

**Multi-Family  
Group  
Treatment Manual  
for Traumatic Brain  
Injury**

# **Multifamily Group Treatment Manual for Traumatic Brain Injury**

**Bruce Becker, MD**

**Dennis Dyck, PhD**

**William McFarlane, MD**

**Diane Norell, MSW, OTR/L, CPRP**

**Anne Strode, MSW**

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Washington Institute for Mental Illness Research & Training  
310 N. Riverpoint Blvd., PO Box 1495  
Spokane, WA 99210-1495  
Telephone: (509) 358-7614  
Fax: (509) 358-7619  
Washington State University Spokane

URL: <http://www.spokane.wsu.edu/research&service/WIMIRT>

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# I. INTRODUCTION

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## *Introduction*

Traumatic brain injury has a significant and long standing impact upon the injured person as well as their family. Traumatic brain injury creates disabilities that can dramatically alter the fabric of family life. The ripple of impact spreads from the affected individual through the immediate family and into the social network that surrounds the family.

The current figures available from the National Institutes of Health state that two million brain injuries occur each year with 500,000 of those injuries severe enough to require hospitalization. A brain injury occurs every 15 seconds in this country. Two-thirds of all persons sustaining head injuries are under the age of 34. The typical brain injury victim is a young male, between the ages of 16 and 24 who is injured in a vehicular accident. The Centers for Disease Control and Prevention, and the National Center for Injury Prevention and Control estimates that 5.3 million Americans are living today with a Traumatic Brain Injury (TBI) related disability.

Each year more than 80,000 Americans survive a hospitalization for TBI, but are discharged with TBI-related disabilities.[1] The majority of these individuals return to their homes with either parents or spouses who are inexperienced in the types of deficits/problems that may be present. Too few resources assist the family in preparing for the long term of recovery. Many families are left to fend for themselves and to find a path to cope with the many implications and consequences of the injury. Studies show that many families continue to struggle with the physical, emotional and social impacts of the injury for months and years. The resulting strain may cause some to experience health problems themselves over the years.

Social support systems can be a significant source of strength in coping with the injury and managing stress. There is a clear need for methods that help the patient and family adjust and cope with the consequences of such injuries. However, studying effective strategies for support and management have been difficult because the family structure is a vital ecosystem with many environmental forces at play at any given instant.

Although researchers have identified early signs of at-risk families, effective intervention and treatment strategies are wanting. Nonetheless, many families cope admirably, surviving the physical, emotional and economic burdens of an acutely disabled family member with relatively small impact on the fabric of family life, and a remarkable show of durable resourcefulness. Other families, often with seemingly similar resources, buckle under resulting in divorce, social isolation and health issues. Behavioral problems, more often than physical limitations, seem to cause the most challenges. As with many other crises, significant economic disruption aggravates all coping abilities. Unfortunately, economic strains are the rule rather than the exception in many families of the newly disabled.

To date, individual or single-family counseling formats remain the standard of care. Very few third party payers will cover group therapy sessions for families of disabled individuals, and

even formal psychotherapy is often unavailable or not reimbursed for the disabled member, let alone caregivers.

Multi-family Group (MFG) treatment is a psychoeducational management strategy originally developed by William McFarlane and colleagues to assist families and patients with schizophrenia to improve their coping and illness management skills. [2] The process is a structured interactive format consisting of social, educational, and supportive sessions provided by two clinicians with six to eight families and their disabled members over a period of months to several years. The MFG intervention has a strong educational component, and contains an interactive and real-world problem solving component. Group sessions occur on a frequent, often bi-weekly basis. The intervention has been rigorously tested in the management of persons with schizophrenia and found to be effective in managing symptoms, reducing adverse events (hospitalizations, relapse) and improving functioning. It has also been successfully used in pediatric cancer patients, and in several other chronic medical illnesses. Multi-family group intervention provides a direct and personal psychoeducational approach to the individual and his or her family. It is neither a medical nor a traditional educational/didactic or psychiatric approach. It requires that clinicians work with families and patients to share professional expertise, personal experiences and information. It uses a formal problem solving format that assists in practical assistance to current patient and family issues. The psycho-educational strategy for managing schizophrenia was derived from work previously reported by Goldstein and associates; Falloon and colleagues; Anderson, Hogarty and coworkers; and Leff and associates. [3-6] Specific treatment interventions implemented by multiple family group clinicians were designed to:

- Engage key members of the family
- Provide information about the disease and the treatment process using a standardized videotape, lectures and written guidelines for coping
- Intervene early in incipient relapse
- Provide ongoing support and formal clinical problem solving for at least nine months
- Expand the family and social network

McFarlane's Multi-family Group Psychoeducation format has proven to be more effective and efficient than single-family psycho-education and support groups. [7] The MFG model retains the collaborative alliance and problem solving emphasis of the earlier models, but expands the social network components. Research in schizophrenia indicates that relative to standard care, MFG participants experience significantly less relapse and negative symptoms than do controls receiving standard outpatient services. Research findings by Dyck and colleagues indicate that MFG reduces psychiatric hospitalization costs without increasing outpatient service utilization.[8]

Since TBI has management challenges in common with schizophrenia, MFG, with some adaptation, appears to have excellent potential for exportation as a model of cost-effective health care for individuals with TBI and their families. The medical, behavioral and social consequences of schizophrenia are fairly unique. Nevertheless, there are significant aspects in common with traumatic brain injury.

Traumatic brain injury and schizophrenia occur most frequently in males, with highest prevalence in younger age groups, thus altering vocational options for them into the career process. While recovery is a reality, both groups carry considerable probability of long-term functional disability. Both involve significant medical ambiguity at onset regarding prognosis. Further, in both, the family unit is most often recruited to assist in living arrangements including

immediate personal and caregiving support. These families may well be under an added economic strain through the loss of a breadwinner and also through potential removal from the workforce of a family caregiver.[9] Both share a risk of social isolation, both face the potential social stigma of having a disabled family member, and both must alter family dynamics to facilitate support for the disabled individual.[10]

The disabilities posed by the brain injury often place responsibilities upon family members for assistance with mobility needs, personal hygiene, self-care, and may also impose economic burdens upon the family unit. The burden is particularly difficult for the spouse, and the spousal relationship is very important to long term successful coping.[11]

More than one third of cases of traumatic spinal cord injury (SCI) are associated with a concomitant traumatic brain injury.[12, 13] Taken alone, the spinal cord injury requires adaptation to impairments of motor function, sensory function and thus often has life-long implications for mobility, self-care and social and vocational function. Obviously, when both spinal injury and brain injury are present in the same patient, deficits are compounded and the family burden increases substantially, as judgment and decision making deficits dramatically increase the probability of secondary SCI complications.

The significant impact of TBI upon the family, the on-going need for medical information, combined with the recognition that social support improvement has been associated with health status improvement in chronic neurological problems has provided the impetus to adapt the MFG intervention to TBI.[14] MFG provides families and the patients with opportunities in social support, learning from each other by sharing experiences at various stages of the injury journey, as well as assist in the reduction of the incidence of secondary complications.

In traumatic brain injury, behavioral approaches have been shown to positively affect psychological outcomes. In recent studies, a cognitive behavioral intervention, given during the acute rehabilitative stay of neurologically injured patients, yielded benefits that persisted for a period of at least two years following rehabilitation. In these studies, cognitive behavioral intervention recipients required fewer hospital re-admissions, used fewer drugs and reported higher levels of adjustment with less depression when compared to untreated control patients. [15-18] In the past 20 years, researchers have compiled a substantial body of work on the impact of behavioral interventions upon brain injury patients. The interventions offered have typically been delivered by clinicians, yet relatively few have actively incorporated the involvement of families of affected individuals over a sustained period of time. In a rare study where families were involved, researchers at the University of Washington (1992) used behavioral therapy interventions related to anger management, teaching patients and their families' active intervention principles to reduce anger control problems. Successful carry-over was noted when subjects were followed over a period of months.[19] The MFG intervention, carefully adapted to TBI, has the potential to make a significant contribution to the treatment of patients and their families in the months following TBI.

This treatment manual is based upon the work of McFarlane and colleagues, with adaptations based upon the work of Dyck and coworkers.[8, 20-23] It strives to create a methodology for adaptation of the MFG model to patients with traumatic brain injury and their families. It describes the steps in forming and working with a Multi-family Psychoeducation Group. However, this manual is intended to be augmented by training and on-going supervision. As well, nothing can substitute for experience in working with patients and their families.

