The Skills of Facilitator Nurses in Psycho-Social Group Intervention for Cancer Patients

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ABSTRACT

Background The objective of this study was to provide cancer patients with a psychosocial group intervention consisting of 3 parts, i.e., education on how to cope with stress and solve problems, group discussions, and progressive muscle relaxation, and to investigate the intervention techniques of Japanese facilitators.

Methods Group interventions for breast cancer patients performed by 3 facilitators were analyzed qualitatively and inductively using a phenomenological approach.

Results The skills of facilitators included 10 intervention techniques and 1 problem in interventions. Intervention techniques, which promote group dynamics and thereby help participants acquire improvements in their coping abilities and quality of life (QOL), were somewhat different between new and experienced facilitators, with the content showing immaturity and maturity in the new and experienced facilitators, respectively. Both experienced and new facilitators faced the risk of experiencing problems in interventions, which countered the purpose of the intervention of improving the participants' coping abilities or QOL.

Conclusion While intervention skills are necessary for facilitators to execute group interventions, it must be borne in mind, that even well-experienced facilitators may not always be able to accomplish skillful intervention.

Key words group intervention; facilitator; nurse; art of intervention; cancer patient

Recent advances in cancer treatment have enabled breast cancer patients to live longer and longer. Accordingly, the problem of breast cancer patients carrying psychological burdens, such as anxiety and depression, and living their lives with psychosocial problems[1] has appeared.

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Received 2015 February 24
Accepted 2015 March 15
Abbreviations: PMR, progressive muscle relaxation; QOL, quality of life

Thus, increasing attention has been paid to the psychosocial problems of breast cancer patients, and studies have been conducted to verify the effectiveness of psychosocial interventions for reducing the psychological burden of breast cancer patients and for improving their quality of life (QOL).[2–4] Group interventions, often consisting of education on how to cope with stress and how to solve problems, group discussions and progressive muscle relaxation (PMR)[4] were first developed in Western countries, and have also been verified to be effective in Japan.[2, 3]

Many attempts have been made to undertake psychosocial group interventions for cancer patients, and these interventions are expected to spread in popularity in the future. Therefore, it is our task to improve the therapeutic environment for providing group interventions. One of the problems in this task is the shortage of people who can act as facilitators. Facilitators execute interventions, while perhaps having difficulty in managing participants with problems and in overcoming anxiety due to a lack of knowledge and fear of executing such interventions.[6] Under such circumstances, there are no systematic reports on the facilitators' intervention methods.

Based on the above background, we undertook psychosocial group intervention in this study consisting of 3 parts, i.e., education on how to cope with stress and solve problems, group discussions and PMR, which has been shown to be useful for Japanese breast cancer patients,[2] with the aim of investigating the actual intervention skills employed in the intervention methods used by Japanese facilitators. Clarification of the facilitators' intervention styles in group interventions for cancer patients in this study is expected to form one of the bases for finding the direction for facilitator education and for contributing to the dissemination of group interventions.

SUBJECTS AND METHODS

Subjects

Facilitators

Group intervention facilitators in cancer centers A and B were eligible for the study if they i) had experience as nurses for 5 years or more, ii) had received facilitator

training in advance and iii) wished to play a role in facilitating discussions among the participants (as facilitators).

Participants of the group intervention

Breast cancer patients followed in cancer centers A and B were eligible for the study if they met the following criteria: i) adult women aged 20 years or older; ii) histological diagnosis of breast cancer and presence of histologically and/or clinically evident breast cancer; iii) no serious systemic conditions; iv) no active double cancer; v) no clinical need for psychiatric treatment (that is, no depression, adjustment disorder, etc.); vi) no difficulty in understanding the purpose of the study (that is, no impairment of consciousness including advanced dementia and delirium, mental retardation, etc.) and vii) pertaining to the disease stage, first recurrence in cancer center A and during or after chemotherapy in cancer center B.

The eligible patients were asked to participate in the study from June 2002 to April 2003 in cancer center A and from October 2006 to February 2008 in cancer center B.

