FAMILY REACTIONS TO THE CRISIS OF ILLNESS

by

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ABSTRACT

This exploratory study was designed to elicit information about family reactions to the crisis of illness and what families perceive to be helpful during this crisis. The study focused on the family crisis of incorporating back into the family a father who had experienced his first myocardial infarction.

The study was conducted with a convenience sample of ten male myocardial infarction patients, their wives, and children living in the household. A semi-structured interview schedule was used with each family one to three weeks following the father's discharge from hospital. The interview data were summarized into categories and descriptive statistics were used.

All 10 families described changes that had occurred in the areas of family roles, interactions, affect and structure since the father had returned home from hospital. The amounts of help received by families varied a great deal and differences of opinion were expressed within some families. Friends and home care nurses were most frequently seen as persons offering the most help to families. Receiving information and reassurance were seen as helpful during this time.

In summary, the results of the study indicate that families do experience a variety of changes when a family member is ill. The quantity and quality of change are related to the family's perception of the nature of the illness, the ill member's enactment of the sick role and the degree of difference between the family's pre-illness and post-illness state. Illness, especially life-threatening illness, fosters a review of individual and family goals which can also produce change.

It is also presumed that family reactions can have an effect on the course of illness. The effect is dependent upon family perceptions of the illness, the amount and kind of controls they can exercise, and the personal needs of individual family members.

More research is required to identify the characteristics and temporal aspects of family reactions to illness and family effects on illness. Innovative approaches to research design and methodology are required to ensure scientific theory development and continued appreciation of the complexity of family systems.

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I. INTRODUCTION

Traditionally, the individual and his symptoms have been the focus of treatment. More recently, a family focus has emerged in health care.

A FAMILY FOCUS

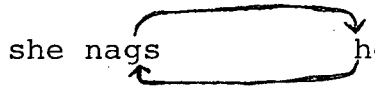
The family has undergone changes through time but continues to be an important social unit. It is responsible for the socialization and orientation of the young. It provides the opportunity for intimate social interactions and the base of personal security for all its members. It has influence on most aspects of human life.

Families are viewed as social systems which are distinct from other systems in that they are composed of persons or groups of persons who interact with and influence the behavior of others. The family is distinguishable from other social systems such as business organizations by its goals, functions, and climate of feelings (Anderson and Carter, 1974).

Families are open systems in that they exchange material, energy, and information with their environment (Watzlawik, Beavin, and Jackson, 1967, p.122). Families,

like all open systems, have the property of wholeness (Watzlawik, Beavin, and Jackson, 1967).

"Wholeness" characterizes aspects of system organization and interaction. A family system behaves as an inseparable whole. It is greater than the sum of its independent parts. A change in one family member produces a change in each family member and the family system. Another interactive component of the property of wholeness is the circularity of relationships among system elements. A family member's response is also a stimulus in an established pattern of interaction. An example of the circularity of a pattern of interaction is:



This interdependent relationship of the family system is recognized as having implications for health care.

> The overall health of the family unit and the health of the individual are interdependent... (Rakel, 1977, p.342).

Families are very complex organizations and the development of a family focus requires a framework for looking at families. Karl Tomm (1977a) offers a cognitive framework for assessing family systems which is made up of three interrelated parameters: family structure, family function, and family development.

The parameter of family structure includes factors which identify who is included in the family. The nature of the connections across the family boundary (with the social network and other community institutions) and the

family's location within the community (geographic and socio-economic) further defines the family.

Family function is the most dynamic of the three parameters because it includes the family behaviors which define and redefine family rules and roles to ensure the family's continuance as an organized and stable system.

Stages of family development relate to marriage or the beginning family, child-rearing, individuation of members, departure of children, retirement and death of a spouse (Fisher, 1977). It is assumed that "families must attend to the tasks of one stage before they can adequately master the task of the next" (Solomon, 1973, p.183).

With a framework for understanding what families are and how they function, it is possible for health care professionals to affect the health of all family members regardless of which family member is the current identified patient.

