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Multiple Family Groups for Adult Cancer Survivors and Their Families: A 1-Day Workshop Model

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Abstract

With marked advances in early detection and aggressive multimodality treatment, many adult cancers are now associated with good prognoses for disease-free survival. A burgeoning literature examining posttreatment quality-of-life issues has highlighted the numerous challenges experienced by patients and families in the aftermath of cancer treatment, further underscoring a need for new family-based psychosocial support interventions for cancer survivors and their families. This paper describes the clinical protocol for one such intervention, a 1-day “workshop” version of a multiple family group (MFG) for head and neck cancer survivors and their families. Data are reported from our experiences in running five 1-day workshops. Families uniformly reported that they were *highly satisfied* with their MFG participation, leading us to conclude that the abbreviated 1-day MFG model we are advocating is a promising family-focused support intervention for cancer survivors and their families.

Keywords

Multiple family group; Cancer treatment; Families and medical illness

INTRODUCTION

Initially developed for working with families of patients with major psychiatric disorders, psychoeducational multiple family groups (MFGs) have been enjoying increasing popularity in medical settings, especially as family-focused psychosocial interventions for chronic medical illnesses (Asen, 2002; Gonzalez & Steinglass, 2002; Kazak, 2005; Steinglass, 1998). Differing from family support groups because they typically include both patient and nonpatient family members, MFGs have by now been applied to a wide spectrum of chronic medical illnesses, including diabetes (Lavelle, 2007; Satin, LaGreca, Zigo, & Skyler, 1989), asthma (Wamboldt & Levin, 1995), HIV/AIDS (Pomeroy, Rubin, & Walker, 1995, 1996), infertility (Lemmens et al., 2004), chronic pain (Lemmens, Eisler, Heireman, Van Houdenhove, & Sabbe, 2005), and cancer (Chiquelho, Mendes, Relvas, & Sousa, 2010; Kazak et al., 1999; Manne et al., 2005; Ostroff, Ross, & Steinglass, 2000; Shields & Rousseau, 2004), and are almost without exception positively endorsed by participating families.

The growing interest in MFGs for families dealing with major medical illnesses parallels a more general interest in providing better support services for the *non-ill* family members in these situations (Feder, Komisar, & Niefeld, 2000; Schene, Wijngaarden, & Koeter, 1998). This interest has been fueled by the demands placed on family caregivers not only by the illness itself, but also by the trend away from hospital-based care toward an increasing reliance on home-based care (Gaugler et al., 2005; Rodrigue & Hoffmann, 1994).

This family burden, especially the magnitude of psychological distress and traumatic stress symptoms among spouses and children, has been an area of particularly intense study when the illness involved is cancer (Baider, Cooper, & Kaplan De-Nour, 2000; Kazak et al., 1997; Kim et al., 2008). With marked advances in early detection and aggressive multimodality treatment, many adult cancers are now associated with good prognoses for disease-free survival (American Cancer Society, 2009). But many of the most successful treatment protocols involve highly toxic procedures with short-term and long-term posttreatment sequelae, sequelae that profoundly affect quality of life for both patients and family members (Baider, Walch, Perry, & Kaplan De-Nour, 1998; Kim & Given, 2008). Some investigators have even likened the psychosocial impact of cancer survivorship to posttraumatic stress (Brown, Madan-Swain, & Lambert, 2003; Erickson & Steiner, 2001; Kazak, Boeving, Alderfer, Hwang, & Reilly, 2005).

In concert, these findings have led to recognition of the need for better support services and family-based interventions for family care-givers who are increasingly burdened by the stresses and physical demands associated with cancer (Institute of Medicine, 2007; Kim, Kashy, Spillers, & Evans, 2009). Yet despite the growing awareness of the need for family-based support services for families coping with the chronic challenges of cancer survivorship, MFGs have often proven difficult to implement in cancer care settings where the ready acceptance of treatment has been low (Manne et al., 2005; Ostroff, Ross, Steinglass, Ronis-Tobin, & Singh, 2004; Stehl et al., 2009). Although many oncology clinics now offer caregiver support groups, it remains unusual to find patients and family members participating *together* in these groups.

Several notable barriers exist that most likely contribute to the relative paucity of family-based psychosocial support services, including the lack of staff training in family systems, practical scheduling demands, and family ambivalence about attending such groups (Coyne & Racioppo, 2000; Gonzalez & Steinglass, 2002). One of the practical strategies proposed to overcome scheduling difficulties has been to reduce the multiweek schedule typically required for MFG participation. An example is the 1-day MFG for adolescent cancer survivors and their families designed by Kazak and her colleagues—the Surviving Cancer Competently Intervention Program (SCCIP) (Kazak et al., 1999)—an MFG directed at reducing posttraumatic stress symptoms of family members by addressing and altering family beliefs and communication patterns about cancer and its treatment. Findings from a large-scale controlled clinical trial of the SCCIP protocol have strongly supported the potential benefits of participation in such groups (Kazak et al., 2004).