Intervention methods

This study employed a short-term (6-week) psychosocial group intervention, which has been verified to be effective in Japanese primary and recurrent breast cancer patients.[2]

In the group intervention, a total of six 90-min weekly sessions were undertaken for groups of 3 to 8 participants each. Each session consisted of education on how to cope with stress and how to solve problems (20 min), discussion on the ability to cope (50 min) and training for PMR (20 min).

Evaluation

Intervention scenes were recorded with a digital video camera or IC recorder and later transcribed verbatim. The original recorded data were discarded after the verbatim transcripts were prepared.

Ethical considerations

The study was approved by the Ethical Committees of the 2 research facilities and the Fukuoka Prefectural University. The outline of the study, the voluntary nature of participation and the preservation of anonymity were explained verbally and in writing to the study subjects and group intervention participants, and written consent to participate in the study was obtained from each of the participants.

Analysis methods

For the analysis, we used a method of qualitatively and inductively extracting the facilitators' intervention styles from verbatim transcripts according to the purpose of the study, by reference to the phenomenological method.[7] First, we repeatedly read the verbatim transcripts to grasp the whole context, and then divided and classified the transcripts into expressions with similar meanings. Next, we comparatively investigated the relationships among these expressions and gave them names with meanings. We reviewed the verbatim transcripts again and again to check whether the given names represented the true nature of the data, further divided and classified the expressions according to their meanings, and comparatively investigated the relationships among them. We gradually abstracted the expressions by repeating these procedures, which allowed extraction of the true nature of each expression, and obtained the facilitators' intervention methods.

In this process, we repeatedly held discussions to improve the reliability and validity of the study, i.e., investigated whether the results were reliable and represented the "real" world of the study subjects (reliability), and whether the study was conducted in context considering the environment of the study subjects and all circumstances (meaning in context), whether all possible explanations and interpretations were thoroughly considered, and whether the results found in this study were applicable to other similar contexts or situations (transferability).

RESULTS

Subjects' characteristics

Experienced facilitator

One facilitator in cancer center A who had experience as a nurse for more than 10 years, had 3 years' experience of nursing breast cancer patients, had received facilitator training and had 3 years' experience as a group intervention facilitator took charge of a total of 18 sessions for 3 groups.

New facilitators

Each of the 2 facilitators in cancer center B who had experience as a nurse for more than 10 years on average and had received facilitator training took charge of 6 sessions for 1 group each (total 12 sessions). These facilitators performed the 6-session intervention for the first time.

Skills of facilitators

The analysis of the facilitator nurses' intervention methods enabled extraction of the "skills of facilitators" as the core category (Table 1). In addition, there was a dif-

ference in the categories derived from this core category between the experienced and new facilitators. Hereinafter, the core category is shown in " ", the categories in [ ], the subcategories in < >, the discussion themes in italics with *, and the facilitators' interventions based on which the categories were extracted in bold.

Table 1. Comparison of the skill of facilitators between experienced and new facilitators

Core category	Categories	Subcategories (experienced facilitators)	Subcategories (new facilitators)
Skill of facilitators	Intervention skills	To proceed with the intervention	To proceed with the intervention
		To speak for the participants	To speak for the participants
		To encourage participants to reflect on themselves	To encourage participants to reflect on themselves
		To protect the participants' physical health	To protect the participants' physical health
		To protect the participants' mental health	To protect the participants' mental health
		To face participants with the facilitators' reality	To face participants with facilitators' reality
		Presence	Presence
		To grasp the context	To grasp the context
		To return the topic to the theme	To return the topic to the theme
		To weave different skills together	
	Problem in interventions	Inability to perform skillful interventions	Inability to perform skillful interventions

"Skills of facilitators"

This core category refers to facilitators steering the discussion according to the theme with the aim of making the group dynamics work, toward a decrease in psychological burden and improvement in the QOL, which are the purposes of group interventions, and use the necessary techniques for the participants. The categories of [intervention techniques] and [problem in interventions] were extracted from this core category.