For many clinicians, conducting psychoeducational groups, as described in this manual, may be quite different than their normal clinical interactions with patients and families. The process, although structured, requires the clinician to socialize and share personal experiences more than many have previously done. Rather than maintaining “psychological distance,” the clinician’s role is an active and interactive one, leading families in a highly participative instructional dialogue and problem solving process. Clinicians are asked to balance directing and listening in these roles.

There are four stages in the implementation of the treatment program:

1. Joining with individual patients and families’
2. Conducting an educational workshop for families;
3. Promoting healthy adaptation to injury, reducing secondary complications and facilitating early identification of potential medical or psychological issues through interactive problem solving attended by both patients and families; and
4. Encouraging and facilitating social, vocational and community re-integration through the use of problem solving groups attended by both patients and families.

Each of these stages will be described in detail in the following chapters. To assist clinicians in adopting this new approach, the manual is designed to be a handbook of how to accomplish each step. Examples are included where appropriate.

## II. JOINING WITH THE PATIENT AND THEIR FAMILY

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### ***Introduction***

Joining means to connect, build rapport, convey empathy and establish a collegial alliance with patients and families. In the Multi-family Group Psychoeducation (MFG) model, joining with patients and families is the first stage of the MFG intervention. Joining continues throughout the families' involvement, and is especially important in the beginning. There are a number of components included in each joining session, but the overarching goal of joining is to develop a strong relationship between the clinician and family, and between the clinician and the patient. Building a strong, collaborative and respectful relationship through the joining process is an essential element of the model.

Most families begin the MFG process after the patient has just experienced hospitalization, rehabilitation and re-entry into the home. In the original model of the MFG intervention, the joining phase is comprised of three sessions with each family and three sessions with each patient. A successful modification in working with persons with traumatic brain injury and their families has been to facilitate joint sessions in which the family and patient meet together with the clinician at least for part of the sessions. This may be necessary because of the patient's need for family support and cognitive cueing. We have learned that it is important not to over-stimulate the patient through lengthy or complex discussions and therefore, briefer separate meetings with the patient may be called for. It is important for the clinician to join with the patient as well as the family to establish that he or she is there as much to help the patient as the family.

Meetings with the patient and the family begin as soon as possible after hospitalization. This prompt attention is both needed and reassuring. The goal is to establish the clinician as an advocate and resource for both the patient and the family. The two clinicians who will eventually co-lead the multi-family group divide the responsibility: each joins with half the patients and their families. The sessions occur within three-four weeks of the educational workshop, generally one hour for families and approximately 30 minutes for patients if the sessions are held separately.

### ***Family Joining Sessions***

Whether the joining sessions are facilitated separately with families and patients or together, they follow a clear sequence of important steps:

#### Family Session 1:

The clinician begins by socializing with the family for 15 minutes about such things as traffic, getting to the meeting, weather, or recent holidays. The goal is for the family and the clinician to get to know each other as people apart from the injury and to establish that the clinician will behave as a colleague and an advocate. It also helps everyone to relax. After 15 minutes of socializing, the clinician inquires about the medical history of the patient. Next, the clinician introduces the Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. SWOT analysis is a way to analyze these four quadrants within the family and how they affect success

of reaching a goal. Together, the clinician and the family identify strengths, weaknesses, opportunities and threats for persons with traumatic brain injury in general. After discussing the areas that are common to most people dealing with a brain injury, the clinician will discuss the concepts of individual differences in patients and in families.

Following the discussion of individual differences, the clinician then describes the Multi-family Group Psychoeducation process in which five to eight families will meet every-other-week for one and a half hours for the established number of months. The last five minutes are spent socializing to reinforce the building of relationship and the importance of normal daily life.

#### Family Session 2:

The clinician socializes with the family for 15 minutes at the beginning of the session. The clinician reviews the SWOT and assists the family in completing a SWOT assessment related to the patient and the primary family member.

At the end of this process, the clinician invites the family to consider between now and the next session additional items that could be included on the SWOT. Next, the clinician inquires about the family's social support network and generational history using two formal techniques; an ecomap and a genogram. An ecomap is a diagram of the family within its social context and includes a genogram, a diagram of the family's generational configuration.[24] The ecomap helps to organize data on the supports and stresses in the family environment while the genogram organizes data on the major figures in the patients' interpersonal environment. Both techniques provide additional information and understanding related to the patient and family's support resources. Finally, a flyer describing the upcoming educational workshop is provided for the family to share with others. The session ends with five minutes of socialization.

#### Family Session 3:

The session begins with 15 minutes of socializing with the family. The clinician reviews the SWOT analysis with the family and any additional information is added. The clinician asks about the family's experiences in living with the injury; what challenges they face in coping on a daily basis and how they have experienced the health care system. The clinician prepares the family for the regular meetings of the multi-family group that will follow the educational workshop. The clinician inquires about the family's experience with groups and what concerns they might have, including confidentiality, shyness and feeling pressured to speak in the workshop or group meetings. The family is assured that they need contribute only as much as they wish. The clinician briefly describes how the group will proceed and what other families have gained from similar groups, particularly new and workable solutions to difficult problems in coping. Additional sessions may be scheduled as needed. Extra sessions should be scheduled if the educational workshop is to be held more than two or three weeks from the third joining session.

### ***Patient Joining Sessions***

As previously indicated, joining sessions with the patient may be conducted separately from the family or conjointly. If the meetings are held separately, they may be shorter and less structured than those with the family. The main goal is to allow the patient to become acquainted with the clinician and to see him or her as an interested, empathetic person who will act as the patient's advisor and advocate. The general structure described for the family joining sessions will be followed for the patient joining sessions.

## ***Clinicians' Role***

From the first meeting the clinician is active in guiding the conversation. An important aspect of joining is providing concrete help and being available to patients and families. This kind of involvement shows that the clinician will be acting as a colleague and can be trusted. A warm, low-key, quietly confident manner tends to be the most successful approach. However the clinician demonstrates control of the sessions and structures them from the beginning. Structure helps the patients and families to feel less anxious as well as assists the patient cognitively. Within the structure, the clinician also answers questions and gives recommendations; if needed. Some family members may on occasion quarrel or monopolize discussions or make repetitive complaints. This non-productive kind of communication can be interrupted and redirected by the clinician by acknowledging the person's frustration and worry about the situation.

The clinician keeps his or her manner positive, informal and collegial. During joining sessions and throughout all the stages of treatment, the clinician needs to be confident in what he or she knows about the injury and also respectful of the family's knowledge and experiences. If the clinician does not know the answer to a question, he or she acknowledges this and assures the family that the information will be sought out. In this model, the clinician emphasizes successful coping and resources. Families also need the opportunity to express their feelings of loss, frustration, anger, despair, hopelessness and guilt. The clinician validates the expression of these feelings without probing for them. When they are left unexpressed they can form a barrier to a family's finding the energy to learn new ways to manage.

Whenever relevant during the joining stage, the clinician shares information about TBI with the family. In this model, the clinician is open and forthcoming about whom he or she is as a person. The clinician also takes an interest in each member of the family apart from their involvement with the injury. One way this principle is realized during joining is through the socializing built into each session and continued in the multi-family groups.

Whenever a crisis occurs during this period for either the patient or family, the clinician deals with it as soon as possible. The clinician can use a crisis as an opportunity to demonstrate willingness to help, especially in concrete ways.

It is important for clinicians to receive supportive supervision beginning with the preparation for contacting families. For many clinicians, the techniques described will be new and challenging (i.e. to learn new ways of forming alliances and conducting sessions). It can also be difficult to hear about the experiences and emotional pain the families must endure. Supervision can be helpful in dealing with these challenges when conducted with the same positive, supportive, collegial tone that clinicians use with patients.

### **III. EDUCATIONAL WORKSHOP**

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After families have participated in two to three joining sessions they are provided with an all-day educational workshop by the clinicians, commonly held on a weekend day. The purpose of the workshop is to present information on the nature of TBI and effective ways of managing the disabilities and challenges associated with TBI. The leaders continue to behave in an open, collegial manner. This manner creates an atmosphere in which families can comfortably ask questions and discover one another's similar experiences and problems.

The two clinicians who lead the multi-family group conduct the workshop. Other members of the multidisciplinary team such as nursing, physiatry, therapy and case management may be invited to participate as well, offering not only an enriched curriculum but an opportunity for families to interact with other members of the rehabilitation team. This is the first time families meet the other members of the multi-family group and the family clinician with whom they did not yet join.

