Resilience:** capacity to maintain a relatively stable healthy levels of psychological and physical functioning.

(Bonanno 2004)
<table>
<thead>
<tr>
<th>Type</th>
<th>Study Title</th>
<th>Year</th>
<th>Journal</th>
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<td>TBI</td>
<td>Kreutzer et al 2016</td>
<td>2016</td>
<td>Arch Phys Med Rehabilitation</td>
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<td></td>
<td>Hanks et al 2016</td>
<td>2016</td>
<td>Rehabilitation Psychology</td>
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<tr>
<td></td>
<td>Collicutt &amp; Linley 2006</td>
<td>2006</td>
<td>Brain Injury</td>
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<td>SCI</td>
<td>Catalano et al 2011</td>
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<tr>
<td></td>
<td>Bonanno et al 2012</td>
<td>2012</td>
<td>Rehabilitation Psychology</td>
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</tbody>
</table>
INTRODUCING FAMILY RESILIENCE

“The concept of family resilience extends beyond seeing individual family members as potential resources of individual resilience to focusing on risk and resilience in the family as a functional unit” Walsh, 2003.

“resilience involves key processes over time that foster the ability to “struggle well”, surmount obstacles, and go on to live and love fully” (Walsh, p.1)
A FAMILY RESILIENCE FRAMEWORK
(Walsh 2003)

Belief systems: making meaning of adversity, positive outlook, transcendence/spirituality

Organisational patterns: flexibility, connectedness, social and economic resources

Communication processes and problem solving: Clarity, open emotional expression, problem-solving
FAMILY BELIEF SYSTEMS

Making meaning of adversity

Positive outlook

Transcendence, spirituality
ORGANISATIONAL PATTERNS

Flexibility
- open to change
- stability
- good leadership

Connectedness
- being there

Social and Economic Resources
COMMUNICATION/PROBLEM SOLVING

Clarity
  • clear, consistent messages

Open Emotional Expression
  • sharing feelings
  • mutual empathy
  • humour

Collaborative problem solving
INTRODUCING FAMILY RESILIENCE

• Balancing the illness with other family needs
• Maintaining clear family boundaries
• Developing communication competence
• Attributing positive meaning to the situation
• Maintaining family flexibility
• Maintaining a commitment to the family as a unit
• Engaging in active coping efforts
• Maintaining social integration
• Developing collaborative relationships with professionals

Patterson (1991)
RESILIENCY MODEL OF FAMILY STRESS, ADJUSTMENT and ADAPTATION

**Figure 1**

The Resiliency Model of family stress, adjustment and adaptation: The adaptation phase for families of children with a TBI. Adapted from McCubbin and McCubbin (1996).
COMMUNITY RESILIENCE
ROLE OF RESILIENCE IN FAMILY ADJUSTMENT TO TRAUMATIC INJURY
STARTING POINT: LIMITED LITERATURE

Families play a key role in recovery (Robinson-Whelen & Rintala, 2003)

Current research focuses on burden and distress (e.g., Alfano et al, 1994; Boschen et al, 2005; Chan, 2000)

Few studies explore the experience of coping well and resilience after traumatic injury (Perlesz et al, 1999)

Limited resilience research in family adaptation to Spinal Cord Injury (White et al., 2008) or Traumatic Brain Injury (Perlesz et al, 1999)
INITIAL STUDY

Test hypothesised relationships between resilience and family member outcomes

Does resilience correlate to positive and negative affect?

Does resilience correlate to carer burden?
RESILIENCE, AFFECT and BURDEN

Resilience scores → Positive affect  \( (r = 0.67^{**}) \)

Resilience scores → Negative affect  \( (r = -0.42^{**}) \)

Resilience scores → Carer burden  \( (r = -0.32^*) \)

Independent of injury severity (FIM score)

N=61, \*p<0.05; **p<0.01
DO CARERS ADAPT OVER TIME OR JUST BURN OUT?

