Family or group therapy for cancer patients?
An exploration of different ways of working and the inherent challenges therein

Nicholas P. Sarantakis

Family and couple vs group-based psychological interventions could be portrayed as two different territories on opposite sides of the same planet: the first one would look like a forest during a foggy afternoon, where a cluster (group) of trees (individuals) are intertwined in complex ways, both visible and invisible; on the other hand, groups would probably look like rather independent figures of trees standing on their own during a still dark dawn. These ‘trees’ would probably observe each other, while their mutual impact would be more vague. Nevertheless, both territories belong to the same ‘planet’ of systemic work, which is embedded in the fundamental idea that the whole is greater than the sum of its parts.

Aristotle, who first introduced this idea, conceptualised both nature and human communities as entities (systems) that function and change as a consequence of their intrinsic network of dynamics, rather than due to the isolated effects of their comprising parts (Johnson, 2005). Within the psychology domain, Gestalt therapists argued first that the whole has much more power to determine its parts than the opposite (Perls, Hefferline& Goodman, 1976). From that perspective, all neurotic presentations are seen as expressions of the frustrations that humans experience when a satisfactory balance between the person and the world around them cannot be achieved and maintained (Perls, 1973). That means that psychological difficulties are much less understood as a personal deficit of the individual as the medical model would normally hypothesise. Instead, psychological difficulties are seen predominantly as a failure of the system to synthesise the needs of its members and the needs of the system as a whole in a way that is experienced as satisfactory by all parts.

Although a systemic understanding is critical for these modalities of therapy, family and group therapies do vary widely as they are often combined with different theoretical
paradigms. For instance, O’Leary (1999) advocates a systemically-informed, person-centred approach aiming towards an open, congruent communication that facilitates self-actualisation, while Bion (1989) highlights how the understanding of the systemic tensions can reveal the members’ unconscious modes of relating to others in general.

An Example

A simple example of a systemic approach vs an individualistic approach would be the following: a married couple decides to spend their vacations separately, as they both feel very strongly about doing totally different things during that time. Should the marital system not exist, they would probably both feel happy with their choices. Nonetheless, within the marital relationship, there are also expectations that correspond to the marital system’s needs. Therefore, the couple needs to find a way to combine their individual needs with those deriving from expectations of a shared life. In Perls’ terms (Perls, 1973), the ‘problem’ derives from the imbalance between the couples’ individual needs and the needs of their common system, their marriage.

Such issues resonate with the common phenomenon in couples and families of the ‘identified patient’, where the family or one part of the couple identifies the behaviour of a particular member as the sole ‘problem’ (Walrond-Skinner, 1977). Thus the underlying assumption of the family myth (Byng-Hall, 1973), is that should the identified patient chose to behave ‘normally’ there would be no interpersonal problems in the family whatsoever.

Nevertheless, there are cases where individual anti-social or extreme behaviours can arguably initiate severe problems in the family or couple and this cannot be overlooked by the therapist. Examples of such behaviours, which probably set the limitations of systemic thinking, are highlighted by various authors. For instance, Carter (1992) emphasises that people exerting domestic physical abuse should be held accountable for their actions, regardless of the pressures that their family may impose on them, while Efran, Greene & Gordon (1998) stress that, in the light of the recent discoveries on the biological predisposition of schizophrenia, attributing such phenomena unilaterally to the family’s dysfunctions cannot be convincing.

The Therapeutic Alliance and the Relationships within the ‘System’

Such systemic dysfunctions present significant challenges and opportunities for therapists. They will often need to invite clients to consider their issues from a systemic perspective, while at the same time they will have to validate their individual views in order to nurture the therapeutic alliance with all involved parts. This is a double task of paramount importance for practitioners since it could be the ‘key bridge’ to facilitating clients to build their own internal alliances within their families or with partners towards common goals.

From the group therapy perspective, Schnur and Montgomery (2010) reviewed an extensive body of research and concluded that therapist-client rapport and alliance, as well as group cohesion (the therapeutic alliance at group level) were the two therapeutic factors predominantly associated with positive therapeutic outcomes. Other prominent group therapy
models conceptualise such factors in terms of the quality of the relationships within the group, rather than as an alliance, since an alliance presupposes a focus on particular goals. A highly influential group psychotherapy approach identifies cohesiveness, universality, altruism, development of socialising techniques, and corrective recapitulation of the primary family experience as the most prominent relational therapeutic factors (Yalom & Leszcz, 2005).

