

Multi-family Group Education

Treatment Manual for

Spinal Cord Injury

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I. INTRODUCTION

Introduction

Spinal cord injury (SCI) has a significant and long standing impact upon the injured person as well as their family. Spinal cord 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 National Spinal Cord Injury Statistical Center in Birmingham, AL estimates that there are approximately 253,000 persons in the United States living with spinal cord injury (SCI). The annual incidence of new spinal cord injury has remained fairly stable at 40 cases per million Americans, a total of approximately 11,000 cases per year. [1] SCI primarily affects young males by a ratio of nearly four males to every female injured, with an average age at injury of 38 years. Slightly over half of the newly injured are single at time of injury. Nearly two-thirds of all patients with new injuries were employed at time of injury, but less than half have returned to the workplace by year 10 post-injury. 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.

Family equilibrium is disrupted as family members attempt to adjust to the injury and its consequences. Families continue to struggle with the physical, emotional and social impacts of the injury for months and years after the injury. Caregivers are heavily impacted, and because of the strain some may experience health problems themselves over the years. Spouses of persons with SCI suffer levels of stress comparable to those of their injured partners. [2]

Formal and informal systems are a significant source of strength in coping with the injury and managing stress, yet there is a need for interventions that help both the patient and family to adjust and cope with the consequences of such injuries. Too few resources assist the family in preparing for the long term of recovery. Many families are left to fend for themselves and while some find a way to cope with the physical, emotional and economic burdens of an acutely disabled family member, others buckle under with divorce, social isolation and health issues emerging. Behavioral problems, more often than physical limitations, seem to cause difficulties. 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.

A patient-oriented or single-family counseling format remains the standard of care. Yet very few third party payers will cover assistance for families of disabled individuals, and even formal psychotherapy is often unavailable or not reimbursed for the disabled member, let alone caregivers.

Multifamily 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. [3] 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 many 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. [4] 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. [5] It has also been successfully used in pediatric cancer patients, and in several other chronic medical illnesses.

The Multifamily group intervention provides a direct and personal psychoeducational approach to the individual and his or her family. It is neither a medical or 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 Anderson, Hogarty and Reiss; Goldstein and associates; Falloon and colleagues; and Leff and associates. [6-10] 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 video tape, 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 Multifamily Group Psychoeducation format has proven to be more effective and efficient than single-family psycho-education and support groups. [5] 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. [11]

Since SCI 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 SCI and their families. The medical, behavioral and social consequences of SCI are fairly unique. Nevertheless, there are some significant aspects in common with schizophrenia: both conditions occur most frequently in males, with highest prevalence in younger age groups, thus altering vocational options for a group early into the career process. While recovery is a reality, both conditions carry considerable probability of long-term functional disability. Furthermore, both schizophrenia and SCI involve significant medical ambiguity at onset regarding prognosis. In both, the family unit is most often recruited to assist in living arrangements including immediate personal and care-giving support, and these families may well be under an added economic strain, both through the loss of a breadwinner and also through potential removal from the workforce of a family care-giver.[2] 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. [12] Social support improvement has been associated with health status improvement in chronic neurological problems. [13]

The disabilities posed by the spinal cord 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. [14]

More than one third of the cases of spinal cord injury are also associated with a concomitant traumatic brain injury. [15,16] Taken alone, the spinal cord injury requires adaptation to impairments of both motor and sensory function and thus often has life-long implications for mobility, self-care and social and vocational functioning. 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 SCI upon the family, combined with the on-going need for medical information, the opportunity to learn from sharing experiences with similar families at various stages of the injury journey, and the potential to reduce the incidence of secondary complications, have provided the impetus to adapt the MFG intervention to SCI.

In spinal cord 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. [17-20] In the past twenty years, researchers have compiled a substantial body of work on the impact of behavioral interventions upon injured 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. [21] The MFG intervention, carefully adapted to SCI, has the potential to make a significant contribution to the treatment of patients and their families in the months following SCI.

This treatment manual is based upon the work of McFarlane and colleagues, with adaptations based upon the work of Dyck and colleagues. [22] It strives to create a methodology for adaptation of the MFG model to spinal cord injury patients and their families. It describes the steps in forming and working with a Multifamily psychoeducational group. However, this manual is intended to be augmented by training and on-going supervision. We have found that videotaping sessions are imperative in the supervision process and to insure treatment fidelity. 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.
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 learning 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

Introduction

Joining means to connect, build rapport, convey empathy and establish a collegial alliance with patients and families. In the Multifamily 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.

It is helpful to begin the MFG process shortly after the patient has experienced inpatient hospitalization and rehabilitation and is re-entering the home. If possible, it is useful to schedule meetings separately with the patient and the family at this point because the emotional issues faced by each party are often quite different and have rarely been overtly discussed. However, at times, combining patients and families together in the joining sessions is preferable or necessary due to issues related to transportation, geographic distance and the need for medical support. The goal of the joining meetings is to establish the clinician as an advocate and resource for both the patient and the family.

Each clinician joins with up to four patients and their families. The meetings are goal oriented and length depends upon the physical and psychological tolerance of the patient and family, however the sessions are generally no more than an hour.

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 fifteen minutes about such things as traffic, getting to the meeting, weather, or recent holidays. The goal is for the family and 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 fifteen 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. [23] 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 the SCI population in general and their family members in particular.

The family and patient are invited to consider their particular strengths, weaknesses, opportunities and threats for discussion at the next joining session. Then the clinician explains the core components of the multifamily group and gives an overview of the upcoming educational workshop. The family is asked to consider inviting other family members and friends who would

benefit from education regarding their injury. The last five minutes of each joining session are spent socializing to reinforce the importance of normal daily life.

Family Session 2:

The clinician socializes with the family for fifteen 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 in the SWOT analysis. 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 which is 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 fifteen 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 multifamily 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 completed independent of 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 actively guiding the conversation. A major component of the joining process is providing concrete help and being available to patients and families. This demonstrates the clinician's ability to act as a trusted colleague. The clinician assumes a directive stance during the sessions providing structure from the beginning which assists the patients and families to feel less anxious. Within the structure, the clinician also communicates empathy and understanding, answers questions, provides relevant information and offers recommendations.

Sometimes family members may quarrel or monopolize discussions or make repetitive complaints. This kind of communication can be nonproductive and therefore it is useful to divert this dialogue by acknowledging the person's frustration and worry about the situation.

The clinician always keeps his or her manner positive, informal and collegial. During joining sessions and throughout all the stages of treatment, the clinician demonstrates confidence in what he or she knows about the injury as well as respect for what the family knows and has experienced. If the clinician does not know the answer to a question, he or she acknowledges this with the assurance that the information will be sought out. Part of the role of the clinician is to provide practical information that can be immediately helpful to the patient and the family thus demonstrating an advocacy role. As well, whenever a crisis occurs during this period for either the patient or family, the clinician addresses it as soon as possible again, demonstrating a willingness to help in concrete ways.

The clinician shares information about spinal cord injury with the family and emphasizes successful coping and resources. However, families also need the opportunity to express their feelings of loss, frustration, anger, despair, hopelessness and guilt. If these feelings are left unexpressed they can form a barrier to a family's ability in finding the energy to learn new ways to cope. The clinician validates the expression of these feelings without probing for them. Eliciting reactions to the injury and validating the range of emotional responses expressed can go a long way to diminish pent up anger and frustration as well as offer tremendous support to families and patients.

The development of interpersonal relationships that will expand the social network of the patients and families begins with the socialization component built into each joining session and continued in the multiple family groups. Socialization helps people to become more comfortable with each other and assists the clinician in taking an interest in each member of the family apart from the injury. It requires that the clinician be open and forthcoming about whom he or she is as a person sharing appropriate personal information with patients and families.

It is important for clinicians to receive supportive supervision beginning with the preparation for contacting families. For many clinicians, the techniques described above are somewhat new and require support. Usually, it is stressful to learn new ways of forming alliances, of conducting sessions and hearing about the difficult experiences and emotional pain the families have experienced. Supervision can be helpful in dealing with these stressors when it is conducted with the same positive, supportive, collegial tone the clinician uses with patients. Supervision is also necessary to assist inexperienced clinicians to adhere to the model.

III. EDUCATIONAL WORKSHOP

Introduction

After families have had at least three joining sessions, an all-day educational workshop is commonly held. The purpose of the workshop is to provide information about the nature of spinal cord injury and effective ways of managing its impact. The two clinicians who will be leading the multifamily group conduct the workshop. Whenever possible, other professional disciplines such as nursing, physiatry, psychology, physical, occupational and speech therapy, and case managers are invited to participate. It is the first time families meet the other members of the multiple family group and the family clinician with whom they did not yet join.

Clinicians may feel apprehensive at first about organizing and presenting factual information to a group. It is helpful to review the materials in advance of the workshop as practicing presentations with colleagues improves confidence. Anticipating the kinds of questions that families may ask and rehearsing responses also increases preparedness. Clinicians attempt to create a classroom atmosphere so that the structure of the first meeting of group members is as free of social tension as possible. Chairs for families and space for wheelchairs are set up around tables facing the front and the leaders use blackboards, charts, slides or other audiovisual aids. Family members each receive a packet containing printed information, guidelines, diagrams, reference information, and other aids that can be followed throughout the day. Refreshments and beverages are supplied including morning coffee, lunch, and afternoon snacks. 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. "This workshop is the first 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 stress and new independence 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 at our next meeting." 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 present the medical and physiologic information about spinal cord injury in the morning and early afternoon. There is a great deal of information to be covered in the workshop, so it is important to stick to the agenda of the day 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 also be continued, either after the workshop or during a meeting of the multifamily group. The staff remains with the families during lunch which is a time to continue to model socialization apart from the injury.

In the afternoon the agenda shifts to the emotional and coping management strategies related to spinal cord injury. 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 other families have described similar responses and that they are logical responses to the situation in general. Clinicians point out that they will be discussing methods of coping with the injury using the Family Guidelines, which are based on the specific effects of spinal cord injury on the patient and the families.

Next is a discussion of the Family Guidelines (See list below). Each person present 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.

Additionally, a list of “areas of significance” is discussed. This has been generated to assist the group in focusing on the most important areas of concern related to setbacks and rehabilitation. They are helpful to clinicians in focusing and guiding the go around discussion more succinctly. Copies of both the Family Guidelines and Areas of Significance are distributed at the workshop with the suggestion that they be posted on the refrigerator at home. The guidelines and areas of significance are:

FAMILY GUIDELINES

Below is a list of things everyone can do to help make things run more smoothly:

1. Go Slow.

Recovery takes time. Practice relaxing every day. Adequate rest is important.

2. Keep It Cool But Positive.

Develop a win/win attitude. Believe in yourself and trust your support system and peers belief in you.

3. Give Each Other Space.

Time out/alone is important for everyone.

4. Talk About It.

Talking things out with someone who cares makes it much easier to keep going.

5. Set Your Goals.

Set your goals so that they can be achieved in the time you have. Remember, don't try to be perfect or “back to normal”.

6. Work On Meeting Life On It's Terms.

Change is not easy. Don't judge yourself. Give yourself time and look for the opportunities for growth in each challenging situation.

7. Keep It Simple.

Say what you have to say clearly, calmly and positively.

8. Follow Doctor's Orders for Activity and Medication.

Tell your doctor if you are having problems or if something does not make sense to you.

9. Develop A Sense Of Humor.

Everyone has a sense of humor, but when we are under stress we sometimes forget to take advantage of one of our greatest and most healing powers. So share a funny story or joke. Get involved in recreation programs, play games, have fun just for the fun of it.

10. Re-Establish Family Routines.

Stay in touch or re-connect with family and friends who can be valuable resources.

11. Practice.

With time and practice, your new skills will become more natural, your confidence will increase, and you will begin to feel more like yourself again. Solve problems step-by-step.

12. No Street Drugs or Alcohol Abuse/Misuse.

It sounds easy, but it is not easy for most. Find alternative things to do.

13. Take One Day At A Time.

Lower expectations temporarily. Break it down to small, manageable segments; a few minutes, an hour, a day. Compare today with the day after your spinal cord injury not the day before.

AREAS of SIGNIFICANCE

Below is a list of areas to focus on when thinking about rehabilitation

- Physical safety in the home
- Medication compliance
- Medical complications
- Role changes
- Financial challenges
- Drugs and alcohol
- Life events: family celebrations, moving, deaths or other losses
- Outside agency events: changes in program, therapists
- Disagreement among family members
- Conflict with a family guideline
- Equipment issues/changes

OUTLINE OF THE EDUCATIONAL WORKSHOP DAY

- 9:00 - 9:15 Coffee and Informal Interaction
- 9:15 - 9:30 Formal Introductions and Explanation of the Format for the Day
- 9:30 - 10:30 A. Neuroanatomy basics
 B. ASIA Classification System
 C. Clinical Syndromes
 D. Benefits and Evidence of MFG Success
- 10:30 - 10:45 Break, snacks and Informal Discussion
- 1045 - 12:00 E. Medical Complications
 F. Treatment
 1. Therapy
 2. Medications
 3. Healthy Lifestyle
- 12:00 - 1:00 Lunch and Informal Discussion
- 1:00 - 3.00 The Family and Adjustment
 1. Grief: dealing with loss and change
 2. Adjustment
 3. Family Guidelines
 4. Multi-family Group Structure: What To Expect
- 3:30 - 4:00 Questions regarding Specific Problems
 Wrap up
 Informal interaction

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

After the joining sessions and the Educational Workshop, the Multifamily Group meets for the first time. The patient and his/her family have been prepared to meet with five to seven other families for 1-1/2 hour meetings every other week. 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 significant length of time, and it is important to begin to feel comfortable with one another. It is very helpful during this group meeting to think of it being like 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 clinicians act like hosts or hostesses guiding 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, or what plans people have for holidays or vacations. Serious topics may be discussed as well, as long as they have little 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 7:00 to 8:30 p.m. We will be working together on solving problems, to help to prevent setbacks and to design small steps towards making life 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 it is helpful if we begin by learning more about each other. What we will do during this meeting is go around the room and each of us will say something about ourselves. We will go one person at a time and everyone will have a turn. If we run out of time, we can finish at our next session. It is normal under these circumstances to want to talk about the injury and the problems it presents. However, we ask you to hold that until the next group meeting. Tonight, we would like to talk more about the rest of life. I would like to start by telling you about myself.

In telling something about her 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 is possible which will encourage others to follow by example.

As indicated previously, sharing personal information is an essential part of this model, which relies on 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 Amanda Sanders. I have lived in the area for 13 years and have worked at the rehabilitation unit for 10 years. I came here right after graduation from college. I am married and have two children. They are Aaron, who is three years old, and Brittany, who is seven. Brittany is in second grade at Franklin 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. Aaron 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 physical 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 going bike riding. 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 used to before the kids were born, but we do rent DVD's about once a week. We like to take the kids on short trips on the weekends especially camping and hiking. I spend two afternoons a week volunteering at Brittany and Aaron's school, which I really enjoy. 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 YMCA, so maybe that will help. The whole family is excited about Thanksgiving coming up. We always go to my parents' home in Seattle. I have two brothers and a sister. We all come home for the holidays. Everyone pitches in and helps with the cooking. I was raised in Seattle and went to college at the University of Washington. I enjoy going back to Seattle for visits and really love living in a smaller community like Spokane now. "

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 am interested in learning more about you." or "It's natural to want to talk about the injury and we will get to that in the next group. Today, I'd like us to get to know one another and other aspects of our lives."

In situations where a family member offers a minimal amount of information about him or herself, the clinician asks questions to help the person 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?), participate in sports, do crafts, belong to organizations, go to church, volunteer, garden, have pets.

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 will get 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 Multifamily Psychoeducational Group: “How Spinal Cord Injury Has Changed Our Lives”

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 multiple family group. The goal of the second meeting of the multifamily 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 fifteen 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 County Fair this year. Was anyone else able to attend? Or did anyone else see the huge pumpkin exhibit?”

It is important to socialize for fifteen 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.

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 someone 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, frustration, anger, sadness and mourning. It is also important to express some hope about new treatment approaches to 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 SCI patients and families. I have been a therapist at the rehabilitation institute for the past five-years. If applicable you might say something like the following:

From a more personal side, I have had the experience of a friend having a spinal cord injury. Christine and I were best friends in high school. I remember feeling

shocked when I heard she had been in a car accident. I felt sad to see her and didn't quite know what to say. I continued to visit Christine during her rehabilitation and have admired the tremendous strength she has in dealing with life from the perspective of a wheelchair. Christine's experience exposed me to rehabilitation and in particular occupational therapy. 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. "You have experienced this directly; how has the injury affected your life?" The first clinician facilitates the discussion halfway around the circle. The second clinician takes over until everyone has had a chance to speak.

Some individuals will find it difficult to talk about their experiences. To assist self disclosure, it can be helpful to ask questions about how things are different since the injury, how the injury affected their plans and what might they 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 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 somber. Often, the mood is one of sadness and mourning, with some anger and frustration expressed as well. Many patients and families will take this opportunity to express dissatisfaction with the health care system. When this happens the clinician's role is to validate the experiences that give rise to these feelings. It is important not to gloss over 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 may say:

"I can see that's a problem that's been bothering you a lot. We'll be working on solving specific problems starting in the next meeting, so I'd like you to keep that one in mind so we can return to it. For now though, could you share more with us 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 there is a crisis or it seems like a significant issue that should not wait until the next session.

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 acknowledge 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 about 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: “Introduction and Preparation For Group”

After the joining sessions, educational workshop and first two meetings of the multifamily group (“Getting to Know Each Other” and “How Spinal Cord Injury has Changed Our Lives”), all the 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 thirty minutes before each group is advisable. They review several questions:

1. In what phase of rehabilitation is each patient?
2. What issues and events have likely occurred since the last group?
3. What issue was used for problem solving during the last group, and what might be expected to have happened?
4. Which families have participated in a problem solving in the last several groups and which families have not?
5. From present knowledge, what may be some of the possible issues that would be best to focus on?
6. 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. Often, 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 or poster of the guidelines and areas of significance and an outline of the problem solving steps are also useful. Although most multifamily groups are facilitated in a circle format, there is a need for tables for patients who are in wheelchairs to place things on. One can adapt a circle format around a few tables to assist in this needed support. Clinicians sit across from each other during the meeting. Other recommendations include:

- Refreshments are offered.
- Group members are told where smoking is allowed.
- The clinicians make sure that the meeting will not be interrupted by telephone calls or people walking through the room, except for emergencies. Members are asked to turn their cell phones off.

- 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 fifteen minutes of social conversation. This underscores the collegial relationship among patients, 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 want 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 or family are deflected, ignored, or reframed. Concerns related to the injury are reframed as well. The clinicians divert problem discussion by saying something like "We really want to hear about that, and we will be able to discuss 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 uncomfortable. Also, one group member should not dominate socializing. Group members are encouraged to talk to each other directly without starting side conversations. 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 okay—is that correct?"

The clinicians are careful to spend fifteen 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 issues, concerns and problems related to the injury."

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 recurring problem or setback; or
- b) Issues having to do with the next step in rehabilitation. The clinicians need to obtain 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 thirty minutes. The brevity of the go-around can be a challenge to complete in just thirty minutes. Therefore, the clinicians need to be careful not to illicit more information than is needed to determine what the patient and family issues and potential problem solving possibilities might be.

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 and plan we developed last time?" The clinicians briefly review the plan and implementation steps and praise the family for their efforts. If the experimental solution and plan 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.

If the solution did not seem to help, the clinicians review the steps in greater detail, looking for things they might have overlooked, such as unexpected 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 need to explicitly take responsibility for any failure. A possible statement might be, "I'm sorry, I didn't realize that we were going too quickly", or "I did not take into account the employer's reaction when we were developing this solution." It is critically 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 treatment compliance, and behavioral issues. Usually the check-in begins with the patient; however 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 lists generated for each patient during the joining sessions. They also review the following list identified as "areas of significance" listening for any changes or problems with:

- Physical safety in the home
- Medication compliance
- Medical complications
- Role changes
- Financial challenges
- Drugs and alcohol
- Life events: family celebrations, moving, deaths or other losses
- Outside agency events: changes in program, therapists
- Disagreement among family members or conflict with a family guideline
- Equipment issues/changes

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, dissatisfaction, discouragement, anger or frustration. Then, after all the families have had a chance to report, the clinicians briefly discuss each family's situation in turn. 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; 4) continue with the course of rehabilitation if things are going well; or 5) decide that the situation be used for problem solving at this meeting. In order to remember these five options during the go-around, clinicians have developed an easy "mental list" to assist them to include: 1) teach in the moment; 2) offer a quick fix; 3) just wait and see; 4) keep on going on; or 5) problem solve.

If a patient is known to have difficulty with treatment compliance, 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, how have you been doing dealing with your pressure sores. Have you been able to get out of your chair and change positions regularly?"

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:

- a) Factors leading to a setback complications
- b) Issues having to do with the next step in rehabilitation.

The clinicians need to consider carefully any report of actual or potential management complications. As mentioned earlier, areas of particular significance are: 1) physical safety in the home; 2) medication compliance; 3) medical complications; 4) role changes; 5) financial challenges; 6) drugs and alcohol; 7) life events: family celebrations, moving, deaths or other losses; 8) outside agency events: changes in program, therapists; 9) disagreement among family members or conflict with a family guideline; and 10) equipment issues/changes.

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 worked at the next meeting
- b) In a crisis or if an issue needs immediate attention, offer to meet outside the group
- 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 rehabilitation. 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 spinal cord injury and their families which can make excellent problem solvings.

TABLE: 1.1 Examples of Common Problem Solving Issues	
Ways to structure for success	Keeping a job
How to use time in a meaningful way	Dealing with equipment issues
Managing stress	How to adapt one's house/apartment
Acquiring/using adaptive equipment	Maintaining oneself in independent living
How to be intimate in a relationship	Learning how to travel
Managing physical issues: urinary tract infections, skin, bowel, bladder care, infections	Resuming family roles (father, mother, wife)
How to manage weight and diet	Resolving conflicts with family members
How to deal with financial difficulties or issues	Issues with effects and side effects of prescribed medications
Coping with: depression, anger, frustration, loss, change	Ways to communicate effectively with peers, family members etc.
Coping with holiday stress	Finding and using community resources
Substance usage: positive and negative effects	Navigating a wheelchair in inaccessible areas
How to work successfully with a vocational program	Conflict with a Family Guideline
How to deal with stigma and discrimination	
How to re-enter the work force	

D. SOLVING A PROBLEM

After the socializing, the go-round, and the selection of a problem/issue, 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 Ian Falloon and colleagues in their work with persons with mental illness. [25] Approximately thirty-five minutes is 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 are reviewed at the second group meeting. The goal of formal problem solving in a multiple family group is to help families to use the information about spinal cord injury and the guidelines that follow from this information. This model also draws on the experience of the other patients and families who have had a variety of experiences, 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 and plan 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 problem solving process by using a white board in which the six steps are clearly defined. The clinician records the information on the whiteboard. The other clinician ensures group participation and suggests additional solutions. One clinician may record the information on a note pad or invite someone to assist. The recorder can be a clinician, family member or patient. The use of a white board has the advantage of being visible by all and the note pad can be used to make copies for the family involved in the problem solving or other families who may be interested in the information. The clinicians should keep a copy of the problem solving to refer to when reviewing the success of the solution and plan in the next session.

After a recorder is chosen, the clinicians carefully follow each step 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)
- Step 6. Review implementation at the next MFG meeting. (Clinicians)

Each step is important and will be covered here 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.

Step 1: Define the Problem

The overall goal of this step is to narrow the definition of the problem/issue 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 in terms of the relevant biological information and the guideline that will implement it. The clinicians question family members, gathering relevant details. The definition must be one to which every family member present can agree. It is very helpful to elicit each person's view on 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 rehabilitation recommendations, medication compliance, 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 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.

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

Step 2: List all possible solutions

The clinician asks the group members for suggestions of solutions to the problem. The object is to obtain 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 issue/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 unrealistic; 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 this step. 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 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 solution 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 it 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?" "How might you accomplish 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 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.)

In the course of facilitating the group, some clinicians have found it initially useful to utilize a form (see Appendix) that outlines the group format and identifies possible areas of concern by the patient. It can assist the clinicians in keeping on track from group to group as well as be helpful in the documentation process.

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 injury. 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 leave the group feeling positive, more likely to return to the next meeting and more likely to want to work together again on problems.

VII. Social, Educational and Vocational Reintegration

In the meetings, there is a shift from solving problems related to the management of complications and setbacks to those related to the next steps in rehabilitation. One of the common concerns is the architectural difficulties of the community at large and consequent mobility difficulties. Also, as the patient becomes more comfortable in the community, even momentary setbacks such as falling out of the wheelchair or the accidental loss of bladder or bowel control can cause major emotional crises. It is essential to develop a level of confidence with social integration within the community before it is feasible for the patient to resume some of their former interests i.e., how to return to work. At this time it is particularly important for patients and families to be reminded that progress is rarely linear but far more commonly slow and uneven. As in other stages of treatment, it is important to base plans and progress in rehabilitation for the patient on his/her unique circumstances and not on what others are accomplishing since no two recovery courses are identical. Reminding patients and families to use some of the family guidelines such as go slow, keep it cool, and meet life on its terms can again be helpful at this juncture.

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.

Vocational programs are explored as possible solutions to the problems identified during this stage of treatment. However, before patients are encouraged to pursue a vocational direction, the emotional and logistical aspects associated with spinal cord injury and rehabilitation is addressed. 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 multiple family group and help follow up leads that are generated in the group.

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

Group Validation

A benefit that families and patients gain from their participation in multifamily psychoeducation groups 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 multifamily 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 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 and 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.

New Members

If the multifamily group is going to be facilitated as an open ended group with patients and families invited in as they are completing hospitalization or rehabilitation, 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 maybe 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:

- 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/her the focus of attention, despite the temptation to focus on such issues as the new member’s medical issues, or family disagreements.

IX. General Points

Experience in facilitating multiple family groups 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 and welcomes 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 get full benefit of the multifamily group experience.

Meetings with Small Attendance

If at any one session the group is small, there will be time saved in the go-round. The extra time is spent on problem solving. In the first three or more months of the group it is a good idea to call all members before the meeting to remind them of the time and place. The clinicians mention absent members in the transition from go-around to problem solving, and share information that is appropriate, if the subject has not come up earlier. The clinicians follow up with absent members by calling them, telling them they were missed and asking whether they need help to get to the next group.

Violence and Suicidal Thinking

Threats of violence or suicide are dealt with immediately. The clinicians take charge and direct families regarding 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. It may be useful to 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 multiple family 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 keep things cool at home; how to keep things simple during the holidays; 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.

Generic Problem Solving

There are times when a problem or issue is shared by most or all of the families. In those instances the problem solving process can be shared by the entire group. This can be most useful in the first few months of the group as a means of developing group cohesion and experience with the model. It can serve to avoid focusing on any one family or patient when they do not seem prepared to manage the focus of attention. It can also generate interesting and a variety of useable solutions for families. Generally this approach is less effective than a single family problem solving because it does not allow for a specific plan to be implemented by a particular family.

Transitioning of Group Leaders

If a multifamily group continues for an unusually long period of time, a clinician may need to leave the group and be replaced by another. These departures can be difficult for the patients and the family members. Often the attachments that have occurred over the course of time are not as obvious because so much of the emphasis has been on the problem solving process. However, clinicians need to pay attention to the array of emotional responses that may be expressed in the group. As with any group leader transition, identifying a new clinician a number of weeks prior to the departure of the original clinician is most beneficial. When both the current and new clinician participate in the group for the last two or three sessions, group members are provided with an opportunity to adjust to the change. During those sessions the new clinician needs to "join" with the group, actively socializing with time provided within the structure for a mini "getting to know you" session with the patients and families. The current leader takes a less active role during the transition. By the last session the new clinician is fully in charge and co-facilitating with the other clinician while the departing clinician expresses his or her goodbyes, sentiments and confidence in the new leader. A small celebration honoring the departing clinician is common and should be encouraged. The goal is to maintain as much emotional stability as is possible rather than disruption to the group in which a rebuilding of the relationships will need to occur at a later time.

Problem Solving 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 i.e., 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 pros and cons section and be actively involved in developing and committing to trying the plan. The results can be surprising 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-around, 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 multifamily 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.

X. Summary

This manual has described a method for conducting psychoeducational multifamily groups with persons with spinal cord injury and their families and is a modification from the work of McFarlane and colleagues. It can serve as an effective model for engaging families and patients in support for each other, education related to spinal cord 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 multifamily 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 lead multifamily 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 spinal cord injury.

Bibliography

1. The National Spinal Cord Injury Statistical Center, University of Alabama at Birmingham, 2006 Annual Statistical Report, July 2006 NSCISC@uab.edu
2. Kreuter, M., et al., *Partner relationships, functioning, mood and global quality of life in persons with spinal cord injury and traumatic brain injury*. *Spinal Cord*, 1998; 36(4): 252-61.
3. McFarlane, W. R., Lukens, E., Link, B., Dushay, R., Deakins, S. A., Newmark, M., Dunne, E. J., Horen, B., & Toran, J. Multiple-family groups and psycho-education in the treatment of schizophrenia. *Archives of General Psychiatry*, 1995b; 52: 679-687.
4. McFarlane, W. R. *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*. 2002 New York, Guilford Press, 2002
5. McFarlane, W. R., Link, B., Dushay, R., Marchal, J., & Crilly, J. Psycho-educational multiple family groups: Four-year relapse outcome in schizophrenia. *Family Process*, 1995a; 34: 127-144.
6. Anderson, C. M., Reiss, D. J., Hogarty, G. E. (1986). *Schizophrenia and the family*. New York: Guilford Press.
7. Hogarty G., Anderson C., Reiss D. *Family psychoeducation, social skills training and maintenance chemotherapy in the aftercare treatment of schizophrenia*. *Archives of General Psychiatry*. 1986; 43: 633-642.
8. Goldstein, M. J., Rodnick, E. H., Evans, J.R., May, R.R.A., & Steinberg, M.R. *Drug and family therapy in the aftercare of acute schizophrenics*. *Archives of General Psychiatry*, 1978; 35: 1169-1177.
9. Falloon, I., Boyd, J., McGill, C., *Family Care of Schizophrenia*, New York, NY, Guilford Press, 1984.
10. Leff, J.P., Kuipers, L., Berkowitz, R., Eberlein-Vries, R., & Sturgeon, D. *A controlled trial of social intervention in the families of schizophrenic patients*. *British Journal of Psychiatry*, 1982; 141: 121-134.
11. Dyck, DG, Hendryx MS, Short RA, Voss, WD, McFarlane, WR. *Multi-family groups, Service Use Among Patients with schizophrenia in Psychoeducational Multiple-Family Group Treatment*. *Psychiatric Services*, 2003; 53: 749-756.
12. Brzuzy, S. and B.A. Speziale, *Persons with traumatic brain injuries and their families: living arrangements and well-being post injury*. *Soc Work Health Care*, 1997; 26(1): 77-88.
13. Anson, C.A., D.J. Stanwyck, and J.S. Krause, *Social support and health status in spinal cord injury*. *Paraplegia*, 1993; 31(10): 632-8.
14. Holicky, R. and S. Charlifue, *Aging with spinal cord injury: the impact of spousal support*. *Disabil Rehabil*, 1999; 21(5-6): 250-7.
15. Iida, H., et al., *Association of head trauma with cervical spine injury, spinal cord injury, or both*. *J Trauma*, 1999; 46(3): 450-2.
16. Davidoff, G., et al., *Closed head injury in acute traumatic spinal cord injury: incidence and risk factors*. *Arch Phys Med Rehabil*, 1988. 69(10): 869-72.

17. Craig, A., et al., *The effectiveness of group psychological intervention in enhancing perceptions of control following spinal cord injury*. Aust N Z J Psychiatry, 1998; 32(1): 112-8.
18. Craig, A., K. Hancock, and H. Dickson, *Improving the long-term adjustment of spinal cord injured persons*. Spinal Cord, 1999; 37(5): 345-50.
19. Craig, A.R., et al., *Immunizing against depression and anxiety after spinal cord injury*. Arch Phys Med Rehabil, 1998; 79(4): 375-7.
20. Craig, A.R., et al., *Long-term psychological outcomes in spinal cord injured persons: results of a controlled trial using cognitive behavior therapy*. Arch Phys Med Rehabil, 1997; 78(1): 33-8.
21. Uomoto, J.M. and J.A. Brockway, *Anger management training for brain injured patients and their family members*. Arch Phys Med Rehabil, 1992; 73(7): 674-9.
22. Dyck, DG, Short RA, Hendryx MS, Norell, D., Myers, M., Patterson, T., McDonell, MG, Voss, WD, McFarlane, WR. *Multi-family groups, schizophrenia, and the management of negative symptoms: Twelve-month outcomes*. Psychiatric Services, 2000; 51: 513-519.
23. *Rand D., Kizony R., Feintuch U., Katz N., Josman, N., Rizzo A., Weiss P. Comparison of Two VR Platforms for Rehabilitation: Presence: Teleoperators and Virtual Environments 2005, 14:2 147-160.*
24. Compton, R., Buelah, Dalaway, Burt, *Social Work Processes*, Brooks/Cole Publishing Co., 1998.
25. Falloon IRH, ed. *Handbook of behavioral family therapy*. New York: Guilford Press, 1988

APPENDIX

SOLVING PROBLEMS AND ACHIEVING GOALS

STEP 1: WHAT IS THE PROBLEM/GOAL

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

STEP 2: LIST ALL POSSIBLE SOLUTIONS

Brainstorm all ideas without judgment. Encourage everybody to come up with at least one possible solution. List the solutions without discussion.

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 (Who, What, When, Where)

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

¹ Problem-Solving Worksheet excerpted from Falloon, et al., 1988

Spinal Cord Injury Multi-Family Group Outline

Socialization: 5-15 minutes
Go-Around: 30-45 minutes

Member: _____

- _____ Skin Condition
- _____ Equipment Issues
- _____ Pain Management
- _____ Family Conflict
- _____ Mood/Emotions
- _____ Substance Abuse
- _____ Transportation
- _____ Finance/Job
- _____ Care Provider
- _____ Navigating Systems
- _____ Body Pressure Mapping

Comments: _____

Member_____

- _____ Skin Condition
- _____ Equipment Issues
- _____ Pain Management
- _____ Family Conflict
- _____ Mood Emotions
- _____ Substance Abuse
- _____ Transportation
- _____ Finance/Job
- _____ Care Provider
- _____ Navigating Systems
- _____ Body Pressure Mapping

Comments: _____

Go Around Reminders:

- Begin with the family who solved a problem in the previous session (if family not present, acknowledge their absence).
- Review implementation plan
- Praise their effort
- Thank other family members for their specific suggestions
- Discuss possible reasons if plan was unsuccessful
- Offer alternative suggestions
- Reinforce Family Guidelines through comments offered
- Offer to intervene with THE SYSTEM when appropriate
- Identify issues as a possible problem solving as we go

Problem Solving: 45 Minutes

Six steps to solve a problem:

1. Define the problem/goal (family/clinician)
2. List all possible solutions (all)
3. Discuss advantages first, then discuss. (all)
4. Choose solution (family)
5. Plan how to carry out (family/clinician)
6. Review implementation (clinician)

Notes: _____
