EVALUATION OF THE ARTHRITIS MEN'S GROUP

by

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ABSTRACT

Approximately 18 months ago, an Arthritis Men's Group was started by the Social Work Department at the Vancouver Arthritis Centre. Having identified the need for such a group, interim objectives were proposed for the group which was still in the pilot stage of its development.

The purpose of the study was to conduct a formative evaluation of the Men's Group to take a closer look at what was happening in the sessions, to examine the feasibility of the objectives and whether these objectives were being achieved. This information would be used by the planners to improve and/or modify the program.

The underlying conceptual approach to the study was 'naturalistic'. In the context of this framework, several data collection methods were used including: interviews, quantitative measures, monitoring and narrative descriptions of group sessions.

The findings suggested that interim objectives were being met in the sessions which focussed specifically on psycho-social issues. In addition, other sessions were serving an important 'informational' function which was recognized and valued by group members. Interviews with core-group members did indicate the perceived acceptance and usefulness of open discussions on psycho-social issues. However, over the short duration of the monitoring period no significant changes were found on the measures pre to post so that the positive or negative effects of the achievement of higher levels of emotional openness is not known.

The study did provide a good preliminary data base on the nature of the group process and the heterogeneity of the membership. Useful information was gathered both on the kind of group process which may facilitate the achievement of the specific program objectives as well as the informational function of the group. Overall, group members seemed satisfied with group process and content and wanted to see the group continue.
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CHAPTER I

Background and Problem Area of Thesis
Since the 1970's there has been a growing awareness among men in North American society that the male role stereotype and accompanying values and attitudes may no longer be functional in a more egalitarian society (Wong, 1978). The desire on the part of these men has been "to expand the range of emotions and behaviors open to them" (Wong, 1978). The beginning awareness of a need for change has led to the establishment of consciousness-raising groups for men.

It is the ongoing process of change in how men think about themselves that has contributed to the possibility of the present study. Consciousness-raising groups have helped men deal with feelings and attitudes in relation to societal expectations. They have not, however, focussed on how these expectations affect the way they view and cope with their health.

The present study is an evaluation of a Men's Support Group for men with arthritis. This group was started 18 months ago at the Vancouver Arthritis Centre, Social Work Department. The group was conceived as providing a supportive forum in which to discuss concerns around the issue of 'what makes it difficult to be a man and have a chronic condition'.

The Prevalence of Arthritis

The impact and prevalence of chronic disease is profound. Burish and Bradley (1983) write:

Most people reading this book will probably die of a chronic disease. Indeed, 8 out of the 10 most common causes of death in the United States are chronic diseases, including the 3 leading causes of death - heart disease, cancer, and cerebrovascular diseases.

While arthritis is not considered a 'killer disease' it is the most prevalent chronic condition. It strikes one out of every seven people, affecting one out of every three families (Arthritis Foundation, 1985).
In a recent study of the epidemiology of musculoskeletal disorders and related disability in Canada, Lee et al (1985) analyzed the data collected (but not published) from the Canada Health Survey (C.H.S.) in 1981 on musculoskeletal disorders. The percentage of the sample - 16% with arthritis, rheumatism or back, limb or joint disorders - shows the magnitude and prevalence of the disease. In terms of the Canadian population as a whole, this percentage represents 3,686,000 people out of a total population of 23,002,000.

Results from the C.H.S. showed that overall, prevalence was greater among females, 18.8% as opposed to 13.2% for males and that prevalence and the disparity in the sex ratio, increased with age. In the 15-64 age cohort, 19.4% were females and 14.6% males. In the 65+ age cohort, 50% of the sample were affected: 55.7% female and 39.3% male. While the age group under age 15 constituted only 1.3% of the sample population, this translates into 74,000 children in the Canadian population with musculoskeletal conditions.

In terms of ability to work, 16% of the sample population were affected. Twenty-one percent of the sample (representing 3.4% of the Canadian population) reported limitation of activity during the last year, and of those with arthritis and rheumatism in the working group, 20.8% of males and 17.4% of females reported activity limitations. Overall, the magnitude of disability days in the total Canadian population on an annual basis was estimated as being an astounding 41,056,080 days, an average of 11.1 days per person per year.

The Psycho-social Problems of People with Chronic Disease

With the expansion of the medical model in recent years has come an acknowledgement of the psycho-social and emotional problems associated with a chronic
condition. The influence that these factors may have on the disease has also been recognized.

While there is no proven causal effect between emotional stress and arthritis, it is accepted that when a person has arthritis, emotional stress can exacerbate the disease. Indeed "coping with disease, disability and pain is itself a source of tension, depression and fatigue" (Kerson & Kerson, 1985).

In terms of theory, the recognition of the influence of psycho-social stress on a chronic condition can be traced in recent theories of rehabilitation described by Duval (1982) as 'integrative theories' which incorporate both intrapsychic and environmental factors. These may be seen as the theories upon which holistic approaches to treatment are inherently based. This has led to the concept of the 'team approach'. This approach values and supports the role of the social worker whose primary function is to help the patient deal with the psycho-social effects of the disease.

In the case of arthritis treatment, the adoption of the team approach at the Vancouver Arthritis Centre to include the rheumatologist, physiotherapist, occupational therapist, nurse and social worker can be seen as an expansion of the medical model to accommodate and encompass a psychosocial perspective.

The physical and psychological consequences of chronic disease are often difficult to separate and have ramifications on every important aspect of the person's life. The person with arthritis must face:

The often sporadic nature of the condition itself; the necessity for continuous drug therapy; the physical effects - pain and deformity; the effects on activities of daily living and the resultant frustrations with the simplest of tasks, frequent necessity to change jobs with consequent financial loss, [and] humiliation; . . . the effect on families who might need to alter and adapt roles; the change in social life; alteration of one's self image . . . (Henkle, 1975).
One practical model of chronic illness (Mailick, 1979) suggests that there are three adaptation phases. In each of these phases the model delineates and addresses the psycho-social problems of chronic illness for the patient and family and the role of the social worker. Typically, both the patient, family and/or significant others experience particular psychosocial problems at each disease stage.

During the diagnostic stage the individual has to deal with the stress of uncertainty, the strain of tests and visits to numerous health professionals and the crisis of the diagnosis itself. Adjustment to the disease (phase 2) demands significant physical and emotional adjustment. The person must cope with the emotional and physical strain of discomfort, pain, loss of physical control and changes in physical appearance. If the disease goes into remission, (Stage 3) as may be the case with arthritis, the patient and family have to deal with 'uncertainty and regulation of hopefulness' which requires 'the balancing of opposing emotional tasks . . . the image of the patient as presently well but eventually ill again' (Mailick, 1979). Paradoxically, remission is often a time when emotions previously ignored or masked by the intensity of the disease process, may resurface.

Self-Help Groups in Health Settings

When considering the role of a self-help group for people with a chronic condition, it is important to note the nature of chronicity as opposed to acute illness. A chronic illness is permanent and present throughout the life-cycle. The damage caused is usually irreversible. The disease may be in remission or exacerbation and may require ongoing rehabilitation as well as drug therapy.

Self-help groups are now a well-established educational and psychosocial intervention technique used to help deal with the stresses of a chronic illness. The
problems that people with arthritis frequently face relate to adjustment, the need for support and practical problems.

The growth of self-help groups in the health field has expanded rapidly since the 1970's (Katz & Bender, 1976). According to Lurie and Shulman (1983), this was concurrent with activist movements, trends towards community involvement and control of health services, the women's movement with concerns about relationships in the male-oriented, male-dominant health care field, and other pressures, both financial and service directed, upon the various components of the health care system.

Self-care groups fill gaps in ongoing support and assistance following acute or chronic care episodes and as such can be seen as "therapeutic and physical extenders of services" (Lurie & Shulman, 1983). Allowing a philosophy of self-direction, they advocate a person's right and responsibility to understand his/her own health needs and decide and act on health care problems, regardless of whether they are institutional priorities (Lurie & Shulman, 1983).

The benefits of group experiences for people with chronic illness are described by Cunningham, Strassberg and Roback (1978). The group facilitates 'instillation of hope' such that members of the group whose disease is active may be encouraged by seeing members who are presently feeling well. The members experience 'universality' by sharing common experiences relating to their condition. They are able to give and receive information. The group is a forum for 'interpersonal learning' and the 'development of socializing techniques'. A sense of group cohesiveness may counteract isolation and provide a safe environment in which the individual has the opportunity to express themselves, which can lead to a form of catharsis. Moreover, benefits of the group process may extend beyond the group in friendships and extragroup activities.
The 'helper-therapy' principle (derived from role theory) underlying a self-help group works to provide individual members with several additional benefits, (Gartner & Riessman, 1984). Being an 'effective helper' raises the interpersonal competence of the member; leads through giving and receiving to a sense of equality with other members; may facilitate personal learning through helping another group member; and affords the 'effective helper' social approval (Gartner & Riessman, 1984). The importance of social, particularly peer approval is also emphasized by Lurie and Shulman (1983) who write that:

for people who have suffered severe physical and psychological trauma, the need for resocialization and peer approval is often a strong and important therapeutic agent in the rehabilitation to independent status.

Also the participant as an 'effective helper' may become less dependent, is able to see his/her own problem more objectively by helping another with a similar problem and gains by playing a 'socially useful' role (Gartner & Riessman, 1984).

Recent literature shows that the predominant focus of self-help groups "is to provide opportunities for ventilation and universalization of feelings, hope, identification and other mutual-aid experiences" (Berkman et al, unpub. paper). In respect to chronic illness support-group studies with this focus have been reported with cancer patients (Berger, 1984), multiple sclerosis patients (Hartings & David, 1979), Mastectomy patients (Euster, 1979), Alzheimer's patients (Carey & Hansen, 1985), wives of patients with Alzheimer's (Vorgna, 1979), people with scoliosis and their families (Hinrichsen, Revenson & Shinn, 1985), as well as with home care staff such as home hemodyalysis assistants (Roy, Flynn & Atcherson, 1982).

There are several articles on arthritis using a group therapy approach (e.g. Udelman, 1978 and Schwartz, Marcus & Condon, 1978) but not a support-group approach.
A good recent article on group intervention and arthritis is the first random controlled study on patients with Rheumatoid Arthritis using a group psychotherapeutic technique (Strauss et al, 1986). This study tested the hypothesis "that a psychosocial intervention would lead to improvement in functional status or disease activity" (Strauss et al, 1986). The results of the study were not very positive. The researchers were not able to show "significant improvements in self-reported functional status, social or psychological adaptation, psychological symptoms, or disease activity" (Strauss et al, 1986).

While there is a small body of literature specifically on the use of support groups as an intervention for people with chronic disease, the literature on support groups for men with a chronic condition is extremely limited.

The concept of a self-help group was discussed in two studies on the importance of the relationship between men, their social supports and health. The first study (Pancoast, 1984) researched 'the contribution of social support to the successful functioning of men with epilepsy'. One hundred men with epilepsy were interviewed on variables of history of their illness, employment history and their personal support network. Results showed that informal "support from family and friends is limited, strains these relationships and may reinforce patterns of dependence" (Pancoast, 1984). Recommendations of the study were to focus the attention of the social activities of these men "towards a more 'normal' pattern of general sociability and equal exchange, rather than dependence on a few, close ties" (Pancoast, 1984). This study suggests the feasibility of a men's support group for this population of men with chronic illness.

In a controlled study of male myocardial infarction patients, 105 men aged 30-65 were asked to report on the number of confiding relationships they had and their subjective perceptions of their social environment (Winefield, 1982). Some evidence was found for the hypothesis put forward in the study that "social supports act as a
mediating or buffering influence upon vulnerability in the face of adverse life circumstances. Results showed that hospital patients who said they had a greater number of confiding relationships and those who had joined a support group to discuss adjustment following discharge, were inclined to feel better than other patients 6 - 7 months later. While a significantly strong relationship was not found between social support and recovery, social supports were seen as one important influence affecting recovery. It was emphasized that support groups which serve to create supportive helping networks should be a primary focus of rehabilitation efforts.

The most pertinent literature combining the variables of men, support groups and chronic disease is the most recent literature on Acquired Immune Deficiency Syndrome (A.I.D.S.).

The complicated medical, psychological and social conditions of A.I.D.S. demands an expansion of the restricted mental health component of treatment typically available for people in a hospital setting (Morin, Charles, Malyon, 1984). One report discusses how "support groups have become an intrinsic part of the treatment of people with AIDS": for men diagnosed with A.I.D.S.: for men in the 'gray zone' who are labelled as 'pre-AIDS', 'Lesser AIDS' or 'prodonal AIDS'; as well as for the 'worried well' (Morin, Charles, Malyon, 1984).

For men diagnosed with A.I.D.S. as for men with other chronic conditions, the support group offers a safe environment in which to share feelings and to gradually move towards an acceptance of the disease. A special benefit of support-groups to the A.I.D.S. patient is the physical contact afforded by participation in the group which may be denied elsewhere due to a fear of casual contagion (Morin, Charles, Malyon, 1984). The support-group environment is also conducive to the expression of anger, resentment and loss, particularly important for A.I.D.S. patients to express.
The uncertainty experienced by men with 'pre-AIDS' results in significant psychological distress, in some cases leading to anxiety disorders (Morin, Charles, Malyon, 1984). Support groups for this population serve to provide a 'nonjudgemental atmosphere' so that issues can be openly discussed and anxiety and stress levels lessened (Morin, Charles, Malyon, 1984). They also promote sharing and acting on health seeking behaviors (Morin, Charles, Malyon, 1984). As with other chronic conditions, stress is seen to have a negative effect on the course of the disease, in this case "contributing to immune suppression" (Morin, Charles, Malyon, 1984).

The 'worried well' may often show serious psychological symptoms relating to the anxiety generated by:

- Obsessional thinking about A.I.D.S., fear of contagion,
- reduced social life, health concerns, sexual issues, loneliness,
- grieving due to the loss of friends and lovers who have died from A.I.D.S., confusion regarding how to deal with friends and loves who have just been diagnosed, and difficulties in dealing with medical aspects of the crisis (Morin, Charles, Malyon, 1984).

In A.I.D.S. support groups these are the issues most frequently discussed.

Wolcott, Fawzy and Pasnau (1985) in an article on the psycho-social and psychological distress associated with A.I.D.S. have designed 'an ideal comprehensive program to meet the needs of 'AIDS-affected' individuals'. Support groups for AIDS-affected individuals, as for family members and significant others are an integral part of the program. Of particular interest is the program component of support groups for health care professionals caring for this population. These support groups help to minimize stress and 'chronic professional stress syndrome' by allowing "for expression of feelings engendered by patients' illnesses and death" (Wolcott, Fawzy & Pasnau, 1985).

In the search for literature on men, support groups and arthritis, no articles were found.
Psycho-social Problems of Men with Arthritis

It is generally agreed that a person's reaction to arthritis and ability to cope with adjustment to the disease depends on several interrelated factors: age and stage in the lifecycle; the severity of the disease; personality or temperament; social supports; past life experience; future plans; environmental circumstances; coping ability; and tolerance of pain. Moreover, while every person has to deal with universal stressors (e.g. food and shelter) and personal stressors (e.g. marriage and death of a loved one) a person with arthritis has also to deal with chronic illness stressors, (e.g. pain, fear of the future and effects on the family) (Ziebell, 1981). In addition, the person's social network is affected on all system levels: the nuclear family; the extended family; the social family; the professional family; and the community at large.

For a man who is diagnosed with arthritis however, an extra set of factors come into play to do with his learned expectations of his social role. Men are socialized and expect to be in control, independent, self-reliant, in charge, able to overcome adversities and achievement oriented. These expectations are characteristically focussed on the man's work role and career plans which are often synonymous with his sense of identity. Ironically, adjustment to the disease for a man implies to some degree a surrendering, softening or 'reframing' of these expectations. Adjustment may also necessitate significant re-evaluation of life-long or even trans-generational traditional male values, attitudes and norms. In terms of the man's work, adjustment may mean needing to make a change within the work setting, making a complete career change and/or retrain or facing the fact that he can no longer work.

Male Socialization

The literature on male social, psychological and physical characteristics
gives several indicators which help explain the kinds of problems that a male with arthritis might face.

Four major socializing agents seen as influencing differences between males and females are parents, the mass media, the educational system and peers. Each of these agents overtly or covertly support the differential treatment of girls and boys and a reinforcement of male attributes so that men are socialized to become independent, aggressive, in control and able to overcome adversities.

Results of the socialization process and the development of sex-role identity are evident in certain behaviors which characterize a man’s personality such as self-reliance, aggressiveness and guarding against self-disclosure. Cicone and Ruble (1978) characterize the ‘typical male’ in terms of three descriptive categories of traits:

1. "How a man handles his life" (active and achievement oriented - a go-getter striving for worldly success);
2. "How a man handles others" (dominant - i.e. "the putting of self over and against other people");
3. "How a man handles his psyche" (the ‘typical man’ is seen as cool, self-contained and level-headed).

In respect to the first trait, the impact of arthritis would seem to imply a complete role reversal. A man who is ambitious and achievement oriented may find he is unable to continue working in the same capacity, or possibly unable to work at all. This could lead to loss of his sense of identity, a lowering of self-esteem and a fear of a future with no economic security. In view of the second trait, a man who is used to being dominant and exercising control, the effects of the disease - which undermines body integrity and thereby tends to increase the need for support and a dependent rather than an independent lifestyle - could be profound.
As for 'handling his psyche', in an attempt to uphold his male image a man may choose to underplay his disease, not to seek help or only when things reach crisis proportions. Self-disclosure is synonymous with being vulnerable and undefended and as such is incompatible with the male role. For this reason the man may try to deal with his disease alone, refuse to recognize his own or others' emotions and/or express them with significant others. Farrell (1974) sees men as having "emotional dependency constipation". They cannot deal with others' or their own emotions. He sees their sense of identity as dependent on the consistent projection of independence regardless of circumstances.