- 46 carers of people with SCI
- Consecutive series
- Assessed at 6 wks pre-discharge, 6 wks post-discharge, 1 and 2 years post-discharge
- Completed measures for psychological distress (GHQ-28) and health-related quality of life (SF-36)
- Are scores consistent with adaptation vs wear and tear hypothesis
WEAR AND TEAR vs ADAPTATION AMONG SCI CARERS

Psychological distress (General Health Questionnaire-28) significantly decreased across the four time points.
Health related quality of life (SF-36) Mental Component Score score significantly improved across the four time points, Physical Component Score remained stable.
TRAJECTORIES OF CARER ADAPTATION AFTER SCI

128 caregivers of people with SCI followed up for one year post-discharge

24% of the caregivers fell into the “chronic distress” category (high levels of depressive symptoms)

24% recovery, 48% resilient categories

Conclusion: a large percentage of caregivers were resilient in the first year after SCI

People in the “resilient” group characterised by enduring levels of positive affect and supportive social networks
CLINICAL SIGNIFICANCE OF RESILIENCE

People with low resilience score around 100 had a 90% chance of depression.

People with high resilience score around 150 had a 6% chance of depression.

Figure 2: Probability of depression by resilience scores: findings from logistic regression. Abbreviations: LCL, lower confidence level; UCL, upper confidence level. Note: Cutoff point for possible depression 8 or greater on the Hospital Anxiety and Depression Scale.

LCL = Lower confidence level, UCL = Upper confidence level
Note. Cut-off point for possible depression ≥ 8 on the Hospital Anxiety and Depression Scale.
SPIRITUALITY AND RESILIENCE

Spirituality makes an important contribution to resilience (White et al 2008)

Systematic scoping review found only 2 of 28 studies that addressed spirituality and adjustment to SCI looked at this in families

Took a broad approach to spirituality including religious faith, meaning making, purpose in life, sense of coherence, PTG, and hope.
SPIRITUALITY AND RESILIENCE PERSON WITH SCI

• Positive associations between spirituality and life satisfaction, quality of life, perceived health; also negative correlations to depression

• Underlying themes of meaning making, new life, openness to change, and growth through suffering

• However spirituality was treated as an end within itself, with only 1/28 studies extending this to look at the relationship between spirituality and resilience
SPIRITUALITY AND RESILIENCE

- Relationship between SOC and adjustment to disability for both spouse and person with SCI. Also spouses well-being related to some degree to the status of their partner (Feigin 1998).

- Interviews with 20 dyads identified 7 themes: looking for understanding in a life that is unknown; stumbling along an unlit path; viewing self through a stain-glassed window; challenging the bonds of love; being chained to the injury; moving forward in a new way of life; reaching a new normalcy.

- White et al (2010) found a significant positive correlation between resilience, satisfaction with life and intrinsic spirituality.
PERSONALITY, COPING AND RESILIENCE

Tackle the question of the relationship between personality types and resilience.

How does resilience interact with related constructs of coping, self-efficacy and hope?

Is resilience associated with mobilising social support?
SAMPLE (n=131)

Family members
• parents (58/131, 44%) or spouses (59/131, 45%)
• average age 53.8±11.4 years

Relatives with TBI
• average age 41.4±14.3 years
• average duration of PTA 71.7±64.3 days
• 3.0±3.9 years post injury
Model accounted for 63% variance in resilience
Small direct link from Extraversion to resilience
Problem Solving related directly to both SE and resilience
Strong relationship between SE and resilience
Resilience direct link to Pos affect
Resilience has a protective role with caregiver burden mediated through social support
Resilience has a protective role with poor mental health mediated through hope
Neuroticism has strong association with poor MH and increased burden

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SO WHAT ARE FAMILY MEMBERS DOING?

Do people with higher resilience scores use different carer management strategies to people with lower resilience scores?