Some clinicians may be unaccustomed to organizing and presenting factual information to a group. It is necessary for clinicians to prepare and review the materials in advance of the workshop. Practicing presentations with colleagues increases confidence and provides an opportunity to receive comments on clarity, manner, rate of speech, etc. Anticipating the kinds of questions that families may ask and rehearsing responses also increases preparedness. Clinicians report that the more often they conduct workshops, the easier and more manageable they become. In some rehabilitation settings, educational materials are already available to patients and families. The rehabilitation team may already have developed a curriculum which can then be easily adapted to the educational workshop.

Clinicians attempt to create a classroom atmosphere so that this first meeting of group members is quite structured and as free of social tension as possible. Chairs are set up in rows facing the front and the leaders use blackboards, charts, slides or other audiovisual aids. Family members each receive a folder containing printed information, diagrams, references, and other aids that can be followed throughout the day. Refreshments are supplied throughout the all-day workshop, including morning coffee, lunch, and afternoon snacks. A variety of beverages are served and there is no smoking in the meeting room. Refreshment breaks provide an informal setting for spontaneous socializing. The group leaders act as hosts and hostesses during these interludes.

After coffee and a light snack, the leaders identify themselves and explain the day's agenda. They also provide a rationale for the workshop, i.e., "This workshop is only one step of our treatment program. After the workshop, we will be meeting together as a group of families, including patients, on a regular basis and we will continue to provide relevant information and assistance to you. We have found that working together with patients, families and the MFG team in a program similar to this has resulted in decreased uncertainty and new useful information for patients and families. We will answer as many questions as possible in this workshop today. If we cannot answer something, we will find someone who knows the information and get back to you."

The leaders then repeat their names and their position and ask the rest of the group to give their names, including any other staff members attending. The leaders begin with a presentation of the neuroanatomy and the effects of a traumatic brain injury. There is a great deal of information to be covered in the workshop, so it is important to stick to the agenda and to keep track of the time. Sometimes families will ask good questions that may lead to long discussions. Because it is likely that questions will be answered by the content covered later in the day, clinicians may ask families to save certain detailed questions until after the appropriate section is presented. Discussions can be continued, either after the workshop or during a meeting of the multi-family group. The staff remains with the families during lunch, sharing in this more informal time.

The leaders ask which methods family members have used to cope with and manage the changes in their family member. Here, too, the clinicians normalize the answers by acknowledging that many other families have described these same responses and that they are logical responses to situations in general. Family members report such things as: attempting to reason with the patient; ignoring the situation; centering all family life on the patient; and watchful attention to the patient's condition. Leaders can ask how these have been helpful and suggest that while they are natural and useful responses to an illness like pneumonia, they may not prove as successful with TBI. Clinicians point out that they will be discussing alternative methods of coping with the injury using the Family Guidelines (listed below), which are based on the specific effects of TBI on the patient and the families.

Then there is a discussion of the Family Guidelines. Each person will have a copy of the Guidelines to refer to as the leaders go over them, one by one. Clinicians take turns reading a guideline, connecting it to the biological information discussed in the morning and asking family members for their reactions, questions, and experiences. It is helpful to illustrate the guidelines with generalized examples based on the kinds of problems described by families during joining sessions. This is the first time family members have heard the guidelines explained formally as they relate to coping strategies. The clinicians should make every effort to be clear and use concrete examples. A tone of hopefulness is used as the new ideas are introduced. Copies of the Family Guidelines are distributed at the workshop with the suggestion that they be posted on the refrigerator.

## **FAMILY GUIDELINES**

A list of things everyone can do to help make life run more smoothly:

**STRUCTURE THE ENVIRONMENT FOR SUCCESS.** Whether it is the amount of stimulation, the time of day, access to specific items or the routine, plan ahead to optimize success. For example, if the patient gets tired in the late afternoon, you would not want to schedule appointments or activities that require him/her to participate at a high level during that time. This is setting everyone up for failure.

**PATIENCE AND MORE PATIENCE.** Everything is slower and takes more time than before the injury. Basic everyday tasks that were done automatically before now take extra time and effort. Plan for it and expect it. That will decrease your frustration. Let the patient do as much as he/she is capable of doing for him/herself.

**IT DOESN'T HAVE TO BE PRETTY IF IT WORKS.** Many things are different than before the injury. This is a time to look at small successes and improvements in independence--not perfection. It is more important to modify tasks or ways of getting the task accomplished than to have it done exactly the way it was before. Gaining independence is much more important to

the patient than doing something a certain way, even if it takes more time or the patient struggles in completing a task (i.e., tying shoelaces).

**DON'T PERSONALIZE BEHAVIORS.** For the most part, the behavior of persons with brain injury is not specifically intended to irritate or upset others. The nature of the injury results in deficits that cause behaviors that can be irritating to family members. For example, when a patient asks the same question over and over. This behavior is not intended to irritate the caregiver rather it reflects a short term memory problem. The patient doesn't know that they keep asking the question over and over because their brain is unable to store the answer.

**GET HELP WHEN YOU NEED IT.** Brain injury often results in a roller coaster of emotional, financial and health concerns. Very few families can go through this type of experience without help on multiple fronts. However, when patients get home, many of the resources become scarce. This is a long haul for a spouse and family. You need help to get over the multiple bumps in the road that will occur. Resources for help can include your physician, case manager, brain injury association, local mental health organizations, other families, etc.

**GET OUT AND PLAY.** This guideline is both for the patient and the family/caregivers. You have to get out and have some fun and time for yourself. You can have fun together but you also need time away from each other. Patients need support in establishing social circles and leisure activities. Families need this for overall physical and emotional health. Prior to the injury, the families' members had a mix of together and alone time, which needs to be re-established to restore balance.

**MAINTAIN ROLES IN THE FAMILY.** In times of crisis, the family often drops routines and gets what ever needs to be done completed. In brain injury, when a spouse or parent is the person injured it is not uncommon to have a child modify their role and step into a role of responsibility. This may work well in the short term; however, as time passes it is necessary for all involved to re-establish family roles, as soon as possible. Although the patient may have some behavior problems or deficits that make the parent role difficult without supervision, that person should function in that role whenever possible. For example, because of short-term memory problems the patient is not safe without supervision therefore he/she can not be left alone. He/she cannot supervise children in the house. However, the patient may be able to read or listen to a story with the child, or help with daily chores around the house, etc. All parties involved will do best when the normal roles are re-established.

## **OUTLINE OF THE EDUCATIONAL WORKSHOP DAY**

9:00 - 9:15 a.m.	Coffee and Informal Interaction
9:15 - 9:30 a.m.	Formal Introductions and Explanation of the Format for the Day
9:30 - 10:30 a.m.	Neuroanatomy Basics <ul style="list-style-type: none"><li>• What happens in TBI</li></ul>
10:30 - 10:45 a.m.	Coffee Break and Informal Discussion
10:45 - 12:00 a.m.	Treatment <ul style="list-style-type: none"><li>• Levels of care</li><li>• Types of deficits (Physical, Cognitive, Emotional, Communication, Social)</li><li>• Therapy, Medications</li></ul>
12:00 - 1:00 p.m.	Lunch and Informal Discussion

- 1:00 - 3.00 p.m.      The Family and Adjustment
- Typical and Normal Family Responses to the New Life
  - Family Guidelines and their Application
- 3:00-3:15 p.m.      Break
- 3:15 - 4:00 p.m.      MFG Structure
- Questions Regarding Specific Problems
  - Wrap up
  - Informal Interaction

#### **IV. FIRST MEETING OF THE MULTI-FAMILY PSYCHOEDUCATION GROUP: “GETTING TO KNOW EACH OTHER”**

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After the joining sessions and the educational workshop, the Multi-family Psychoeducation Group meets for the first time. The patient has participated in joining sessions but typically has not attended the workshop. The patient and their family have been prepared to meet with five to eight other families for one and one half hour meetings every other week for a predetermined number of months. Refreshments are provided by the clinicians to allow relaxed interactions before and during the group.

The goal of the first group is for clinicians and family members to get to know each other in the best possible light. Everyone will be working together for a number of months, and it is important to begin to feel comfortable with one another. It is very helpful during this first group meeting to think of it being similar to any group of people who are just meeting each other for the first time. In such a group people tend to put their best foot forward. The clinician acts like a good host or hostess and guides the conversation to topics of general interest, such as: how people travel to the group, where people live, what kind of work people do both inside and outside the home, hobbies, how people like to spend their leisure time, and what plans people have for holidays or vacations. Serious topics may be discussed as long as they have nothing to do with the injury.