Conclusions of a study by Guerin, Veroff and Field (1960) on how males and females describe themselves also reflect the traditional male-stereotyping process. When asked about their shortcomings, "men were more likely to stress external failures and visible achievements" and points of strength were associated with their work, i.e. their traditional role as provider. It was concluded that men were less introspective and that achievement was found to be a negative motivator to guard against failure. In his study on physical perception of self Bradley (1972) concludes that men downplay body sensitivity, ignore and suppress bodily cues and have difficulty coping with body distortions.

Findings from both studies show the way in which the onset of a chronic illness such as arthritis could work to undermine a man's traditional self-image and profoundly affect his social and familial relationships and roles. Adjustment to and/or adaptation to the disease would therefore warrant at least a re-evaluation of the male societal pressures imposed on a man to be the 'prescribed' male.

Particularly in regard to male societal pressures, another important dimension to be considered (Carter and McGoldrick, 1980) is the individual and the family life-cycle. The man's own place in the cycle and that of his family may serve to
heighten or soften the importance and impact of these pressures both on the man and his family.

**Formation of the Men's Support Group at the Vancouver Arthritis Centre**

The need for a support group for men with arthritis was first suggested at the time of the appointment of a male social worker in the Social Work Department at the Vancouver Arthritis Centre. More men were referred for psychosocial counselling following the appointment and as the social worker's contact with this population of patients grew, he was able to identify common themes of concern that arose during the sessions. Issues of concern were: loss of self-esteem; concerns with the future in relation to employment; problems with relationships; loneliness; and anger. More than this the worker describes his sense of these men's "self-sufficiency wearing thin and a need to reach out, to talk and to share".

During counselling sessions, the worker began introducing the idea of an all male self-help group to discuss what it was like to be male and have a chronic condition. Characteristically, his suggestion was met with a wall of resistance. Some men however did agree to give the group a try. The worker kept the more resistant clients up to date with the progress of the group in ongoing counselling sessions. Some of these men later agreed to give the group a try.

The subject of male resistance to joining an all-male group is well documented. For example, a man's socialization to be independent and aggressive works against the acceptance of this concept. Farrell and Stein (1974) writing on men's consciousness raising groups see that a man's initial decision to attend a group is a sign of self questioning and is an indication of some measure of openness to change "a sign of willingness to ask for help and engage in introspection".
Even in the case of A.I.D.S. patients in the crisis of new diagnosis hesitation to join a support group is characteristic (Morin, Charles, Malyon, 1984). This is understandable in that for this population of men,

Attending the group means one accepts the diagnosis and is willing to confront in the words, faces, and physical conditions of the other group members what the future may bring. (Morin, Charles, & Malyon, 1984).

**Objectives of the Program**

A hierarchy of interim objectives was designed for the group (see Table 1). The lowest level objective was for the man to make a commitment to come to the group to talk about the problems of being male and having a chronic condition. The objectives were created such that each level in the hierarchy represented a step towards more emotional openness on the part of the man. It was hoped that talking, interacting, opening up on an emotional level and sharing and offering support would eventually lead to the highest level objective of emotional problem solving. The intervention hypothesis was that by questioning and re-evaluating perceptions and feelings in respect to being male, these men would feel less burdened by male societal pressures and expectations and be more able to focus their attention and time on dealing with their arthritis.

The program for individual group sessions was decided in advance of each session as a result of group discussions between the group leader (who takes a passive role in sessions) and group members. Members chose topics of interest to discuss or requested that guests from, for example, different government departments or agencies, be invited to join the discussion. Group meetings varied ranging from discussion on how pain (both emotional and physical) is experienced by individual members, to job retraining.
### Table 1

**Hierarchy of Objectives**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>To re-evaluate male societal pressures</td>
</tr>
<tr>
<td>7</td>
<td>To problem solve</td>
</tr>
<tr>
<td>6</td>
<td>To share/offer support</td>
</tr>
<tr>
<td>5</td>
<td>To open up - talk on an emotional level</td>
</tr>
<tr>
<td>4</td>
<td>To interact with other men</td>
</tr>
<tr>
<td>3</td>
<td>To talk</td>
</tr>
<tr>
<td>2</td>
<td>To keep coming</td>
</tr>
<tr>
<td>1</td>
<td>To come to the all-male group</td>
</tr>
</tbody>
</table>
The group has now been running for 1 1/2 years. Since the group is still in the pilot-demonstration phase of its development, it was decided that it was time to conduct a formative evaluation. The purpose of the evaluation was twofold: to gain more knowledge about what was happening in the group; to see whether the intervention hypothesis was valid and objectives were actually being met; and to use data gathered in the evaluation to aid program planners with possible program changes and development.

The sorts of questions that the evaluation would address were: What is actually taking place at the group meetings? Are the interim objectives being met? Is the group process leading men to feel more comfortable with male expectations? Do the men feel they can deal better with their arthritis? What are their individual perceptions of the group process? Why did they choose to come and keep coming to the group?

**Self-Help Groups and Evaluation**

Issues of evaluation and self-help groups have only recently gained attention (Gartner & Riessman, 1984). As of 1984, no large-scale longitudinal studies were reported and few used control groups (Gartner & Riessman, 1984). In respect to evaluation of self-help groups in health settings, Berkman et al (unpub. 1982) found no controlled studies. However they report that:

...several authors attempted some evaluation of the usefulness of the group experience. Positive results were reported by patients in follow-up questionnaires and by group leaders and primary care givers through observation of group member behavior following the group.

Similarly Gartner and Reissman (1984) see that "what has been found is suggestive, reinforcing of participants' reports of satisfaction and a clear signal for further more systematic attention".
Examples of evaluation of groups for people with a chronic condition are Johnson and Stark (1980) on a group program for 'cancer patients and their family members' and Videka (1979) on psycho-social adaptation in a medical self-help group'.

In the literature most relevant to the present study, on A.I.D.S. which brings together the three variables of men, support groups and a chronic health condition, no reports of the evaluation of support groups were found.

**Self-Help Groups and the Role of the Social Workers**

In respect to the role of the social worker in relation to self-help groups, the involvement of the social worker may span a variety of roles which may include:

1. providing material support to maintain a self-help group;
2. serving as a linkage by connecting traditional services, clients, and self-help groups to one another;
3. serving as a consultant to a self-help group;
4. initiating and developing a self-help group (Toseland & Hacker, 1982).

Evaluation of these programs is mandatory if social workers are to demonstrate that what they are doing is valid, as well as the effectiveness and impact of chosen interventions.

**Contents of the Thesis**

The present study is a formative evaluation of a Men's Support Group for Men with Arthritis.

Chapter 2 is a discussion of methodological issues in the study, specifically, the role of the observer and the development of a monitoring system. Chapter 3 describes the research design, methodological orientation, methods of data
collection and plans for data analysis. Chapter 4 reports the results of the study and Chapter 5 is a discussion of the implications of the findings.
CHAPTER I


CHAPTER 2

Methodological Problems:
The Role of the Observer and
the Development of a Monitoring System
The broadest definition of naturalistic observation is presented by Denzin (1978) who defines it as a multi-purpose method which "simultaneously combines document analysis, interviewing of respondents and information, direct participation and observation and introspection" so that the "entire observation system can be conceptualized as an assessment instrument" (Haynes & Wilson, 1979). Others have suggested narrower conceptualizations in which naturalistic observation can be seen as a way of "understanding" people and the meaning behind their activities" (Williams, 1986) by observing behavior in the natural setting in which it occurs. Polansky (1975) describes naturalistic observation of social interaction as a method "to take note systematically of behaviors occurring among two or more people who are typically compresent physically and psychologically". In respect to naturalistic evaluation, the focus can be seen as "describing human processes and using the views of the participants being studied to guide the generation of hypotheses and the development of theories about these processes" (Williams, 1986).

Naturalistic observation has several advantages and disadvantages. It allows the simultaneous recording of behavior as it happens without relying on the observer's memory. Behavior which subjects may not even be aware of themselves can be observed as well as dynamics of relationships such as families and groups accessed. Limitations fall in the realm of high data collection costs due to time involved waiting for the specified behavior or event to occur and resulting large amounts of data to be processed and analyzed. Also, some behaviors are difficult or inconvenient to observe (Atherton & Klemmack, 1982). The involvement of the researcher with the subjects can lead to biased perceptions. Moreover, the presence of an observer intruding into the natural environment can cause 'reactivity' or 'worker effects'. For this reason the presence of more than one advisor is generally advised. Patton (1980) acknowledges the problem of each individual's selective perception and therefore sees the importance of
disciplined training and rigorous preparation of observers to facilitate accurate, valid and reliable reporting.

In discussing the advantages of naturalistic observation for evaluators, Patton (1980) outlines several additional points. By being directly involved with the program the evaluator has a more holistic perspective of both the program and context and may be privy to information that participants may hold back in an interview situation. Moreover, the evaluator by 'seeing' and 'perceiving' what is happening but also adding impressions and feelings to the data, may present a more comprehensive view of the program studied. The naturalistic observer is caught in an interdependent stance since

The personal nature of observations is both their strength and weakness; their strength in that personal involvement permits firsthand experience and understanding, and their weakness in that personal involvement permits the possible introduction of bias and distortion (Patton, 1980).

**Evaluation of the Men's Group Study**

The present study is an evaluation of a men's support group for men with arthritis. Both the structure and focus of such a group setting has had little attention in the literature. The concept of such a group is a new phenomenon about which little is known. For this reason an exploratory approach using both quantitative and qualitative strategies has been chosen to thoroughly describe and explain the phenomena studied. Direct observation is seen as a good method to measure phenomena which are difficult to access in another way and furthermore "as a validity check on measures obtained by other methods" (Polansky, 1975).

However, methodological problems with aspects of naturalistic evaluation are well recognized and documented in the literature. In relation to the present study,
approaches to the role of the observer and the structured data-collection monitoring system developed, raise methodological issues that warrant further discussion.

The Role of the Observer

The precise role of the observer and extent of involvement and participation is an important research decision. A balance needs to be found between the role of the observer and information needs. This may also involve an "ethical" decision (Atherton & Klemmack, 1982) as to the degree of the observer's informed awareness and knowledge of the purpose of the research.

There are varying approaches to the definition of the observer role. Schatzman and Strauss (1973) define several choices along a continuum of participant observation roles regarding level of involvement ranging from a more passive to a more active stance. They describe six role variations along the continuum which may accommodate the degree of chosen participation and the overt or covert portrayal of the role and purpose of the evaluation (Patton, 1980):

1. Watching from outside. The observer is hidden from participant view;
2. Passive presence;
3. Limited interaction. Researcher may ask questions but not try and influence participant behavior;
4. Active control. The researcher controls interaction so as to glean specific information;
5. Observer as participant. The researcher participates but his/her identity as researcher is known to participants;
Patton (1980) has developed a useful schema of five ‘dimensions of variations in approaches to observations’ to help the researcher make conscious decisions regarding the observer role. He presents a range of choices along the following dimensions:

1. Role of the evaluator/observer (degree of participation);
2. Portrayal of evaluation role to others (degree of overt/covert portrayal);
3. Portrayal of the purpose of the evaluation to others (choice of possible explanations);
4. Duration of the evaluation/observation (single observation to long-term observations);
5. Focus of the observation (narrow to broad).

Patton (1980) also suggests that the role of the observer may be changed over time according to evaluation program requirements.

Haynes and Wilson (1979) make a more rigid distinction between what they define as participant observers "individuals who are normally part of the natural environment of the target subject" and outside observers. Following from this definition, participant observation is seen to serve as a supplementary measure to observation by external observers. External observers will generally utilize more complex observation systems than participant observers and more frequently use psychometric qualities of observation such as reliability, validity and sensitivity (Haynes & Wilson, 1979).

In general, the naturalistic observer can be viewed both as participant in the program (an outsider experiencing the program) and an observer (an insider relaying program descriptions and information to people outside the program) (Patton, 1980).

Whatever type of evaluator is selected, whether the researcher, a practitioner working with the client population, a ‘relevant other’ or a trained outside
observer, each choice will have advantages and limitations. While each observer is trained and prepared for the role, he/she brings a particular subjective perspective to that position. Each observer will bring a cultural perspective and values. In addition he/she has attitudes regarding the program and/or participants. These will vary according to the observer’s degree of involvement with the program and/or subjects, and/or investment in program outcome. While it may seem that the least biased observer would be the trained outside observer, the effect of having a total stranger as participant observer even in the most passive role may also to a greater or lesser degree interfere with group process.

Regardless of how the role of the observer is defined, subjects generally behave differently when they know they are being observed than when they are unaware (Patton, 1980). It follows that the more ‘covert’ the observation and the less direct the intervention in group process, the greater the ethical dilemma for the researcher.

There are several sources of error and reactivity in relation to behavioral observation reiterated by Haynes and Wilson (1979) including: the method of assessing inter-observer agreement; training of observers; feedback to observers; observer presence; observer bias; complexity of observation codes; observer expectations; and predictability of subject behavior.

Regarding observer presence White (1977) found that the presence of observers significantly affected activity levels of family members observed through a one-way mirror. However, the presence of the observer is only one aspect of the research situation. Patton (1980) suggests that the situation is changed by the presence of the observer, the type of evaluation and program, the personality of the evaluator and the methods used. He recommends that when deciding on the role of the evaluator/observer, situations that may be affected by the observer’s presence be anticipated if possible and a strategy to handle them agreed upon.
Polansky (1975) has a practical prescription for observer presence: take a ‘friendly neutral’ stance, expect your credibility and neutrality to be challenged and anticipate that participants will express curiosity regarding your hypothesis.

The literature is replete with acknowledgements of observer effects and problems around the issue of the role of the observer. But much less attention has been given to the assessment of observer qualifications, training and the reliability and validity of observations. In a recent article addressing these omissions (Wilson, Griswold, Sunderland, 1984) 52 empirical studies from psychological and counselling journals were classified according to: the use of the observer in the study; type and length of training; and the way in which reliability and validity was assessed. Their method, major results and recommendations are summarized below in table form:

(Quoted from Wilson, Griswold & Sunderland, 1984.)

<table>
<thead>
<tr>
<th>Method</th>
<th>Results of typical study</th>
<th>Researchers should report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. the purpose for which observers were used in the study;</td>
<td>1. Measurement of the dependent variable i.e. measure outcome of experimental procedure;</td>
<td>1. the qualifications sought and the methods used for selecting observers;</td>
</tr>
<tr>
<td>2. the type and length of training given to the observers;</td>
<td>2. Simply stated observer was trained, no details re observer preparation;</td>
<td>2. the methods used for training observers for their tasks;</td>
</tr>
<tr>
<td>3. the manner in which the reliability of the observers was assessed;</td>
<td>3. Reliability coefficient usually provided form experimental data. e.g. product-moment correlation between paired observers (48%) and inter-observer agreement (25%);</td>
<td>3. the homogeneity, equivalence and/or stability of the observer's observations not only during the collection of the experimental data but also during practice trials or during a criterion-training task;</td>
</tr>
<tr>
<td>4. the manner in which the validity of the observations was determined or defended.</td>
<td>4. Validity only substantiated by claim of observers being experts.</td>
<td>4. evidence that the observers' observations constitute a valid measure of the phenomenon under study</td>
</tr>
</tbody>
</table>
Role of the Observer in the Present Study

In the present study the observer chosen was the student researcher. The choice was made on practical grounds in that there was no funding for an outside observer and other social workers in the department did not have the time to take on this role or take on the role of a paired observer. The role of the observer was to monitor Men's Group meetings over a period of three months using the monitoring system developed from the evaluation to see if the interim objectives of the group were being met.

The apparent advantages of this choice are that: the student researcher did a student placement in the social work department at the Arthritis Centre last year; is familiar with the Centre itself; with staff members; with the programs offered; and has met some of the Men's Group members when they came in for treatment. The student observer has also attended a number of group meetings and co-led one meeting. It is possible therefore that the presence of the observer is more familiar and possibly less intimidating for group members. By the same token, this familiarity could be less than advantageous in that the observer has formed preliminary opinions and views of the program and participants and has some investment in the outcome of the study. Although the observer was known by some group members, it was still decided that she would sit in on the group for a couple of meetings before monitoring began, to soften the sense of observer intrusion into the group setting. This could almost be called a 'mother-in law' approach to evaluation - 'You may not like it but you get used to it.'

Using Patton's (1980) schema, the observer's role can be defined as passive, an onlooker, not participant. The evaluator role can be defined as 'overt' since participants and staff were informed about the observations and the identification of the observer. A partial explanation of the purpose of the evaluation was given to the group. The men were told that an evaluation was being conducted to see what was...
happening in the group now that it has run for 1 1/2 years. This was not an unusual request in that the Centre has an inbuilt quality assurance program so that evaluation of programs is standard procedure and all programs are reviewed.

Group members were told that agreement to participate would involve filling out pre and post measures, and having a short interview with the student researcher. Furthermore, the student researcher would be present but not participating at group meetings. They were not shown the hierarchy of interim objectives or the monitoring system developed to operationalize these objectives. This information was not shared to guard against biased responses such as responding to please the observer by behaving in ways they 'think' are wanted (Orne, 1962) or the reverse. The duration of the evaluation would be three months, the focus of the observation being the specific verbal interactions defined in the development of the monitoring system.