Comparable reports of positive endorsement from families participating in short-term MFGs for other chronic illnesses like asthma and chronic pain syndromes (Lemmens et al., 2003;

Wamboldt & Levin, 1995) suggest that further exploration of “workshop” versions of MFGs clearly seems reasonable. In this paper, we describe one such protocol—a 1-day MFG workshop designed for adult head and neck cancer patients and their families, a clinical population thought to be particularly vulnerable to negative psychosocial sequelae both because of the social isolation attributable to the physical disfigurement and disabilities resulting from the surgical and radiological approaches used to treat these cancers, and because of often unresolved family conflicts secondary to smoking and alcohol—two well-known etiologic factors associated with these cancers.

A pilot study of our 1-day protocol was therefore carried out to examine the acceptability and relevance of the protocol for participating families (Ostroff et al., 2004). A total of five separate workshops were held with 15 families participating in all. The patients were referred to us by their oncologists at Memorial Sloan-Kettering Cancer Center, where they had all received their primary treatment. All patients were considered cancer-free at the time of recruitment (6–12 months following their initial treatment) but were typically experiencing a wide range of side effects secondary to complications of highly invasive surgery and/or radiation treatment. The other workshop participants were the patients’ primary caregivers—usually their spouses, but in other instances an adult child, sibling, or in-law relative. The demographic and treatment characteristics of the 15 patients and their family caregivers are summarized in Table 1.

Given the pilot nature of the study, testing the efficacy of the MFG workshop model was clearly not feasible at this stage. However, we can report that postworkshop interviews of participating families indicated that the MFG protocol was extremely well received and endorsed as an experience they would recommend for other cancer patients and families. A detailed description of the 1-day MFG workshop model therefore seems warranted so as to spur greater interest in the refinement and evaluation of this promising psychosocial treatment for families affected by serious medical illnesses like cancer.

CONCEPTUAL FRAMEWORK AND GOALS FOR THE 1-DAY MFG MODEL

Our MFG model drew heavily from the ideas developed by Steinglass et al. (1987), Rolland (1994), Wood (1993), and Fiese (2007), among others, regarding family-oriented treatment approaches to chronic medical illness. These investigators have posited that by tracking the impact of chronic medical illness on family priorities, daily routines, and problem-solving styles, one can determine the extent to which a family has become reorganized around illness as a central life theme. The overarching premises are as follows:

- Serious medical illness or physical disability profoundly affects every member of the family, and the family as a unit.
- As chronic illness comes to dominate family life, family resources (financial, parental attention, time) are increasingly allocated to illness management.
- With rare exceptions, all family members experience emotional and social isolation, both within the family and with extended family and friends.

- There is an interaction between “family style”—problem solving, affective style, communication, organization—and the illness, reciprocally affecting the family’s premorbid identity and management of the illness or disability.

To counteract these processes, the 1-day MFG protocol was designed as a psychoeducational “workshop” with four primary goals:

- Educating families* about the ways family life is affected by cancer diagnosis and treatment;
- Normalizing* the experiences, reactions, and struggles families have in attempting to cope with the posttreatment adjustment phase of cancer recovery;
- Confronting and challenging the isolation* these families often feel from their support networks; and
- Exploring ways in which families can develop an effective *balance between illness and non-illness issues and priorities* in their lives.¹

To accomplish these goals, three to six families were brought together to form a “community” of people dealing with posttreatment issues related to cancer and its treatment, and were led through a day-long protocol by two trained facilitators with expertise in both psycho-oncology and family systems therapy. The cofacilitators had two main tasks: (1) eliciting the multiple viewpoints and feelings participants had about the family’s cancer experience; and (2) organizing these ideas, feelings, and concerns into a useful framework that could serve as a reference for discussion within the MFG. The central illness/family themes explored were

- that the impact of cancer on family life, if allowed to remain unexamined and unaltered as families progress from acute diagnosis to active treatment to chronic rehabilitation, threatens to take over the family’s identity and to interfere with (distort or inhibit) the family’s ongoing development;
- that in an effort to attend to the issues raised by having to live with cancer, other family goals and needs (including those of the patient) are being neglected; and
- that the MFG experience can be used to explore ways to reverse this process through a reexamination of the family’s current balance between responsible attention to illness demands versus engagement in non-illness family activities and issues.

Although overall responsibility for structuring and facilitating the workshop protocol fell to the facilitators, much of the content of the workshop was provided by the families themselves via the sharing of their cancer stories. Also important was the establishment of a *nonblaming, nonpathologizing atmosphere* within the group, a characteristic that many investigators have posited as critical to the success of psychoeducational MFGs (Asen, 2002; McFarlane, 2002; Steinglass, 1998). One way to establish such an atmosphere is to

¹A central metaphor that has been used in all versions of our MFG protocol to connote this balance between illness and non-illness priorities in family life is to look to the goal of “finding a place for the illness in the family while at the same time keeping the illness in its place.”

encourage collaborative sharing of both illness experiences and coping strategies for dealing with illness-created demands and psychological sequelae.

DETAILS OF THE MFG WORKSHOP PROTOCOL

Toward the above goals, the day-long workshop was designed around four main components:

1. An *Introductory* component which included both family introductions and an orientation to the day's activities by the group leaders.
2. An *Illness Impact* component focusing on the identification of cancer-related family issues and perspectives, and the facilitation of connections between group participants occupying analogous family, developmental, and illness roles.
3. A *Family Development* component in which the family's view of the impact of cancer on its life is elucidated via the construction of art montages visually representing pre- versus postcancer families and cross-family presentation and discussion of these visual family stories about cancer.
4. A *Family-Illness Integration* component in which families develop rituals to help them separate cancer from noncancer family issues and to map out strategies for the future.

