Family Discussion Groups for Patients with Chronic Pain: A Pilot Study

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This pilot study investigated the benefits of discussion groups for patients with chronic pain and their family members. Nineteen patients with chronic pain and 41 relatives participated in four consecutive groups. Most patients and family members found their participation clearly helpful for themselves and for the family. The group helped them to improve communication, support and mutual relationships, and to better cope with the pain. Reported beneficial factors were experiencing communality, having a place to discuss things with each other, gaining insights, and learning from fellow-sufferers and their own family. Post treatment, patients also felt less distressed by the pain, less depressed, less insufficient[1] and showed an increase in life-control[1] and social activities. Moreover, some aspects of the family climate improved, but only in the perception of the family members. The present study points to the value of a multifamily format in chronic pain therapy and suggests the appropriateness of further controlled investigation.

Families play an important role in the course of chronic pain problems (Bebbington & Delemos, 1998). Rolland (1998) views them as an important environment in which health-related beliefs and behaviours are learned, and their potential either for diminishing a pain problem, or exacerbating and/or nurturing it into chronicity, has been well documented in the last two decades (Kerns, 1995; Romano, Jensen & Turner, 2000; Schwartz, Slater & Birchler, 1996; Turk, Flor & Rudy, 1987). Families are often themselves burdened by the chronic pain problem of one of their number (Hunfeld et al., 2001). Chronic pain problems can, for example, reduce social activity (Hunfeld et al., 2002; Neuman & Briskila, 1997), and cause financial strains (Snelling, 1994), marital problems (Rowat & Knafl, 1985), and affective problems in the spouse (Schwartz, Slater & Birchler, 1991). These observations support the importance of involving the family in treating the patient with chronic pain (Flor, Turk & Rudy, 1987; Kerns & Payne, 1996; Schanberg et al., 1998). However, until now, most clinical programs appear to maintain a largely individual focus (Kerns, 1999), despite some evidence for the effectiveness of involving family members in the treatment of chronic pain (Keefe et al., 1999; Radojevic, Nicassio & Weisman, 1992; Saarijärvi et al., 1992). Where the family is involved in treatment, it tends to be limited to a subset of members, most often patient and spouse, or patient and parent (Kerns, 1999).

As a part of a program for patients with chronic pain participating in a residential chronic pain management program, we have conducted several Family Discussion Groups (FDGs) with patients

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and their family members. This is a form of multiple family therapy in which two or more families are invited to attend joint meetings to discuss how they can make use of the different experiences of each family in trying to tackle issues of mutual concern. The therapists leading such groups act as facilitators whose principal role is to help the families work together as a group to find solutions and new ways of coping. The group context is also often used to provide relevant psycho-educational information. Multifamily groups develop a strong collaborative relationship between group members and professionals, they help reduce the stigma that families may experience, and are often a powerful way of fostering a sense of hope (O'Shea & Phelps, 1985; Strelnick, 1977). Multifamily group therapy has already been used in different psychiatric and somatic patient populations and has been shown to benefit its participants (Asen, 2002; Baucom et al., 1998; Dare & Eisler, 2000; McFarlane, 2002; O'Shea & Phelps, 1985; Steinglass, 1998). In chronic pain problems, this form of family intervention is less well established. Langelier and Gallagher (1989) have assessed the impact of outpatient group treatment for patients with chronic pain and their spouses. They found that group treatment significantly reduced pain-related problems, especially anxiety, depression, and interpersonal sensitivity.

The main goals of our pilot study were to investigate whether multiple family group therapy would benefit patients with chronic pain and their relatives, and to examine how they experienced group participation. This study assessed the following research questions: (a) Does the family discussion group have a positive effect on the patient's pain and psychological wellbeing? (b) Does the family discussion group have a positive effect on the family functioning? (c) Is the multifamily group intervention perceived as helpful by its participants? (d) Which helpful factors occurred during the group intervention? We have, therefore, mainly focused on the subjective treatment experiences of the participants, and administered standardised tests pre- and post-treatment.

Methods

Background

At the Psychosomatic Rehabilitation Unit of the University of Leuven (Belgium) patients with chronic unexplained somatic complaints (mostly chronic musculoskeletal pain and fatigue) are treated on an inpatient basis using a biopsychosocial illness approach (Van Houdenhove et al., 1999).

Before the start of this research project, families had little involvement in the patient's treatment. The unit social worker would meet with an important relative of the patient, mostly the spouse or the parents, to gain information about the patient and his/her illness and to inform the relative about the unit's treatment program. In addition, an interactive educational session was held every month to inform nuclear or extended family members, and friends of the patients, about chronic pain and chronic fatigue problems, their treatments and the unit's therapeutic program.

This changed with the establishment of a collaboration between the unit and the Department of Family Therapy, when a family program was designed for the patients. It included a weekly psycho-educational session for all newly admitted patients giving information on the impact of illness on the family, and the impact of the family on the illness (Rolland, 1994), the possibility of therapy for individual families, and the start of a family discussion group. The study described in this paper includes the first four group cycles that were held on the unit.

Sample Selection

All patients were recruited from the above-described unit. The inclusion criteria for the study were: (1) a chronic pain disorder as defined by DSM-IV (American Psychiatric Association, 1994); (2) having at least one significant relationship with a family member. No other selection criteria were used. A group cycle started after four to six patients and their families had given written informed consent to participate in the study.

Subjects

In total, nineteen patients and 41 relatives participated during four consecutive group cycles. All patients were involved in, or had completed, the inpatient treatment program of the unit. The mean duration of patients' pain was 60 months (*SD*: 37.9, range: 12–144). Six patients had an additional diagnosis of chronic fatigue syndrome. Their mean age was 36.4 years (*SD*: 10.8, range: 19–55), and the mean age of the family members, 34.6 years (*SD*: 15.3, range: 9–69). Seventeen patients were female; of the relatives, 24 were male and 17 female. Sixteen patients were married or living with a partner. Two patients were still living with their parents, and one patient lived alone. Nine patients had no children,

TABLE 1
Participants in the Different Family Discussion Group Cycles

Group Cycle (*N* = 4)	Families (*N* = 19)	Composition of group	Mean age of patients	DSM-IV diagnosis of patients	Mean duration of pain (months)
1	4	4 female patients, 1 mother, 1 stepmother, 2 fathers, 1 brother, 3 stepsisters, 2 spouses, 2 therapists, 6 female and 1 male observer	26 (19–35)	3 pain disorders associated with both psychological and a general medical condition (307.89) (one additionally with Chronic Fatigue Syndrome [ICD-10: G93.3]) 1 pain disorder associated with psychological factors (307.80)	62 (12–120)
2	5	5 female patients, 5 spouses, 2 sons, 2 therapists, 3 female and 1 male observer	39 (28–52)	3 pain disorders associated with both psychological and a general medical condition (307.89) (one additionally with Chronic Fatigue Syndrome [ICD-10: G93.3]) 2 pain disorders associated with psychological factors (307.80) (one additionally with Chronic Fatigue Syndrome [ICD-10: G93.3])	46 (16–84)
3	6	4 female patients, 2 male patients, 6 spouses, 7 daughters, 3 sons, 2 therapists, 3 female and 1 male observer	42 (35–55)	4 Pain disorder associated with both psychological and a general medical condition (307.89) (one additionally with Chronic Fatigue Syndrome ICD-10: G93.3) 2 Pain disorder associated with psychological factors (307.80) (one additionally with Chronic Fatigue Syndrome [ICD-10: G93.3])	69 (30–120)
4	4	4 female patients, 3 mothers, 1 aunt, 3 spouses, 1 father, 2 therapists, 2 female observers	34 (24–48)	3 Pain disorders associated with both psychological and a general medical condition (307.89) 1 Pain disorder associated with psychological factors (307.80) and Chronic Fatigue Syndrome (ICD-10: G93.3)	63 (30–144)

five had one or two children, and five had three or more children.

Participants in each group cycle (Groups 1–4) are described in Table 1. Two families stopped attending the group early (after session two in Group 4 and after session three in Group 3 respectively). None of the families had individual family therapy sessions during a group cycle. Two family therapists/psychiatrists (a male and a female) led family discussion groups 1–3. The same male therapist and a female psychiatrist in training from the unit led the fourth group. The observation team in groups 1–4 consisted of respectively seven, four, four, and two mental health professionals from the unit and/or trainees in family therapy.

Organisation of the Family Discussion Groups

Every group cycle consisted of five sessions. The sessions were held once every fortnight in the evening. A session lasted about 90 minutes with a break after 60 minutes. Each session was videotaped. The same therapists and observers were involved throughout each group cycle.

The conceptual model informing the family discussion group was a systemic multiple family therapy group approach (Lemmens, Heireman & Sabbe, 2001; Lemmens & Van Houdenhove, 1998). Similar multi-family groups had already been conducted in a psychiatric day clinic of the same University Hospital (Lemmens et al., 2003a). Major treatment goals were to decrease the impact of the chronic pain problem on the family unit, to search for healthier 'family stories', to restore family functioning and communication, and to help the families adapt to the different stages of the illness and the family life cycle (Rolland, 1994).

After a brief introduction of all participants in the first session, the families were invited by the therapists to talk about their experiences with the chronic pain problem, its impact on the family members (e.g. spouses, children, or parents), and their coping mechanisms.

The content of the following sessions was mainly determined by the questions or experiences of patients and family members. Important topics were, for example, the effect of the illness on the children, couple or parent–child relationship, how to deal with the illness, or how to have a (family) life beyond the illness. During the group discussion, the therapists made sure that all participants, patients as well as

family members, could express their experiences, and pointed to important similarities and differences in the stories told by the group members, in the hope that new stories would be generated. They also tried to let the information 'reverberate' as much as possible in the group.

Homework tasks (e.g. family members were asked to bring an object that symbolised the healthy aspects of the patient) could be given at the end of the session. Information about the illness and treatment was given as part of the exchange of the group members' experiences, and not in a structured way, as in psycho-education (Steinglass, 1998). Patients and family members participated on average in respectively 4.4 (*SD*: 0.9, range: 2–5) and 3.4 (*SD*: 1.5, range: 1–5) sessions.

Measures

Patients were asked to fill in questionnaires pre- and post-treatment, including the *Symptom Checklist* (*SCL-90*) (Arrindell & Ettema, 1986; Derogatis, Lipman & Covi, 1973), the *Multidimensional Pain Inventory* (*MPI-DLV*) (Kerns, Turk & Rudy, 1985; Lousberg et al., 1999), and the *Family Climate Scale* (*GKS-II*) (Jansma & de Coole, 1996; Moos & Moos, 1986). The latter questionnaire was also given to the family members. Furthermore, both groups were asked to fill in our own *Group Evaluation Questionnaire* after the ending of the family discussion group.

The *SCL-90* is a widely used and validated measure of psychological symptom severity (Arrindell & Ettema, 1986; Derogatis, Lipman, & Covi, 1973). The primary symptom constructs used in this study were agoraphobia, anxiety, depression, somatisation, insufficiency,[1] interpersonal sensitivity, hostility, sleeping problems, and psycho-neuroticism. The *SCL-90* shows good reliability and validity (Arrindell & Ettema, 1986). It was used to rate the psychological symptoms of the patients for this study.

The MPI-DLV was used to evaluate the patient's pain, its interference with the daily activities of the patient and the responses of the spouse to the pain. The MPI-DLV is the Dutch version of the Multidimensional Pain Inventory (Kerns, Turk, & Rudy, 1985; Lousberg et al., 1999), which measures several aspects of the subjective experience of chronic pain. It is a 61-item inventory, divided into three parts, containing 11 subscales. The first part evaluates five dimensions of the pain experience: pain severity, support from significant others, perceived interference of pain in various areas of patients' functioning, self-control, and negative mood. Part 2 examines the responses of the spouse to the patient's expression of pain: perceived frequency of punishing, solicitous, and distracting responses. The third part assesses the patients' report of their participation in daily activities: household chores, outdoor work, social, and general activities. The MPI-DLV has been shown to have good reliability and validity (Lousberg et al., 1999).

The patients' and family members' perception of specific characteristics within the family environment were assessed using the GKS-II. The GKS-II is based on the Family Environment Scale (FES) (Jansma & de Coole, 1996; Moos & Moos, 1986). It is a 77-item scale, which measures how the social climate of the environment is experienced, in terms of cohesion (the degree to which members are committed to one another); expressiveness (the degree to which members express their feelings directly); conflict (the degree to which members express anger and aggression); organisation (the degree of importance attached to organisation and structure in planning activities and assigning responsibility); control (the degree to which explicit rules and procedures are used to organise the family's life); norms (the degree to which ethical and religious issues and values are emphasised within the family); and social orientation (the degree to which members participate in social and recreational activities). Normative data are available, and previous research supports the scale as both internally consistent and reliable (Jansma & de Coole, 1996).

Finally, our own *Group Evaluation Questionnaire* contains two open-ended questions about the participants' experiences of the family discussion group: (a) '*Has the family discussion group been particularly helpful or important for yourself?*' (b) '*Has the family discussion group been particularly helpful or important for your family?*' Further, the responders were asked to describe briefly *what* was helpful or important and to indicate on a three-point scale ('*little–clearly–extremely*') *how* helpful or important the group was. The response rate of the post treatment measurements for the patients was about 82%, and for the family members about 71%. No post measurements were obtained from three families, including the two families who left the group.

Data Analysis

The data were included in the statistical analysis only when pre- and post-treatment measurements were available: the drop-outs were left out of the analysis. All questionnaires used in the study (SCL-90, GKS-

II, and MPI-DLV) and the scores comply with the normal distribution assumptions required for the use of parametric statistical testing. Thus, patients' experiences of the pain and psychological symptoms were evaluated pre- and post-treatment by paired t tests. The family climates of the patients and the family members (including 27 family members of 15 different families) were also analysed by paired t tests. Additionally, effect sizes were calculated as a measure of difference (with more than 0.1 indicating a small difference, more than .25 a medium difference, and more than 0.40 a large difference) and power analyses (2-sided) performed. Finally, as a verification of the findings of the paired t-test analysis, permutation tests, which are better suited for the analysis of data from a small sample size, were performed and an exact p was calculated on this basis. The responses to the Group Evaluation Questionnaire were described for the patients and the family members.

Results

Pre- and Post-Measurements

While there was no difference in the level of pain experienced by the patients at the conclusion of the group cycle, patients showed a significant increase in life-control ($t = -2.779$, $p < .05$; exact $p < .05$) and social activities ($t = -2.211$, $p < .05$; exact $p < .05$), and a significant decrease in affective distress ($t = 2.167$, $p < .05$; exact $p < .05$) on the *MPI-DLV*. Further, they felt significantly less depressed ($t = 3.304$, $p < .005$; exact $p < .005$), and less insufficient[1] ($t = 2.314$, $p < .05$; exact $p < .05$) on the *SCL-90* (see Table 2).

On the GKS-II, family members showed a positive change for measures of organisation ($t = -2.282$, $p < .05$; exact $p < .05$) and control ($t = -2.146$, $p < .05$; exact $p < .05$) within the family, as well as for ethical and religious issues and values ('norms') ($t = -2.170$, $p < .05$; exact $p = 0.058$)[2] (Table 2).

Evaluation of Treatment by Patients and Family

Most patients and family members found their group participation helpful and important for themselves as well as for the family (Table 3). The patients experienced the treatment as slightly more helpful (for themselves: 87.5% and for the family: 81.2%) than did the family members (72.4% and 75.9% respectively). But, these differences were quite small.

The comments on the Group Evaluation Questionnaire offered a range of interesting data about what the patients and family members have viewed as helpful in a family discussion group format (see Appendix I), as summarised below.

(a) Helpful comments reported by both the patients and the family members: The family discussion group was perceived as a place where the patients and family members could openly discuss things ('Discussing openly with other persons was a relief for me', 'the openness for the discussion of personal or couple problems'), where they experienced universality ('I've recognised myself in others', 'We're not the only ones with these problems') and learnt from their experiences ('hearing how others try to cope with the pain problem', 'I learned a lot from the other families how they cope with it'). The group discussion helped them to gain new insights and broaden their viewpoints during and after the sessions ('We gained more insight in the pain problem', 'The different opinions in the group helped me to gain better insights in searching different ways to support my partner in difficult times') and to better cope with the pain problem ('I'm accepting it slightly better', 'We got more grip on the problem and can better deal with it together').

As a result of the group, involvement and support within the family increased ('Every [member] of my family wanted to participate', 'After each session, I feel more involved and less powerless'), together with an improvement of family communication 'Because of the group things are more discussible with my husband', 'Our children have started to talk about problems at home') and the relationships ('a positive change in the relationship with my mother', 'The relationship between mother and daughter has improved').

(b) Additional helpful comments reported either by the patients or the family members. The discussion group helped the patients to experience hope ('This gave me courage').[1] They also valued the fact that in the family discussion groups, their family members got the opportunity to express their thoughts and feelings ('For my parents that they could get certain things off their mind') and to get support ('having a place where my parents could get help for their questions and problems'). Finally, the family members also appreciated the understanding within the group ('I felt understood straight away'), that they could help others ('being a support for other families'), and that they were allowed to participate in the treatment as a family ('I found it very important that we got involved as a family').

Discussion

In this pilot study, we have investigated the benefits of family discussion groups for patients with chronic

TABLE 2

Pain Experiences, Psychological Symptoms, and Family Climates of Patients and Their Family Members Pre- and Post-Family Discussion Group

	N	Pre-Group Mean (*SD*)	Post-Group Mean (*SD*)	*T*	*P*	Effect size	Power 2-s	Exact *p*
Patients								
MPI-DLV								
Pain severity	15	4.27 (1.12)	4.07 (1.0)	0.751	0.465	0.19	0.11	0.551
Interference	15	4.35 (0.84)	4.21 (1.28)	0.508	0.619	0.13	0.08	0.669
Life control [1]	15	2.82 (1.53)	3.78 (1.04)	−2.779	0.015*	0.72	0.74	0.016*
Affective distress	15	3.57 (1.36)	2.75 (1.35)	2.167	0.048*	0.56	0.52	0.044*
Support	15	4.78 (1.28)	4.93 (1.59)	−0.831	0.420	0.22	0.12	0.484
Punishing responses	15	1.53 (1.60)	1.46 (1.26)	0.244	0.811	0.06	0.06	0.815
Solicitous responses	15	3.30 (1.26)	3.31 (1.43)	−0.044	0.965	0.01	0.05	0.999
Distracting responses	15	3.69 (1.17)	3.58 (1.58)	0.301	0.767	0.08	0.06	0.803
Household chores	15	3.59 (1.46)	3.48 (1.26)	0.260	0.798	0.07	0.06	0.819
Outdoor work	15	1.36 (1.32)	1.02 (1.24)	0.859	0.405	0.22	0.12	0.437
Social activities	15	1.94 (1.14)	2.55 (1.23)	−2.211	0.044*	0.57	0.54	0.023*
General activity	15	2.29 (1.06)	2.35 (0.95)	−0.207	0.838	0.06	0.06	0.842
SCL-90								
Anxiety	16	26.94 (9.57)	25.44 (9.00)	0.811	0.430	0.2	0.11	0.455
Agoraphobia	16	14.38 (6.33)	14.31(7.44)	0.053	0.958	0.01	0.05	1.000
Depression	16	49.19 (16.25)	41.06 (13.50)	3.304	0.005**	0.83	0.85	0.005**
Somatic complaints	16	35.75 (10.44)	34.81 (10.44)	0.725	0.479	0.18	0.1	0.505
Insufficiency[1]	16	30.75 (5.67)	27.63 (7.08)	2.314	0.035*	0.58	0.55	0.041*
Sensitivity	16	42.50 (16.30)	38.63 (14.64)	1.445	0.169	0.36	0.26	0.176
Hostility	16	10.38 (3.56)	9.38 (3.18)	1.391	0.184	0.35	0.24	0.221
Sleep problems	16	8.56 (3.79)	9.06 (4.36)	−0.460	0.652	0.11	0.07	0.692
Psychoneuroticism	16	238.88 (64.17)	218.88 (59.72)	1.968	0.067	0.49	0.42	0.069
GKS-II		(*N* = 14)						
Cohesion	14	9.00 (1.47)	9.43 (1.09)	−1.147	0.272	0.31	0.19	0.359
Expressiveness	14	8.07 (2.30)	7.93 (2.67)	0.342	0.737	0.09	0.06	0.876
Conflict	14	2.50 (1.99)	2.79 (1.97)	−1.075	0.301	0.29	0.17	0.474
Organisation	14	8.43 (1.87)	8.36 (2.44)	0.168	0.869	0.04	0.05	1.000
Control	14	7.57 (1.99)	7.21 (2.12)	0.862	0.404	0.23	0.13	0.499
Norms	14	7.07 (2.20)	7.71 (2.70)	−1.800	0.095	0.48	0.38	0.140
Social orientation	14	6.14 (2.41)	6.21 (2.81)	−0.111	0.913	0.03	0.05	1.000
Family Members								
GKS-II								
Cohesion	27	9.00 (1.41)	9.04 (1.19)	−0.15	0.882	0.03	0.05	1.000
Expressiveness	27	7.41 (3.00)	7.96 (2.19)	−1.278	0.213	0.25	0.24	0.252
Conflict	27	3.26 (2.44)	2.96 (2.19)	0.764	0.452	0.15	0.12	0.512
Organisation	27	8.26 (2.16)	9.22 (1.72)	−2.565	0.016*	0.49	0.69	0.021*
Control	27	7.81 (1.94)	8.63 (1.84)	−2.25	0.033*	0.43	0.58	0.042*
Norms	27	8.78 (1.72)	9.26 (1.61)	−2.164	0.040*	0.41	0.54	0.058
Social orientation	27	6.04 (2.50)	6.33 (2.62)	−0.915	0.369	0.18	0.15	0.431

Note: * = $p < .05$, ** = $p < .005$, *SD* = standard deviation, *N* = number of patients or family members, *p* = significance based on paired *t* test, Exact *p* = significance based on permutation test, Effect size (>.10 = small, >.25 = medium, >.40 = large), Power 2-s = power 2-sided

pain and their family members. Furthermore, we have examined which specific experiences in the group were perceived as helpful.

Consistent with Langelier and Gallagher's findings (1989) about marital group therapy, we found post group that the patients with chronic pain felt less distressed, less depressed, less insufficient,[1] and showed an increase in life-control[1] and social activities, even though there were no differences in the level of pain they were experiencing. Unlike the patients, the relatives perceived a change in family climate, with an increase of organisation, control and norms[1] in the family. Most patients and family members experienced their participation in the group as helpful, in the range of ways we have just summarised.

As we try to interpret the above results, different possibilities — probably in combination — arise. One could hypothesise that experiencing common

TABLE 3
Results of Group Evaluation Questionnaire

	Patients (N = 16)	Family Members (N = 29)
1. Helpful for yourself		
a. No	0 (0%)	6 (20.7%)
b. Yes	14 (87.5%)	21(72.4%)
Little	1 (6.25%)	0 (0%)
Clearly	10 (62.5%)	18 (62.1%)
Extremely	3 (18.7%)	3 (10.3%)
c. No reponse	2 (12.5%)	2 (6.9%)
2. Helpful for your family		
a. No	1(6.2%)	5 (17.2)
b. Yes	13 (81.2%)	22 (75.9%)
Little	0 (0%)	2 (6.9%)
Clearly	8 (50%)	16 (55.2%)
Extremely	5 (31.25%)	4 (13.8%)
c. No response	2 (12.5%)	2 (6.9%)

ground in the group helped all participants realise that they were not alone in their suffering, and that their reactions, feelings and struggles were normal. Hence, they felt less isolated and more supported. Indeed, despite several years of medical or psychological treatment, for some patients and relatives the family discussion group was the first opportunity to meet with other families with chronic pain problems.

Further, one could argue that the comparison of their own 'pain story' with others' helped the patients and their families to put the pain in a different perspective, and enhanced their own coping mechanisms. Families often pointed in these groups to the greater value of the learning from others compared to the advice of the therapists.

It is also possible that having a place for individual patients and their families to discuss jointly the pain problem and its consequences contributed to better communication and more support within the families. The family discussion group functioned in some ways as a sheltered workshop for developing social and communication skills, where participants could experiment with (new) relationships (McFarlane, 1990; McFarlane et al., 1995).

Another explanation could be that the prominent focus in the group on the creation of 'healthier', 'non-pain-related' stories helped the patients and the family members to feel more confident and secure in dealing with the pain. Therefore, they felt more in control and less burdened, and the pain took a less dominant place in their lives. The focus on functional rather than dysfunctional family interactions may have helped the patients as well as the family members to interact in a more supportive way. This therapeutic focus on solutions and moving ahead could partially explain the different outcome in our study compared to the poorer clinical outcome of patients with chronic fatigue syndrome participating in patients' support (Prins et al., 2001) or self-help groups (Bentall et al., 2002; Darbishire, Ridsdale, & Seed, 2003; Sharpe et al., 1992), in which the focus on illness and the medical model might reinforce symptoms. It is highly significant that in the latter groups, family members were not involved, whereas in the family discussion group all patients were accompanied by family members, and each family participated alongside other families.

“It is possible that having a place for individual patients and their families to discuss jointly the pain problem and its consequences contributed to better communication and more support within the family.”

Several post-treatment changes were found in the viewpoint of the family members. During the group, they often started to show a more positive attitude towards the patients and were for example more likely to take into account the patient's physical limitations. This might have resulted in attaching more importance to planning and organising their family life and explicating family rules. By acting in this way, the patients might have become less worried about responsibilities, control, or planning. On the other hand, for the change in measures of norms, one could suppose that the family discussion group, as a 'reference group' with specific rules and values, could act as a kind of 'ethical committee', which questioned and advised the families. Further research will be necessary to clarify why the changes in the family climate mainly occurred in the perception of the family members, and far less in the perception of the patients.

Overall, most participants experienced their participation as helpful for themselves and for their

family. Interestingly, both patients and family members found the family discussion group almost equally helpful for themselves and for the family. Moreover, both mentioned broadly similar helpful factors, such as experiencing communality with others, learning from others, discussing openly, and gaining new insights. These factors, which have already been well documented in multifamily group therapy with other patient groups (Asen, 2002; Lemmens et al., 2003a; McFarlane, 2002; O'Shea & Phelps, 1985; Steinglass, 1998), seemed to play an important role in family discussion groups with chronic pain patients as well. This is further supported by the fact that similar helpful factors were found post session (Lemmens et al., 2003b) and post-treatment. Although the relationship of these helpful factors with a positive treatment outcome needs further exploration, they help us understand how therapy works in these groups. At the moment, emphasising them in multifamily groups with patients with chronic pain seems a feasible therapeutic strategy.

Some potential limitations of this study need to be addressed. First, no control condition was included, to rule out the effects of other therapeutic elements of the inpatient treatment. For ethical and clinical reasons it was difficult to refuse families the chance to participate in the group after the implementation of the family program on the unit. While this raises potential problems in defining what the specific effects of the family discussion group were, the investigation of the subjective treatment experiences revealed, nevertheless, specific information about the family discussion group format itself. One could also argue that this multifamily group intervention, which mainly addressed the context of the pain problem, was designed from the start as an adjunct to the inpatient treatment rather than a treatment for chronic pain on its own.

Second, most measurements relied on self-report and did not investigate possible confounding factors. This makes it difficult to draw any conclusions about the limitations of the family discussion group. Nor can we speculate about any long-term effects of the group because at this stage we have no follow-up information.

Third, no specific treatment protocol was designed for each session, except for overall guidelines regarding the systemic family discussion group concept. While this might have influenced the treatment consistency between the different group cycles, one could argue that the therapist, as a developer of the systemic format and an experienced multifamily group therapist for several years, was sufficiently familiar with these guidelines. Also, in favour of this interpretation was the consistency of our findings in each successive group.

Finally, the size of the sample was clearly a further limitation and any conclusions drawn have to be treated with a degree of caution and preclude any generalisations.

Conclusions

The present study points to the importance and the additional value of a multi-family format in the treatment programs of patients with chronic pain. Having a place to discuss the pain problem with other families is not only perceived as very important and helpful, but it also offers families additional support, symptomatic relief, and different strategies for better coping with the pain problem. The families in our study mostly benefited from experiencing universality or community, gaining new insights, and learning from other families. Although this pilot study has important limitations, the results warrant further investigation using a control group and a larger sample.

Endnotes

1. Concerning the structured questionnaires: the Dutch questionnaires sometimes use a different name/word for a category compared to the original English version.
   - SCL-90: They use 'insufficiency' instead of 'obsessive-compulsive'. I have added 'of behaviour and thought' to better explain this category.
   - GKS: The Dutch version uses 'norms' instead of 'moral-religious orientation'. I have changed it to 'moral orientation' because the term 'norms' probably has a different meaning in English/Australia.
   - MPI-DLV: in the Dutch as well as in the English version 'life control' is used.
   - 'This gave me courage'. In Dutch, 'courage' has a range of meanings, from bravery to hope. In the paper it is used not in the sense of 'bravery' or 'nerve', but more in the meaning of 'feeling confident about the future', 'having faith in the future or having hope'. This is something one 'has', rather than something one can 'show' or display. I searched for another word to replace 'courage', but it can only be replaced by 'hope' without changing its meaning.
2. Given the relatively large number of *t* tests some would argue that a more conservative level of 'significance' should be used. As this is an exploratory study we have not done so but acknowledge that results need to be interpreted with caution, particularly where the findings are at the 5% level of statistical significance.

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APPENDIX I

All comments of the patients and the family members regarding the helpfulness of the family discussion group for self and family after five sessions

1. Helpful for Oneself

A. Patients: 'Afterwards a lot of things surfaced in everybody, because of these sessions', 'It was important to hear each other', 'It was important for my parents, which in turn had indirect positive effect on me', 'Learning to know the viewpoints of the other families', 'Being heard by others', 'Although my physical complaints have remained the same, my attitude towards them has changed', 'I'm becoming more and more conscious that I have to work for a solution, and that it's possible', 'It was a well guided group where you could be yourself', 'I've recognised myself in others', 'Discussing openly with other persons was quite a relief for me', 'We've gained more insight into the pain problem', 'It helped me to see that I'm doing all right in coping with my problem and in the way I'm in the relationship with my partner', 'Because I often have thought that I alone had problems, it was helpful to hear the problems of the other families and the way they tried to deal with them, this gave me courage', 'hearing how others try to cope with the pain problem', 'exchanging of experiences', 'to hear how other partners treat their ill partner', 'I'm accepting it slightly better', 'that I could hear persons with similar problems', 'the calm way in which

the therapist discussed things with us', 'that the relationship between myself and my parents and between them have got more clearly and that this could be expressed'

B. Family members: 'There are also other persons with similar problems', 'I'm starting to better understand things', 'We're not the only ones with so many problems', 'I felt straight away understood and people really listened to each other', 'We have got some useful hints', 'the support within the family', 'We have met some like-minded families', 'I've heard how other persons deal with an ill person in certain circumstances, so that I can apply it when it is necessary, now or later', 'that other families too are concerned about the evolution of the ill person', 'that it's difficult to change your rigid ideas about things, but if the circumstances demand a change of ideas and it's not happening, it certainly will lead to problems and difficulties', 'Every session caused a further exploration of the different discussed topics', 'Opportunities can better be discussed and the limitations are better accepted', 'After each session, I feel more involved and less powerless', 'the openness for the discussion of personal or couple problems', 'You learn to broaden your viewpoint on your problems; the "almost identical" pain problem has so many different aspects', 'The confrontation with the other "similar" couples led to an enriching exchange of experiences under professional guidance', 'It's quite stimulating that you learn to put things in perspective, that you start to think, and that you question yourself and your relationship', 'As a child, I was happy that I was allowed to be here and to say something', 'Everybody could express his ideas', 'I learned a lot from the other families how they cope with it', 'I've learned a lot', 'You can learn a lot about the illness and how to deal with it', 'The different opinions in the group helped me to gain better insights in searching for different ways to support my partner in difficult times', 'It helps to discover new feelings'

2. Helpful for the family

A. Patients: 'That every one of my family wanted to participate', 'For my parents that they could get certain things off their mind', 'For my brother and sisters that they learnt to talk in group', 'Being able to listen in the group, and at the same time discussing things afterwards was a relief for everybody and for everything that was stuck in our family', 'The family has found a response', 'Having a place where my parents could get help for their questions and problems', 'It was important for us as a couple', 'Because of the FDG things are more discussible with my husband', 'My partner could express his feelings regarding our way of dealing with the pain problem', 'My partner could identify himself with and got understanding from the couples', 'You learn in a different way to stand still in life', 'You learn to start thinking about things', 'It confirmed that we are doing all right, and that we got closer in our relationship', 'That my family was asked to participate, and that they could express their feelings and thoughts and could ask the other families how they were dealing with the problems and the support we have got from them', 'the involvement of the family', 'learnt a lot from the others', 'that family members with similar problems could talk to each other', 'definitely for my husband who could ask some questions', 'a positive change in the relationship with my mother and be more clearly in the relationship with my father without feeling afraid'

B. Family members: 'There are also other persons with similar problems', 'They (= parents) know better where they can get help for certain problems', 'They can talk with somebody who has almost similar problems', 'Everybody learnt something', 'Everybody knows now that we are not the only ones with problems', 'I believe that we now better accept the illness', 'Our children start to talk about the problems at home', 'The children realise that there's something wrong with their sister', 'Being a support for other families', 'With further discussing things after the session, we got more grip on the problem and we can better deal with it together' , 'You should not always see a person as only being ill, putting the illness in perspective was very helpful for our family', 'The participation of our children, they now are aware that life is not always easy,

but that you can get help if you allow it', 'My partner has changed and this had a positive effect on our family', 'My father tries to accept his illness', 'We hope that it will turn out all right in our family', 'I found it very important that we got involved as a family', 'Now, you know a lot more how to understand and support an ill person', 'I've gained a better insight that every family has its own difficulties and that an improvement is not expected to be very quick and large', 'The relationship between mother and daughter has improved', 'We're doing our best', 'The discussion with others'.

Ron Perry Receives OAM

Some of Ron's colleagues at the Institute of Counselling in Sydney, which Ron has directed for nearly 35 years, thought that his long community service should be recognised. They enlisted two of the people who have collaborated with Ron at the Institute over much of that time, Bryan Gray and Sr. Margaret McGovern. Margaret, the recipient of an AO award some years ago, undertook to write the recommendation letter, and seek out the other supporting people. Quite poignantly, it was the last document she signed before returning to hospital shortly before her death in October 2003. Margaret facilitated, with Ron, a number of the meetings that were preparatory to the formation of PACFA, so she made sure that her letter referred to Ron's work with PACFA.

In an interview with the local paper for the Australia Day awards, Ron said:

> 'These awards come to an individual, but they belong more properly to the group of colleagues and collaborators who make a contribution possible. I am very pleased that in this case, it is also a recognition of the importance of counselling in the community.'

Ron has been an assessor for *ANZJFT* since 1985, and his 1993 article 'Empathy—Still at the Heart of Therapy' (*ANZJFT*, 14, 2: 63–74) continues to find new audiences. We are pleased to congratulate Ron on receiving this award.

Subscription Reminder

'… youth worker […] John Embling, who runs the Families in Distress Foundation in Footscray, with his partner Heather Pilcher … a mix of holding methods that have saved lives, literally, and restored many others … his success was the result of such vocational self-sacrifice that it cannot reasonably be expected of all of us' (Barry Hill, p. 15, of 'The Mood we are in: Circa Australia Day 2004, Overland, 174: 10–21).'

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