A potential source of error centres around the fact that there is only one observer and therefore one subjective perspective. This tends to curtail assessment of validity and reliability of the data. However this may also be viewed as a potential source of strength in terms of consistency. That is, having one observer using one method. The practical limitations described did not allow for more than one observer to be present at group meetings.

A second potential source of error and limitation in the study is that the observer is also the researcher and developer of the monitoring system. This again reduces the possibility of alternative perspectives on the research methodology process and analysis of results.

A potential source of 'reactivity' is the fact that the observer is a female observing an all-male group. This brings up the possibility of changes in the men's behavior which might not normally be part of the group process. Both Farrell (1974) and Doyle (1973) give examples of men's behavior change in the presence of females.
It was agreed with the group leader before the monitoring began that the descriptive data on each session would include a section on the 'quality of the data' (Patton, 1980) which related to this issue. That is, reactions of group members and overt references to the presence of the observer by participants would be noted. It was also agreed that the student researcher and the group leader would meet together after every meeting to debrief and to come to a general consensus as to what happened in the group. Since the group leader takes a guiding rather than active role in the group, it was agreed that he could observe and share his impressions with the student researcher. He would therefore take the role of a key-informant.

Regarding the 'training' in the use of the monitoring system, the system was used for a trial period of two meetings. This was to allow time for: the observer to become familiar with using the system; to see if the system was workable; to identify any implementation problems; and make any necessary changes or modifications.

In regard to the observer, there is evidence for face-validity. What is being observed - certainly with interim objectives 3, 4, 6, and 7 (see Appendix 1) - is simple overt behaviors. The observer is not asked to make inferences as to the meaning of these behaviors. In the case of variable 5 'opened up on an emotional level' (that is, stated how they felt about something) it is negotiable that this particular variable may be slightly more complex to measure. However, there are particular verbal clues, an identifiable vocabulary of words such as 'I felt', 'I hated', etc. plus substantial tone of voice changes e.g. much more assertive/aggressive or withdrawn and passive. Therefore it can be argued that the observer does not have to make inferences, even with this more complex variable.
Problems of the Development and Use of a Monitoring System

In the present study, a simple checking method was developed to be used by the observer to monitor each group meeting, following the hierarchy of interim objectives 3 - 7 outlined in Chapter 1, Table 1. In addition, the observer would have a debriefing session with the group leader after each group meeting and narrative descriptions of each meeting would be written by the observer.

There are several forms in which interaction can be recorded: narrative accounts; scales (rating/ranking); and category systems (Polansky, 1975). Narrative accounts may be written descriptively to give a sense to an outsider of what happened in the group without attempting to interpret interaction or dynamics (Polansky, 1975). Alternatively the emphasis could be on interpretation in which case the narrative, as a source of individual insights, would add depth to the data. Both forms may be used in a study.

In the Men's Group study, it was agreed that a more descriptive rather than interpretive approach would be taken. However, in reality, the selective perception of the observer prevents any account from being totally descriptive. The choice of what is important to describe and what is not becomes an interpretive choice in itself. Also, quality of data issues such as 'reactions to the presence of a female observer' previously mentioned, may be emotionally charged for the observer. This might lead to an incorrect and/or more interpretive description as well as preventing disclosure on the part of the group members.

For example, after one group meeting the observer noticed that there had been no overt references to her presence and that the men even made some sexist jokes. She discussed this with the group leader after the session, suggesting that this might mean that group members were feeling more comfortable in her presence. He pointed out that in his estimation the men had been generally a lot less 'rowdy' since
the observer had been attending meetings. This became evident at a subsequent meeting when one man was going to talk about his sex life but said he couldn't "... in the presence of a lady".

In the present study scales were thought to be an inappropriate method to use since the objective was clearly not to rate or rank order specific interactions but to tap into specific areas of interaction. For this reason, a category system was chosen. Polansky (1975) writes:

> When using a category system, the observer tallies each separate instance of interaction occurring during the observational time which satisfied the definition of some particular category or subcategory of that system.

Polansky (1975) sees that errors of judgement such as impression bias are less likely using this counting method than with narrative accounts or scales. He goes on to say that focussing on isolated selected behavior minimizes error. Moreover, a representative sample of interaction is based on many acts and is therefore more reliable than a single rating based on a possibly faulty overall impression.

In the Men's Group study it was decided that the social interaction to be recorded would be verbal interaction (what is said), not paraverbal behavior (how it is said) or nonverbal behavior. This decision was made on practical grounds due to the limited capacity of the availability of one observer. This decision was made in the knowledge that important paraverbal and nonverbal behaviors would be missed.

**The Choice of a Group Observational System**

Regardless of the method chosen to record observation, observers must use "behavior coding systems that define the universe of recordable events ... to limit to a manageable number the thousands of potentially observable events" (Haynes & Wilson, 1979).
There are a range of observational systems which have been developed to measure social interaction. Perhaps the most simple observation procedure to analyze in a group 'who talks to whom and how often' is to use sociometric analysis. Names of group members are drawn in a circle and lines drawn between names when members speak. Arrows are drawn to indicate the direction of the conversation. Lines may also be drawn towards the centre if a member is addressing the group as a whole. This system can be used for example to "map individual preferences for leaders" but on the whole reveals a very limited amount of information (Burgeon, 1974).

At the other extreme of complexity an observational system used for small groups is Bales' Interaction Process Analysis (1970). It can be used to record both verbal and non-verbal behavior. There are 12 mutually exclusive categories and frequencies of each member's interaction are categorized within this system. There are four behavior areas: positive reactions, negative reactions (socio-emotional areas) and answers, questions (task areas).

This system was initially developed as a general purpose descriptive and diagnostic procedure to produce relevant measures for small groups. It focusses on social and emotional behaviors of individuals, records their roles, gauges their status within the group over a period of time and estimates the strengths of underlying determinants of overt behavior. The observer keeps track of the category describing each act, who initiates it, and to whom it is directed for each member of the group. This information is then tabulated into matrices for analysis.

Polansky (1975) outlines the advantages of using a general observational scheme: definitions of categories are clear; inter-observer reliability is known; there is usually evidence of validity. Moreover, the schema is usually broad enough to be reduced to a couple of global dimensions such as assertiveness-non-assertiveness, to suit a particular study. Polansky (1975) also points out that the universality of a system
may prove inefficient for a particular hypothesis. Moreover, the implicit theory and conceptions underlying the observational scheme may not be relevant in a particular study.

In the Men's Group study it was decided not to use a system such as Bales' IPA. One main reason was that a system for observing groups such as Bales' IPA is used to observe cohesive groups over time. Since the Men's Group is a support group there is no consistency of group membership and different people may attend each meeting. On a practical level, Bales' IPA is too complex to use within the limited timeframe and scope of the study. The purposes of monitoring the Men's Group study did not demand complex observations of group dynamics, roles or determinants of behavior. The object of using a monitoring system in the present study was to record the frequency of simple overt behaviors over time in order to see if objectives 3 - 7 of the study were being met. (See Appendix I and II.)

**Development of a Monitoring System**

A clear hierarchy of interim objectives was defined for the Men's Group which is still in the pilot-demonstration phase of its development (see Table 1 Chapter 1). It was decided to develop a simple monitoring checking system to be used at each group meeting to monitor interim objectives 3 - 7. The purpose of this instrument was to see if there was an increase in the frequency of higher level objectives over time. The categories were therefore developed to reflect and operationalize numbers 3 - 7 of the interim objectives.

One of the first problems in developing such a system is to decide on the size of one irreducible unit of interaction (Polansky, 1975). For example Bales (1970) defined the interaction unit for the IPA as a 'single act' which "in its context may be understood by another member as equivalent to a single simple sentence". However,
units can also be categorized in terms of interactional sequences such as 'statement and response' (Polansky, 1975). Temporal units, that is, fixed time observation intervals can also be used. Polansky (1975) equates small units with simplifying observer training and reducing use of inferences. Also, these units can be arranged into larger unit sequences according to the objectives of the study. Hence it is important that an observational scheme have categories that are not too broad (categorization may be unreliable) or too narrow (data may become meaningless).

In the present study the basic irreducible unit of interaction was defined as a single monologue of one individual.

The Coding System and Pretest

In order to operationalize numbers 3 - 7 of the interim objectives, key words were defined in terms of the interaction to be observed (see Table 2). These definitions were discussed with the group leader who was 'acculturated' to the group.

Each level in the hierarchy was to be represented by a key letter on the checklist. For example, 'interacted' (objective number 4) defined as 'initiating a conversation' was represented by the letter 'I'. A simple checklist was to be drawn up by the observer at each meeting visually following the way the group was seated at that meeting. It was thought this would make the checking more comfortable and efficient than if a pre-designed form was used (see Table 3 for sample checklist).

The original coding system was pretested by the observer at a Men's Group meeting before the monitoring period began.

There were several difficulties experienced by the observer on first using the monitoring system. It was found necessary to wait for each person to finish speaking before recording. By this time the man may have demonstrated several of the overt behaviors in the hierarchy of objectives. This raised the question of how and
**Table 2**

**Monitoring System**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Definition</th>
<th>Example and/or indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3</td>
<td>talk, that is, respond to group leader or fellow members (R on checklist)</td>
<td>brought up a new subject</td>
</tr>
<tr>
<td>Objective 4</td>
<td>interact, that is, initiate a conversation (I on checklist)</td>
<td>Listen for verbal clues such as 'I felt' or 'I hated' plus substantial tone of voice changes e.g. much more assertive/aggressive or withdrawn and passive</td>
</tr>
<tr>
<td>Objective 5</td>
<td>open up on an emotional level, that is, state how they feel about something (OEL on checklist)</td>
<td>Example: Acknowledgement of similar feelings. &quot;The same thing happened to me. It just cut me up.&quot;</td>
</tr>
<tr>
<td>Objective 6</td>
<td>offer emotional support, that is, empathize and/or express sympathy following another group member expressing his feelings (OES on checklist)</td>
<td></td>
</tr>
<tr>
<td>Objective 7</td>
<td>problem solving, explaining the way(s) they coped with a particular emotional problem or situation (PS on checklist)</td>
<td></td>
</tr>
</tbody>
</table>
when the behavior categories should be checked. The suggestion was made to pick out only the highest level objective achieved during the interaction. This would automatically imply that the lower level objectives had been fulfilled. However, it was finally decided to do both a before and after category check. The first check at the beginning of the interaction would indicate whether the speaker was responding (objective 3) or initiating conversation (objective 4). The second check at the end of the unit of interaction would indicate the highest level objective reached.

The other monitoring problem that arose was the breadth of categories 6 'offer support' and 7 'problem solve'. It was decided that these should be more narrowly defined to look at 'offering emotional support' and 'emotional problem solving'. This would make the monitoring more manageable and more focussed on the purpose of the observation which was to monitor levels of emotional openness.

As a result of the pretest, changes and refinements were made to the monitoring system. The definition of a single interaction was made more specific. A single interaction was one man's monologue. Furthermore, responses of group members of e.g. affirmation or negation during a monologue were not to be recorded. Unless another man interrupted and took over the conversation entirely, this would not be recorded as another interaction.

As can be seen in Table 2 showing the final monitoring system categories and coding, 'offering support' (objective 6) and problem solving (objective 7) were redefined as offering emotional support and problem solving of emotional problems or situations.

In respect to the monitoring itself, the procedure in regard to checking was outlined. Each time a man began to speak, the observer was to decide whether he was a) responding to another group member (R on the checklist) or b) whether he
initiated the conversation (I on the checklist). One of these columns would be checked accordingly.

When the man finished speaking the observer would make a decision as to the highest level of interaction reached:
- opened up on an emotional level (OEL on the checklist);
- offered emotional support (OES on the checklist);
  or
- problem solved (PS on the checklist).

The most appropriate level would be checked. If however in the opinion of the observer the man did not reach any of these levels, no checks would be recorded at the end of the interaction.

**Plans for Analysis**

The method of checking described would allow data to be collected on overall frequency of interaction (objectives 3 and 4) as well as frequency of higher level interactions (objectives 5 - 7). Specifically, the interest was in the proportion of the interaction spent on lower level and higher level objectives. It was assumed that in all cases, the proportion of the interaction spent on the lower level objectives (3 and 4) would always be greater than the proportion of the interaction spent on the higher level objectives (5, 6 and 7). This is because objectives 3 and 4 would naturally occur before 5, 6 and 7. Expressed in numerical form,

\[ 3 + 4 > 5 + 6 + 7 \]

(3 + 4 are greater than or equal to 5 + 6 + 7)

Frequency of higher level objectives obtained over time were determined both for individual group members and for the group as a whole.
Being a support group in which different members would attend different meetings, it was decided to focus analysis of the monitoring data on: 1. the core group members a) as individuals and b) as a group and; 2. on all attendants of group meetings as a separate group. In this way both individual and group patterns could be established.

**Test for Inter-Rater Reliability**

It was agreed after examination of the coding system by the researcher and group leader that the categories chosen were good categories to monitor the interaction of the group and that the system would therefore appear to have good face validity.

It was then decided to test for inter-rater reliability. The first step was to video-tape one of the first group meetings to use for monitoring purposes. There was the ethical issue of outside observers viewing the tape. Also it was felt that the observers should be 'acculturated' to the group process and individuals in the group to be able to use the monitoring system effectively. It was therefore decided that the group leader and the observer would do the test. Both read the instruction sheets (see Appendix III). A trial period of 15 minutes using the monitoring system was conducted to become comfortable with the instrument. For the inter-rater reliability test the observers monitored the video-tape for 30 minutes.

When scores for the two raters were compared, reliability was found to be very high. This was despite the fact that the observer had had some experience using the system and the group leader had had none. No differences in scores were found for the three higher levels of interaction (objectives 5, 6 and 7). There was however a slight discrepancy in ratings of the first two categories of 'response' and 'initiate'. The
suggestion was that this might be due to the fast pace of dialogues in some sections of
the tape and the quality of the sound of the video.

While the categories were found to be good, problems with the system
were identified. It was agreed by the raters that when there was an ongoing dialogue,
it was sometimes difficult to keep pace and check every 'response' or 'initiation' of
interaction.

In regard to the category of 'opening up on an emotional level' it was felt
that the instrument was limited in that it could not pick up the degree and depth of
emotional openness expressed. In order for the instrument to be more sensitive to the
wide variety of responses of emotional openness, additional categories would have to be
designed. Also it would be interesting to be able to monitor variables such as whether
the man was speaking on an emotional level about 'self' as opposed to 'other'.

It was acknowledged that in the development of the instrument by deciding
to limit the monitoring to observations of verbal communication only, information on
interaction and group process which took place non-verbally, e.g. body-language, group
laughs, was being lost. Similarly, the decision to ignore one-word cues and minor
exclamations ('interruptions' during a monologue) meant that aspects of group
interaction were not accounted for. However, together with the narrative descriptions
of group sessions, a good overall picture of group process was drawn.

Within the limits of this study, the problem of the validity of the
observations could not be fully dealt with. Nevertheless, the use of a mix of self-
report and observational data did permit an assessment of 'instrument effects'. That is,
the degree to which the trend of the changes revealed depends on the method of data
collection.
CHAPTER 2

NOTES


CHAPTER 3

Research Design
The Arthritis Men's Support Group was started by the Social Work Department at the Vancouver Arthritis Centre, 18 months ago. Having identified the need for such a group, interim objectives were set up. The group is still in the pilot-demonstration stage of its development, a time when new approaches and organizational structures can be tried out on a flexible and easily reversible basis. Having run for 12 months, the Social Work Department felt it was time to take a closer look at the program to examine the feasibility of its objectives and whether the objectives were being achieved. The kind of evaluation chosen at this stage of the program's development was a formative evaluation.

The issues for research centred around two main objectives:

1. The production of scientific knowledge about the nature of therapeutic processes, social support systems and small groups, and

2. Program development and evaluation (Gartner & Riessman, 1984).

Gartner & Riessman (1984) see research on self-help groups as generally focussing more on one or the other of these objectives. The present study while focussing on program development and evaluation, aimed to contribute to the knowledge base regarding the self-help group process with a population of men with a chronic condition.

Specifically, the purpose of the evaluation was two-fold: to gain more knowledge about what was happening in the group, whether the hierarchy of objectives was feasible and objectives were actually being met, and to use data gathered in this evaluation process to aid program planners to modify/alter the program as required.

Information Needs

Using Rossi, Freeman and Wright's (1979) intervention model, the central hypothesis of the study relating to the achievement of the highest level objective (see Table 1, Chapter 1) - the social work intervention model - can be explained as follows:
**Causal hypothesis**: the premise of the causal relationship that currently exists "between a phenomenon and the condition or behavior in which change is sought" (Rossi, Freeman & Wright, 1979).

**Men's Group Study**: The greater the men's perceived pressure to achieve male societal expectations the more difficult it is for them to cope with having a chronic condition.

**Intervention hypothesis**: specifies the relationship between the program/intervention and the phenomena (in the causal hypothesis) associated with the behavior/condition to be changed.

**Men's Group Study**: The greater the change toward taking role expectations less seriously the better the men will be able to cope with their chronic condition.

**Action hypothesis**: specifies whether this is the way things happen in the real world.

**Mens' Group study**: Men who participate in support groups tend to develop a greater awareness of strategies for coping with their condition.

With this social work intervention in mind, the hierarchy of objectives was developed for the group (see Chapter 1, Table 1).