Carer Assessment of Managing Index (38 items)

- Establishing a regular routine and sticking to it
- Taking one day at a time
- Keeping the person as active as possible
- Trying out a number of solutions until I find one that works

(N=61, t-test, p<0.002, Bonferroni correction)
A trend for:

Another 9 strategies that the group with high resilience scores may have been MORE likely to do

Plus one item that the group with high resilience scores were LESS likely to do

(N=61, t-test, p<0.05)
ARE THERE RESILIENCE-BASED DIFFERENCES IN PATTERNS OF COPING?

“constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141)

Ways of Coping Questionnaire  
(Folkman & Lazarus 1988)

Identified 7 studies, of which only one used the full 8 subscales (Tartar et al 1990)
## RESILIENCE-BASED DIFFERENCES IN WOC

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Low Resilience (n=49)</th>
<th>High Resilience (n=82)</th>
<th>T Test Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscale 1: Confrontive coping</td>
<td>4.8 ± 2.8</td>
<td>6.6 ± 3.9</td>
<td>2.84**</td>
</tr>
<tr>
<td>Subscale 2: Distancing</td>
<td>5.2 ± 3.3</td>
<td>7.1 ± 4.4</td>
<td>2.65*</td>
</tr>
<tr>
<td>Subscale 3: Self-controlling</td>
<td>9.4 ± 3.4</td>
<td>10.3 ± 4.3</td>
<td>-</td>
</tr>
<tr>
<td>Subscale 4: Seeking social support</td>
<td>7.8 ± 4.4</td>
<td>9.7 ± 4.9</td>
<td>2.22*</td>
</tr>
<tr>
<td>Subscale 5: Accepting responsibility</td>
<td>3.2 ± 2.6</td>
<td>2.9 ± 2.9</td>
<td>-</td>
</tr>
<tr>
<td>Subscale 6: Escape-avoidance</td>
<td>6.4 ± 4.5</td>
<td>5.4 ± 4.1</td>
<td>-</td>
</tr>
<tr>
<td>Subscale 7: Planful problem solving</td>
<td>8.2 ± 3.8</td>
<td>10.3 ± 4.1</td>
<td>2.84**</td>
</tr>
<tr>
<td>Subscale 8: Positive reappraisal</td>
<td>6.8 ± 4.3</td>
<td>7.9 ± 5.5</td>
<td>-</td>
</tr>
<tr>
<td>Combined Subscale: Problem Focused</td>
<td>16.0 ± 6.7</td>
<td>20.0 ± 7.7</td>
<td>2.96**</td>
</tr>
<tr>
<td>Combined Subscale: Emotion Focused</td>
<td>35.7 ± 15.5</td>
<td>40.3 ± 18.8</td>
<td>-</td>
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</table>
## CONTENT OF THE SIGNIFICANT WOC SUBSCALES

<table>
<thead>
<tr>
<th>Subscale</th>
<th>HR&gt;LR</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confrontive coping</td>
<td>HR&gt;LR p=.005</td>
<td>Aggressive efforts to alter the situation and suggests some degree of hostility and risk-taking</td>
</tr>
<tr>
<td>Distancing</td>
<td>HR&gt;LR p=.009</td>
<td>Cognitive efforts to detach oneself and to minimise the significance of the situation</td>
</tr>
<tr>
<td>Seeking social support</td>
<td>HR&gt;LR p=.028</td>
<td>Efforts to seek informational support, tangible support, and emotional support</td>
</tr>
<tr>
<td>Planful problem solving</td>
<td>HR&gt;LR p=.005</td>
<td>Deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem</td>
</tr>
<tr>
<td>Problem Focused Coping</td>
<td>HR&gt;LR p=.004</td>
<td>Combined subscales comprising Planful Problem Solving’, ‘Seeking Social Support’</td>
</tr>
</tbody>
</table>
BUILDING RESILIENCE
ASSESSMENT

- Dual clinical target for assessment and t’x?