ILLNESS AS A FAMILY CRISIS

Serious and prolonged illness in an individual has a drastic effect on both the individual and the family. It usually precipitates a crisis which is experienced as a period of disequilibrium and disorganization (Olsen, 1970).

> Crisis in its simplest terms is defined as 'an upset in a steady state'...the habitual problem-solving activities are not adequate and do not lead rapidly to

> the previously achieved balanced state (Rapoport, 1965, p.24).

The various phases of illness (onset, sick role, convalescence) and chronicity or impending death have inherent adaptive tasks which may precipitate a crisis depending upon the person's perception of these events and factors such as physical and emotional status (Murrary and Zentner, 1975).

The family's response to the crisis has implications for the course of illness.

> Should the family decompensate and fail to support...the ill member...convalescence (may be) prolonged (Rakel, 1977, p.343).

The family's response also has implications for its own health.

> Successful experience with crisis tests and strengthens a family, but defeat in crisis is punitive on family structure and morale (Hill, 1965, p.46).

POTENTIAL SIGNIFICANCE OF THE STUDY

A crisis is not necessarily a bad experience. It can be an opportunity to learn new problem-solving skills and devise creative solutions for daily living. Satisfaction and levels of functioning may eventually exceed pre-crisis levels. Following an adaptive experience, future crises may be handled in a superior manner (Glasser and Glasser, 1970). It is during a crisis that individuals and families are most amenable to help and change (Aguilera,

Messick, Farrell, 1974). By helping families cope effectively with physical illness of a family member, nurses can promote optimal recovery of the sick individual and safeguard the integrity of the family (Livsey, 1972).

How do nurses help families cope? Before we can begin to prescribe how to help families cope, nurses must have a better understanding of how families function and what a family experiences when a member is ill. It is hoped that information elicited in this study will add to existing knowledge about how families experience crisis and how nurses can give effective care to patients and their families as they cope with the crisis of illness.

PROBLEM STATEMENT

The focus of this study is the family's experience of the crisis of illness. Specifically, the study attempts to elicit information about families' reactions when they are faced with the crisis of having a member who is ill and about what families perceive to be helpful during this crisis.

For purposes of this study fathers experiencing their first myocardial infarction are used as the example of illness of a family member. This study focuses specifically on the family crisis of having to incorporate the disabled father back into the family.

PURPOSE

The purpose of this study is two-fold. The first purpose is to describe reactions that occur in families when fathers who have experienced their first myocardial infarction have been home from hospital for one to three weeks. The second is to describe what people and services families report to be helpful during this one to three week period.

ASSUMPTIONS

1. It is assumed that illness and disability of a family member produces disequilibrium in a family.
2. It is assumed that variables such as previous learning experiences, individual personality factors, and socio-economic levels influence the response of the family system.

LIMITATIONS

1. This is not a study utilizing an experimental design in which hypotheses are put forth and then tested using rigorously controlled procedures. It does not focus on relationships between variables or causality. The focus of the study is on qualitative data.
2. No attempts have been made to obtain a random sample hence the results are not generalizeable beyond the families of the study.
3. The size of the sample was limited by availability of eligible families and by limits of time.
4. The effects of extraneous variables were not controlled. The purpose of the study was to categorize variables and examine relationships.

5. The family description of reactions may be distorted through effect of time and/or family rules regarding disclosure, eligible spokespersons, degree of individuation of members. The family rules that represent family functioning (e.g. mother always speaks for the family) are less a limitation to the study than the distortions that do not represent family functioning. (e.g. mother is the spokesperson for this one occasion).

6. A difference of opinion among family members may have been lost in their consensus of a family description of reactions. More sophisticated methods of obtaining a family's perception of change are not known to this investigator.