Based on the interim objectives developed for the program, the following research questions were developed:

1. Why do the men come to the group?
2. What is the nature of the group interaction process?
3. Is the pattern of interaction changing over time?
4. Does participation in the group meetings help men express their feelings?
5. Does participation in the group: a) shift men's perceptions of themselves in any measurable way, b) encourage a shift in how much control they feel they have over their health, c) modify the impact of the disease on their daily lives?
6. What are the individual and group characteristics of the people that attend?
7. What are the perspectives and opinions of the men coming to the group with respect to the above questions.

Instrument choice and construction was designed to address these specific research questions. Questions 1 and 7 were addressed through a semi-focussed interview with each core-group member. Questions 2 and 3 were assessed through the monitoring of group sessions using an instrument designed for the study. In addition, narrative descriptions of group meetings were written following each session.

Three questionnaires administered pre and post were used to address questions 4 and 5. The Bem Sex-Role Inventory was used to see how the men perceive their maleness on the continuum of masculinity through androgyny to femininity. The Wallston Health Locus of Control was used to assess each man's perceived control over his health. Subscales from the Arthritis Impact Measurement Scale (A.I.M.S.) were used to look at the psychosocial impact of having a chronic condition.

Question 6 was addressed through the gathering of demographic variables to create an individual and a group profile.

Knowledge-Building Functions of the Research

One of the purposes of conducting a formative evaluation of a program in the pilot/demonstration stage is to provide information for a summative/impact evaluation at a later stage. Complications of methodological issues with self-help groups as opposed to psychotherapy groups are seen to be increased (Gartner & Riessman, 1984). For example, "self-help group members serve as both providers of help and recipients of help" (Gartner & Riessman, 1984). For this reason, it was particularly important to obtain as much detailed information about the program as possible using a formative evaluation process, to lay the ground for a summative evaluation.
The study was looking at a relatively unknown phenomenon, a combination of variables (a) self-help group, (b) men, and (c) arthritis, that has not been researched in the literature. The study would therefore contribute to knowledge of this phenomenon.

Research on self-help groups has only recently been recognized as challenging. Moreover, evaluation of self-help groups - particularly in respect to effectiveness - is largely lacking (Gartner & Riessman, 1984). Furthermore, formative as opposed to summative evaluation research "has traditionally received less attention in the evaluation literature than has summative" (Monette, Sullivan, Dejong, 1986). For these reasons the present study serves an important knowledge-building function.

In addition, the study contributes to knowledge of "the nature of therapeutic processes, social support systems and small groups" (Gartner & Riessman, 1984) with this particular population, as well as how they help each other cope emotionally with the stresses of their disease and everyday life. As expressed by Gartner & Riessman, "by observing the operation of self-help groups, we have a unique opportunity to gain insight into the natural psychotherapeutic processes of everyday life".

**Choice of Conceptual Model**

The conceptual model for the study is a *naturalistic formative* evaluation model. This model was chosen as the most appropriate to research the Men's Support Group program at this stage of its development.

Research at this stage of program development is 'exploratory', foundation-building research. For this reason a *formative* evaluation as opposed to a *summative* evaluation was conducted. Describing formative evaluation, Gartner and Riessman (1984) write:
Formative evaluation is intended to provide assessment data which will aid in the development and improvement of programs, and represents a dynamic view of the assessment process. From a general systems perspective, formative evaluation may be conceived of as the feedback loop by which the system monitors and improves its functioning. This kind of evaluation can lead to modifications in the relationships between particular program components... or it could lead to modifications in how a particular self-help group operates.

In contrast, the focus of a summative evaluation is to provide "an assessment of overall effectiveness of a particular program at some set point in time" (Gartner & Riessman, 1984).

From the outset of the study the primary purpose of the study was not to judge overall effectiveness of the program (summative evaluation) but "to collect information that can be used primarily for ongoing program development and improvement (formative evaluation)" (Patton, 1980).

A formative evaluation serves a primarily descriptive function. Sanders and Cunningham (1974) write:

The intent of collecting descriptive information is to describe fully and completely what is, not what should be. A comprehensive characterization of what is will aid greatly in making judgments and in determining where to revise once some deficit is identified.

In the Men's Group study, descriptive information on all aspects of the program was gathered to give an in-depth picture of the program at the present developmental stage, as well as to answer the specific development-related research questions outlined.

Testing and rigorous experimental design is not required in formative evaluation, although the researcher must be aware of the threats to internal and external validity in regard to the results of the study. Emphasizing the importance and function of formative evaluation Malcolm Provus (1971) writes:

An evaluation that begins with an experimental design denies to program staff what it needs most: information that can
be used to make judgments about the program while it is in its dynamic stages of growth.

The Researcher's Control Over Phenomena Studied

The overall conceptual approach of this study, the evaluation of a support group for men with arthritis in the pilot project stage may be described as naturalistic. However, the methodological orientation chosen is best described as mixed qualitative and quantitative. The study fits more exactly Reid and Smith's (1981) concept of the exploratory formulative study or Tripodi's (1964) combined exploratory descriptive approach which would be "used to gain preliminary understanding of phenomena or to stimulate the development of concepts, hypotheses and theories" (Reid & Smith, 1981). In this case, the concept of a support group for men with arthritis is a new phenomenon about which little is known so that an exploratory formulative approach using descriptions which are "in both quantitative and qualitative form, and the accumulation of detailed information by such means as participant observation" (Tripodi, 1969) will help to thoroughly describe and explain the phenomenon studied.

The use of a mixed orientation is therefore seen as a way of expanding the naturalistic concept of multiple perspectives in order to present as comprehensive and in-depth a picture of the program as is possible.

Sampling Design

In regard to theoretical scope, this study utilizes a form of selective sampling for which "units are chosen to display some behavior the researcher wants to explore in depth" (Reid & Smith, 1981). In this study the area of exploration is the ways in which a particular disease, namely arthritis, together with the psycho-social aspects associated with the disease, impact on a minority population of men with
arthritis. (It is generally agreed that the ratio of men to women having arthritis is 1:3).

The units of which the sample is composed are individual males, the treatment or independent variable being an all-male self-help group for men with arthritis.

Summary of Methodology

Naturalistic observation in its broadest sense can be seen as a multi-purpose method utilizing several techniques such as interviewing, direct participation and observation and document analysis (Denzin, 1978). The overall assessment instrument can therefore be seen to consist of several component parts. In the present study, more than one technique was chosen in order to be able to observe and describe the phenomenon of an arthritis men's support group from several perspectives. It was possible to gain a more in-depth picture of the nature of the phenomenon being evaluated by using different exploratory techniques.

A clear hierarchy of interim objectives was defined for the men's group program (see Table 1, Chapter 1). Observation techniques were chosen to operationalize these objectives in order to evaluate whether they were in fact being met. Closely following interim objectives numbers 3 to 7 of the program, a monitoring system to observe frequency of interaction and levels of emotional openness (as described in Chapter 2) was developed. This system was used to monitor six group meetings over a period of three months. Narrative descriptions of these meetings were also written by the observer after consultation with the group leader following each meeting. In addition, patient interviews were conducted to gather the opinions and feelings of group members about the group.
The naturalistic concept of multiple perspectives is expanded in the study with the use of pre and post quantitative measures to look at the highest objective of the program. Objective number 8 is that men will re-evaluate male societal pressures such that they will not feel as pressured by male societal expectations, will be better able to cope with their arthritis and will feel more in control. Three measures were chosen to measure the implications of objective 8: the Arthritis Impact Measurement Scale (A.I.M.S.) to ascertain whether the overall impact of arthritis on different aspects of the individual man's everyday life was lessened over the course of the study; the Bem Sex-Role Inventory to measure each man's concept of maleness and see whether this in any way shifted over time; and the Wallston Health Locus of Control to see whether their perception of control over their health was in any way altered by the end of the study period.

In addition to the methods outlined above, demographic information on each group member was gathered. In order to measure the lowest level interim objectives, numbers 1 and 2, records of attendance were kept.

**Group Setting**

Each group meeting was previously held on the third Thursday of every month at the Vancouver Arthritis Centre in the staff lounge at 7:30 p.m. In response to the group members' expressed need to meet more than once monthly, meetings beginning in January 1987 were scheduled on a fortnightly basis. This change also allowed more opportunity for observation and monitoring. The meetings continued to be held on Thursday evenings at the same location and time.
Size and Heterogeneity of the Sample

The group itself is only homogeneous in that all the members are male. Group members are different in terms of age, background and kind of arthritis. Moreover, the number of people attending meetings has also varied over the course of the first year of the program. The smallest attendance was 6 men and the largest 22. The group can therefore be seen as heterogeneous.

Rationale for Choice of Methodological Orientation

The chosen methodological orientation was mixed qualitative and quantitative. The study was looking at an unknown phenomenon and therefore demanded an in-depth multiple-perspective orientation to monitor, measure and begin to understand what was happening in the group.

The program is in the demonstration phase of its development, a time when new approaches and organizational structures or procedures can be tried out on a flexible and easily reversible basis. The concept of a support group for males with arthritis was posited as an appropriate intervention and implemented on a pilot or demonstration basis, following guidelines as to the way it was thought it could work. The strategy employed by the group leader has depended upon what appeared to be effective. Flexibility, innovation, redirection and variation were demonstrated to manipulate or alter aspects of the program. Usually, at this stage of program development, the basic research issues that are pursued include:

- to see if the program is being implemented the way it was planned;
- to investigate receptiveness of the program among participants;
- to explore the timing and patterning of change;
- to find out the nature of the demands the program places on the planners;
- to discover new ways of doing things;
- to investigate problems of administrative feasibility regarding various changes;

Research at this stage of program development is 'exploratory', the main objective being to learn enough about the program to be able to move ahead to the development of a program which can be evaluated in a more systematic manner.

The first main requirement of the evaluation therefore was to obtain information on all aspects of the program e.g. who attends, problems shared in the group, etc., the emphasis being placed on the feedback of information to the program planners.

The research design did not necessitate methodological rigor. The research concentrated on interim objectives, looked for indicators or surrogates of success/failure, for side effects and at the pace of change.

Hence the appropriate methodological orientation for this program at this stage of its development was seen to be a combination of descriptive naturalistic evaluation and quasi-experimental evaluation i.e. time series before and after.

Data Collection and Plans for Analysis

Methods of Data Collection

The methods of data collection used in the study, the information sought and the strengths and weaknesses of these methods as well as the rationale for their choice are summarized in Table 1.
TABLE 1
DIFFERENT DATA-COLLECTION METHODS USED IN THE MEN'S GROUP EVALUATION

<table>
<thead>
<tr>
<th>Methodology/Measurement Instruments</th>
<th>Type of Information</th>
<th>Objectives Addressed</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi Focus Checklist</td>
<td>Opinions, feelings, attitudes, suggestions</td>
<td>Subjective reactions to and individual evaluation of group experience</td>
<td>Direct information, reflects psychological and sociological process</td>
<td>Approach lacks flexibility. Standardized questions may not be relevant, may hinder naturalness of response</td>
<td>Best method for obtaining reactions from group participants</td>
</tr>
<tr>
<td>Audio tape of core-group member interview using Patton's standardized open-ended approach</td>
<td>* Arthritis Impact Measurement Scale</td>
<td>* BSR - How men see themselves in respect to being male</td>
<td>Widely used measures with good validity and reliability</td>
<td>Questionable applicability in measuring objective 8. Question of whether these are good surrogate measures</td>
<td>Need relatively objective measures as part of multi-perspective framework of evaluation</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>* BSR - How men see themselves in respect to being male</td>
<td>AIMS - the psycho-social impact of having a chronic condition on their daily lives</td>
<td>Widely used measures with good validity and reliability</td>
<td>Best surrogate measures to tap into objective 8 - that men will relax more about male societal pressures so they feel better able to cope with their arthritis</td>
<td>Need relatively objective measures as part of multi-perspective framework of evaluation</td>
</tr>
</tbody>
</table>

Pre and post measures given to core-group participants (n=9) Instruments: * Wallston Health Locus of Control (HLC) * Bem Sex-Role Inventory (BSRI)
TABLE 1 Cont'd

DIFFERENT DATA-COLLECTION METHODS USED IN THE MEN'S GROUP EVALUATION

<table>
<thead>
<tr>
<th>Methodology/ Measurement Instruments</th>
<th>Type of Information</th>
<th>Objectives Addressed</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>To monitor frequency of interaction and levels of emotional openness</td>
<td>3 - 7</td>
<td>Face validity. Good inter-observer reliability; (Use of videotaped session to practice monitoring skills and check for inter-observer reliability)</td>
<td>Has only face validity and inter-observer reliability</td>
<td>Systematic method for reporting patterns and/or changes in group interaction over time.</td>
</tr>
<tr>
<td><strong>Narrative Description</strong></td>
<td>To provide descriptive information regarding group process, content and interaction/contribution group members</td>
<td>3 - 7</td>
<td>complimentary method to monitoring and core-group member interviews</td>
<td>Presents the observer's subjective perceptions of the group meetings</td>
<td>Best method for giving the planners a description of what happens in group sessions</td>
</tr>
<tr>
<td>Methodology/Measurement Instruments</td>
<td>Type of Information</td>
<td>Objectives Addressed</td>
<td>Strengths</td>
<td>Weaknesses</td>
<td>Rationale</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------</td>
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<td>-----------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Record Keeping</td>
<td>Attendance patterns for core-group and group as a whole - 2</td>
<td></td>
<td>Indirect measures of individual commitment to group process</td>
<td>Men may choose not to attend because of a range of other factors. ‘Attending’ does not mean the same for everyone. e.g., a man could attend and not participate or be pre-occupied</td>
<td>Method to keep track of shifts in group participation</td>
</tr>
<tr>
<td>Review of Charts</td>
<td>Demographic information</td>
<td>1 - 2</td>
<td>Permits analysis of similarities and differences among group participants</td>
<td></td>
<td>Relatively objective method to gather data on background characteristics of group participants</td>
</tr>
</tbody>
</table>
The rationale for utilizing several methods to collect different sources of information in the present study is clearly supported by Patton’s (1980) statements on qualitative evaluation that:

Multiple sources of information are sought and multiple resources are used because no single source of information can be trusted to provide a comprehensive perspective on the program.

He goes on to write that:

By using a combination of observations . . . the evaluation fieldworker is able to use different data sources to validate and cross-check evaluation findings.

In respect to the mixed qualitative/quantitative (though predominantly qualitative) orientation, the methods can best be seen as points on a qualitative/quantitative continuum as illustrated in Table 2. In the case of the monitoring system for example, qualitative data on interaction in the group is transformed through a coding system in which frequency of interaction and levels of emotional openness are categorized and recorded. Also, while a review of patient charts provides quantitative demographic information it also offers background information giving the researcher a more personal view of each group member and as such is a source of qualitative data.

Following is a more detailed description of each of the methods used in the evaluation and plans for analysis.

Descriptions of Methods and Plans for Analysis

A. The Monitoring System

As described in Chapter 2, following the search for a suitable standardized monitoring instrument to observe ‘frequency and level of emotional openness of interactions in group sessions’ it was decided to develop a simple monitoring system
Table 2

Location of Methodological Techniques Along A Continuum from Qualitative to Quantitative

<table>
<thead>
<tr>
<th>QUALITATIVE</th>
<th>QUANTITATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video tape interviews</td>
<td>Review of Attendance</td>
</tr>
<tr>
<td>Audio-taped Narrative</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>description (transformative)</td>
<td>patient patterns</td>
</tr>
<tr>
<td>charts</td>
<td>charts</td>
</tr>
</tbody>
</table>
specifically for the study. The development of the system, as well as the pretest of the instrument and test for inter-rater reliability were described in detail in Chapter 2.

The strength of the system is that being designed specifically for the study, it has good face validity. Inter-rater reliability was found to be very high.

The rationale for using this method is that a relatively simple and systematic method for reporting changes in group interaction, that is, 'emotional openness over time' was needed and a suitable standardized measure was not found.

**Plan for Analysis**

The method of checking would allow data to be collected on overall frequency of interaction (objectives 3 and 4) as well as frequency of higher level interactions (objectives 5 - 7). Specifically, the interest was in the proportion of the interaction spent on lower level and higher level objectives. It was assumed that in all cases, the proportion of interaction spent on the lower level objectives (3 and 4) would always be greater than the proportion of the interaction spent on higher level objectives (5, 6 and 7). This was because objectives 3 and 4 would naturally occur before 5, 6 and 7:

\[ 3 + 4 > 5 + 6 + 7 \]

(3 + 4 are greater than or equal to 5 + 6 + 7)

Frequency of higher level objectives obtained over time could be determined both for individual group members and for the group as a whole.

Being a support group in which different members would attend different meetings, it was decided to focus analysis of the monitoring data on: 1) the core group members, a) as individuals, and b) as a group and; 2) on all attendants of group meetings as a separate group. In this way both individual and group patterns could be established.
B. Narrative Descriptions of Group Meetings

The rationale for using this method in the present study is well expressed by Patton (1980) who writes on the responsibilities of the naturalistic observer to experience and be involved in the study at first hand:

The observer's primary responsibilities are to experience and describe what is going on in the program . . . . In naturalistic inquiry the observer's own experience is a crucial part of the data. The purpose of getting close to the program through fieldwork is to permit the observer to experience what it is like to be in that setting.

The observer's direct involvement in the study can be seen both as the strength and subjective weakness of the method. These narrative descriptions are subject to measurement errors in that they are subjective, selective, they may be incomplete or inaccurate (Patton, 1980). However they are an integral and component part of this kind of formative evaluation which go towards creating a comprehensive picture of the program appropriate to the project at this stage of its development.