- Currently assess psychopathology, should we focus on our A’x of strengths?

- Clinical interview

- Measures (resilience, PTG, spirituality)

- Challenge – multi-faceted, do we know the clinical significance yet?
MAKING MEANING OF ADVERSITY

• Attribution of blame
• Spiritual dimension

POSITIVE ATTRIBUTION

• Can people see any good that has come out of the injury?

What sort of good have others found through this experience?
Family organisation

FLEXIBILITY

- Role changes
- Keys to flexibility

Getting stuck – here are some keys

- Do I have to do it?
- Does it have to be done now?
- Can I learn how to do it?
- Can someone else do it?
- Can someone else learn how to do it?
- Can I do it differently?

CONNECTEDNESS

- Maintaining social integration
- Mobilising social and economic resources
Family organisation

REGAINING SOME BALANCE

- What is missing from your life?

FAMILY COHESION

- Sharing the load
- Communicating support need
- Degree of family drift

Close/r On hold Distant

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MANAGING THE CHALLENGES

- Develop communication competence
- Open emotional expression
- Active coping
- Collaborative relationships with HPs
- Organization skills
- Problem solving
REVIEW OF RESILIENCE SCALES

- No longer possible to infer the presence of resilience indirectly
- Windle et al (2011) identified 19 measures (15 actual + four refinements)
- Tested on 8 psychometric dimensions and scored on a scale ranging from 0 to 18
- Connor-Davidson Resilience Scale; Resilience Scale for Adults, Brief Resilience Scale all scored 7/18
- Resilience Scale scored 6/18
- The conceptual and theoretical adequacy of a number of the scales was questionable (Windle et al 2011)
CONNOR-DAVIDSON RESILIENCE SCALE

- 25-items
- 5-point Likert scale
- Scores range 0 -100, greater resilience
- 5 factors but used as uni-dimensional
- Modest one-off fee

PLEASE COMPLETE IN BLACK INK ONLY.

Connor-Davidson Resilience Scale
(CD-RISC)

<table>
<thead>
<tr>
<th>not true at all</th>
<th>rarely true</th>
<th>sometimes true</th>
<th>often true</th>
<th>true nearly all the time</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>3</td>
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Research Article

DEVELOPMENT OF A NEW RESILIENCE SCALE: THE CONNOR-DAVIDSON RESILIENCE SCALE (CD-RISC)

Kathryn M. Connor, M.D.,* and Jonathan R.T. Davidson, M.D.
RESILIENCE SCALE

Development and Psychometric Evaluation of the Resilience Scale

Gail M. Wagnild, PhD, RN
Heather M. Young, PhD, RN

- 25-items
- 7-point Likert scale
- Scores range 25-175, greater resilience
- Five interrelated components of equanimity, perseverance, self-reliance, meaningfulness, and existential aloneness
- 2 Subscales – Personal Competence, Acceptance of Self and Life
- Modest one-off fee

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
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<tr>
<td>1</td>
<td>When I make plans I follow through with them</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>2</td>
<td>I usually manage one way or another.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>3</td>
<td>I am able to depend on myself more than anyone else</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>4</td>
<td>Keeping interested in things is important to me</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>
CHECKING OUTCOMES - DASS-21

DEPRESSION, ANXIETY, STRESS SCALE - 21

- 21 items
- 4-point Likert scale
- 3 subscales with 7 items each
- Depression, Anxiety, Stress with scores ranging from (0-21)
- Double the scores and chart to convert to standardised scores
- Able to classify scores onto clinical severity bands (nil, mild, moderate, severe, very severe)
- Able to purchase manual and materials for modest fee, no restrictions

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:
0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1 I found it hard to wind down 0 1 2 3
2 I was aware of dryness of my mouth 0 1 2 3

Name:  
Date:  

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POSSIBLE INTERVENTIONS

Very few evidence-based interventions directly designed to address resilience

Paediatric
TBI    Resilience    Family Forward    Hickey et al 2016

Adults
ABI    Strengths-based    Review (5 studies)    Tam et al 2016
PROBLEM-SOLVING THERAPY

Problem-solving interventions (PSI) with caregivers can “(a) enhance caregiving skills and (b) minimize the stressful nature of the caregiving role” and effective problem-solving abilities may benefit caregivers by promoting a “sense of mastery or control, which in turn, contributes to positive mental health” (Nezu, Palmatier, & Nezu, 2004, p. 224).