The clinicians begin by introducing themselves. Then the clinicians welcome the entire group, and remind them of the format of future groups. For example, the clinician might begin in this way: “This is our first meeting. We’re going to be meeting every-other-week on Mondays from 5:00 p.m. to 6:30 p.m. We will be working together on solving every day problems, to help to prevent setbacks and to design small steps towards making life a bit easier and less stressful”.

The clinician continues by setting the agenda for this particular group. He or she might say: “Tonight we will be focusing on getting to know each other. Since we will be working together for a long time we need to start to get acquainted. What we will do during this meeting is to go around the room and each of us will say something about ourselves. We will talk one person at a time; everyone will have a turn. In case we run out of time, we can finish next week. It is normal under these circumstances to want to talk about the injury and the problems it presents. However, we want you to hold that until the next group meeting. Tonight, we would like to talk more about the rest of life. I will start by telling you about myself.”

In telling something about herself or himself, the clinician needs to keep in mind that the families will closely follow the clinician’s example. It is therefore important that the clinician cover as many areas of life as possible. As a general rule, it is recommended that each clinician share information for five-seven minutes. Although this may seem like a long time it is important to role model a variety of topics about oneself and an openness toward the group.

Sharing personal information may be a departure from the clinician’s usual way of conducting groups. However, it is essential since this approach relies heavily on establishing a collegial relationship between families and clinicians. Clinicians often find it useful to rehearse with each other what they will say at this stage.

For example, a clinician might say: "As I mentioned earlier my name is Rosemary Hawkins. I am married and have two children. They are Danny, who is three years old, and Alice, who is seven. Alice is in second grade at Thompson Elementary. She really likes her teacher so far. My husband and I were worried about her reading at first, but now she's doing pretty well. Danny is in preschool three mornings a week. I love to see the projects he brings home. Last week it was a collage of colorful leaves to show what autumn looks like. He was very proud of it, and I must admit, so was I." "I am a therapist and I work 20 hours a week at the rehabilitation institute. When I'm not working--and when I have the time--I enjoy some of my hobbies. I like to cook, especially Italian recipes like lasagna and baked ziti. My husband and I both like to listen to music at home. We mostly like jazz. We don't go to movies as much as we did before the kids were born, but we do rent videos about once a week. We like to take the kids on short trips on the weekends especially camping and hiking. I also am interested in photography and love to organize my photos into scrapbooks for the kids. There are two things I would like to do more of: reading and exercising. It seems like I never have time for those. But I'm signing up for an aerobics class next month at the YWCA, so maybe that will help. The whole family is excited about Thanksgiving coming up. We always go to my parents' house; they live in Seattle which is where I was born and raised. Everyone pitches in and helps with the cooking. I'll probably make the pies. I have two older brothers and one younger sister. Everyone tries to make it home for the holidays so we can catch-up on each others' lives."

Then the clinician turns to the next person and continues around the circle, thanking each one after his or her contribution. The second clinician sits halfway around the circle, and takes his or her turn in sequence, reinforcing the first clinician's modeling of sharing personal information.

Usually the family members follow the clinician's lead. However, the clinician needs to interrupt when: a) a family member speaks for someone else, or b) a family member follows the natural impulse to talk about the injury and its problems. The clinician can restate the purpose and format of this particular group. For example, the clinician might say: "Right now I'd really like to hear about you." or "It's natural to want to talk about the injury and we'll be getting to that in the next session. For now I'd like us to first get to know each other as people."

In situations where a family member offers a minimal amount of information about him or herself, the clinician asks questions to invite the person to elaborate and give more details. The group will then get a fuller picture of each person's life. For example, the clinician may ask whether the person likes to watch TV (which shows?), read, follow the news, cook (what favorite recipes?), eat out (what restaurants?), listen to music, go to the movies, follow sports (which teams?), do crafts, take walks (where?), belong to organizations, go to church, volunteer, garden.

The clinicians use opportunities to point out common interests in the group, and help the group members to see similarities among themselves. There are also opportunities to highlight different approaches to things. The group meeting benefits from humor and a light touch.

Since each clinician has joined with only half of the families present, he or she can use this group as an opportunity to get to know the rest of the families and patients in the group.

If family members are shy about speaking, the clinician can acknowledge the difficulty in talking in a group while pointing out that with time and familiarity, talking usually gets easier. The meeting ends with the clinicians thanking everyone for coming and reminding everyone the date, time and place of the next meeting.

## **V. SECOND MEETING OF THE MULTI-FAMILY PSYCHOEDUCATION GROUP: “HOW TRAUMATIC BRAIN INJURY HAS CHANGED OUR LIVES”**

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The clinicians have joined with the patients and families, conducted a full-day educational workshop for the families, and have met with patients and families together in the first meeting of the multi-family group. The goal of the second meeting of the multi-family group is to talk about how the injury has affected everyone’s lives.

Both clinicians welcome members to the group as they arrive and direct them to the refreshments. To start the group, one clinician outlines the agenda for the meeting. He or she begins by saying, “I am happy to see everyone here tonight. Last week we spent time beginning to get to know each other. Let’s begin by socializing for about 15 minutes. That’ll give us a way to catch-up since the last meeting. Then we’ll talk about how the injury has affected each of our lives.” The clinician begins the socializing with a comment or question unrelated to the injury, such as “I really enjoyed the Fall Festival this year. Did anyone else see the huge pumpkin exhibit?”

It is important to socialize for 15 minutes. For an example of initial socializing, see Chapter II. The clinicians encourage participation by modeling, pointing out connections between people and topics, and asking questions. Side conversations, interrupting, monopolizing and speaking for others are discouraged with positive supporting remarks, such as “It’s hard for me to hear when more than one person is talking,” or “That’s interesting; I wonder if Mr. Smith has something to say about this,” or “Your wife says she thinks you’re over the flu; how long were you sick?”

After socializing the clinicians move explicitly to the topic for this meeting. One of them might say, “As I mentioned earlier, we will talk tonight about how the injury has affected all of our lives. I’ll start by telling you about my experience.” As in the first group, the families will closely follow the clinician’s example and as in the first group, the clinicians talk for 5-7 minutes. Again, although this may seem lengthy, it does model the kind of depth of discussion that is desired.

It is helpful to share as much as possible about relevant professional and personal experiences. From the professional side, clinicians can describe how they became interested in the field, and how they have been affected by treating the injury, including both frustrations and feelings of accomplishment. From the personal side, the clinicians may talk about any family members or friends who may have experienced an injury or a patient they were close to. It is important to model talking about the feelings stirred up by these experiences, especially the feelings that families commonly have but are reluctant to express. Examples of common feelings are: anxiety, confusion, fear, guilt, embarrassment, frustration, anger, sadness and mourning. It is also important to express some hope about new treatment approaches in rehabilitation. If clinicians feel uncomfortable talking about their own experience, it is useful to practice what they will say with a colleague. For example, a clinician might say: “My work is very much involved with working with TBI. I have been a therapist at the rehabilitation institute for the past five years working with persons with traumatic brain injury. From a more personal side, I have had the

experience of a friend having a traumatic brain injury. Gene and I were best friends in high school. I remember feeling shocked when I heard he had been in a car accident. I felt sad and somewhat uncomfortable to see him. I suppose this experience is one of the reasons that I started to work in this field.”

When the clinician finishes, she or he pauses, and then turns to the person in the next chair. “How has it been for you? How has the injury affected your life?” The first clinician goes halfway around the circle. The second takes over until everyone has had a chance to speak.

Some individuals may find it difficult to talk about their experiences. It can be helpful to ask questions about how things are different since the injury, how has the injury affected their plans, and what they might be doing now if the injury had not occurred. People can say as much or as little as they wish.

After each account of an experience, the clinician thanks the group member for participating. She/he may point out that other group members have had similar experiences and responses. This group meeting may be the first time some families realize that they are not alone, and comments such as “I’m not the only one who went through this,” may be voiced.

In comparison to the first group meeting, the tone of the second meeting is usually a bit more somber. The mood is usually one of sadness and mourning, with some anger and frustration. Many patients and families take this opportunity to express dissatisfaction with the health care system. If this happens the clinicians validate the experiences that give rise to these feelings. It is important not to gloss over the reactions and to elicit concrete and specific details about their complaints. Of course, it is important to not let this discussion dominate the session.