The plan for analysis was to present the narrative description of each meeting in a form of descriptive paragraphs that would give an outsider a clear inside view of the program, the participants and the group process. More specifically, the reader would gain a sense of the level of emotional openness in group interaction and changes in the group process over time.

C. Semi-focus Checklist

Audio-taped patient interviews were chosen to access the individual perspectives, opinions, attitudes, reflections and feelings which cannot be directly observed. The overall objective of the interviews was therefore to gather subjective reactions and individual evaluations of group experience.
The method chosen was a semi-focus checklist or in Patton's (1980) terms a standardized open-ended interview. This is one in which wording and question sequences are pre-determined so that the same questions are asked of each interviewee in the same order (Patton, 1980). Patton (1980) outlines three major reasons for using this format as part of an evaluation:

1. the exact instrument used in the evaluation is available for inspection by decision makers and information users;
2. variation among interviewers can be minimized where a number of different interviewers must be used; and
3. the interview is highly focused so that the interviewee time is carefully used.

The rationale for choosing this method in the present study was that it was the best method for obtaining reactions and views of individual core group members of the program within the time constraints of the study.

The strengths of using this method were that since the same questions are asked of each individual, the ability to compare responses on the same topics is increased and moreover organization and analysis of the data is facilitated (Patton, 1980). In addition by using this method, direct information is obtained which reflects both individual, psychological as well as social processes.

The weakness of the method lies in the standardization of the questions and wording. This prevents the flexibility of relating the interview to the interviewee so that questions and/or wording may be awkward and/or irrelevant which may hinder the naturalness of the person's response (Patton, 1980). Moreover, the way subjects report may vary significantly from week to week according to extraneous variables such as the degree of pain they are presently feeling, family and/or work events, how they felt about the last group session as well as the period of time since they last attended the group. The fact that the group is a support group and members may not attend all
meetings made controlling for these variables all the more difficult. It was decided to conduct interviews over a two-week period at the end of the monitoring period of the study.

In the Men’s Group Study categories of important information were selected and open-ended questions designed to allow the interviewee “to take whatever direction and use whatever words they want in order to represent what they have to weight” (Patton, 1980). The kinds of questions asked can be seen as experience/behavior questions, opinion/value questions and feeling questions (Patton, 1980). The final categories and questions are shown in Table 3. 10 core-group members were interviewed.

The plan for analysis of this data was to summarize responses for each question in order to get a sense of the range and variety of individual and group responses to each question.

**Interview with Core-Group Members**

Patton’s standardized open-ended interview approach was used. This is one in which wording and question sequences are pre-determined so that the same questions are asked of each interviewee in the same order (Patton, 1980).

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>INTERVIEW QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why the men came</td>
<td>1 After you heard about the group, what made you decide to</td>
</tr>
<tr>
<td></td>
<td>1a Why did you continue to come?</td>
</tr>
<tr>
<td></td>
<td>2 What do you think you get out of coming to the group?</td>
</tr>
<tr>
<td></td>
<td>2a What are the best things you get out of coming to the group?</td>
</tr>
<tr>
<td>Opinions on the group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2b Are there things that have happened in the group that you didn’t like?

Spouse’s reaction

3 What does your spouse think about you coming to the group?

Friends’ reaction

4 Have you talked to friends about the group?

Group experience

5 What happens in the group?

5a How does it feel sitting and talking with a group of guys?

Feeling of safety to disclose

6 If you had something really private to say, would you share it with the group?

Male dominance

7 Do you think some men talk all the time and don’t give the other men a chance to talk?

Opinions of benefits of the group

8 Do you think this kind of a men’s group is useful?

Perception of change in the group

9 Have you noticed any changes in the group since you’ve been coming?

Additional comments

10 Is there anything else you’d like to say about the group?

D. Pre and Post Measures/Questionnaires

The pre and post measures selected to look at objective number 8 ‘that men will re-evaluate male societal pressures so that they can cope better with having arthritis’ were the Arthritis Impact Measurement Scale (A.I.M.S.), the Bem Sex-Role Inventory (B.S.R.I.) and the Wallston Health Locus of Control.

These measures were chosen: a) for descriptive purposes, to give the evaluator a sense of how these men perceive themselves as males and cope with their disease and in what ways as individuals and as a group they may be similar or different and b) to ascertain whether there were any changes in their perceptions of themselves by the end of the study period.
Since these instruments were not specifically designed to measure objective
8 of the study, their applicability, or whether they are good surrogate measures, is
questionable. However, they did appear to be the best existing measures in the
literature to look at: how men see themselves in terms of being male (B.S.R.I.); how
having a chronic disease affects how much control they perceive they have over their
health (Wallston Locus of Control); and the practical and psycho-social aspects of their
daily lives (A.I.M.S.). All three measures have good reliability and validity.

The rationale for the choice of these measures was that relatively
objective measures were seen as an important component of the overall framework of
evaluation.

Following is a description of each measure used.

1. **Arthritis Impact Measurement Scale (A.I.M.S.)**

The A.I.M.S. is a multidimensional index composed of "previously studied
and newly created health status scales" which measures the health status of people with
arthritis and assesses "physical, emotional and social well-being" (Meenan, Gertman &
Mason, 1980). This measure is distinct in that it reflects a holistic view of the person
and sees the impact of the disease as emotional and social as well as physical. The
scale is practical to administer and score and meets accepted standards of reliability and
validity. As such it is considered to be a good outcome measure of health status.

The A.I.M.S. index is a 66 item questionnaire. The first 45 items are
broken down into 9 subscales: mobility; physical activity; dexterity; household activity;
social activity; activities of daily living; pain; depression and anxiety. Items 46-48 look
at general estimates of health status and items 49-52 at general health perceptions.
Item 53 estimates the overall impact of arthritis. Item 54 provides an estimation of
medication usage. Items 55-57 look at co-morbidity and Items 58-66 deal with demographics.

In the present study, it was decided to use only the scales assessing the psycho-social variables which related most directly to the study. These were the scales measuring: health perceptions; pain; anxiety; and depression.

ii. Bem Sex-Role Inventory

The B.S.R.I. "was designed to measure the extent to which a person divorces himself from those characteristics that might be considered more 'appropriate' for the opposite sex" (Bem, 1974). The scale conceptualizes individuals as being potentially masculine, feminine or androgynous. The B.S.R.I. sees the sex-typed person as "someone who has internalized society's sex-typed standards of desirable behavior for men and women . . . on the basis of social desirability" (Bem, 1974) and sees these persons as having a limited range of behaviors.

In respect to internal consistency the results of two normative studies with college students at Stanford University and Foothill Junior College in 1973 show scores to be highly reliable in both samples (see Table 4 below).

<table>
<thead>
<tr>
<th></th>
<th>Masculinity</th>
<th>Femininity</th>
<th>Androgeny</th>
<th>Social Desirability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stanford University</td>
<td>.86</td>
<td>.80</td>
<td>.75</td>
<td>.85</td>
</tr>
<tr>
<td>Foothill Junior College</td>
<td>.86</td>
<td>.82</td>
<td>.70</td>
<td>.86</td>
</tr>
</tbody>
</table>
When administered for a second time to a portion of the Stanford sample it was found to have good test-retest reliability (Masculinity .90; Femininity .90; Androgyny .93; Social Desirability .89).

This measure is specifically designed to assess a continuum of behaviors from masculinity through androgyny to femininity. This is in contrast to such scales as the California Psychological Inventory (Gough, 1957). The B.S.R.I. would therefore appear to have good face validity. Concurrent validity tested in conjunction with the California Psychological Inventory and the Guilford Zimmerman Temperament Survey was not found to be high. The authors argue however that "the BSRI is measuring an aspect of sex roles which is not directly tapped by either of these two scales" (Bem, 1974) which are limited by being bi-polar in their construction.

iii. Wallston Health Locus of Control

The H.L.C. scale is a standardized area-specific measure that predicts the relationship between a person's internally or externally oriented beliefs and behavior in relation to health care.

The H.L.C. scale has a fair test-retest reliability reported to have been .71 (Wallston, Kaplan & Maides, 1976). Reverse scoring is used on the test which provides a mechanism for ascertaining internal reliability.

Relative to Rotter's more general I-E (Internal-External) scale, this area-specific measure which measures locus of control in regard to health-care beliefs, would appear to have good face validity. Concurrent validity tested in conjunction with Rotter's I-E scale is low with a .33 correlation and a 10% common variance. The authors argue however that "a new test should not correlate too highly with measures from which it is supposed to differ" (Wallston, Kaplan & Maides, 1976). Preliminary evidence for construct validity of the H.L.C. scale has been derived from studies using
two population sources - subjects with hypertension and females who are overweight. Results obtained indicate that H.L.C. scores were more congruent with the hypothesis that subjects with an internal locus of control are more likely to seek information concerning their health condition than the scores obtained from the Rotter I-E scale (Wallston, Kaplan & Maides, 1976).

**Plans for Analysis of Quantitative Measures**

In view of the small sample of 9 core-group members who filled out both pre and post measures, to look at tests of significance for these questions it was decided that non-parametric statistics were the most suitable to use in data analysis. These statistics would look at rank rather than actual size and identify where differences might be to lead to the formation of hypotheses.

Siegal (1956) outlines the following merits of nonparametric testing which he sees as "uniquely suited to the data of the behavioural sciences":

- the tests are "distribution free" and do not assume that scores are e.g. from a normal distribution population;
- nonparametric techniques can be used "with scores which are not exact in any numerical sense but in effect are simply ranks";
- they are easy to computate;
- they are useful with small samples, a feature particularly "helpful to the researcher collecting pilot study data . . .".

On reviewing the data, the Wilcoxon Sum Test and Signed Rank Test were chosen. Reasons for the choice were the small sample size (N = 9), the absence of normal/continuous distribution of data and the interest in ranking as opposed to absolute numbers.
Specifically in respect to the Wallston Health Locus of Control the plan for analysis was to see whether each individual had an internal/external locus of control in regard to their health care and whether this orientation of beliefs changed over the period of the study. The Bem Sex-Role Inventory would provide information as to how each man describes himself in terms of basic personality characteristics, in particular in terms of his male/female, and androgynous sex role behaviors. The scale also provides a way of assessing the range of sex role definitions among individual group participants and an overall group profile. It was anticipated that the Bem scores may change moderately in the androgynous direction over the course of the evaluation.

In respect to the Arthritis Measurement Impact Scale, data from the scales selected from the index was put together and analyzed as one scale looking at health perceptions, pain, anxiety and depression. The scales of health perceptions and pain were also analyzed as separate scales.

Data from the three questionnaires was correlated with the demographic data.

E. Record Keeping & Definition of Core Group Members

It was decided to keep a record of attendance patterns, the rationale being to keep track of shifts in group participation. This method was seen as an indirect measure of individual commitment to group process. However, non-attendance could be due to external factors. Moreover coming to the group may not necessarily mean the same to each group member and gave no indication of involvement in group process, e.g. a member might attend but appear to be 'preoccupied'.

For the purposes of the study, core-group members were defined as men who attended the group sessions during the monitoring period more than once and filled out the pre and post measures.
F. Review of Patient Charts

Patient charts in the Social Services Department at the Vancouver Arthritis Centre were reviewed in order to document background characteristics of group participants. The rationale for the use of this method was to gather relatively objective data on background of group participants. Demographic variables were: age; length of time the arthritis had affected the man's work; the number of meetings attended during the course of the study; the number of meetings attended previous to the study; whether working or in school full-time; whether living alone or with someone. This information was gathered for the 9 core-group members who attended the group during the three-month monitoring period of the evaluation.

The plan for analysis was to create a demographic profile of participants as a group. This descriptive data would be augmented by correlating the demographic data and data from the three quantitative measures.

Methods to Check and Verify the Data

Qualitative Data

Several of the sources of error described by Miles and Huberman (1984) in qualitative data collection and ways to check and verify data are relevant to this study.

1. Checking for Researcher Effects

As outlined in Chapter 2, there are methodological problems with the role of the observer in the study. These issues can be summarized as: the presence of only one observer; the observer being the researcher and developer of the monitoring system; the observer's familiarity with the program and subjects; and the presence of a female observer in an all male group.
2. Triangulating

Miles & Huberman (1984) write that "triangulation is supposed to support a finding by showing that independent measures of it agree with it or, at least don't contradict it" and could be considered as a form of qualitative concurrent validity. In this study this issue has been addressed through the use of different methods of measurement to give a comprehensive and indepth view of the program from several different perspectives and provide repeated measures of verification. Moreover, "putting indicators together from different measures yields some multiple and causally linked evidence" (Miles & Huberman, 1984).

3. Weighting the Evidence

Miles and Huberman (1984) raise the question of how to weight the research. They state that it is important to be aware that: data from some informants are better; circumstances of collection can strengthen or weaken quality of data; and data quality may be strong because of the researcher's validation efforts.

Data quality issues were particularly in evidence in respect to the role of a female observer monitoring an all-male group. It was decided therefore to write a section as part of each narrative description of Men's Group meetings as to how the presence of a female observer appeared to affect the quality of the data received. This issue was also discussed with the group leader for verification following each group meeting.

4. Getting Feedback from Informants

Miles and Huberman (1984) stress the importance of feeding findings back to the informants. This is seen also as an opportunity to learn more about the program participants and program site (Miles & Huberman, 1984). In the present study the group
members expressed particular interest in receiving the scores from the three questionnaires and having them explained, as well as learning more about the study findings. It was agreed that one of the group sessions after the study period would be used for this purpose.

**Ethical Issues**

1. University of British Columbia Ethics Committee forms were written and presented to the Ethics Committee both at the Vancouver Arthritis Centre and at U.B.C. The study was approved by both committees (see Appendix I).

   A consent form was made for the study and signed by each group member attending group sessions during the period of the study (Appendix II).

2. One ethical issue that arose during the study concerned the use of a video of the group to test the monitoring system for inter-rater reliability. While it appeared methodologically sound to ask outside observers to view the tape, the idea was rejected on grounds on confidentiality. The observer and group leader carried out the test.

**Limitations of the Study**

The study is limited in scope, as well as in experimental control and maturity of measurement.

The primary constraint of the study is the three-month time-limited framework. A longer time-period was not feasible due to the time-frame of the student researcher's academic year. As a result, the group observation period of the study of three months duration was relatively short. This is a limitation because the group is a support group and members may not attend each meeting. For this reason it may not have been realistic to look for change over the observation period both in terms of
group process and the pre and post measures. However, since the study was 'exploratory' in nature it was feasible to use several methods to provide multiple perspectives of the program being evaluated.

In terms of the design of the study, the original concept was for a more rigourous controlled design. The intention was to have a control group of men who had been seen in the Social Work Department. Under normal circumstances these men would have been invited to join the group but not until after the study period. They would be asked whether they would like to take part in the study which would entail filling out pre and post measures.

Due to the time constraints of the study, it was only possible to find 3 men who were willing to participate in this capacity. It was therefore decided, due to the already small sample size of the 'treatment' group (n=9), that a control group was not feasible.

Having a small sample size (n=9) of core-group members with no control or randomization, posed threats to internal and external validity.

Several of the threats to internal validity as outlined by Campbell and Stanley (1963) are relevant to the present study. In respect to 'history', it was not possible to control for other events that may have occurred during the study period that could be responsible for patterns of change. 'Maturation' is also an issue since there is no way of knowing if any psychological or physical process happened within each group member that might have influenced outcome (Bloom & Fischer, 1982). This would seem to be especially important with a population with a chronic condition. In respect to 'testing', the effects of the group members being observed and measured were not controlled for.

In relation to external validity or generalization of research findings, 'practitioner effect' and 'differences in clients' (Campbell & Stanley, 1963) were possible
threats. Regarding 'practitioner effect', the particular practice style of the group leader may influence outcome. In the Men's Group, the group leader takes a passive leadership role but he is also known to group members in another capacity through individual counselling sessions.

This client group is both a specialized group (males with arthritis) and also a strikingly heterogeneous group of men. These 'client differences' may affect the generalization of results.

Another issue in the study being an evaluation of a support group is that there are no set attendance expectations. It may be, as has been the experience with the Lupus Support Group at the Centre, that people may not come when they are feeling good or alternatively when their disease is active. However, the study is limited by the fact that there is no theoretical knowledge base in this area which documents what is likely to happen. The study is therefore 'exploratory' in nature.
NOTES

CHAPTER 3


CHAPTER 4

Results
Results

What follows are the results for: monitoring of the Men's Group sessions; narrative descriptions written following each meeting; interviews with core-group members; and scores of pre and post measures.

Description of the Sample

The Men's Group is heterogeneous in nature. In the core-group, members have different kinds of Arthritis: Ankylosing Spondilitis; Rheumatoid Arthritis; Osteoarthritis; and Scleroderma. While it is apparent that three of the core-group members are physically disabled by their disease, the other members do not show any overt physical signs. The different ages of the men are 19, 26, 29, 38, 38, 40, 45, 54, and 60. Of the 9 core-group members, 3 live alone and 6 with another person (friend/spouse). Four men are fully occupied with work or school and five are unemployed. Five men live within the greater Vancouver area and four outside of Vancouver.

1. Monitoring of the Men's Group Sessions

The meetings that were monitored as part of the evaluation began on January 29, 1987. They were held twice monthly on the second and fourth Thursday of each month. They commenced at 7:00 p.m. in the evening and ran until 9:30/10:00 p.m. depending on when the men felt it was time to stop.