Rivera et al Arch Phys Med and Rehab 2008
• RCT evaluating a PS intervention (n=33) vs education along (n=34)
• Treatment delivered across 4 home visits and 8 follow-up phone calls over 12 months
• Sig decreases in depression, health complaints, dysfunctional PS
• NS changes in caregiver burden, well-being and constructive PS
SUPPORTING SPIRITUALITY
(Jones et al 2016)

• Incorporate client religious views into assessment
• If appropriate support client use of spirituality
• Rehab nurses have unique opportunity to promote spirituality
• Explore clinical interventions around meaning making to be incorporated into rehabilitation process
• Importance of peer support in bringing hope for the future
• To support hope, explore the meaning and appraisals clients currently attach to their experience
# Family resilience after traumatic injury

## STRENGTH 2 STRENGTH

### PROGRAM DEVELOPMENT

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Literature review</th>
<th>Focus groups</th>
<th>Empirical Study</th>
<th>Steering committee brainstorm</th>
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<tbody>
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<td>Session 1</td>
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<tr>
<td>Session 5</td>
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</table>
TARGET GROUP

Target group

• Family members of any kinship, friends
• Aged 18 years and older
• Relative with TBI or SCI less than 30 years post-injury
• Although designed for families supporting relatives with traumatic injury, it can also be delivered to families supporting relatives with SCI or TBI acquired through illness
• Moderate English fluency is needed to fully benefit from the group
PROGRAM FOCUS

Focus

• Primary focus on building family participant resilience
• Not an information program
• Not predominantly skills training in how to provide support or care to relative
Family resilience after traumatic injury

PROGRAM DEVELOPMENT INFORMED BY . . .

- Cognitive-behavioural approaches
- Grief and loss
- Strengths-based theory
- Solution-focused theory
- Family Systems theory
- Group work theory
PROGRAM STRUCTURE

PROGRAM OUTLINE

Session 1
“Telling Your Story”
A time to get to know one another, share your story and discuss the idea of resilience. We will look at where we have each been, where we are now, and where we are hoping to be.

Session 2
“Active Participation”
In this session we will hear from a family member of a person with a traumatic injury, discuss information overload and strategies to manage it, and talk about different ways to share information with family and friends.

Session 3
“Staying on Top”
During this session we will begin by looking at our strengths. We will also consider whether anything good or positive has come from our experience and see what others have had to say about this topic.

Session 4
“Regaining some Balance”
This session we will talk about rest, health, and ways to take time for ourselves.

Session 5
“Staying Connected”
We will start this session looking at the different needs you and your family members have and how you juggle the balance. This is our last session, and will be a chance for us to provide you with some information on supports and services. We will finish off with a group celebration.
SESSION 1: “TELLING YOUR STORY”
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Clinical constructs addressed in session 1: 

*Making meaning and open emotional expression*

**Aim:**
To introduce group program and idea of resilience
To allow participants to reflect or make meaning of their experience since injury

**Objectives:**
(i) Introduce group and program
(ii) Make meaning of the experience of the injury
(iii) Introduce concept of resilience
SESSION 2 : ACTIVE PARTICIPATION

ACTIVE PARTICIPATION

- Too many things happening
- Feeling angry
- Feeling left out
- Feeling scared
- Feeling frustrated
- Can't keep track
- Worried about the future
- Having no say
- Looking for answers

Communication, Information, Organisation
SESSION 2: ACTIVE PARTICIPATION

Clinical constructs addressed in session 2:
*Developing communication and personal organization competence, Developing collaborative relationships*

**Aim:**
To enhance participant’s knowledge and understanding of the rehabilitation and community support processes, thus enabling them to participate more actively and to gain a sense of control and competence.