[Intervention techniques]

This category means that facilitators promote group dynamics when performing group interventions. This was useful for the participants to acquire improvement in their coping ability and QOL. From this category the following subcategories were extracted: <to proceed with the intervention>, <to speak for participants>, <to encourage participants to reflect on themselves>, <to protect the participants' physical health>, <to protect the participants' mental health>, <to face participants with the facilitators' reality>, <presence>, <to grasp the context>, <to return the topic to the theme> and <to weave different skills together>. Of these, <to weave different techniques together> was only extracted in the experienced facilitator.

<To proceed with the intervention>

This subcategory is an intervention method in which facilitators take care so that the group intervention goes on without problems, by correctly allocating time to each part of the group intervention and giving each participant an equal opportunity to speak. Facilitators may answer medical questions, if they think that it would reduce the participants' anxiety and thereby allow the intervention to go on more smoothly. This is an intervention technique with which facilitators proceed with interventions not as the chair, but by taking an overview of the whole group and grasping the participants' feelings.

Participant 26: "Oyster supplement, I know that. It is said to be good for health, particularly for people with cancer."
Participant 20: "A small bottle is very expensive, and costs 10,000 yen, but my mother worries about me and sends me several bottles of the supplement. Like so, people around me worry about me."
Facilitator A: **"Well, it may depend on how you tell people around you. This topic is the theme in the next week, and I hope you will talk a lot about it again next week. Now, let's begin relaxation."**
(Start of relaxation)

<To speak for the participants>

This subcategory is an intervention method in which facilitators sympathize with and express in words what the participants really want to say and how they feel. The participants were often unable to well express their feelings in words, and their true intentions often lay behind their words.

Participant 31: "Colleagues in the workplace are in their 20s and 30s, and I told them, 'You should at least undergo breast cancer screening'. I actually let them touch my

breast, saying 'This stiffness! If you feel this stiffness in your breast, it's absolutely too late!'"
Facilitator B: **"Those people will never forget it. You don't want them to suffer as you do. I suppose that is the thought dominating your mind."**
Participant 31: "That's right."

<To encourage the participants to reflect on themselves>

This subcategory is an intervention method in which facilitators try to make the participants aware of coping and management methods that the participants themselves may not be aware of from the various experiences that are talked about. The purpose of this intervention method is to make participants understand their own trends in coping and other people's coping methods and utilize such understanding in the future.

Participant 3: "We are planning to go to Tokyo, and this is the second visit to Tokyo in my life. So, I'm looking forward to it. I am going to expand my activities. Now I take very good care of myself to avoid becoming ill."
Facilitator A: **"In your story you seem to enjoy your life more than ever before…."**
Participant 3: "Yes…, it seems like I am freed from my fetters. I was a housewife and I kept to my house. I used to feel timid when I went on a visit and stayed over somewhere."

<To protect the participants' physical health>

This subcategory is an intervention method in which facilitators show that they try to support participants, prevent a participant isolated from the others in discussions, consider the participants' health status, etc.

The facilitators took care of the participants' health, asked them in advance about any physical problems such as pain, and provided cushions for everybody if any participants of the group had pain. In addition, because most participants were receiving chemotherapy, the facilitators provided them with water or hot tea for hydration.

<To protect the participants' mental health>

This subcategory is an intervention method in which facilitators provide participants with a safe, easy-to-talk place by keeping the discussion confidential themselves and asking the participants also to do so.

Participant 30: "(After self-introduction) Every day there are times when I feel tremendously blue, and every day I shed tears. Please don't be put off! I am naturally sentimental (while shedding tears)."
Facilitator B: "(While handing Participant 30 facial tissues) **It is important to express your feelings, and nobody will laugh or be put off. This is a place that we can share, that is protected, and that we try to protect.**"
Participant 30: "Thank you (she continued to shed tears)."

<To face participants with facilitators' reality>

This subcategory is an intervention method in which the facilitators frankly speak what they themselves feel while facing the participants. The relationship between facilitators and participants is not the same as the relationship between therapists and patients; a facilitator is always one of the group members who views things from the perspective as the participants.