Table 1 shows the number of meetings attended by each group participant (n=20). Looking at the attendance patterns for the entire group it was found that: 15% attended 5 times; 20% attended 4 times, 20% attended 3 times; 20% attended twice and 25% attended once.
Table 1

Number of Meetings Attended by Each Group Participant (n=20)

<table>
<thead>
<tr>
<th>Individual Group Participants</th>
<th>Number of Sessions Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>5</td>
</tr>
<tr>
<td>C</td>
<td>3</td>
</tr>
<tr>
<td>D</td>
<td>2</td>
</tr>
<tr>
<td>E</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
<td>2</td>
</tr>
<tr>
<td>G</td>
<td>3</td>
</tr>
<tr>
<td>H</td>
<td>4</td>
</tr>
<tr>
<td>I</td>
<td>5</td>
</tr>
<tr>
<td>J</td>
<td>1</td>
</tr>
<tr>
<td>K</td>
<td>2</td>
</tr>
<tr>
<td>L</td>
<td>3</td>
</tr>
<tr>
<td>M</td>
<td>4</td>
</tr>
<tr>
<td>N</td>
<td>5</td>
</tr>
<tr>
<td>O</td>
<td>1</td>
</tr>
<tr>
<td>P</td>
<td>2</td>
</tr>
<tr>
<td>Q</td>
<td>3</td>
</tr>
<tr>
<td>R</td>
<td>4</td>
</tr>
<tr>
<td>S</td>
<td>5</td>
</tr>
<tr>
<td>T</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 2 shows the number of meetings attended by each member of the core-group (n=9). Among core-group members, 22% attended 5 times, 33% attended 4 times, 33% attended 3 times and 12% attended twice.

Table 2

<table>
<thead>
<tr>
<th>Number of Meetings Attended by Each Member of the Core Group (n=9)</th>
</tr>
</thead>
</table>

![Bar chart showing the number of meetings attended by each individual core-group participant (A to I).]

Individual Core Group Participants

Looking at the two distributions it is evident that core-group members did attend meetings more frequently than the group as a whole.
Table 3 shows group attendance at each of the 6 monitored sessions (n=20).

Table 3

Group Attendance at Each of the Six Monitored Sessions (n=20)

Sessions 1 - 6
In examining group attendance at each of the 6 monitored sessions it was found that 33% had 12 men participating, 50% had 9 men participating, while 17% of the sessions had 8 participants.

Table 4 shows core-group attendance at each of the six monitored sessions (n=9). At monitored session number 2, all the core group members were in attendance. At the other sessions attendance of core group members ranged from a low of 3 up to 7.

It is the core-group that formed the unit of analysis in the study.

Table 4

Core-Group Attendance at Each of the Six Monitored Sessions (n=9)

Sessions 1 - 6
Table 5 shows frequency of interaction ratings for all objectives (3-7) monitored for the core-group members. On observing Table 5 it appears that while at meeting one almost all the interaction was at the lowest levels, at meeting six, the proportion of higher and lower level interaction is almost equal. However, this is not a gradual progression. Only in two out of the six meetings was there any emotional problem solving (objective 7). These were the open-discussion meetings where there was no guest invited and psycho-social issues were discussed. These were also the meetings in which greater frequencies of higher level objectives were achieved.

Table 5

Frequency Ratings for the Core-Group over 6 Monitored Sessions (n=9)

<table>
<thead>
<tr>
<th>No. of Core-Group Members Attending</th>
<th>Session No.</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>1</td>
<td>124</td>
<td>17</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>278</td>
<td>29</td>
<td>10</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>78</td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>85</td>
<td>6</td>
<td>47</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>31</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>48</td>
<td>7</td>
<td>49</td>
<td>10</td>
<td>3</td>
</tr>
</tbody>
</table>

TOTALS: 644 73 115 24 7
Table 6 looks at the same information for all the different individuals including core-group members who attended group sessions during the monitoring period. The same observations can be made regarding the patterns of interaction for this group as for the core-group.

Table 6

**Frequency Ratings for all Group Members over 6 Monitored Sessions (n=20)**

<table>
<thead>
<tr>
<th>No. of Core-Group Members Attending</th>
<th>Session No.</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>1</td>
<td>287</td>
<td>26</td>
<td>21</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>415</td>
<td>31</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>170</td>
<td>16</td>
<td>13</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>171</td>
<td>14</td>
<td>93</td>
<td>35</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>123</td>
<td>8</td>
<td>12</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>153</td>
<td>11</td>
<td>113</td>
<td>17</td>
<td>9</td>
</tr>
</tbody>
</table>

**TOTALS:** 1319 106 263 60 15

In that it was anticipated that over the course of the meetings that men would start to interact at the higher levels, Table 7 looks at the percentage of the total interaction of each session spent on the higher level objectives for the core group. Whereas the frequency is 3% and 4% in the first 3 meetings, there is a noticeable difference in meeting 4 of 41% and meeting 6 of 53%. Meeting 4 is described in section 2 on narrative descriptions.
Table 7

Percentages of Total Interaction in Each Session

Spent on Higher Level Objectives (5, 6 and 7) for the Core Group (n=9)

While there are differences in the percentage of total interaction spent on the higher level objectives between the 9 core-group members and for the 20 different
individuals who attended the session, the overall pattern of lesser or greater percentages in the different sessions in comparable. Table 8 follows.

Table 8

Percentages of Total Interaction in Each Session

Spent on High Level Objectives (5, 6 and 7) For the Whole Group (n=20)
Table 9 illustrates the percentage of interactions for each high level objective achieved for core group members. It can be observed that when higher level objectives were achieved, 88% of them were in the area of objective 5, 10% in the area of objective 6 and only 2% in the area of objective 7.

<table>
<thead>
<tr>
<th>Higher Level Objective for Core Group Members (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

Men's Group Sessions

A note of caution is that when men did interact at a higher level of emotional openness, only the highest level achieved was checked. For example, if a man was involved in emotional problem solving (objective 7) this was the only objective that would be checked, regardless of whether objectives 5 or 6 had been achieved. For this
reason the frequency of the ratings for all but the highest objective may be under-represented.

The percentage of interaction spent on the higher level objectives for the entire group deferred slightly from that of the core group in that 83% were in the area of objective 5, 14% in the area of objective 6 and 3% in the area of objective 7. The differences between the two groups could be caused by a number of factors such as chance alone or one member (not a core-group member) showing his emotions (See Table 10.)

Table 10

Proportion of Interaction in Percentages Spent on Each Higher Level Objectives for the Whole Group (N=20)

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>12%</td>
<td>8%</td>
<td>13%</td>
<td>26%</td>
<td>14%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>84%</td>
<td>92%</td>
<td>87%</td>
<td>70%</td>
<td>86%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>
2. **Narrative Description of Group Session**

Space does not permit the presentation of the narrative descriptions written for all group meetings monitored. Each of these narratives included a description of what went on in the meeting as well as additional observations, such as quality of data issues in relation to the presence of the observer.

The narrative descriptions did verify the data from the monitoring sessions, that the interim objectives - including the higher level objectives - were met in the open-discussion meetings, sessions 4 and 6.

In both these meetings a good proportion of the interaction was spent on the higher level objectives (session 4, 41% and session 6, 53%). It was clear from the narrative descriptions that these sessions were emotionally charged and that men were opening up, offering emotional support, and emotional problem solving. In relation to the achievement of the higher level objectives however, since only sessions 4 and 6 specifically focussed on psycho-social issues, it was not possible to look at the pattern of change in group interaction over time.

The following is the narrative description written following session 4. For reasons of confidentiality, names of group members are represented in letter form.

March 12, 1987  **Men's Group Meeting**  (9 men attended)

The group leader spoke at the start of the meeting about using this meeting to discuss what pain means to the individual members of the group. This was in preparation for the next meeting when the guest to join the group would discuss pain management. It was an opportunity to share pain experiences and to get a sense of how it affects other men's lives and how they cope with it.

The idea was that each person would be asked to address:

- how the pain starts
what it is like when it starts to worsen
what it makes the person feel
what the person does about it.

Each man would be given a chance to speak. One group member volunteered to start.

This was a very emotionally charged meeting. For this reason I am aware that the following notes from the meeting may be more interpretive than descriptive since while in the role of the observer, I too felt emotionally involved.

There was a very high level of emotional sharing and support and even problem solving in the meeting. Also there were differences and individuality in each man's experience of pain, its meaning in their everyday lives, what it feels like and how they handle it. Each had his own words to express pain, words that encompassed both a physical sensation and/or a mental attitude or state. Pain was described as 'burning', feeling 'like bone rubbing on bone', 'crushing', 'mental anguish', 'tunnel pain', and 'freezing pain'.

Without exception, each group member was, to varying degrees, emotionally open about his experience. As more men opened up there was more sharing of emotional support and identification with parts of another's experience. The atmosphere at certain points in the meeting - particularly when K and C were speaking (they seem to be the most emotionally in touch with their feelings and experiences) - was so focussed it was electric.

In particular, the body language was striking to observe. There seemed to be a real sharing of emotional support in the expressions on men's faces, in the bowed heads, intense gazes, the group silences as one member opened up and the nods of understanding and sympathy.

In terms of emotional problem solving a range of options were given. N's down to earth approach was "you simply have to readjust your life". S similarly
recognized that while acknowledging the losses and frustrations accompanying the condition (loss of physical strength and body image) that acceptance and adjustment was the only way. He said "the best thing is to take your ego and put it in your back pocket, take medications and have a positive attitude".

C's and K's responses were very different. C had a solution, an anacronym that he calls D.R.E.A.M. - a program to health the success of which depends on your attitude. K's response was even more intense and spiritual. His way to fight his disease is to wage a positive mental battle against it. "Change is the key" he said, "you can't pursue the same route, you can't accept the fact that there is no hope. You have to go beyond that or you'll never arrive. Change comes from within, you have to keep enlarging on this position, this space".

Each member made a very personal contribution to the meeting. The following vignettes are written to give a sense of the different pictures of pain presented.

B

B talked about feeling angry when in pain and anti-social, "living on the edge and hurting". He talked about wanting to sleep to forget his pain and that tension and pain went hand in hand and set up a hard cycle to break. He said he doesn't know what it is like to be pain free - "it takes over your life". He described how he may inflict acute pain on himself to counteract chronic pain. He also talked about the problem of addiction to pain killers. Describing chronic pain he said "it's hard to explain - it's like a toothache when you have an exposed nerve ending but you can't go to the dentist the next day". His solution was to occupy your mind with something, to train yourself in this way to gradually forget the pain and hopefully to take less medications.
A talked about how he experiences such pain that even on his better days ordinary people wouldn't want to get up - that they'd want to die rather than face the day. He's tried alcohol and pot - they don't work for the 'cold' and 'excruciating' pain he feels. He tries like B to keep his mind off the pain by working. He has been treated for his suicidal tendencies. Sometimes he just finds the pain too hard to handle.

N

His experience of pain seems less intense. He feels the pain as a freezing sensation and annoying but he copes well with it.

M

He describes his pain as 'deep inside' him. He described how the moment he feels pain he freezes - he sits and stares, hardly moves until the pain lessens. He called it 'tunnel pain'. He said the worst times for him are when he can't make love to his wife because he can't use his wrists. A bad time for him was when he found he could no longer do his work because he couldn't lift anything heavy anymore.

S

S gave a very clear picture of what it meant to be male and have arthritis: problems of body image, male ego and work. "It's demeaning to me" he said "I stand there. I'm big. People look at me and think I look fine". He talked about how he used to work-out and take marshal arts, that one day he could do something physically and the next day that he simply could not. Now he says "I have to take my arm each morning and move it a couple of times to get it to work". He had to quit being a car mechanic after 22 years. He used to be the fastest but has had to come to the realization that he has to change trades. He described the pain he feels as 'throbbing and crushing'. "Nothing masks the pain when it's severe" he said, "it's
severe and excruciating all the time". Talking about coping with pain later in the meeting he said "the best thing to do is to take your ego and put it in your back pocket, take medications and have a positive attitude".

C

In the coffee break he made an interesting comment. He talked about how he totally related with what some of the members were describing in respect to pain and not at all with others.

When he related his experiences of pain, he chose to give his solution - an anacronym D.R.E.A.M. (Diet, Rest, Exercise, Attitude and Medications), his program to health. It is noteworthy that his present condition is so serious that he is hospitalized.

He talked about having experienced so much pain that he was under no illusions about it. His pain was 9.5 on a scale of 10 most of the time. "Walking. Walking is like walking on knives". He talked about pain as both physical "agony" and "mental anguish". His final comment was "I don't want to create my own prison anymore. I'm not ashamed to ask for help when I'm in pain".

K

K's description of his experience was intense and seemed to command a different quality of attentive silence from the group. "I don't know how to explain pain, it's just there. I can only deal with it through my mind. Sometimes you get in it so deep it will tear you apart. Other times you can cope". When he is in pain he describes himself as feeling "like a butterfly with a pin through my neck". In terms of the image of the productive male, sexually and otherwise the impact of chronic pain is a blow to the ego. "It's an insult that I can't do what I could. I feel like a phantom took over".
Drugs are not an answer for K. "Drugs put off the inevitable. They burn bridges and then there's no way back." Rather than take medications, K meditates and does yoga. "I must change for the better, fight a positive battle and fight this thing that consumes me." He went on to say, "I glean people's courage and understanding. Kinship with people is tremendous medicine".

Observations

1. Purpose of the group.
One member made an interesting statement about the purpose of the group. He said, "We don't have to bullshit around here. We're here to try to help each other".

2. Presence of the female observer.
At one point in the meeting one of the members began talking about his sex life. He stopped short saying "too bad the secretary is here".

3. Interviews with Core-Group Members

10 men were interviewed using the semi-focus checklist of questions described in Chapter 3. Nine of these men were core-group members who had filled out pre and post measures. One man had attended regularly, had not filled out the questionnaires but wanted the opportunity to voice his opinions of the group.

Interviews were transcribed from the audio tapes and then summarized according to recurring themes that emerged. Since each man often raised more than one theme, themes are grouped according to number of times mentioned. The following is a summary of the range of group responses for each question.

Question 1
Category: Why the men came
Question: After you heard about the group what made you decide to come the first time?

Five out of the ten men said they came 'out of curiosity'. Two men saw the group as a good place to meet other people with arthritis and to gain a sense of support. One man came because he was involved in organizing the first meeting, a second came because a friend of his had joined. Another man came specifically with the idea that any information he could glean about arthritis would be helpful.

Question 1a

Question: Why did you keep coming?

When asked why they kept coming to the group, one theme that was raised by 7 of the men was the experience of universality, of being with a group of people who shared a common problem and therefore 'understood' how they felt. This gave one man in particular a sense of belonging and a chance to talk frankly about a subject equally important to himself and other group members. Another man spoke of how he did not return for the group after the first meeting for quite a while because he was not interested in what he saw as 'a lot of men belly-aching'. However, on returning to the group and attending a session (meeting 4) on the discussion of pain, he did find the meeting interesting. "It enabled me to find out that there are people who have what I do. I'm not the only one", he said.

Another reason for continuing to come to the group expressed by 3 group members was to gain insight and learn about themselves through listening and learning about others.

One member liked what he heard when he came and kept coming because he wanted to see the group continue - "It's a support group" he said, "without people, there's no support".
Question 2
Category: Opinions on the group

Question: What do you think you get out of coming to the group?

Again the theme of gaining insight by listening to the experience of others who share the same problem was brought up by 8 out of the 10 men. One man expressed this as "seeing how different people live with the same handicaps", another as "Sharing - finding things I want to improve on reflected by other people".

The theme of gaining knowledge and information from the meetings was mentioned by 4 of the men. Three men talked about the sense of their social circle expanding and finding new friends. One man said that he always leaves the group feeling good because no matter how bad he is feeling there is always someone worse off. He appreciated the opportunity to get his feelings out - "I get a lot off my mind in the sessions" he said.

Question 2b

Question: What are the best things you get out of coming to the group?

The two main themes were a sense of companionship/friendship and of gaining information and knowledge. Each of these themes was raised by 5 men. Three men talked about 'being able to communicate' with people who understood and two men said the best things they got out of coming were receiving acknowledgement and understanding from other group members.

Question 2c

Question: Are there things in the group that you didn't like?

Three men said there was nothing in the group that they hadn't liked.
Another three men said how they didn't appreciate group members' "woe is me" attitude in respect to their disease. One man said "I'm not interested in people bickering about their aches and pains. They're there, accept them". Another said, "If you're going to belly-ache, go to the bar, don't come to the meeting and destroy it".

Two men were irritated with one of the guests who had been invited to join the group discussion.

Three men made individual comments. One man did not like hearing about what the government or agencies could do for him. In his opinion people should decide what they want and get it for themselves. Another man thought the meetings should be longer, "just when we are getting into things it's time to go home". A third man didn't like the fact that the group was what he called "monotone" rather than "dynamic" because the same people would talk and others were shy to speak up. He wanted to see more leadership guidance on the part of the group leader.

Question 3
Category: Spouse's reaction
Question: What does your spouse think about you coming to the group?

This question was only relevant for 3 men. The first man who responded is separated from his wife. He mentioned it to her but she is still unable to accept that he has arthritis and did not respond. The second respondent said his wife liked the idea of the group, reminded and encouraged him to go. The response from the third man was that his wife herself would like to be invited to attend the meetings.

Question 4
Category: Friends' reaction
Question: Have you talked to friends about the group?
According to 4 men, friends that they had talked to about the group thought it was a good idea and were supportive. Friends of 3 men did not understand what it was all about. "I've told friends exactly what goes on in the group" one man explained "but they don't understand. They're not in the same boat".