7. The semi-structured interview schedule may have restricted some content.

DEFINITIONS

crisis - a period of disorganization and emotional upset that occurs when customary problem-solving activities do not produce a steady state.

family - a social system composed of mother, father, and at least one child (natural or adopted) living in the same household in the Vancouver area; a family can include persons related by blood or marriage who have lived in the household three months or more.

first myocardial infarction - the father's first known and treated myocardial infarction which has been diagnosed during the hospitalization ending one to three weeks ago.

helpful - people and services perceived by the family to be useful in regaining a steady state.

reactions - verbal statements of cognitive (thoughts), affective (feelings), and behavioral (observeable behaviors) changes that occurred in and among family members during the one to three week period following father's return home.

steady state - a system's level of functioning characterized by a dynamic balance between accommodating change and maintaining status quo.

II. LITERATURE REVIEW

This review focuses on publications related to family crisis, illness as a crisis, the effects of illness on families, and the effect of families on illness.

Although the example of illness in this study is the convalescent phase of a physical illness, the dearth of studies warrants a review which includes a variety of phases and types of illness.

FAMILY CRISIS

The family, like all systems, is self-correcting and resistant to randomness. Jackson used the term "homeostasis" to describe this tendency in his early writings about family systems (Jackson, 1957). The family also has a great capacity to accommodate the many maturational and situational changes of its members and its environment. The term "steady state" is currently used to describe a system in dynamic balance - both changing and maintaining itself. It does not imply that a fixed minimal level of stress must be maintained. A steady state dictates a level of functioning within a range of acceptable limits which can accommodate the realms of play, creativity, and self-realization

(Bertalanffey, 1968).

Families can experience crisis when there is "an upset in a steady state" (Rapoport, 1965, p.24). Caplan, who pioneered much of the development of crisis theory, defines crisis as occurring when obstacles to important life goals have not been effectively resolved with customary problem solving methods. There is a rise in inner tension, anxiety, and disorganization of function which is referred to as "crisis" (Aguilera, Messick, and Farrell, 1974, p.6). The phases and characteristics of particular kinds of crises in individuals have been studied. Bowlby focused on separation trauma of children entering hospital and Lindeman observed grief reactions following bereavement (Rapoport, 1965).

Crisis theory was applied to families by Hill (1965) in his studies of war separations and war reunions. With war separation families, Hill described family crisis and adjustment as a period of shock followed by disorganization, lack of enthusiasm for role enactment, and strained relationships. Then, through trial and error or thoughtful planning, new routines are developed and things begin to improve. This process was not evident in the study of war reunions, however (Hill, 1965, p.49). According to Hill (1965), there are three variables which determine whether a situation constitutes a crisis for the family: the hardships accompanying the event, the family's definition of the event (threatening or non-threatening to status and goals),

and the family's resources (role structure, flexibility, previous experience with crisis).

Parad and Caplan (1965) studied families in crises precipitated by premature birth, congenital anomaly, and tuberculosis in a family member. They used the categories of life style (including value systems, communication network, and role system), problem-solving mechanisms, and need-response patterns which relate to the needs of individual members, to organize and analyze their data. They found that the family's life style influences its' perception of the crisis in the impact phase. The family's attempts to problem-solve must be balanced with family members' needs for love, support, and independence; freedom and control; and role models. Parad and Caplan support a current rather than retrospective approach to the study of crises because "...useful information about the crisis (can) be obtained only by interviewing the family while it (is) actively engaged in its coping efforts" (Parad and Caplan, 1965, p.54).

Langsley and Kaplan (1968) applied the crisis model to families in a study exploring family crisis therapy as an alternative to patient hospitalization for mentally ill patients. They describe crisis as a struggle to master a situation in which previous coping mechanisms have been ineffective and a state of imbalance persists. They determined that stress outcomes are related to the stressor, the individual's personality factors, and the social field in which he lives. The social field includes a variety of

social subsystems which influence the struggle for stress mastery (Langsley and Kaplan, 1968).

Glasser and Glasser (1970) looked at families experiencing the situational crises of poverty, disorganization, illness and disability. They found that the impact of stress may be accompanied by psychological stress or family demoralization. For relief, the family may have to make:

> ...alterations in group structures and processes...for example, shifts in the family power structure, means of communication, affectional relationships, tasks assigned members, or ways of solving problems and resolving conflicts. