ACCEPTABILITY OF THE PSYCHOSOCIAL CONSEQUENCES OF TRAUMATIC HEAD INJURY AMONG EMPLOYER GROUPS

by

Glenis Anne Mobberley

A Thesis submitted in partial
fulfilment for the degree of

MASTER OF SCIENCE IN PSYCHOLOGY

MASSEY UNIVERSITY

1993

In memory of my partner

Frank Albert Brittain

ABSTRACT

A questionaire was used to survey 213 employers to identify differing levels of acceptability of the psychosocial consequences of traumatic head injury across employer groups. Gender differences in responses and the acceptability of two factors that could affect the level of acceptability were sought. These two factors were the importance of good public relations skills and the necessity to be able to work as part of a team. The questionaire was developed from the literature, with additional content validity being obtained by trialling the questionaire on local head injury rehabilitation professionals. Case studies were also sought of people who had received a THI and had returned to work.

It was found that the professional/managerial group had a significantly higher level of unacceptable responses than the sales/service group which in turn had a mean level of unacceptability significantly higher than manufacturing/construction/trades. A difference existed between manufacturing/construction/trades and farming but the difference did not reach significance. Employers requiring good public relations skills had a significantly greater mean level of unacceptability than those who did not. Those who required employees to be able to work as part of a team had a greater mean level of unacceptable responses but this did not reach significance. The gender difference between employers also did not reach significance but the number of women employers was very small.

Case studies reflected the unacceptability of the effects of a THI to employers. Symptoms experienced by those in the case studies supported those reported in the literature. These results have important implications for those working in the vocational rehabilitation of people with THI.

ACKNOWLEDGEMENTS

I would like to acknowledge the help of the following people.

I would like to thank my supervisor Dr. Dave Clark for his guidance, expertise and assistance, especially through the intricacies of the SPSS-PC.

Special thanks to my mentor Dr. Bob Gregory for his patience, encouragement and support throughout my years in the department. Also, for his help in contacting the Head Injury professionals in the study.

I would also like to thank Jim Coombs for his help in contacting the majority of farmers in the study.

I wish to acknowledge the help of the Head Injury professionals and employers of Palmerston North who gave their time to make this study possible.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

OVERVIEW OF THE INTRODUCTION

The psychosocial consequences of THI have been well documented. These include: difficulties with memory, learning and concentration and an inability to carry out executive function tasks such as problem solving and problems with initiation and task completion. Perceptual problems occur such as a lack of awareness of their own deficits and an inability to pick up social cues, as do emotional and behavioural problems such as depression, irritability and socially-inappropriate behaviour. Even a minor head injury can leave a person with psychological deficits that seriously affect day to day lives (Long, Gouvier & Cole, 1984).

Although most people experience an improvement over time, studies have shown that features such as tiredness, difficulty in becoming interested and sensitivity distress may get worse. Many experience consequences such as memory problems and personality change that are permanent. These consequences have important implications for employment.

In 1991, 8411 New Zealanders were hospitalised with a head injury. Many more were treated in Accident and Emergency departments and discharged. The largest group were young males with their whole working lives in front of them. The age and number of people involved has created an increasing need for rehabilitation services aimed at helping these people work towards independence, including financial independence.

Research highlighted three major factors affecting a return to work. They were the severity and site of injury, and the time elapsed since injury. For those who suffered a severe THI the prospect of a return to work was bleak. Most people who had experienced a minor head injury

returned to work but a small percentage were still not back at work a year later. Factors which were counter-indicative of a return to work were: problems with visuo-spatial memory, emotional lability, difficulties in communicating, loss of organisational abilities and difficulties interpreting the facial affect of others. Competitive employment was successful for those who were aware of their deficits and either compensated or obtained employment in areas where their deficits were not a barrier.

Research indicates that seventy five percent of those hospitalised with a head injury return to the workforce but by five years post-injury only thirty percent remain employed (Prigatano, 1991). The reasons for this are unclear as, although the consequences of THI have been well documented, little has been done to survey the employers' role in this handicap. The one study found that did attempt this was Blair and Spellacy's 1989 paper. They surveyed 122 employers in Washington State about the acceptability of selected PS consequences of THI in entry-level positions and received 44 responses. On combining four groups into two they found the general labouring group (comprised of employers from agriculture/forestry and manufacturing/construction) had a significantly greater number of acceptable responses than the service group (service and wholesale/retail). "Lack of initiative was found to be the most acceptable behaviour, followed by memory difficulties, movement and fatigue problems, personality disturbances and distractibility"(p.8). Details of the items used in their questionaire were not published but it would appear from the journal article that only these six consequences of THI were surveyed.

It is important those working in the vocational rehabilitation of people recovering from a THI have information on the acceptability of the consequences of THI from a wide range of employment areas and levels.

DEFINITION OF TERMS

Head injury

The term traumatic head injury (THI) as used in the literature covers several types of traumatic injury to the brain. Gronwell, Wrightson and Waddell (1990) divided THI into open, closed and crush injuries. In an open THI the brain is exposed. In a closed THI the brain is not exposed and injury occurs due to acceleration or deceleration which may force the brain against bony protuberances of the skull and stretch nerve fibres. In a crush injury the head is crushed between or within objects.

Blunt injury refers to damage from a blunt object which can cause diffuse damage as opposed to injury from projectiles, such as bullets, in which damage is usually limited to the path of the projectile.

Most THI results from MVA (motor vehicle accidents) or falls but traumatic head injury can also follow assaults and anoxia (Moore & Bartlow, 1990). In times of peace most THIs are closed with the major causes being MVA and assaults. In closed THI there is often widespread damage (McClelland, 1988). This damage may be temporary or permanent (Ostwald, 1989).

Psychosocial

Papers surveyed in the literature tended to use this term without defining it. Generally the term referred to cognitive, perceptive and behavioural changes and their social consequences. This is the definition followed in this research.