If group members begin to talk about specific problems that they want to solve immediately, the clinician helps them to return to the agenda of the meeting. The clinician might say, “I can see that is a problem that has been bothering you a lot. We’ll be working on solving specific problems starting in the next meeting, so I would like you to keep that problem in mind. For now, though, let’s talk more about how the injury has affected your life.” It is also appropriate to make a brief suggestion using a guideline or to offer to meet with someone after the meeting if it seems like a crisis.

It usually takes at least an hour for everyone to have an opportunity to speak. If time runs out, set aside a portion of the next group to allow the rest of the members to tell about their experiences and feelings.

At the end of the group, the clinicians thank everyone for their participation and summarize that everyone has had some very difficult experiences. If appropriate, they summarize the feelings shared by several people in the group. They also remind group members that during the next meeting everyone will be working on solving problems similar to the ones raised during this meeting.

Five to ten minutes are set aside for socializing at the end of the group. The clinician might ask if people are anticipating any problems with traffic on the way home; what plans people may have for the upcoming weekend or if any one is taking a trip or has special upcoming plans.

## VI. PROBLEM SOLVING MEETINGS OF THE MULTI-FAMILY PSYCHOEDUCATION GROUP

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### *Introduction and Preparation for Group*

After the joining sessions, educational workshop and first two meetings of the multi-family group (“Getting to Know Each Other” and “How Traumatic Brain Injury has Changed Our Lives”), then all remaining group meetings are centered on solving problems. The format of a 90 minute problem solving group is:

Initial Socializing	(15 minutes)
Go-Round	(30 minutes)
Selecting a Problem to Work On	(5 minutes)
Solving a Problem	(35 minutes)
Final Socializing	(5 minutes)

Each of these steps will be discussed in detail in this chapter.

A meeting of the co-leaders scheduled thirty minutes prior to each group is advisable. They review several questions:

- In what phase of rehabilitation is each patient?
- What problems and events are likely to have occurred since the last group?
- What problem was used for problem solving during the last group, and what might be expected to have happened?
- Which families have solved problems in the last several groups and which families have not?
- From present knowledge, what problem would be best to focus on?
- Are any absences expected?

In the beginning phase it may be helpful for clinicians to plan a division of tasks, such as who will lead the socializing, the go-round and the problem solving. These tasks are rotated, especially during the first six-months of the group. The clinicians make sure that the room and equipment are prepared, and check the video equipment (picture, sound, microphone, on-screen clock) if the session is being taped for supervision. Other equipment such as chalkboard or conference pad, pencils and paper, copies of the guidelines, and an outline of the problem solving steps are also useful. The clinicians round-out the circle and bring chairs close enough so that people can communicate easily. Any extra chairs are removed. Clinicians sit across from each other during the meeting. An adaptation that may be necessary is the use of a table (preferably round or square) if patients are using wheelchairs so they have some means of support for refreshments. Other recommendations include:

- Refreshments are set out, and group members are told where smoking is allowed.
- The clinicians make sure that the meeting will not be interrupted by such things as telephone calls or people walking through the room, except for emergencies.

- The session starts on time. Latecomers are greeted briefly by a clinician and told what has gone on up to that point, and then the group resumes the discussion where it was interrupted.

## **A. Initial Socializing**

Every meeting starts with 15 minutes of social conversation. This underscores the collegial relationship among injured persons, family members, and clinicians. In addition, it allows group members to exercise social skills that may have diminished as a consequence of the isolation that is often a social effect of the injury. Clinicians can use this time to demonstrate their interest in the events of people's lives that have nothing to do with the injury. This emphasis reinforces group members' sense of competence and mastery. For further discussion, please see Chapter II. The conversation can be light or serious, as long as there is a place for humor.

At the beginning of each meeting during the first few months, one clinician reminds everyone of the agenda. Either clinician may begin the socializing section by saying something such as, "Let's catch up on what's been going on in the last few weeks," and, if need be, takes the initiative in introducing a topic of conversation.

The content is kept light. The clinicians model the kind of small talk that they would like to hear from the group. Good openings include talk about holidays, weather, food, children, hobbies, movies, sports, TV or local events. Complaints and criticisms about the patient are deflected, ignored, or reframed. The clinicians divert problem discussion by saying something like "We really want to hear about that, and we will get to it in the go-round stage. That's when we focus more on problem areas."

The clinicians attempt to balance participation among group members. It is ideal if everyone says something during socializing. Members should be encouraged to participate but should not be pushed if they appear too uncomfortable. Also, one group member should not dominate the discussion. Group members are encouraged to talk to each other directly without starting side conversations and to respond in socially appropriate ways. The clinicians stop any side conversations and avoid being drawn into them. For example, the clinician may say "Excuse me, I'd really like to hear what you're saying, but I can only hear one person at a time." The clinicians limit interruptions and speak for others, for example, the clinician might say, "Can you hold that thought for just a minute?" or "Joe, your father says you think that's OK--does he read you correctly?"

The clinicians are careful to spend 15 minutes socializing, and postpone talk about problem areas until the go-round stage. The socializing begins on time, regardless of late arrivals. The clinician is explicit when he or she is moving to the go-round section. The best transition from socialization to the go-round is to bring everyone up to date on members who are absent. Then the clinician can say, "Now it is time to start the go-round section of the group. This is the time when we hear about problems and issues connected with the injury and focus on the areas of significance that we have listed on the poster on the wall."

## **B. The Go-Round**

The section of the group meeting following the socializing period is the go-round. It has two goals: checking on the current concerns of each family about the injury; and selecting a single

problem for the problem-solving section of the session. The families' concerns tend to fall into two areas:

- a) Factors which might lead to a setback; or
- b) Issues having to do with the next step in rehabilitation.

The clinicians need to get enough information to determine the nature of each family's concern. Four to five minutes are allotted to each family, so that this section of the meeting takes no more than twenty five to thirty minutes.

The clinicians begin the go-round by turning to the family who solved a problem in the previous meeting. The family is asked, "How did it go with the solution we settled on last time?" The clinicians briefly review the implementation steps and praise the family for their efforts. If the experimental solution or some other option tried by the family seems to have helped, the family is praised again. All the group members are thanked for their participation in problem solving and the clinicians point out any specific suggestions made by other families that contributed to a solution. The clinician inquires as to whether the family would like to continue to use this solution when this particular problem may arise in the future. If the family indicates that it is a viable long term solution, the clinician makes note of this and continues to ask about the use of the solution in subsequent meetings when relevant.

If the solution did not seem to help, the clinicians review the steps in greater detail, looking for factors they might have overlooked, such as life events, taking on too much, other demands on the family, or proceeding too quickly. When solutions don't work, families tend to assume that it is their fault, that they have done something wrong. To counter this assumption, clinicians explicitly take responsibility for any failure of the solution. Possible statements might be, "I'm sorry, I didn't realize that we were going too quickly" or "I forgot to take into account the employer's reaction when we were developing this solution." It is important to relieve the family of any burden associated with failure of a solution. Then the clinicians may suggest an alternative solution to help the family to proceed in dealing with the situation. This suggestion may come from the list generated in the previous meeting or it may arise from the review of the implementation steps.

After checking in with the first family, the clinicians move on to the next family. They inquire explicitly about specific areas of concern for that family, such as medication compliance, and medical issues. Usually there is a spokesperson for each family, but it is useful to check in briefly with all family members if time permits. In the go-round the clinician both looks for and inquires about evidence of any setbacks using the SWOT list generated for each patient and family during the joining sessions. They also listen for any changes or problems with:

- Safety in the home: e.g., smoking in bed, aggressive behaviors
- Medication compliance
- Drugs and alcohol
- Managing one's activities of daily living
- Life events: family celebrations, moving, deaths or other losses
- Behavioral issues
- Other rehabilitation activities: changes in program, therapists, financial aid
- Disagreement among family members
- Conflict with a guideline from the educational workshop: e.g., going too fast, expecting too much

Frequently families will spontaneously indicate potential management complications or setbacks without attaching significance to it. The clinician must be sure to inquire further into this situation at this point.