The protocol, along with the specific objectives of each of the core components, is outlined in Table 2. The sequencing of the four components was designed to walk participants through a process of (a) retelling their already familiar cancer stories (diagnosis; initial treatment; rehabilitation); (b) being exposed to alternative ways of seeing their stories; and (c) being given an opportunity to integrate this new information into their lives as they look toward the future. The underlying assumption was that as this sequence unfolded over the course of the workshop day, families would open themselves up to new possibilities for how to cope with the ongoing impact of cancer, including finding new ways to better balance illness and non-illness priorities in family life.

Particularly important was the prioritizing of experiences during the course of the day that could afford participants opportunities to *observe* and *synthesize* the ideas and experiences of others within the group, including their own family members. Two techniques were primary here—a group-within-a-group exercise; and the construction of a family collage representing the cancer experience, both of which had been successfully used in earlier multisession versions of our MFG protocol for families dealing with cancer (Ostroff et al., 2000).

THE GROUP-WITHIN-A-GROUP

The group-within-a-group technique has been a core feature of *all* our prior versions of medical illness MFG programs, not just cancer (Steinglass, 1998). Its purpose is to allow family members to gain an appreciation of the different viewpoints and emotions generated by the experience of cancer in the family, and to examine how family roles (patient, nonpatient, spouse, son/daughter, etc.) dictate the nature of these response sets. To facilitate

this goal, a series of subgroups are formed based on illness role and each subgroup in turn carries out a focused discussion in the presence of the other group members who act as observers and responders regarding what they have heard during the subgroup discussion.

In the 1-day workshop protocol, a five-step sequence is used:

1. *The patient subgroup.* One of the facilitators invites the patient family members to join with him/her for a discussion of the impact of the head and neck cancer on family life. Chairs are traded and rearranged so that this *patient-only* subgroup is clearly demarcated from the rest of the group (see Figure 1a and b). The *patient* subgroup leader begins this discussion by asking the subgroup members to communicate with each other about the effect they think cancer has had on them (and by extension on their family, work life, and friendship relationships). In guiding the discussion, the subgroup facilitator attempts to bring the conversation to the level of the family as a unit, although personal stories and reflections are more likely to emerge during this phase of the discussion. Throughout this part of the discussion the cofacilitator's primary task is to monitor the rest of the group to ensure that they maintain an observer stance.
2. *The nonpatient observer group.* The transition from patient subgroup discussion to observer group discussion is facilitated by a rearrangement of the chairs to make clear that it is now the observer group's turn to talk with each other, while the patient subgroup becomes the listening group. The new seating arrangement will then look like the diagram in Figure 1c. The observers then talk among themselves (without input from the patient subgroup), with the group facilitator focusing on drawing connections between the thoughts and feelings of different members of the nonpatient group about what they have heard.
3. *The nonpatient subgroup.* The purpose here is to focus on the feelings and viewpoints of the nonpatient family members (as opposed to the prior step in which the mandate was to focus on *observations* about the content of the patient subgroup discussions). To initiate group discussion, the nonpatient members from each family (most likely a spouse or adult child) meet in a subgroup following the same format as above to discuss the ways in which the cancer affects *well* family members. The goals here are the same as for the patient subgroup meeting: (a) to have the members discuss their viewpoints and feelings with one another; (b) to achieve as much clarity and specificity as is possible about the impact of the cancer on well family members; and (c) to focus on the family as a unit, including how members interact with one another in response to illness-related problems.
4. *The observer group discussion.* Repeating a sequence similar to Step 2, after about 20 minutes those group members who have been listening are asked to respond to the prior discussion. Again, a free-ranging exchange of ideas and feelings is encouraged to develop, with the observers talking among themselves while the others listen.
5. *Group-as-a-whole discussion.* In the final step of this process, the discussion is opened to the group as a whole, with facilitators exploring and emphasizing any

similarities or connections that have been noted between different members' experiences, and then underscoring the important themes of the patient only, nonpatient member, and observing subgroup discussions.

By the end of this five-step process, multiple perspectives on the impact of the illness on family life have been summarized. The assumption is that the group-within-a group activity highlights the differing illness-related points of view and experiences of various family members and the analogous roles—developmental, family, and illness—across families that provide supportive connections within the group. In highlighting shared perspectives across families, the differing attitudes and feelings that might exist within each family are more likely to be seen as reasonable reactions to cancer rather than right or wrong.

Examples of this process from our head and neck cancer groups included a new appreciation on the part of caregivers of the impact on patients of posttreatment sequelae like chronic low-level pain and disruption of salivation and swallowing, and the confusion experienced by caregivers when patients kept symptoms (and worries) to themselves. During subgroup discussions assumptions about the possible cancer reemergence that had remained silent concerns on the part of both patients and caregivers were given voice, legitimized, and then addressed.