Two men said they had no friends and a third said he only discussed it with his close family. Two men also mentioned that they had spoken to friends with arthritis to try to recruit them for the group.

Question 5
Category: Group experience
Question: What happens in the group?

This question proved to be problematic. Group members were not clear as to whether the question was referring to process or content and found the question 'ambiguous' and 'vague'. Possibly because of the open-endedness of the question, the responses were quite varied.

Three people responded to the question as a content question and described the general format of the meeting. Content, 'gaining understanding by being around people like yourself' was again mentioned by 3 men.

The remaining responses were very individual. One man talked about the group facilitating problem-solving: "Questions are presented and solutions are then offered. We don't necessarily have all the solutions but we have directives, means and the will to put forward solutions".

Another man saw that what happened in the group was the communication of ideas so that the group became a "think-room". Another man saw the "generation of hope" so that the group was for him a forum to speak and a place to go. The fourth man's response was that what he thought happened in the group was "a very cagy
counsellor little by little turning these people back into human beings. It's interesting to watch all the changes in the different people from downright 'rah rah' to at least a little swell".

Question 5a

Question: How does it feel sitting and talking to a group of guys?

Seven men said that they felt comfortable about it. This feeling was qualified with expressions/comments like "I feel relaxed", "more relaxed than with both sexes", "feeling equal", "like being with family", "I feel open knowing what I say stays within the group".

One man's response was particularly open and insightful:

It was hard for me to begin with. I'm usually pretty secretive. It's only once in a while that I open up. That one night I opened up. That's the first time I've talked about it in the last 10 years. It got away. I wasn't going to say that much and it got away. Now it doesn't really bother me to sit and talk with the guys. But I don't want to be a sounding board for people who are more unfortunate although I understand where they are coming from. It's hard for me. It brings me down. I don't have the psychological training not to fall into the trap.

Question 6

Category: Feeling of safety to disclose

Question: If you had something really private to say, would you share it with the group?

Three men clearly stated that they would not share a private issue with the group. Two men said they would and already had done. Two qualified their decision to 'open-up' as being dependent on the feeling of trust and confidentiality in the group. Two other men's responses would depend on whether the issue was relevant.
to their own experience. If it was, then they would disclose. One man's comments showed feelings of ambiguity around the issue of disclosure:

I'm a private individual. I try to keep things to myself but they seem to build up with pressure. I s'pose everybody has a dark corner in the heart so that they say 'maybe next time'. I'd feel more comfortable in a one on one situation rather than in the group.

Question 7
Category: Male Dominance
Question: Do you think some men talk all the time and don't give other men a chance to talk?

The range of perceptions in response to this question was interesting. They ranged from a definite "I know they do" (3 responses) through "I'm guilty of that myself" (3 responses), "It sometimes happens" (1 response), "It's hard to say" (1 response), "I hadn't noticed that in the group", (1 response) to "No, the idea is to be spontaneous, when people hurt they should get rid of it".

Question 8
Category: Opinions of benefits of the group
Question: Do you think this kind of Men's group is useful?

All the men thought the group was in some way useful. There were a number of qualifying responses.

For 5 men the group was useful to share ideas, to find out how others cope with the disease and learn new coping skills. One man said "It gives us a better focus on the problem and the disease, stress management and how not to handle it with anger and ignorance". Another man's response was that "it opens up a lot of avenues
for the different guys that they never thought of. You can't think of everything yourself".

Three men saw the group as a means of companionship and social support. One man pointed out that meeting with people with different degrees of disability promotes understanding of yourself and others. Another man said he found the group useful unless he was in severe pain in which case he couldn't sit for long and found it hard to focus.

Question 9
Category: Perceptions of change in the group
Question: Have you noticed any changes in the group since you have been coming?

This question was added when the interviewing was already underway, for this reason only 6 responses were recorded.

Two men talked about the changing membership of the group, a mixture of oldtimers and newcomers who come and go.

Two men saw changes in attitudes. One saw a "positive attitude shift". Through association with people he felt the men were coming out of themselves and beginning to learn from and help one another. The second man said about the change in attitudes "they seem to be more willing to help someone out rather than do them a favor". Also he felt "the wrestling back and forth for control has stopped". He also pointed out what he thought had not changed "the group still isn't very cohesive. Someone says something and then there are a dozen and a half jokes. I know what they are going through. It's a form of hiding. You've got to face it. Take the Mr. Macho stuff and get rid of it because you're a human being".
One member said that he felt the men were getting to know each other more intimately and another felt the guests chosen were more 'enthusiastic' than guests who were invited when the group first started.

Question 10
Category: Additional comments
Question: Is there anything else you'd like to say about the group?

Each man's response was different. The responses which are listed below include the expression of thanks, complaints and suggestions.

- "I like the frequency of the meetings."
- "I wish the meeting times were adhered to from 7 - 9 p.m. There have been nights when I've come home at 10:00 and it's just too long. ... either start a bit earlier or say the meeting is from 7 - 9:30 p.m."
- "I hope it continues."
- "It's a good group"
- "A good attitude grows with positive association ... We can expand energies we have generated as a group."
- "The chairs are uncomfortable and some people are embarrassed to get up in the middle of the meeting."
- "I would like to see more guys come out because it's worthwhile."
- "It's one of the best things that have happened to me. There are times when you are ready to go off the deep end and the group makes all the difference."
- "I would like the group to be more cohesive and the relationship between the people more deep. It would be nice to get each other's telephone numbers and meet outside the group. It would be more relaxing to meet in someone's home and to take wives
or friends so they know what's going on. A show of slides on arthritis would be a good idea."

- "There should be more interaction. It would be good to have groups with spouses or family involved. My wife would like to have more understanding of arthritis."

Suggestions given in response to other interview questions were that the meeting time be lengthened and that the leader take a more active role in the group.

**Summary of Main Themes**

When core-group members were asked why they came to the group, for opinions on the group and about the group experience, several recurring themes emerged:

- Universality - the experience of being with a group of people who share a common problem and therefore understand how you feel;

- Gaining insight and learning about yourself through listening and learning about others;

- Gaining knowledge and information from the meetings;

- Gaining a sense of companionship.

Generally the men felt comfortable about talking with a group of men but were more reticent regarding sharing something private with the group.

All the men thought the group was useful. The main theme raised was that the group was useful to share ideas, to find out how others cope with their disease and learn new coping skills.

Generally, the feeling expressed was that the group was more cohesive than when it first started and that people were more comfortable, friendly and open.
In the open-ended section of the interview there were a wide range of suggestions including: involving family members in the group; having the group leader take a more active role in the sessions; as well as contradictory comments regarding the lengthening or shortening of group meetings.

4. Scores of Pre and Post Measures

Pre and post measures using three measurements were taken for the 9 core-group members of the study. These three measurements were chosen as indicators or surrogates for the highest level objective (objective 8) that men will begin to re-evaluate and feel less pressured by male societal expectations so that they will be better able to focus on and cope with their condition.

The pre program measures were conducted at the first group meeting. The post program measures were taken following the 6 group meetings. The means for the 9 core-group members on pre scores were compared to the 9 core-group members on the post scores. The hypothesis testing method was used to determine if changes in the means between pre and post scores (if indeed there were any changes) could be attributed to chance alone.

In hypothesis testing, statistical significance expresses the degree of confidence that the results could have occurred by chance alone. It is an indirect reasoning logic: assuming there is no difference (H₀); constructing a model (provided by statistical theory); choosing a significance level (5%); finding the critical region; assessing whether differences fall within this critical region; and either accepting or rejecting the null hypothesis (Wright, 1979).

In the study a non-parametric statistic (Wilcoxon Signed Rank Test) was used because: one could not assume a normal distribution or that the data was
continuous, whether it would or would not be unimodal or symmetrical; and most importantly, there were only 9 subjects.

The two main reasons for the choice to use pre and post quantitative measures was 1) to see whether change did take place pre to post and 2) regardless of the presence or absence of significant change, to provide a good description of these men in relation to the 3 measures.

1. **Bem Sex-Role Inventory (BSRI) Scores**

   The assumption for using the Bem Sex-Role Inventory (BSRI) was that over the course of the meetings, the BSRI scores may change moderately in the androgynous direction. That is, move towards more feminine attributes such as 'understanding' and 'sensitivity to the needs of others', (Bem, 1974).

   Table 11 shows the BSRI pre scores for masculinity, femininity, androgyny and social desirability.

   **Table 11**

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<thead>
<tr>
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</thead>
<tbody>
<tr>
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<td>Subject 9</td>
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</tr>
<tr>
<td>St. Dev.</td>
<td>1.04</td>
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<td>1.87</td>
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</table>
Table 12 shows the post scores for same variables.

### Table 12

**Bem Scores for Core Group (Post)**

<table>
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</thead>
<tbody>
<tr>
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<tr>
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<td>Subject 3</td>
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<td>-3.90</td>
</tr>
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<td>5.00</td>
<td>4.90</td>
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<tr>
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<tr>
<td><strong>Mean</strong></td>
<td>5.34</td>
<td>4.57</td>
<td>-1.61</td>
</tr>
<tr>
<td><strong>St. Dev.</strong></td>
<td>0.66</td>
<td>0.53</td>
<td>1.61</td>
</tr>
</tbody>
</table>

A person displays masculine or feminine personality characteristics if they have endorsed society's sex-type standards of socially desirable behavior for men or women (Bem, 1974). The BSRI sees a person as masculine, feminine or androgynous according to the "extent to which a person divorces himself from those characteristics that might be considered more 'appropriate' for the opposite sex" (Bem, 1974). The social desirability scale represents items which are neutral in respect to sex.

In regard to scoring Bem (1974) writes:

The Masculinity and Femininity scores indicate the extent to which a person endorses masculine and feminine personality characteristics as self-descriptive. Masculinity equals the mean self-rating for all endorsed masculine items, and Femininity equals the mean self-rating for all endorsed feminine items. Both can range from 1 to 7. ... The Androgyny score is the difference between an individual's masculinity and femininity normalized with respect to the
standard deviations of his or her masculinity and femininity scores.

Since the direction of change was unspecified, to test for significance two-sided P-values were used. The two-sided P-values for the BSRI variables (Masculinity, Femininity, Androgyny and Social Desirability) were 0.68, 0.86, 0.91 and 0.55 (see Table 13 below). Generally only P-values less than 0.05 are seen to constitute strong support for the hypothesis of a difference pre to post. Therefore, in the present study, as illustrated in Tables 7 and 8, there were no statistically significant changes pre to post in any of the variables.

Table 13

<table>
<thead>
<tr>
<th>Bem Score Means Pre and Post</th>
</tr>
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<tbody>
<tr>
<td>Pre</td>
</tr>
<tr>
<td>St. Dev.</td>
</tr>
<tr>
<td>Post</td>
</tr>
<tr>
<td>St. Dev.</td>
</tr>
<tr>
<td>P-values</td>
</tr>
</tbody>
</table>

Mean scores were comparable to the norms found in studies at Stanford and at Foothill Junior College (Bem, 1974), excepting mean scores for masculinity (5.37 pre, 5.34 post) which were slightly higher than the norm (4.97 Stanford and 4.55 at Foothill).
ii. Wallston Health Locus of Control (HLC) Scores

The HLC was used on the assumption that if group members had more perceived control over their disease, they would be better able to cope. It was hoped that scores would indicate more perceived control that is, a more internal locus of control over the study period.

Table 14 reports HLC pre scores and Table 15 HLC post scores.

Table 14

HLC Scores for Core Group (Pre)

<table>
<thead>
<tr>
<th>HLC Score</th>
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<tbody>
<tr>
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<tr>
<td>Subject 4</td>
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<td>Subject 5</td>
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<tr>
<td>Subject 6</td>
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<tr>
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<tr>
<td>Subject 8</td>
<td>42.00</td>
</tr>
<tr>
<td>Subject 9</td>
<td>34.00</td>
</tr>
</tbody>
</table>

Mean 34.67
St. Dev. 8.96

Table 15

HLC Scores for Core Group (Post)

<table>
<thead>
<tr>
<th>HLC Score</th>
<th></th>
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</thead>
<tbody>
<tr>
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<td>45.00</td>
</tr>
<tr>
<td>Subject 9</td>
<td>43.00</td>
</tr>
</tbody>
</table>

Mean 38.11
St. Dev. 7.25
A high score on the questionnaire is indicative of a subject perceiving himself as being less in control of his health, that is, having a more external locus of control. A low score therefore indicates a greater sense of control and a more internal locus of control.

The two-sided P-value for the HLC score was 0.08, (see Table 16 below). If this is taken as some evidence of a change in scores, then it would appear that the scores went up in value, since the mean HLC score for post is greater than that for pre. Since a high score is indicative of less perceived control, if the test result is interpreted as significant, it follows that subjects felt less in control of their health at the end of the study period.

Table 16

<table>
<thead>
<tr>
<th>HCL Pre and Post Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
</tr>
<tr>
<td>34.67</td>
</tr>
<tr>
<td>St. Dev.</td>
</tr>
<tr>
<td>8.96</td>
</tr>
</tbody>
</table>

| Post                   |
| 38.11                  |
| St. Dev.               |
| 7.25                   |

| Two-Sided P-value      |
| .08                    |

Scores for the Men's group are comparable to the HLC normative data scores.
iii. **Arthritis Impact Measurement Scale (AIMS) Scores**

Using scales selected from the Arthritis Impact Measurement Scale (AIMS) looking at health perceptions and pain and a combined measure of health perception, pain, anxiety and depression, the supposition was that the impact of the disease may be lessened over the period of the study.

The AIMS scales are scored consistently so that a low value is an indication of a high health status.

Table 17 shows the results of the pre measures and Table 18 the results of the post measures.

### Table 17

<table>
<thead>
<tr>
<th></th>
<th>Pain</th>
<th>Health Perceptions</th>
<th>Combined Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject 1</td>
<td>4.00</td>
<td>0.63</td>
<td>4.16</td>
</tr>
<tr>
<td>Subject 2</td>
<td>8.00</td>
<td>6.25</td>
<td>6.73</td>
</tr>
<tr>
<td>Subject 3</td>
<td>0.0</td>
<td>1.25</td>
<td>2.23</td>
</tr>
<tr>
<td>Subject 4</td>
<td>4.67</td>
<td>6.88</td>
<td>6.97</td>
</tr>
<tr>
<td>Subject 5</td>
<td>5.33</td>
<td>4.38</td>
<td>5.68</td>
</tr>
<tr>
<td>Subject 6</td>
<td>2.67</td>
<td>3.75</td>
<td>4.10</td>
</tr>
<tr>
<td>Subject 7</td>
<td>6.67</td>
<td>2.50</td>
<td>3.71</td>
</tr>
<tr>
<td>Subject 8</td>
<td>6.00</td>
<td>8.75</td>
<td>7.02</td>
</tr>
<tr>
<td>Subject 9</td>
<td>7.33</td>
<td>2.50</td>
<td>5.63</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>4.96</td>
<td>4.10</td>
<td>5.14</td>
</tr>
<tr>
<td><strong>St. Dev.</strong></td>
<td>2.50</td>
<td>2.73</td>
<td>1.68</td>
</tr>
</tbody>
</table>
The two-sided P-values for the AIMS variables of Pain and Health Perceptions of 0.86 and 0.46 showed no evidence of change. The two-sided P-value for the third AIMS variable, the combined measure, was 0.14, which could be taken as mild evidence of a change (see Table 19 below). Since the sample mean did decrease from pre to post and since lower scores indicate better health status, a one-sided test was performed to see whether health status had improved. The one-sided P-value was 0.05, indicating some evidence of a change. However, when many tests are performed, there is a high probability of obtaining low P-values by chance alone.
Table 19

AIMS Scores Pre and Post

<table>
<thead>
<tr>
<th></th>
<th>Pain</th>
<th>Health Perceptions</th>
<th>Combined Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>4.96</td>
<td>4.10</td>
<td>5.14</td>
</tr>
<tr>
<td>St. Dev.</td>
<td>2.50</td>
<td>2.73</td>
<td>1.68</td>
</tr>
<tr>
<td>Post</td>
<td>5.11</td>
<td>4.24</td>
<td>4.73</td>
</tr>
<tr>
<td>St. Dev.</td>
<td>1.89</td>
<td>2.70</td>
<td>1.62</td>
</tr>
<tr>
<td>P-value</td>
<td>.86</td>
<td>.46</td>
<td>.14</td>
</tr>
</tbody>
</table>

On the basis of the results, that is, the pre and post differences of the means, the null hypothesis cannot be rejected since there are no real differences between pre and post measures.

From a practical stance, significance tests are highly sensitive to the size of the samples. As explained by Wright (1979):

The reason is that the test statistic contains the sample size; the larger the sample, the smaller the standard error or the sampling distribution, and hence the larger the ratio of the observed difference to the standard error.

Hence, with this small sample size, there is large average variation in the values of T. In other words, extreme values of T are expected relatively more frequently than with larger sample sizes. Therefore, it is less likely with small sample sizes that any true difference in the group means can be detected by the test. The likelihood of such detection is called the ‘power’ of the test.
Correlations between Pre Scores and Demographic Variables

Initially in the design of the study, it was assumed that if results showed significant change, demographic variables would be correlated with post scores. Since change was not indicated, it was feasible to use pre or post scores. Pre scores were chosen.

The statistic chosen was the Spearman Correlation which is defined as the Pearson correlation coefficient formula applied to the ranks of the observation. Observations are ranked within each series in increasing order and the Pearson Correlation Coefficient formula is then applied to the ranks.