**Objectives:**
(i) To listen to the experiences of another consumer (DVD) to compare and contrast with own experiences
(ii) To increase effective communication and organisational skills
EXERCISE FOR SESSION 2
SESSION 3: STAYING ON TOP
SESSION 3: “STAYING ON TOP”

Clinical construct addressed in session 3: Positive appraisal

Aim: To enhance awareness of strengths and challenges in the context of family and community systems

Objectives:
(i) To identify pre-existing strengths that participants have employed in adapting to the challenges, as well as new strengths
(ii) To facilitate a process of developing positive appraisal in relation to the changes and challenges
SESSION 4: REGAINING SOME BALANCE AND RECHARGING THE BATTERIES
SESSION 4: “REGAINING SOME BALANCE AND RECHARGING THE BATTERIES”

Clinical constructs addressed in session 4:
*Balancing injury and other needs, Flexibility*

**Aim:**
To explore strategies for restoring some balance and recharging batteries

**Objectives:**
(i) To increase the number of pleasant events that participants schedule during their week
(ii) To evaluate and identify strategies for maintaining or improving participants health and well being
(iii) To learn brief relaxation strategies
SESSION 5: STAYING CONNECTED
SESSION 5: “STAYING CONNECTED”

Clinical constructs addressed in session 5: 
Connectedness, family cohesion, mobilizing social and economic resources

Aim:
To address family cohesion, means to mobilize social and economic resources, and to facilitate group closure.

Objectives:
(i) To examine strategies for facilitating family cohesion
(ii) To identify the range of service supports that may be of assistance
(iii) To learn some self-advocacy strategies for mobilizing resources
(iv) To facilitate group closure
10 tips for building resilience
assembled by The American Psychological Association

1. Make connections
2. Help others
3. Maintain a daily routine
4. Take regular breaks
5. Promote a balanced lifestyle
6. Keep moving toward goals you care about
7. Nourish a positive self view
8. Cultivate an optimistic outlook
9. Develop your ability to play to your strengths
10. Keep learning
RESULTS
TREATMENT VS STANDARD CARE

**PANAS Positive**

- Treatment
- Standard Care

Time 2 comparison $p = .015$

**Carer Assessment Managing Index**

- Treatment
- Standard Care

Time 2 comparison $p = .008$
REBEKAH REURICH: A 2\textsuperscript{nd} PILOT

3 carers, all F
2 spouses / 1 parent
mean 48 yrs age
2 TBI, 1 CVA, mean 38 yrs
14 months post injury/illness
Completed S2S (10 hours, 5 sessions)
Completed measures at pre, post- and 8 week follow-up
Assessed resilience, depression and stress

- Significant improvements in resilience for participants 1 and 2
CAN WE HELP TO BUILD RESILIENCE?

Significant decreases in depression for participants 1 and 2
Significant decreases in stress for all 3 participants
CONCLUSIONS

New theoretical developments are advancing our understanding of adaptive human responses to trauma and adversity.

Early empirical data among family caregivers is promising in confirming a number of the theoretical predictions, and demonstrating the benefit in (i) broadening our understanding outcomes for caregivers, and (ii) the role of resilience, spirituality and PTG in mediating outcomes.

Limited evidence-base for interventions and further debate about the need for new interventions vs enhancing or refocusing existing practice.
QUESTIONS

“There are no stupid questions, so let’s also agree there are no stupid answers.”
THANK YOU

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If we knew what it was we were doing, it would not be called research, would it?

(Albert Einstein)