THE FAMILY COLLAGE COMPONENT

Just as the group-within-a-group device uses nonverbal as well as verbal techniques to highlight and examine family beliefs about cancer utilizing structural rearrangements of seating patterns to emphasize different perspectives on illness, all versions of our MFG model have also relied on a variety of *visual activities* to bring into sharper focus family beliefs about illness. Because the creation of art requires thought processes that involve reflection and abstraction, the use of a visual technique provides the family with an alternative means for expressing and sharing its thoughts about the cancer experience.

The art technique used for the 1-day workshop is the *family collage*, a cocreated visual representation of the family in its relationship to the cancer experience. In constructing their collages, families draw on their core beliefs and values to generate ideas about how they might want to change their approach to living with cancer. But this time the vehicle for discussion is a visual representation of the family—the family collage.

Making the collage is described to the families as creating a “family portrait.” It is an activity that will give the family an opportunity to organize its thoughts, to step back and *look at* the problems it has experienced in adapting to cancer, its treatment, and its aftermath. Each person, in trying to understand someone else's picture of him or her, starts to *see* aspects of his or her own experience. Further, the collages, when viewed all together provide material that can then be used to help other families reconcile their various views of themselves and *visualize* directions for their future.

Also important is that families characteristically experience the creation of collages as fun, in marked contrast to so many of the interactions they have had both internally and with health care professionals around illness issues. Typically, during the collage experience the

mood in the room is animated and jocular, in marked contrast to the somber, serious mood that had been the norm previously when they were asked to discuss topics related to their history of cancer. That is, the collage component seems to give families permission to treat the cancer experience with humor as well as seriousness, and to free them to expand their ways of thinking about the future.

The format for the MFG collage component encompasses six steps:

1. *During the lunch break.* At the lunch break, participants are given an instruction list for the collage activity and invited to look over a supplies table displaying a variety of colored papers, drawing materials, glue, construction materials, magazines, and newspapers that could be used as part of their collages. They are also encouraged to discuss possible metaphors—expressions and symbols—that might be used as representations of their family and to jot these metaphors down, as well as doodling images and clipping out magazine/newspaper pictures and headlines illustrative of the metaphors they had jotted down. In this way, family members begin the process of thinking about themselves in visual as well as verbal terms.
2. *Prediscussion.* After the break, one of the facilitators leads the participants through the steps of creating a family art work. Using a metaphoric language to model a way of thinking, the facilitator reminds the family members that they each “have a lot of material that they bring to the table,” and that together as a family they can “organize this material” to “create a picture of the family” that includes the perspectives of all members of the family. They are then invited to move to their respective tables, to “bring their stuff with them,” and to get started in creating the collage in which their “various ideas can come together to depict your family before the diagnosis of cancer.”
3. *The art experience.* With each family seated at a table stacked with art supplies and a poster board, participants are instructed to work together to fill this poster board with every idea that each family member feels would be important in conveying in *words or pictures* a clear sense of who they are and how cancer has impacted their family. The actual construction of the collage occurs as a two-step process: *First*, the family completes *a picture of itself* as it currently exists. (During this step, families in our groups could be seen in lively conversation as members compared pictures, clippings, drawings, and phrases.) Then in step 2, families are given sheets of tissue paper and instructed to use the tissue paper to represent *the cancer experience*, that is, to “give it some shape or form.” Our families differed dramatically in how they handled this second step. For example, one family represented cancer as a barrier in a road they had drawn to depict their life story; another family rolled the tissue paper into a ball, tied a ribbon around it, and hung it from the bottom of their collage (see Figure 2).
4. *Discussion of the collages.* With the completed collages now hanging on the wall, a facilitator asks a volunteer from each family to “tell us about your family”—meaning to use the collage as a way of communicating both the essential characteristics of the family and how the cancer experience has influenced family

life. Based on how families handled this task, it was apparent that they now felt their artwork *contained* their family's experience both of the impact of cancer and their response to this impact. For example, the family that had depicted cancer as a "barrier in the road" visualized their "solution" as a bridge constructed out of pipe cleaners, but with cancer still sitting dead-center in the middle of the collage.

By way of contrast, the family that had represented cancer as a ball hanging from its collage had previously depicted its family as a series of concentric circles—the patient and his doctor (surprisingly) in the center circle, then parents and children, then friends and supporters who surrounded them. Also important to them was their ability to have these circles "all working together" (represented in the collage by a picture of engine gears), while at the same time giving their children "roots and wings" (also depicted in the collage). Their cancer "solution"—the hanging ball—was meant to represent how they had extruded it as a foreign/alien body, but as can be seen it also looks more like a ball weighing down family life.

5. *Discussion of the "future family."* Next, the focus switches to the future. Each family is prompted by one of the cofacilitators to consider the following question: "If all goes well, and we were visiting with you next year, what do you imagine family life would look like?" This conversation with the family is done entirely through the vehicle of the collage, that is, the future is visualized via the family suggesting changes that would occur in the collage if it were now to represent the family a year hence. Often during this phase families became highly emotional, with couples reflexively comforting each other physically (holding hands, giving each other pats on the shoulder, etc.).
6. *Integrating present and future.* Lastly, the family collage component concludes with a group discussion about the themes and ideas that have emerged about future directions for managing and balancing cancer issues in family life. The goal here is to summarize important themes, but also to emphasize that many different strategies have emerged and that each family will have to find the right balance among these different options, consonant with their own identity, values, and priorities. Typical statements during this phase focused on a need to recommit to important goals, to stop putting things off, and to support each other's initiatives "now that nothing is holding us back."