Participant 1: "I visited palliative care unit in my daughter's workplace. How would you feel if your parent were admitted to your workplace…palliative care unit…Ms A (facilitator), will you find it burdensome?"
Facilitator A: "…**Let me think about that?... No, I don't think so**…What does your daughter say about that?"
Participant 1: "My daughter says, 'You can come to our hospital.'"

<Presence>

This subcategory is an intervention method in which the facilitators share space with the participants, stay with them, and understand, or try to understand, and share their natural feelings. The facilitators focused on what was going on among the participants here and now and stayed with their feelings at each moment.

Participant 15: "Clothes…, my husband ask me to buy clothes a lot, but before I die, I won't wear the clothes… But, now I think I will buy some…. I've come to feel like this. I also bought clothes for the first time in several years." (everyone laughed.)
Facilitator A: "**That's a great change, isn't it? (joyfully)**"
Participant 15: "Yes! That's really a great change."

<To grasp the context>

This subcategory is an intervention method in which facilitators judge what the topic of the participants' discussion is at each moment and whether the topic is consistent with the theme of the session or would lead to an improvement in the participants' QOL and coping ability.

**Under circumstances in which the number of times PMR exercises performed by the participants had*

decreased

Participant 26: "Some time ago I was told I should not carry heavy things after shopping in supermarkets."

Participant 27: "In my case, so many people deliver things to me saying, 'I did shopping around here, so I thought I would buy for you."

Participant 20: "I thought the diseased limb just hung down from the body, but I used it a lot."

Participant 27: "I exercise gymnastics in my bed."

Facilitator A: **"Oh, really?" (in response to the remark concerning PMR, the facilitator directed the discussion to the initiation of PMR.)**

<To return the topic to the theme>

This subcategory is an intervention method used when the topic of the group discussion deviates from the theme. The facilitators fully explained the theme to the participants in advance to avoid deviation of the topic of discussion from the selected theme. When the topic of discussion deviated from the theme, the facilitators found parts of the topic overlapping with the theme and pointed out the relationship between those parts of the topic and the theme to return the topic to the theme, or directly pointed out the deviation from the theme.

**Theme: "from surgery to disclosure of the diagnosis of recurrence"*

Participant 10: "On some occasions from the third year…and because I had a job (laughing)…(omission) I worked a little too hard, and I developed recurrence in a little over 4 years. Maybe I was overconfident." (the participants agreed.)

Participant 10: "I had recurrence in the bone…(omission)."

Facilitator A: **"A moment ago you told me that you were overconfident… (the facilitator repeated what the participant said about the condition before recurrence)."**

Participant 10: "That is right. I had surgery in my right breast, and the right breast had been swollen for a long time."

<To weave different techniques together>

This subcategory is an intervention method that was extracted only in the experienced facilitator. The facilitator performed the intervention for multiple participants according to the situation quick-wittedly, combining humor with his/her intervention techniques and dealing with problems that could not be solved at that moment sometime later in the sessions.

**To execute the intervention while considering the participants' feelings*

Participant 1: "After my drugs were changed, I felt uneasy and I visited the doctor every week. Then the doctor told me, 'How about participating in a clinical trial?' The instruction brochure for the trial said, 'For patients with bone metastases from breast cancer', and I knew immediately that I had bone metastases."

Participant 2: "I feel both uneasy and positive. Sometimes I am depressed, and sometimes I feel positive and think I have to work hard. I was told about recurrence… and of course I was shocked. But my feeling of uneasiness and fear of recurrence were gone, and in this sense I felt relieved."

Facilitator A: **"Both of you sometimes think you will work hard and sometimes feel uneasy, but maybe you will eventually work hard by finding your own way to cope. I wonder whether other participants have similar experiences… (while looking at Participant 3)"**

Participant 3: "I don't particularly have such experiences… My initial symptoms were not so severe and I was optimistic. Other participants experience times of serious despair, and I am surprised."