Couples/Family and Group Therapy – Similarities and Differences

Families and couples can be seen as entities of distinct but intertwined units with established, visible relationships. These relationships are often quite complex and manifest in various dimensions such as: how the family shares the same space and functions through living together; the different levels of responsibility and power between parents and their children; how sub-groups or implicit alliances impact on the whole family. When a cloud or shadow brings them to therapy, they can explore less visible aspects of their relationships.

On the other hand, psychotherapy groups are also whole entities where similar principles and systemic dynamics are at play but their members are, at least initially, much more distant and independent of each other. The identity of the whole is formed gradually as the members interact within the group space and as the therapeutic process of each member eventually and increasingly entwines with that of the others. Thus, the identity of the group normally takes some time to develop and so do the relationships between the members. For such groups the metaphor ‘forests being in the dawn of their existence and awareness’ seems fitting.

It is interesting to note here that therapists normally avoid social contact with group members outside therapy and they can invoke robust arguments for doing so. Unlike families and couples, group members are initially total strangers with very limited expectations of forming long-term relationships beyond the therapy space. The whole of such groups differs substantially from the whole unfolding in family and couple therapy where clients have, and are likely to continue to have, close relationships with each other. By contrast external exclusive relationships between individual group members are normally discouraged as they could rupture the cohesion of the group.

In the context of such restrictive boundaries, group members might view group interaction mostly as a rehearsal for their real life relationships with their families, partners or friends. Although some professional literature acknowledges that certain exceptions to such boundaries can be beneficial to clients (Lazarus, 1994; Zur, 2001), research on group members’ perceptions of the effect of intra-group boundaries on their therapeutic gains appears lacking. It would be informative if group therapists understood better whether clients regard group work merely as a rehearsal-for-real-life or whether they value the intra-group relationships as such.

However, there are circumstances – for example when members in art therapy groups share a life-changing situation such as cancer – where they can connect and bond profoundly (Waller & Sibbett, 2005). In addition, in-patients in psychiatric units interact on a daily basis, which inevitably creates close relationships – as well as strong tensions – between group members. My personal experience as a group therapist was within such a framework and I soon realised how different are the atmosphere and principles of in-patient group work to those of the
groups in which I had participated as a client-trainee during my psychodynamic training conducted in private practice.

Overall, I believe that while the family/couple and group therapy modalities are similar in terms of being a systemic whole where the network of alliances and relationships are paramount, their differences are less straightforward.

Based on the above themes, I shall next draw on the opportunities and challenges encountered in family/couple and group therapy respectively when the main psychological difficulty is living with cancer.

**When ‘Cancer Is The Patient’: Opportunities and Challenges in Family/Couples Therapy**

Cancer is a physical illness with indisputable psychological repercussions on both the patient and their spouse or family. Multiple studies have shown that besides the cancer patient, their caregiver or their entire family also frequently suffer from severe psychological distress (Blanchard, 1997). Furthermore, partners and caregivers run the increased risk of psychiatric morbidity when their relationship with the patient is not mutually supportive and they lack their own support network (Pitceathly & Maguire, 2003).

Nonetheless, when families dealing with cancer are able to express their feelings directly with each other, to act openly and manage their issues collaboratively and effectively, they do present with lower levels of depression and anxiety (Edwards & Clarke, 2004, Whitman & Gustafson, 1989) and family-based interventions can improve such symptoms (Griffin et al, 2014).

Although such studies provide indirect support for the potential benefits of family or couple therapy for cancer-related issues, the relevant literature and empirical research does not say much about specific therapeutic factors or strategies that can be utilised in this context. The opportunities and challenges listed below are tentatively suggested; they emerge from the above discussion about systemic understanding and from my practice experience of counselling cancer patients, their carers and partners.

**Opportunity**

- A strong therapeutic alliance between the therapist and couple or family, where the former is perceived as an impartial, facilitating ‘bridge’, can enable clients to communicate more empathically with each other and form their own alliances towards common goals. When cancer comes into play, there is the potential opportunity for the couple/family to ally against the cancer threat and embrace their mutual affectionate feelings and the positive qualities that hold them together as a unit. These can often ‘get lost’ in the daily routine of family/couple life.