The process of making art helps families organize their thoughts, *view* how cancer has affected them, and then *create a picture* of themselves rather than having to simply talk about it. The relief from talk proved particularly appropriate with head and neck cancer patients, many of whom have residual speech or articulation difficulties. Further, for our families it truly gave both patient and nonpatient family members equal voice in constructing a view of the impact of the cancer experience on current and future family life.

PARTICIPANTS' FEEDBACK ABOUT THEIR MFG EXPERIENCE

At the completion of each workshop, participants were asked to complete a brief questionnaire in which they rated different components of the MFG protocol and their

reactions to the MFG experience. Participant responses were uniformly positive, with families endorsing not only the content of the workshop, but also the value of holding it as a 1-day, weekend workshop (vs. consecutive, weekly sessions). Participants singled out for particular mention the small size of the groups and the camaraderie it afforded group members, that is, the “bonding” and “sharing” aspects of meeting others who were coping with similar medical and familial circumstances. Typical comments included the following:

- “Meeting other families all trying to get back on track was incredibly helpful. I thought it was just us who were having problems in the family. I gained a new perspective on how my husband (the patient) was feeling by listening to the perspective of the other patients during the small group discussion.”
- “During treatment we never really stopped to think about what we were going through. We all just did what we had to do. It’s only now that I have a better understanding about how much the cancer disrupted our lives. On the upside, I know what really matters and I’m more hopeful about the future. One thing is for sure, we have to be better about balancing the ongoing concerns about the cancer with other family priorities and needs.”

Similar to reports from other family-based interventions for families dealing with cancer (Fredman et al., 2009; Hammerlid, Persson, Sullivan, & Westin, 1999), many workshop participants remarked that they would have appreciated the workshop more had it been made available at an earlier point in the patient’s course of treatment and recovery (the mean time between diagnosis and MFG participation was 17.8 months). However, given the physical demands associated with head and neck cancer treatment (surgery, chemotherapy, radiation), it is questionable whether families would actually have been able (or motivated) to participate in a psychosocial intervention during this usually strenuous time. Indeed, at least one group of MFG participants reflected that the elapsed time between their diagnosis and their participation in the MFG enabled them to deal with their situation individually before they felt ready to share their experiences with others in a group format.

DISCUSSION

Our intent in this pilot project was to test the feasibility and acceptance of a 1-day workshop version of an MFG protocol for cancer survivors and their families, a protocol that had been previously implemented using a multisession format. Would it be possible to condense the core elements of a six-session protocol into a single-day? And what would the feedback be from participants about the relevance and impact of this 1-day version? Toward that end, we collected data about participants’ reactions to each of the four components of the workshop protocol. These qualitative data indicated that participants were *highly satisfied* with their MFG participation, leading us to conclude that the MFG model we are advocating is a useful family intervention for a cancer population and probably other medical illness families as well, and that administering the protocol as a 1-day workshop is a viable alternative to the multisession versions we had previously utilized (Gonzalez & Steinglass, 2002; Steinglass, 1998).

What speculations can we offer at this point about why our MFG model may be useful for families affected by cancer? The emphasis in our MFG workshop is on helping families to assess how they are doing relative to other families dealing with comparable problems. These efforts have the dual effect of helping to break through the sense of isolation that often plagues the family after an experience with cancer, and also of normalizing many of the reactions and behaviors that family members might otherwise view as pathological.

Further, the workshop is occurring at a time in the clinical course when family members are presumably ripe for a reevaluation of how they want to handle the continuing emotional and practical demands of a serious medical illness. For head and neck cancers, these demands include not only the persistent intrusions of difficulties eating, swallowing, speaking, and managing chronic pain, *but also* the challenges of abstaining from alcohol and tobacco use, well-known etiological agents in head and neck cancer. Ideally, MFGs would be effective in facilitating *both* psychosocial well-being *and* future health-promoting behaviors.

All MFGs assume that the power of these psychoeducational groups derives in part from the opportunity families are given to share information about their illness experiences. This process not only adds to each family's fund of information about illness course and strategies for coping with both the physical sequelae of the illness and the psychological burden of illness management, but also purportedly decreases each family's sense of isolation and stigmatization. Many MFGs are designed to target and alter specific family behaviors, for example, the goal of reducing levels of expressed emotion in families with schizophrenic family members (Hooley, 1998; McFarlane, Dixon, Lukens, & Lucksted, 2003).

Our MFG models have added yet another goal, that of challenging existing *belief systems* within the family about the potential dangers of altering modes of coping vis-à-vis the illness. These beliefs, when embedded in the family, can preclude experimentation with expanded ways of interacting within and outside the family. An example might be a belief that stress can increase the likelihood of cancer recurrence resulting in the family's assiduously avoiding any interaction that might lead to confrontation and emotionality.

We view the MFG experience not so much as a vehicle for replacing family beliefs with "preferred" beliefs (i.e., the beliefs of expert professionals about how cancer should best be managed), but rather as an opportunity for families to *reexamine* these beliefs in an atmosphere of neutrality and curiosity. After having been given this opportunity to take a fresh look at how they have been addressing the issues raised by serious medical illness, families are then presumably free to choose whether they want to "stay the course" or to entertain a new approach suggested either by what they have heard from other families in the MFG or by what they have "discovered" themselves during the workshop.

Toward that end, the exercises built into our MFG protocol—especially the group-within-a-group structural exercise and the family collage visual exercise—have been designed to utilize the potential richness of the MFG to assist families in viewing their situations from multiple frameworks. In each of these exercises, the goal is to create new vantage points from which to view the interactions between illness and family life, and thereby gain a better

appreciation of the complex impact of the illness experience on family life. With these new perspectives in hand, families can then decide if the current way they are managing illness issues should remain unchanged, or if new approaches should be tried.

CONCLUDING STATEMENT

The observations from this pilot study suggest that providing an MFG experience in a 1-day workshop format is both positively endorsed by participating families and leads to a perception on their parts of improved family functioning.² At the same time, if family-focused interventions like MFGs are to have a broader impact, it may well be that more than a single “exposure” will be necessary.

Using cancer as an example, many clinicians have argued that psychosocial interventions should be offered shortly after completion of active cancer treatment as this early-post-treatment period is seen as a critical transition in care (Alfano & Rowland, 2006; Hewitt, Greenfield, & Stovall, 2005). Likewise, an ideal MFG protocol may include *both* an intensive workshop experience soon after the completion of the patient’s medical treatment, *and* follow-up “booster” sessions as the patient and family enter the rehabilitation and long-term survival stages of recovery. Although barriers to engaging families affected by cancer in interventions like MFGs when they are still primarily focused on anxiety about long-term prognosis have been formidable (Fredman et al., 2009; Ostroff et al., 2004; Stehl et al., 2009), making this type of intervention a standard component of psychosocial care would clearly seem warranted.

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References

- American Cancer Society (ACS). Cancer facts & figures 2009. Atlanta: American Cancer Society; 2009.
- Alfano C, Rowland J. Recovery issues in cancer survivorship: A new challenge for supportive care. *Cancer Journal*. 2006; 127:432–443.
- Asen E. Multiple family therapy: An overview. *Journal of Family Therapy*. 2002; 24:3–16.
- Baider, L.; Cooper, C.; Kaplan De-Nour, A. *Cancer and the family*. 2. Chichester, UK: John Wiley & Sons Ltd; 2000.
- Baider L, Walch N, Perry S, Kaplan De-Nour A. Cancer in married couples: Higher or lower distress? *Journal of Psychosomatic Research*. 1998; 45:239–248. [PubMed: 9776369]
- Brown R, Madan-Swain A, Lambert R. Posttraumatic stress symptoms in adolescent survivors of childhood cancer and their mothers. *Journal of Traumatic Stress*. 2003; 16:309–318. [PubMed: 12895012]
- Chiquelinho RNS, Mendes A, Relvas A, Sousa L. ProFamilies: A psycho-educational multi-family group intervention for cancer patients and their families. *European Journal of Cancer Care*. 2010; 20:337–344. [PubMed: 20148938]
- Coyne J, Racioppo M. Never the Twain shall meet? Closing the gap between coping research and clinical intervention research. *American Psychologist*. 2000; 55(6):655–664. [PubMed: 10892208]

²The data regarding perceptions of improved family functioning for participants in our 1-day MFG workshops have been previously reported (Ostroff et al., 2004).

- Erickson S, Steiner H. Trauma and personality correlates in long-term pediatric cancer survivors. *Child Psychiatry and Human Development*. 2001; 31:195–213. [PubMed: 11196011]
- Feder J, Komisar HL, Niefeld M. Long-term care in the United States: An overview. *Health Affairs*. 2000; 19(1):40–56. [PubMed: 10812780]
- Fiese B. Routines and rituals: Opportunities for participation in family health. *OTJR: Occupation, Participation and Health*. 2007; 27(Suppl):415–495.
- Fredman S, Baucom D, Gremore T, Castellani A, Kallman T, Porter L, et al. Quantifying the recruitment challenges with couple-based interventions for cancer: Applications to early-stage breast cancer. *Psycho-Oncology*. 2009; 18(6):667–673. [PubMed: 19061201]
- Gaugler J, Hanna N, Linder J, Given C, Tolbert V, Kataria R, et al. Cancer caregiving and subjective stress: A multi-site, multi-dimensional analysis. *Psycho-Oncology*. 2005; 14(9):771–785. [PubMed: 15750995]
- Gonzalez, S.; Steinglass, P. Application of multifamily groups in chronic medical disorders. In: McFarlane, W., editor. *Multifamily groups in the treatment of severe psychiatric disorders*. New York: Guilford Press; 2002. p. 315–340.
- Hammerlid E, Persson L, Sullivan M, Westin T. Quality-of-life effects of psychosocial intervention in patients with head and neck cancer. *Otolaryngology Head and Neck Surgery*. 1999; 120(4):507–516. [PubMed: 10187943]
- Hewitt, M.; Greenfield, S.; Stovall, E. From cancer patient to cancer survivor: Lost in transition. Washington, DC: The National Academies Press; 2005.
- Hooley J. Expressed emotion and psychiatric illness: From empirical data to clinical practice. *Behavior Therapy*. 1998; 29:631–646.
- Institute of Medicine. *Cancer care for the whole patient: Meeting psychosocial health needs*. Washington, DC: The National Academies Press; 2007.
- Kazak A. Evidence-based interventions for survivors of childhood cancer and their families. *Journal of Pediatric Psychology*. 2005; 30(1):29–39. [PubMed: 15610982]
- Kazak A, Alderfer M, Streisand R, Simms S, Rourke M, Barakat LP, et al. Treatment of posttraumatic stress symptoms in adolescent survivors of childhood cancer and their families: A randomized clinical trial. *Journal of Family Psychology*. 2004; 18(3):493–504. [PubMed: 15382974]
- Kazak A, Barakat L, Meeske K, Christakis D, Meadows A, Casey R, et al. Posttraumatic stress, family functioning, and social support in survivors of childhood cancer and their mothers and fathers. *Journal of Consulting and Clinical Psychology*. 1997; 65:120–129. [PubMed: 9103741]
- Kazak A, Boeving A, Alderfer M, Hwang W, Reilly A. Posttraumatic stress symptoms during treatment in parents of children with cancer. *Journal of Clinical Oncology*. 2005; 23:7405–7410. [PubMed: 16157936]
- Kazak AE, Simms S, Barakat L, Hobbie W, Foley B, Golomb V, et al. Surviving cancer competently intervention program (SCCIP): A cognitive-behavioral and family therapy intervention for adolescent survivors of childhood cancer and their families. *Family Process*. 1999; 38(2):175–191. [PubMed: 10407719]
- Kim Y, Given B. Quality of life of family caregivers of cancer survivors. *Cancer*. 2008; 112(S11):2556–2568. [PubMed: 18428199]
- Kim Y, Kashy D, Spillers R, Evans T. Needs assessment of family caregivers of cancer survivors: Three cohorts comparison. *Psycho-Oncology*. 2009; 19(4):431–440. [PubMed: 19399773]
- Kim Y, Kashy D, Wellisch D, Spillers R, Kaw C, Smith T. Quality of life of couples dealing with cancer: Dyadic and individual adjustment among breast and prostate cancer survivors and their spousal caregivers. *Annals of Behavioral Medicine*. 2008; 35(2):230–238. [PubMed: 18365297]
- Lavelle, L. The healthy families project. In: Linville, D.; Hertlein, K., editors. *The therapist's notebook for family health care*. New York: Haworth; 2007. p. 59–64.
- Lemmens G, Eisler I, Heireman M, Van Houdenhove B, Sabbe B. Family discussion groups for patients with chronic pain. *Australia and New Zealand Journal of Family Therapy*. 2005; 26(1):21–32.
- Lemmens G, Verdegem S, Heireman M, Lietaer G, Van Houdenhove B, Sabbe B, et al. Helpful events in family discussion groups with chronic-pain patients: A qualitative study of differences in

- perception between therapists/observers and patients/family members. *Families, Systems & Health*. 2003; 21(1):37–52.
- Lemmens G, Vervaeke M, Enzlin P, Bakelants E, Vanderschueren D, D’Hooghe T, et al. Coping with infertility: A body-mind group intervention programme for infertile couples. *Human Reproduction*. 2004; 19(8):1917–1923. [PubMed: 15155608]
- Manne SL, Ostroff JS, Winkel G, Fox K, Grana G, Miller E, et al. Couple-focused group intervention for women with early stage breast cancer. *Journal of Consulting and Clinical Psychology*. 2005; 73(4):634–646. [PubMed: 16173851]
- McFarlane, W. Multifamily groups in the treatment of severe psychiatric disorders. New York: Guilford Press; 2002.
- McFarlane W, Dixon L, Lukens E, Lucksted A. Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy*. 2003; 29(2):223–245. [PubMed: 12728780]
- Ostroff, J.; Ross, S.; Steinglass, P. Psychosocial adaptation following treatment: A family systems perspective on childhood cancer survivorship. In: Baider, L.; Cooper, C.; Kaplan De-Nour, A., editors. *Cancer and the family*. 2. Chichester, UK: John Wiley & Sons Ltd; 2000.
- Ostroff J, Ross S, Steinglass P, Ronis-Tobin V, Singh B. Interest in and barriers to participation in multiple family groups among head & neck cancer patients and their primary family caregivers. *Family Process*. 2004; 43:195–208. [PubMed: 15603503]
- Pomeroy E, Rubin A, Walker R. The effectiveness of a psychoeducational task-centered group intervention for family members of persons with AIDS: An evaluation. *Journal of Social Work Research*. 1995; 19:142–152. [PubMed: 10144837]
- Pomeroy E, Rubin A, Walker R. A psychoeducational task-centered group intervention for family members of persons with HIV/AIDS: Strategies for intervention. *Family Process*. 1996; 35:299–312. [PubMed: 9111711]
- Rodrigue JR, Hoffmann RG. Caregivers of adults with cancer: Multidimensional correlates of psychological distress. *Journal of Clinical Psychology in Medical Settings*. 1994; 1:231–244. [PubMed: 24227390]
- Rolland, JS. Families, illness, and disability: An integrative model. New York: Basic Books; 1994.
- Satin W, LaGreca A, Zigo M, Skyler J. Diabetes in adolescence: Effects of multifamily group intervention and parent simulation of diabetes. *Journal of Pediatric Psychology*. 1989; 14:259–275. [PubMed: 2754576]
- Schene A, Wijngaarden B, Koeter M. Family caregiving in schizophrenia: Domains and distress. *Schizophrenia Bulletin*. 1998; 24:609–618. [PubMed: 9853792]
- Shields C, Rousseau S. A pilot study of an intervention for breast cancer survivors and their spouses. *Family Process*. 2004; 43(1):95–107. [PubMed: 15359717]
- Stehl M, Kazak A, Alderfer M, Rodriguez A, Hwang W, Pai A, et al. Conducting a randomized clinical trial of a psychological intervention for parents/caregivers of children with cancer shortly after diagnosis. *Journal of Pediatric Psychology*. 2009; 34(8):803–816. [PubMed: 19091806]
- Steinglass P. Multiple family discussion groups for patients with chronic medical illness. *Families, Systems and Health*. 1998; 16(1–2):55–70.
- Steinglass, P.; Bennett, L.A.; Wolin, S.J.; Reiss, D. *The alcoholic family*. New York: Basic Books; 1987.
- Wamboldt MZ, Levin L. Utility of multifamily psychoeducation groups for medically ill children and adolescents. *Family Systems Medicine*. 1995; 13(2):151–161.
- Wood B. Beyond the “psychosomatic family”: A biobehavioral family model of pediatric illness. *Family Process*. 1993; 32:261–278. [PubMed: 8243617]

Figure 1.

Seating arrangement for group-within-a-group sequence. (a) Phase one: Initial gathering as whole group. (b) Phase two: Patient subgroup. (c) Phase three: Observer subgroup.

- Family membership connoted by varied within-symbol patterns (e.g., the “Polka-Dot” family; the “Diagonal-Line” family; the “Cross-Hatched” family).
- Illness role is connoted by either single (noncancer) or double (cancer patient) outlining.
- Family role connoted by geometric shape (e.g., circles for wives; squares for husbands; triangles for children).

Figure 2.

Two contrasting Family Collages: (a) “Bridging the cancer experience” collage; and (b) “Cancer as a hanging ball” collage.

These two line drawings illustrate actual collages constructed by different families participating in our 1-day workshop multiple family groups. The original collages are multicolored with ideas and emotions expressed through colors as well as shapes. Examples of actual collages are available from the authors upon request.

Table 1

Demographics and Medical Characteristics of Patient and Family Caregiver

	Patient (N = 15)		Caregiver (N = 15)	
	M	SD	M	SD
Age	56.2	6.33	51.05	10.5
Time since diagnosis (months)	17.8	7.40		
Tumor Site				
Oral Cavity	33.3%		—	
Pharynx	40.0%		—	
Other head & neck tumor	26.7%		—	
Gender				
Female	26.7%		86.7%	
Male	73.3%		13.3%	
Marital Status				
Single	6.7%		6.7%	
Married/living with partner	86.7%		93.3%	
Divorced/separated/widowed	6.7%		—	
Living Arrangement				
Alone	6.7%		—	
With partner/spouse + children	86.6%		93.3%	
Adult children/siblings	6.7%		6.7%	
Education				
High school graduate and less	33.4%		26.7%	
Partial college	40.0%		20.0%	
College graduate/Graduate degree	26.7%		53.3%	
Caregiver role ^a				
Partner/spouse	—		75.0%	
Child	—		14.6%	
Sibling	—		6.3%	
Parent/in-law	—		4.1%	
Household Income				
<30k	6.7%		0.0%	
30k to 49,999	20.0%		26.7%	
50k to 69,999	20.0%		26.7%	
70k to 89,999	20.0%		13.3%	
More than 90 k	33.3%		33.3%	
Patient Occupational Status				
Employed	64.3%		66.7%	
Unemployed/homemaker/disabled/retired	35.7%		33.4%	

^a Caregiver role refers to patient-nominated family member instrumental during active treatment.

Table 2

Outline of the 1-Day MFG Workshop Protocol

I. Introductory component (30 minutes)	
A.	Provide an opportunity for families to introduce themselves to each other and to briefly tell their cancer “stories.”
B.	Have group leaders describe the goals of the workshop, and schedule for the day.
II. Illness impact component (90 minutes).	
A.	Use of “group-within-group” technique to facilitate connections between participants occupying analogous family and illness roles.
B.	Identify shared experiences and introduce metaphors to describe these experiences, especially metaphors useful in introducing concept of creating an appropriate balance between cancer-related needs and noncancer family issues (the metaphor of “keeping the illness in its place”).
« 15-minute break/snack »	
III. Family development component (90 minutes)	
A.	Discussion of family life before vs. after cancer as vehicle for “normalizing” the illness experience.
B.	Summary by group facilitators of issues raised by families and shared challenges experiences by MFDG families.
« 1-hour lunch break »	
IV. Family-illness Integration component (90 minutes)	
A.	Describe and clarify current coping strategies and possible changes via construction of art montages visually representing each family’s relationship to cancer.
B.	Presentation of collages to the other MFDG families for feedback and suggestions about possible changes to make to better integrate cancer and noncancer issues in family life in future coping strategies.