Correlations were made between demographic variables of a) age b) meetings attended before the study c) meetings attended during the study and d) time arthritis has affected the subject at work and the pre program scores on each of the three measures, that is, the BSRI, the HLC and the chosen subscales of the AIMS.

Table 20 shows the Spearman correlations between the demographic and BSRI variables.

Table 20

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.454</td>
<td>0.460</td>
<td>-0.167</td>
<td>0.030</td>
</tr>
<tr>
<td>Meetings Attended Before Study</td>
<td>-0.161</td>
<td>0.127</td>
<td>0.068</td>
<td>0.228</td>
</tr>
<tr>
<td>Meetings Attended During Study</td>
<td>-0.139</td>
<td>0.321</td>
<td>-0.052</td>
<td>0.212</td>
</tr>
<tr>
<td>Time Arthritis has Affected Subject At Work</td>
<td>-0.025</td>
<td>-0.100</td>
<td>-0.084</td>
<td>0.094</td>
</tr>
</tbody>
</table>
As could be expected, there was a fair correlation between age and Masculinity (0.454) and age and Femininity (0.460). As age increases self-description in terms of masculine or feminine personality characteristics increases.

Table 21 shows the correlation of the 4 demographic variables to the pre HLC variables.

### Table 21

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Meetings Attended Before Study</th>
<th>Meetings Attended During Study</th>
<th>Time Arthritis has Affected Subject At Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>HLC</td>
<td>-0.487</td>
<td>-0.627</td>
<td>0.135</td>
<td>-0.458</td>
</tr>
</tbody>
</table>

There was a negative correlation between HLC pre scores and the demographic variable of 'meetings attended before study' (-0.627). Since a lower score is indicative of more perceived control over health, it follows that the more meetings attended before the study, the more control the men perceived over their health.

Table 22 shows the correlation of the 4 demographic variables to the pre AIMS variables.
Regarding the variables of age and 'amount of pain felt' there was a 0.410 correlation indicating more felt pain with age. There was a negative correlation between health perception and 'time arthritis has affected the subject at work'. Since a low value indicates a high health status, it follows that the longer the time the arthritis had affected the subject at work, the lower their health perception.

It can be seen from the tables that apart from the described exceptions, the Spearman correlations are close to zero. A cautionary note is that since correlations are unstable with small sample sizes they may or may not reflect any true association present in the population.

Further analysis primarily for descriptive purposes was carried out with the 3 pre measure scores and a) whether the person was living alone and b) whether they were fully occupied with work or school. The results of this analysis are shown in Tables 23 to 28.
Table 23

**Group Means for Bem Scores (Pre)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Alone</td>
<td>5.68</td>
<td>4.92</td>
<td>-1.44</td>
<td>5.20</td>
</tr>
<tr>
<td>Living with Other</td>
<td>5.21</td>
<td>4.46</td>
<td>-1.54</td>
<td>4.86</td>
</tr>
</tbody>
</table>

Table 24

**Group Means for HLC Scores (Pre)**

<table>
<thead>
<tr>
<th></th>
<th>Living Alone</th>
<th>Living with Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29.67</td>
<td>37.17</td>
</tr>
</tbody>
</table>

Table 25

**Group Means for AIMS Scores (Pre)**

<table>
<thead>
<tr>
<th></th>
<th>Pain</th>
<th>Health Perc.</th>
<th>Combined Meas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Alone</td>
<td>5.56</td>
<td>2.5</td>
<td>5.15</td>
</tr>
<tr>
<td>Living with Other</td>
<td>4.67</td>
<td>4.9</td>
<td>5.13</td>
</tr>
</tbody>
</table>
Table 26

*Group Means for Bem Scores (pre)*

*Fully Occupied with Work or School*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>5.9</td>
<td>4.87</td>
<td>-2.02</td>
<td>4.99</td>
</tr>
<tr>
<td>Yes</td>
<td>4.7</td>
<td>4.29</td>
<td>-0.87</td>
<td>4.95</td>
</tr>
</tbody>
</table>

Table 27

*Group Means for HLC Scores (Pre)*

*Fully Occupied with Work or School*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>32.6</td>
</tr>
<tr>
<td>Yes</td>
<td>37.25</td>
</tr>
</tbody>
</table>

Table 28

*Group Means for AIMS Scores (Pre)*

*(Fully Occupied with Work or School)*

<table>
<thead>
<tr>
<th></th>
<th>Pain</th>
<th>Health Perc.</th>
<th>Combined Meas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>6.00</td>
<td>5.00</td>
<td>5.8</td>
</tr>
<tr>
<td>Yes</td>
<td>3.67</td>
<td>2.97</td>
<td>4.3</td>
</tr>
</tbody>
</table>
Group means on the HLC scores were noticeably lower for people 'living alone' than for people 'living with other'. This would indicate people 'living alone' had a greater sense of control over their health.

Group means for HLC Scores and the variable 'fully occupied with work or school' were higher for people who were fully occupied, indicating that these people had less perceived control over their health.

Group means for AIMS scores with the variable of 'living alone or living with other' showed that the people living alone felt more pain but had a better perception of their health. People 'living with other' felt less pain but had a lower health perception.

Once again, these scores are hard to interpret with a small sample size of 9 people. It is not known whether they are representative of the larger group population or not.
NOTES

CHAPTER 4


CHAPTER 5

Implications and Conclusions
The purpose of the evaluation of the Men’s Group at this demonstration stage of its development was primarily to take a closer look at the program, to examine the feasibility of it objectives and to see whether these objectives were being achieved. It was also an opportunity to get feedback on the program from participants. Data gathered in the evaluation would be used to aid program planners to modify or change the program as well as form the basis for a summative evaluation at a later stage.

While the chosen methodological orientation was mixed qualitative-quantitative, results of the study showed that the qualitative data, in particular the interviews with core-group members and narrative descriptions, provided the most useful information.

The Men’s Group was found to be a strikingly heterogeneous group. The only commonality between group members was the process by which they had been informed about the group through individual counselling with the Arthritis Centre social worker and that each man had a form of arthritis. On other important demographic variables group members appeared to be quite different from one another, e.g., age, occupation, type of arthritis, length of affect on work patterns and whether they live alone or with a friend/spouse.

It was clear from the core-group member interviews that men had different reasons for attending group meetings, had different concepts of the usefulness of the group as well as a variety of suggestions - in some cases contradictory- as to how they would like the group to be run. Moreover, questions asked of the core-group members such as ‘Do you think some men talk all the time and don’t give other men a chance to talk?’ and ‘If you had something really private to say, would you share it with the group?’ revealed in the variety of responses different levels of awareness and emotional openness on the part of individual members. These differences were also reflected in the narrative descriptions written following each meeting.
Overall, as expressed in the core-group interviews, the men did appear to gain the benefits associated with the group experience such as: universality of experience; gaining insight through listening to others; gaining knowledge from others on new ways to cope; and gaining a sense of acknowledgement and companionship from group members.

**Group Objectives**

Results of the study from the monitoring data, narrative descriptions and core-group member interviews, show that the interim objectives written for the program were reflected in the psycho-social emotional functioning of the group.

It was clear from the monitoring data that in the open-discussion meetings (sessions 4 and 6) where there was no guest invited and psycho-social issues ('coping with pain' and 'how arthritis has affected your relationships') were addressed, men did open up and interact more frequently on an emotional level. This was evident in that a good proportion of the interaction monitored in these meetings was spent on the higher level objectives. The acceptance and usefulness of these open discussions was apparent from the interviews with core-group members. Generally, the men felt comfortable with these meetings and saw the benefits of sharing ideas and feelings as well as different ways of coping.

However, some of the meetings addressed practical rather than psycho-social issues, such as job retraining. The rationale behind the planning of these meetings was the assumption that problems often had both an emotional and practical component and that each component potentially influenced the other. Therefore emotional problems relating for example to arthritis affecting a man's work or career plans could be dealt with by addressing the problem at a practical level. However, in these meetings there was noticeably less time spent on higher level interaction. This
could be due both to the more practical focus of the discussion and the presence of the
guest-participant at the meeting.

Hence, the evaluation showed that the achievement of the interim
objectives only reflected part of what was happening in group sessions. First of all,
the group did appear to facilitate emotional openness on the part of the members along
with the usual benefits of a group experience. In addition the group also functioned to
provide practical knowledge and information and was perceived by core-group members
as fulfilling this function.

The question was therefore raised as to whether the terms of reference of
the program should be expanded to include knowledge and information as a function of
the program. In this way, program objectives could be redefined so that a balance
would be struck between the facilitation of practical and emotional support. However,
if the primary objective of the group is actually to facilitate emotional openness, more
opportunity for discussion on psycho-social issues should be made and less emphasis
placed on practical issues.

This in turn highlights the dilemma of the planners in the original
conception of the program, i.e., what is the feasibility of facilitating emotional openness
when the impact of such a process is unknown? The only indication in the study
regarding the effect of this process was a sense of the benefits of sharing feelings and
ideas as expressed by core-group members during interviews.

The choice of pre and post measures was an attempt to demonstrate the
benefits found; but there were no significant changes pre to post. However, this was
unrealistic over such a short monitoring period during which there was little program
time. First of all the number of men attending sessions varied such that there was not
enough program per person. In addition, only 2 out of the 6 meetings directly
addressed the interim objectives. Hence the feasibility of measuring the highest level
objective after such a short monitoring period was questionable. Also the small size of the sample in the study (n=9) may have undermined the power of the statistics used. Moreover, while the measures chosen were thought to be the best surrogate measures to look at objective 8, they may not have been suitable measures.

Another method which could have been used to 'tap into' the benefits or problems associated with men opening up on an emotional level was overlooked. This was to gather feedback from the group leader as to what was happening outside the group and in between sessions.

It was apparent from core-group interviews that friendships were forming outside the group. For example, one of the members was hospitalized for knee-replacement operations and was frequently visited by fellow group members. Also, the group leader had allocated time to spend with group members immediately following sessions or in between sessions. He had found this to be necessary since disclosure in group meeting would sometimes render the individual vulnerable to strong feelings and even depression. However, this important process which was unique to the running of this group, was not monitored.

Implications for Future Group Operation

Group Size

At meetings previous to the monitoring period, attendance was reported to be as high as 20 and as low as 3. However, attendance of meetings over the monitoring period fluctuated between 9 to 12 men. This was found to be a comfortable group size affording each man the opportunity to talk as well as accommodating comfortably spaced seating so that no one felt 'excluded' from the group. Certainly, if it is decided by the group planners to continue to emphasize emotional sharing as a primary objective of the group, it would be feasible for the group to remain at its present size.
Duration of the Meetings

Comments on the duration of the meetings by core-group members were not consistent. Some men felt the group sessions were too long, that they became fatigued and others felt they were too short. This could be due to the degree of discomfort resulting from their arthritis. While the starting time of the meetings was 7:00 p.m. some members would come earlier and other later. As may be the case with any night that was chosen, Thursday night was a difficult night for some men to attend who were involved in retraining programs. In respect to frequency of meetings, whether they should be held once or twice a month, a direction of opinion was not established. However, by holding meetings twice monthly, the men did not have to wait a whole month if they missed a meeting, ensuring a greater sense of continuity of support.

Role of the Group Leader

A question which was raised by the study was whether if a group similar to the Men's Group was set up, the group could function with a counsellor who only had contact with the men during the group sessions. In the Men's Group the group leader had previous contact with group members through counselling sessions and was responsible for screening individuals for the group on the basis of expressed concerns and willingness to try the group. He also had ongoing contact following and in between group sessions. For this reason he is familiar with the individual problems and needs of each man and knows how far to question, push or pry.

When the group was first established, there was a dilemma in respect to the kind of group leadership that would be the most conducive and whether a more active or passive role should be taken by the group leader. As group members became
more comfortable and a core-group began to form, a more passive role was assumed by
the group leader.

The group leader presently participates minimally in group sessions and
may only intervene e.g. to protect a group member from being questioned too far or to
discuss plans for future meetings in order to facilitate the expressed interests of
different group members.

However, because these men are outpatients at the Arthritis Centre and
have a chronic condition, contact with these men outside of group sessions is ongoing
and may involve issues other than those relating to the group. In this way, the role of
the group leader with this population of men is expanded beyond the sessions. This
would be an important consideration in the planning of a similar group.

The Interactional vs. Educational Function of the Group

Results of the core-group interviews and narrative descriptions indicated
the strong interactional function that the group serves. If the group was an
educational group, group members would be given information as to how to cope and
what to do. What is unique to this group is that the men are already familiar with the
coping strategies that they could follow. The emphasis is therefore on why and in what
way the majority of men find it difficult to adopt these strategies, to consider new
strategies through guest participation and to allow the men to offer each other their
own practical and emotional methods of coping.

The Monitoring System

The monitoring system developed for the study proved to be a simple and
effective tool for observing frequency of interactions and levels of emotional openness
and was found to have good inter-rater reliability. The sensitivity of the instrument
could be enhanced by developing additional categories so that the instrument could be used in further studies to monitor 'depth' as well as frequency of emotional openness.

**Summary**

In summary, the study found that the interim objectives designed for the program were being met in the open-discussion meetings that focussed on psycho-social issues. However, since only 2 out of the 6 meetings were open-discussion meetings, a pattern of change over time could not be established. It was also found that the group was serving an important 'information' function which was recognized and valued by group participants.

It is recommended that the objectives of the study be expanded to include this additional function. Moreover, in respect to meeting content, planners could plan a more even balance between meetings which focus specifically on the discussion of emotional issues and 'informational' meetings. The group leader could also consider combining these two functions within a single session by facilitating the discussion of both the practical and emotional components of a particular issue raised.

Interviews with core-group members did indicate the perceived acceptance and usefulness of open discussions on psycho-social issues. However, due to the short duration of the monitoring period and no change being found on measures pre to post, the positive and/or negative affects of the achievement of higher levels of emotional openness are not known. A further study would need to look more closely at the positive and/or negative effects of this process on group participants. This would also involve monitoring 'process' between group sessions and the involvement of the group leader as an expert informant to facilitate data collection.

The study did provide a good preliminary data base on the nature of the group process and the heterogeneity of the membership. Useful information was
gathered both on the kind of group process which may facilitate the achievement of the specific program objectives as well as the informational function of the group. Overall, group members seemed satisfied with group process and content and wanted to see the group continue.
APPENDIX I
APPENDIX II
PATIENT CONSENT FORM

The Men's Group has been running for a year and a half and we would like to do an evaluation to gather information on what is really happening in the group.

Participation in the study will involve filling out two questionnaires in January and April which should take you no more than half an hour each time and an interview with the social work student to get your opinions and views on the group.

We will be pleased to answer any questions you may have about the study. Thank you for your participation.

I understand that: I will not be identified in this study or in any report. Data will be restricted to the use of researchers only.

I may withdraw from the study at any time without jeopardising my present or future medical care and treatment.

I understand the protocol and I agree to participate in the study.

____________________  ____________________
SIGNED  WITNESS

____________________
DATE
Evaluation of the Arthritis Men's Group

Instructions for Observers

The Monitoring System

To monitor numbers 3-7 of the interim objectives a simple check system was chosen. This system was designed to reflect and operationalize these interim objectives (see Tables 1 and 2).

The role of the observer is to check for frequency of verbal interactions and the level of emotional openness of each interaction.

Definition of a single interaction

A single interaction is defined as one man's monologue. Responses of group members of e.g. affirmation or negation during a monologue are not to be recorded. If however another man interrupts and takes over the conversation entirely, this should be recorded as another interaction.

Use of the Monitoring System

Before using the monitoring system each observer must become familiar with the different levels of interaction, what they mean and how to recognize them. (See Table 2).

A checking sheet was prepared for the Men's Group meeting video which observers have been asked to monitor. The observer can choose to use the sheet provided or make their own.
The monitoring itself

Each time a man begins speaking, the observer has to decide whether he is a) responding to another group member (R on the check list) or b) whether he initiated the conversation (I on the check list). One of these two columns should be checked accordingly.

When the man finishes speaking the observer must make a decision as to the highest level of interaction reached:

- opened up on an emotional level (OEL on checklist)
- offered emotional support (OES on checklist)
- or
- problem solved (PS on checklist)

The most appropriate level should be checked.

If however in the opinion of the observer the man did not reach any of these levels, no checks should be recorded at the end of the interaction.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>To re-evaluate male societal pressures</td>
</tr>
<tr>
<td>7</td>
<td>To problem solve</td>
</tr>
<tr>
<td>6</td>
<td>To share/offer support</td>
</tr>
<tr>
<td>5</td>
<td>To open up - talk on an emotional level</td>
</tr>
<tr>
<td>4</td>
<td>To interact with other men</td>
</tr>
<tr>
<td>3</td>
<td>To talk</td>
</tr>
<tr>
<td>2</td>
<td>To keep coming</td>
</tr>
<tr>
<td>1</td>
<td>To come to the all-male group</td>
</tr>
<tr>
<td>Objective</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Objective 3</td>
<td>to talk, that is, respond to group leader or fellow members (R on checklist)</td>
</tr>
<tr>
<td>Objective 4</td>
<td>interact, that is, initiate a conversation (I on checklist)</td>
</tr>
<tr>
<td>Objective 5</td>
<td>open up on an emotional level, that is, state how they feel about something (OEL on checklist)</td>
</tr>
<tr>
<td>Objective 6</td>
<td>offer emotional support, that is, empathize and/or express sympathy following another group member expressing his feelings (OES on checklist)</td>
</tr>
<tr>
<td>Objective 7</td>
<td>problem solving, explaining the way(s) they coped with a particular emotional problem or situation (PS on checklist)</td>
</tr>
</tbody>
</table>