- The therapy space can be used to work through conflict resolution by identifying all aspects and perspectives of the conflict, improve problem-solving skills and work collaboratively towards the chosen resolution. However, when working with cancer, the illness can also trigger conflict between family members – for instance with respect to who is taking more or less responsibility, or who is carrying more or less of an emotional burden. Heitler (1993) offers an eloquent step-by-step guide for family conflict resolution.

- There can be an implicit family myth that the cancer predicament is the sole cause for distress or conflict and, unless it disappears, family life cannot improve. The opportunity here for the therapist is to help the family normalise the tension caused by a major
threatening event, to challenge the notion that cancer has taken total control over domestic life and to explore ways that family life can nevertheless be enjoyed.

Challenges

- The therapeutic space and alliance with the therapist may unfreeze hitherto unexpressed, difficult emotions – such as the patient’s feelings of neglect, or the carer’s sense their own needs are being overlooked. In such cases the therapist will need to model containment to the family unit (Carr, 2012).
- Families and couples often believe strongly in their family myths (Byng-Hall, 1973) as they serve significant systemic functions, even if they are unhelpful in the long term. Questioning these myths can be perceived as an attack on fundamental family values and elicit strong resistances. The therapist will need to work collaboratively and tentatively with the family/couple towards illuminating and reframing unhelpful beliefs.

Group Psychotherapy with Cancer patients: Opportunities & Challenges

In contrast to the limited research on family/couple therapy with respect to cancer, there is rich research evidence that supports the benefits of group therapy for cancer patients (Breitbart et al., 2015, Kissane et al., 2004). Meanwhile, an extensive research meta-analysis concludes that there is no evidence that specific strategies or therapeutic approaches within this context are clearly more effective than others (Newell, Sanson-Fisher, & Savolainen, 2002).

As already mentioned, the qualitative differences between family/couple and group therapy are often not straightforward, so some of the challenges and opportunities referred to above will also be relevant to cancer patients’ groups. For example, the web of therapeutic alliances is likely to be equally vital and its absence a major challenge, while conflict resolution can also be important in the group therapy context. There are however some opportunities and challenges that seem more specific to group work.

Opportunities

- Group therapy among cancer patients, where all members share similar life-changing experiences, can provide golden opportunities for the well-evidenced group therapeutic factors of group cohesiveness, universality, altruism, instillation of hope, catharsis and interpersonal learning (Yalom & Leszcz, 2005).
- Existential concerns can be addressed and exploring such topics in group therapy with cancer patients has been shown to improve spiritual well-being (Breitbart et al., 2010, Breitbart et al., 2015), depression and quality of life (Kissame et al., 2004).
- Psychotherapy groups resemble theatre stages on which characters, observe and tangle with each other, ‘act out’ real feelings and experiment with different behaviours within the safety provided by the group space and the companionship of other characters on the same journey. This resonates with the concept of reflective mirroring in group analytic therapy (Foulkes, 1964; Pines, 1983) and it can help cancer patients to explore themselves and process their “identity or meaning crisis after diagnosis” (Yang, Staps, & Hijmans, 2010) without the worry and inhibition of burdening their partners, relatives, family and friends.

Challenges
• Research has identified non-containment of ambivalence, avoidance, anti-group phenomena (for example intolerance of difference) and splitting as common challenges in models of group psychotherapy that are specifically designed for cancer patients (Kissane et al., 2004).

• Reflective mirroring can also have an adverse effect, as witnessing the intense struggles of cancer patients with the least hopeful prognoses could dishearten other members of the group. The challenge for the therapist is simultaneously to hold hope that is not overly unrealistic and acceptance that reality sometimes contradicts our hopes.

Epilogue
Gaps in the literature and my personal experience have led me to contemplate and reflect more on my own understandings and judgments. From a counselling psychology practitioner perspective, this is a capacity of paramount importance. Moreover, in any modality of therapy, and especially I believe in family/couple and group therapy modalities, it is essential to understand how different models conceptualise the therapeutic relationship and alliance(s), to consider different ways of working (HCPC, 2012) and be able to tailor an approach to individual needs and circumstances (NHS, 2011).

Overall, while I endeavour first to be aware and to process my own personal and professional challenges, when I work with cancer patients, I realise how much their existential concerns resonate with mine and how this could become a liberating opportunity, as together we explore acceptance of the uncertainty and the limits of human life.

Nicholas Sarantakis is a Psychologist at the final stage of the Counselling Psychology Doctoral Programme at Glasgow Caledonian University.

References
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Image: The therapy room by Marco40134