When a problem or change has been identified, the clinician first acknowledges any feelings family members may have expressed such as: anxiety, satisfaction, discouragement, amusement or frustration. Then, after all the families have had a chance to report, the clinicians briefly and openly discuss each family's situation in turn with each other. They have several options. They may make a suggestion based on:

- 1) The appropriate biological information or guidelines (as outlined in the educational workshop);
- 2) Offer to intervene directly with the treatment system (medications, rehabilitation programs, residences, etc.);
- 3) Suggest that the family observe the situation and contact the clinician before the next meeting if the situation continues, or
- 4) Decide that the situation be used for problem solving at this meeting.

If a patient is known to have difficulty with medication compliance or substance abuse, it is crucial that the clinicians ask him or her about it directly if the information is not volunteered. It should not be assumed that all is well when the subject is not mentioned. The clinician might ask, for example, "John, have you been using any drugs or alcohol in the past couple of weeks?" and follow with specific questions about when, where, with whom, how much, what was the effect (positive and negative), did he take his medication that day, etc.

### **C. Selecting a Problem to Solve**

The clinicians conclude the go-round by thanking everyone for letting them know how things have been going. The clinicians begin to discuss which problem needs to be worked on in this session. They confer openly in deciding which problem to solve. The selection of a problem usually takes just a few minutes. It is desirable to rotate the problem solving among the families so that each family gets an opportunity to work on one of their own problems approximately every six meetings. All families benefit from the problem chosen, since they have struggled with or will struggle with a similar problem themselves.

As mentioned in the description of the go-round, Section B, the clinicians must be alert to two major areas of concern:

- 1) Factors leading to a setback
- 2) Issues having to do with the next step of rehabilitation

The clinicians need to consider carefully any report of actual or potential management complications. As mentioned earlier, areas of particular significance are:

- Safety in the home
- Medication compliance
- Drugs and alcohol
- Managing activities of daily living
- Life events
- Behavioral issues

- Other rehabilitation activities
- Disagreement among family members
- Conflict with a family guideline

The clinicians use their judgment when the group presents more than one problem which requires immediate attention. In order to decide which problem to work on, the clinicians ask detailed questions such as: how long the problem has existed, what has been tried so far, past consequences of similar situations and time pressure for the problem to be solved.

When the clinicians decide not to work on a particular problem in the meeting, there are several options:

- a) Give a direct suggestion and ask the family to report on how that suggestion works at the next meeting,
- b) In a crisis, offer to meet outside the group, and
- c) Refer to any past solutions that may apply.

There are other considerations to address at this phase of the group. When a patient or other family member attends the group for the first time, problem-solving with that family at that session is unadvisable. The clinicians keep in mind what phase of recovery each patient is in. As time goes by, the clinicians will notice a shift from problems related to the management of complications to problems related to accomplishing the next step in the rehabilitation process. There may be a problem that a family does not wish to address in a particular meeting. They may be ready to do so at another meeting. This should be respected. Table 1.1 provides examples of common problems experienced by patients with traumatic brain injury and their families which can make excellent problem-solvings.

<b>TABLE: 1.1 Examples of Common Problem-Solvings</b>	
<b>Ways to structure for success</b>	<b>Keeping a job</b>
<b>How to use time in a meaningful way</b>	<b>Managing memory loss</b>
<b>Managing stress</b>	<b>Maintaining oneself in independent living</b>
<b>Coping with: depression, anger, frustration, loss</b>	<b>Learning how to travel</b>
<b>Coping with holiday stress</b>	<b>Resuming family roles (father, mother, wife)</b>
<b>Substance usage: positive and negative effects</b>	<b>Resolving conflicts with family members</b>
<b>How to work successfully with a vocational program</b>	<b>Issues with effects and side effects of prescribed medications</b>
<b>Finding and using community resources</b>	<b>Ways to communicate effectively with peers, family members etc.</b>
<b>Conflict with a Family Guideline</b>	
<b>How to reenter the workforce</b>	

#### **D. Solving a Problem**

After the socializing, the go-round, and the selection of a problem or goal, the clinicians then lead the group in formal problem solving, using a six step process based on brainstorming methods from organizational and business practices, adopted by Falloon and colleagues in their work with persons with mental illnesses.[7] Approximately thirty-five minutes are allowed to complete this process.

The goals and rationale of problem solving in a group will have been described to the family in the educational workshop and reviewed at the third group meeting. The goal of formal problem solving in a multi-family psychoeducation group is to help families to use the information about traumatic brain injury and the guidelines that follow from this information. Using a structured approach follows directly from several Family Guidelines: patience and more patience; structure the environment for success; don't personalize behaviors; and maintain roles in the family. This model also draws on the experience of the other families, who contribute more ideas, options and solutions than one family alone could. An advantage of using this approach is that it breaks down problems into a manageable form, so that a solution can be implemented incrementally and thereby more successfully. Experiencing success in small steps gives the patient and the family a sense of momentum and hope that change is possible.

To use formal problem solving, one clinician leads the group through the six steps. The other clinician ensures group participation and suggests additional solutions. The clinicians choose someone to write down the six steps of the problem solving process. This recorder can be a clinician, a family member, or a patient. Initially it is helpful for the clinician to assume the role of recorder in order to role model for other members. The proceedings can be recorded on a chalkboard or a note pad or both. The board has the advantage of being visible by all. The note pad can be used to make copies as needed. Whichever method of recording is selected, the clinicians and the family should have a copy to keep.

After a recorder is chosen, the clinicians carefully follow each of the following steps of formal problem solving:

- Step 1. Define the problem or goal. (Family & clinicians);
- Step 2. List all possible solutions. (All MFG members);
- Step 3. Discuss first advantages and then disadvantages of each in turn. (Family & clinicians, MFG members);
- Step 4. Choose the solution that best fits the situation. (Family);
- Step 5. Plan how to carry out this solution. (Family & clinicians); and
- Step 6. Review implementation. (Clinicians).

Each step is important and will be covered below in detail. Both clinicians carefully track the process to make sure all the steps are completed and in the proper sequence. A problem-solving worksheet is included in the Appendix of this manual.

### **Step 1: Define the Problem**

The overall goal of this step is to narrow the definition of the problem or goal so that it can lead to practical solutions. The clinicians need to acquire information in order to reach a definition of the problem. The clinicians question family members, gathering relevant details. The definition must be one to which every present family member agrees. It is very helpful to elicit each person's view of the problem and what they desire as an outcome.

The clinicians return to the problem raised in the go-round. The clinicians ask additional questions about the situation from the perspective of how it relates to either the management of complications or to the next step in rehabilitation. When considering the management of complications, it is important to review medication compliance, drug and alcohol use, life events, difficulties with agencies providing services, disagreement within the family, and conflict with a guideline. The following questions are often helpful. Some may have been asked in the go-round.

- When did you first notice the problem?
- When does it occur?
- How often does it occur?
- Does it occur with certain people or under certain conditions?
- Is it occurring more or less frequently than when it was first noted?
- Who is affected by the problem, and how?
- What has been tried to alleviate the problem in the past? What was helpful?
- With what activities does the problem interfere?

When a problem has been defined in a way that is acceptable to each member of the family, the clinician asks the recorder to write it down and read it back to the group.

When considering the next step in rehabilitation, the clinicians review behavioral issues, social-vocational activity, the patient's and family's goals, and characteristic reactions to higher levels of activity.

### **Step 2: List All Possible Solutions.**

The clinician asks the group members for suggestions of solutions to the problem. The object is to get ideas about how the problem might be solved or how the goal might be achieved. The more possible solutions, the more likely there will be one that will address the problem or goal well. This step is open to all members of the group, and it is desirable for each family to contribute a possible solution.

The clinicians might begin by saying, "Now that we have defined the problem or goal, let's hear from everyone in the group about possible solutions. This is a time for brainstorming. All ideas are taken seriously and recorded, even if a suggestion seems a bit ridiculous; be as imaginative as possible. Then we will discuss the advantages and disadvantages of each one." At this time, the recorder is asked to write down each suggestion. An attempt is made to generate seven or eight suggestions.

When group members are first learning this model, they may want to discuss the advantages and disadvantages as each suggestion is made. The clinicians need to delay this discussion until the list of solutions is complete. This is to forestall premature rejection of proposed solutions, which in itself inhibits the creativity of other group members. The clinician may say, "Thank you for your suggestion, and we will get to discussing the advantages and disadvantages in the next step. For now, we're focusing on gathering everyone's ideas."