[Problem in interventions]

Facilitators always have to keep this category in mind when performing group interventions. This category does not contribute to improvement of the participants' coping ability or QOL, and both experienced and new facilitators face the risk of experiencing this problem. This category included the subcategory of <Inability to perform skillful interventions>.

<Inability to perform skillful interventions>

This subcategory refers to facilitators becoming enthralled by the participants' words and forgetting their role as therapists and becoming too confused to decide how to intervene. This was more commonly extracted in the new facilitators than in the experienced facilitator.

Participant 35: "But, if I have recurrence, I will think differently…in such a case. So, the first thing I want to think about now is how to prevent recurrence. If I can prevent recurrence by thinking positively, I think I have to think positively."

Facilitator B: **(the facilitator's mind went blank, with the body frozen and the face down, looking at the feet.)**

DISCUSSION

[Intervention techniques], one of the 2 categories under the core category of "skills of facilitators", included the following 10 subcategories: <to proceed with the intervention>, <to speak for participants>, <to encourage

participants to reflect on themselves>, <to protect the participants' physical health>, <to protect the participants' mental health>, <to face participants with a facilitator's reality>, <presence>, <to grasp the context>, <to return the topic to the theme>, and <to weave different techniques together>; the other category, namely, [problem in interventions], included one subcategory, that is, <inability to perform skillful interventions>.

At first, the subcategory of <inability to perform skillful interventions> under the category of [problem in interventions] was commonly observed in the new facilitators. The new facilitators, like the experienced facilitator, also had long experience of interacting with cancer patients in clinical settings and experienced simulation training for facilitators as group intervention facilitators and patients. However, they supported actual patients in group interventions for the first time, and it seemed difficult for them to cope with each situation. Classen[8] reported that interventions by new facilitators cannot contribute to improvement of the participants' QOL. The effect of the intervention was not investigated in this study, however, considering from the results, it is difficult to rule out the possibility that the participants' QOL was not improved by the new facilitators' intervention. In addition, even experienced facilitators sometimes cannot maintain concentration during the 50-min sessions and sometimes cannot instantly grasp the meaning of what the participants are saying. It was revealed that <inability to perform skillful interventions> is a problem that can be faced by both new and experienced facilitators, suggesting that it is necessary for both new and experienced facilitators to continue to earnestly face participants, as described by Spiegel et al.[9] and Kiba and Maruguchi.[10]

Regarding [intervention techniques], we were afraid that there might be facilitator techniques that new facilitators may not be able to use with ease. However, both new and experienced facilitators could use all techniques with equal ease, except for the applied techniques of <to weave different techniques together>. This seemed to be because the facilitators were explained the purposes, methods and effects of group interventions in advance in the facilitator training, therefore, even new facilitators understood the concept of group interventions. On the other hand, both new and experienced facilitators faced the risk of experiencing [problem in interventions]. In addition, the facilitators were also provided simulation training on the techniques necessary for all 6 sessions of the group intervention by role playing. Therefore, it seemed that all the facilitators could use most facilitator techniques effectively. Previous studies[10, 11] have also pointed out the necessity of role-play training, and the results of this study also revealed the effectiveness of facilitator training prior to group interventions. In addition, in this study, the facilitators held discussions about the condition of each participant and trends in each group before and after each group intervention session, which enabled even the new facilitators to understand the direction of their own group and to use most techniques efficiently. However, <to weave different techniques together> is an applied skill using which facilitators can execute effective interventions for multiple participants at the same time, and it appeared that this technique could be used only by the experienced facilitator. The art of intervention revealed in this study was different from that reported by Yalom.[12] This difference could be attributed to cultural differences between Japan and western countries.

Previous reports on group interventions have focused on the effects of the interventions and the facilitators' anxiety and understanding of their roles, but not fully addressed the role of role playing.[11] For reducing the facilitators' anxiety,[6] it is necessary to provide them with a deeper understanding of the interactions between facilitators and participants in group interventions and to provide simulation training on the skills necessary for facilitators. For this purpose, it is considered necessary to develop programs in which the trainees can spend much time in role playing as simulation training.

The authors declare no conflict of interest.

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