The clinicians contribute their ideas without dominating during Step 2. They can insure that both sides of any disagreement are represented in the solutions list so all viewpoints on the situation will be discussed. The families themselves usually come up with the most creative solutions and the ones most likely to succeed. The families also benefit from helping each other in this step. When all the families have contributed suggestions, and when it seems that the most relevant solutions have been covered, the clinicians thank everyone for their contributions.

### **Step 3: Discuss the Advantages and Disadvantages of Each Possible Solution.**

When considering the advantages and disadvantages of possible solutions, the clinician takes into account the strengths and weaknesses in the SWOT analysis.

After the possible solutions have been listed, the clinicians move on to discuss first the advantages and then the disadvantages of each solution. The clinician asks the recorder to read each solution aloud, and then asks the group, “What are the main advantages of this solution?” After the advantages are counted (check mark for each one), the clinician then asks, “What are the disadvantages of this solution?” Advantages are always identified first, and there must always be at least one advantage and at least one disadvantage for each solution.

Sometimes group members want to stop the problem solving process as soon as they discuss a solution that they feel has a strong advantage. The clinician reminds them that all suggestions will be discussed in turn before one is chosen in case the best idea comes at the end of the list. Sometimes group members may jump ahead to planning the implementation of a solution before it has been selected. The clinicians remind them that after a solution has been chosen, the group will focus in detail on how a solution can best be carried out.

#### **Step 4: Choose a Best Solution.**

The clinicians review the solutions aloud and identify which three or four solutions have the most advantages and least disadvantages. The family whose problem or goal is being worked on is asked which of these solutions or any other solution suits them best. Although the problem solving process is done by the group, it is the family with the specific problem or goal who is most involved and who will be carrying out the solution.

#### **Step 5: Plan How to Carry Out a Solution.**

The clinicians help the group break down the solution into manageable steps. Once again, it is the family with the problem or goal who makes the final decisions. The family members are the ones who have the biggest investment in the solution working and they are usually the ones who take the most responsibility. However, group members can often be helpful in making reminder phone calls, giving rides, accompanying someone to an appointment, providing names of helpful agencies or people.

The clinicians help the group to be as specific as possible in each step of implementation by asking such questions as: “What needs to happen first?” “Who will be doing that step?” “When will that step happen?” “Where will people meet for that step?”. The clinicians also help to trouble-shoot things that might go wrong and formulate back-up plans.

When the steps of implementation have been specified as much as possible, the clinicians ask the recorder to read back the steps. The family and the clinicians both keep copies of the problem solving record. The clinicians thank everyone in the group for their hard work and help.

#### **Step 6: Review Implementation.**

In the go-round of the next group meeting, the clinicians ask how the implementation went. What steps did the family complete? What went well? What did not go so well? The clinicians praise the family and any others involved for their efforts and point out any progress made. If relevant, the clinicians might suggest how to continue with the implementation, how to use a back-up plan, how to use an alternative solution. Sometimes the clinicians might suggest “taking a break” from working on the particular problem or goal. (See the go-round description for full details and examples of what clinicians might say.)

## **E. Closing Socializing**

After completing the problem solving process, the group spends five minutes socializing. The goal is to help people relax and think again about topics not related to the illness. The clinicians might say, "Everyone did a great job tonight. Now we'd like to spend the last five minutes just talking together. What are people's plans for the weekend? Is anyone doing anything special after the group tonight?"

Time can pass very quickly in group meetings. It can be tempting to continue solving problems or achieving goals to the last minute. It is extremely important, however, not to omit this five minutes of socializing at the end. When group members end on a social note, they are more likely to return to the next meeting and more likely to want to work together again on problems.

## **VII. SOCIAL, EDUCATIONAL & VOCATIONAL REINTEGRATION**

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The problem-solving groups continue to meet regularly. Over time, there is a shift from solving problems related to the management of complications to those related to the next step of rehabilitation. For example, there are more problems raised about how the patient can meet potential friends or dates or how the patient can find a job that is suited to their abilities and interests. At this time it is particularly important for clinicians to remind the patient, their families, and themselves to pace themselves and to remember the guideline "Patience and more Patience".

There is also a change in how these later sessions are conducted. The group members are more active, and the sessions are essentially led by the patients and families rather than clinicians. Families and patients give more suggestions and offer to help each other, and communicate and socialize outside the meetings.

Social and vocational programs are explored as possible solutions to the problems raised during this stage of treatment. However, in some groups families actively provide job leads or social opportunities for patients in the group. The patient often finds this extremely helpful. The clinicians help make optimal use of the social network of the multi-family group and help follow up leads that are generated in the group. As in other stages of treatment, it is important to base plans for the patient on his/her unique circumstances and progress in rehabilitation.

It is important to move forward in one area at a time. It may be necessary to cut back on some activity temporarily to allow for new activities. For instance, some household chores may be dropped to make time for more rest during the period of adjustment to a new job or program, or going out to the movies with families or friends. Setbacks may appear briefly when patients are trying new levels of activity. If they continue, the care plan can be reviewed, and the activity modified.

## **VIII. OTHER FAMILY BENEFITS**

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### ***Group Validation***

A benefit that families and patients gain from their participation in multi-family group psychoeducation is a sense of validation of their experience by other families in similar circumstances. Validation and understanding provides families and patients with an appreciation that they are not alone, that others who have journeyed through a similar experience can be a tremendous resource to them. Ultimately, this sense of commonality can cause some families and patients to develop a natural network of support that continues after the completion of the group. This again needs to be encouraged by the clinicians.

### ***Sharing Coping Strategies***

The ability to share different coping strategies that families and patients have found to be effective is an important aspect of multi-family groups. There is a significant amount of variation in the extent to which families have tried different strategies for coping with common problems. Families and patients learn from each other and need to be encouraged to share coping strategies and their benefits with each other. One means to accomplish this is through the problem solving process. Solutions generated by the entire group will encourage families to share coping strategies they have successfully used to manage this particular problem and later through the discussion of advantages and disadvantages of what the positive or negative results of their efforts were. Families value the knowledge and experience of those families and patients who have had more time in rehabilitation. This exchange of ideas can create a sense of hope and motivation for those less experienced families.

### ***Communication Between Families***

It is not uncommon for a member of one family to be able to communicate more effectively with a member from another family. Cross-family communication can be a powerful means of helping members understand the issues being addressed without the emotional charged discussion which may occur within their own family or may be willing to accept recommendations by a non-family member more readily than by their own parent or spouse. Clinicians take advantage of these benefits by encouraging these types of interactions.

## IX. NEW MEMBERS

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If the multi-family group is going to be facilitated as an open ended group with patients and families invited in as they are completing rehabilitation or hospitalization, then care needs to be taken with how to best integrate new members into the group. The entry of new members is a significant change for everyone. It is important to be aware of the anxiety that may be generated by this change and create more opportunities for socialization. Changing the format slightly to include more socialization time may be useful or having a meal or snack together in which people have an opportunity to socialize more informally can be of assistance.

Clinicians may find the following points useful when integrating new members:

- New members should have had at least three joining meetings and have attended the educational workshop before they join the group.
- Two to three new families enter the group at the same time when possible.
- When new members attend the group for the first time, the clinicians introduce themselves and ask others in the group to briefly introduce themselves.
- The clinicians remind the group that “When we first met as a group, we all told a little about ourselves and our hobbies; the kinds of things we like to do, and what our interests are.
- One clinician starts by telling something about him or herself in a low key and friendly manner. He or she then asks the new members to tell something about themselves briefly.
- The clinicians briefly review the format of the group (socializing; go-round; problem solving) and then start right in. “Let’s begin our socializing now.”
- When a patient attends for the first time, the clinicians pay close attention to any cues suggesting discomfort or anxiety. They avoid making him or her the focus of attention, despite the temptation to focus on the various issues that maybe troubling the patient and/or family.

## **X. GENERAL POINTS**

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Experience in facilitating Multi-family Group Psychoeducation has enabled us to identify a number of issues that usually develop over the span of a group and some of the techniques and approaches to deal with these issues. The following recommendations may be of use.

### ***Late Arrivals***

When a group member arrives late for a meeting, the clinicians acknowledge the member's arrival, state briefly the stage of the group, and turn their attention back to the group. The flow of the group is not interrupted. If the person arrives after the go-round, the clinicians check up on his or her concerns after the group is over or at the end of the go-round if time allows. If late arrival becomes a pattern for a particular member or family it is beneficial to assess with them reasons for the difficulty in arriving on time as well as remind them that being late is disruptive to other members and diminishes their ability to receive full benefit of the multi-family group experience.

### ***Meetings with Small Attendance***

Meetings with small attendance can be challenging, however if this is the situation, time can be saved in the go-round portion of the meeting allowing for extra time on problem solving. It is a good idea to call all members before each meeting to remind them of the time and place as well as follow up with absent members. During a telephone call to absent members, one can find out if they need help to get to the next meeting and to remind them they were missed by the group members. Developing a three to six month calendar outlining the dates of the group can also assist as a reminder and cue for members.

### ***Violence and Suicidal Thinking***

Threats of violence or suicide are dealt with immediately. The clinicians take charge and direct families about what to do.

### ***Group Interaction***

There are a few general guidelines for communication and interactions within the group which tends to support an open and engaging process:

- The clinicians model the behaviors they desire from the group members by their own example.
- The clinicians are careful in choosing language that is positive and acknowledging in nature rather than critical and blaming and reframe comments from other members into positive affirming messages.
- The clinicians share equally in the leadership responsibilities of the group.
- The clinicians are careful not to speak for patients or family members.

- Whenever appropriate, families are encouraged to talk to other families as much as possible.
- The clinicians encourage the patients to participate, without pressing them to do so.
- The clinicians discourage all side conversations.
- The clinicians follow the structure and timelines of the Multi-family Group Psychoeducation model.

### ***Use of the Family Guidelines***

Clinicians explain guidelines to patients at the earliest possible time, depending upon the patient's phase of rehabilitation. Sometimes this happens during a joining session. Incorporating the family guidelines either as a problem solving issue (i.e. how to use patience and more patience; how to structure the environment for success; realistic goals to work on) or as an advantage in the advantage and disadvantage section of the problem solving can assist the patients and families in specific examples of how the guidelines can be effectively utilized.

Familiarizing the patient's psychiatrist with the guidelines can encourage the psychiatrist to reinforce them with the patient and the family as well as make use of them in treatment with the patient.

### ***Redirecting Interruptions***

It is not uncommon for family members to speak for an injured member. An important intervention is redirecting interruptions by reminding all members that everyone needs the opportunity to speak and finish their thoughts and comments without interruption even though it may take time. Reinforcing the guideline of "patience and more patience" can assist. This redirection over time can assist injured members in feeling validated for their contributions and their participation in social interactions as well as afford them opportunities in communication and social discourse.

### ***Generic Problem Solving***

Developing a problem solving that is shared by most families can be useful to do in the early phases of the group as a means of developing group cohesion or diminish individual family anxiety related to being the focus of a problem solving. At times such as holidays, most families may be dealing with similar issues such as how to structure the holidays for success or how to be consistently patient. If that is the case, developing a problem solving that may be utilized by all the families can be helpful. This can be accomplished by either focusing the problem solving on a specific issue of one family or finding the common issue and problem solving for all families and inviting each family to choose one solution and create a specific plan. One needs to be cautious to not use generic problem solvings as common practice as this method is not nearly as effective as individual family problem solvings. There is less opportunity to develop a specific plan or a means of assessing the success of that plan. When used sparingly, it can be effective.

### ***Exiting and Entering of Group Leaders***

Because multi-family groups tend to be lengthy in duration, it is not uncommon for group leaders to leave the group. These departures can be emotionally difficult for some members therefore clinicians need to carefully plan for this transition paying attention to the emotional responses of the group. Generally identifying a replacement who has been well trained for this type of group a number of weeks in advance of the clinician's departure can be of great benefit. During the last

two or three sessions of the group, the departing clinician and the new clinician are both present for the sessions with the departing clinician assuming a less active role while the incoming clinician becomes more active. Offering some type of ritual in the form of a going away celebration in which group members and the clinician have an opportunity to express their sentiments and appreciation is recommended.

### ***Problem Solvings with Intractable Family Disagreements***

The solving of problems within this model assumes that families are attending the group because they want help in dealing with the problems and issues they are facing currently. Generally this means that families can agree on a proposed definition of the problem. Sometimes however this does not occur. In this circumstance when families do disagree about what the problem is, it can be useful to address the secondary problem, or the tension that occurs from the disagreement itself. One might explore the ways that families can respectfully disagree so that they are not in constant conflict.

As might be expected, one of the most common topics for disagreements are those between the injured member and family regarding lifestyle decisions on the part of the injured person that may place them at physical risk. In these situations, the clinicians frame all positions as having credibility and validity and empathy is expressed for the anxiety and frustration accompanying each position.

The clinicians do not take sides or attempt to adjudicate the conflict. Rather the focus is upon how the family can manage the disagreement without interfering with the rehabilitation process. The potential solutions address the consequences of the disagreement rather than the positions that generate more conflict. Solutions that have practical effects are useful, for example; finding ways to compromise, taking timeouts, or limiting the discussion around the conflict. Family members need to have an opportunity to make comments in the advantages and disadvantages section and be actively involved in developing and committing to trying the plan. The results can be surprisingly positive, with all family members expressing some willingness to approach the situation differently, at least temporarily.

### ***Transferring of Group Facilitation from Clinicians to Group Members***

After the group has been meeting for a number of months, the clinicians may be able to transfer some of the facilitation responsibilities to group members who demonstrate a sense of leadership and are comfortable in this role. Initiating socialization, leading the go-round, identifying issues for a problem solving and facilitating the problem solving all can be successfully done by group members. The role of the clinicians at this point becomes one of support and guidance as well as embracing those opportunities to interject information and comments that may be missed by a group member. Clinicians must take care that the desired structure of the group is not compromised by this shift in leadership. The transfer of facilitation generally is most successful after a significant amount of time and repetition of the group structure.

There are useful benefits in teaching group members the skills needed in facilitation. If the system of care can only provide a multi-family group for a limited time with professional involvement, then this transfer of knowledge and skills can extend the life of the group. The group may be able to carry on as an independent support group creating a valuable network for patients and families.

## ***Group Termination***

As is the situation for any therapeutic intervention that is coming to closure, some form of celebration is recommended. Sharing in meals encourages a sense of community, supports a natural means of socializing and marks transitions for people. Recognition of patients and families progress is also of value at this time.

## **XI. SUMMARY**

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This manual has described a method for conducting Multi-family Group Psychoeducation with persons with traumatic brain injury and their families. It is modeled on the work of McFarlane and colleagues with psychiatrically disabled patients and their families.

The manual can serve as an effective model for engaging families and patients in support of each other, education related to traumatic brain injury and developing increased coping and management strategies during the process of rehabilitation. It is an individualized method in which patients can progress at their own unique pace yet offers its members opportunities in social engagement and support. Families and patients have reported that their experience in multi-family groups has significantly assisted them in their transition back into the community and their adjustment to a new way of life.

Most clinicians who have led multi-family groups have described the experience as gratifying due to the witnessing of change and growth by both patients and families and the opportunity to engage with group members in a more naturalistic manner. Our hope is that this manual will enable other professionals to develop and implement similar groups to assist patients and families with the distinct challenges of living and dealing with the effects of brain trauma.

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## APPENDIX

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### SOLVING PROBLEMS AND ACHIEVING GOALS<sup>1</sup>

#### STEP 1: WHAT IS THE PROBLEM/GOAL

Talk about the problem/goal, listen carefully, ask questions, get everybody's opinion. Then write down exactly what the problem/goal is.

#### STEP 2: LIST ALL POSSIBLE SOLUTIONS

Put down all ideas, even bad ones. Get everybody to come up with at least one possible solution. List the solutions without discussion at this stage.

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#### STEP 3: DISCUSS EACH POSSIBLE SOLUTION

Quickly go down the list of possible solutions and discuss the main advantages and disadvantages of each one.

#### STEP 4: CHOOSE THE "BEST" SOLUTION

Choose the solution that can be carried out most easily to solve the problem.

#### STEP 5: PLAN HOW TO CARRY OUT THE BEST SOLUTION

Resources needed. Major pitfalls to overcome. Practice difficult steps. Time for review.

Step 1) \_\_\_\_\_

Step 2) \_\_\_\_\_

Step 3) \_\_\_\_\_

Step 4) \_\_\_\_\_

#### STEP 6: REVIEW IMPLEMENTATION AND PRAISE ALL EFFORTS

Focus on achievement first. Review plan. Revise as necessary.

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<sup>1</sup> Problem-Solving Worksheet excerpted from Falloon, et al., 1988.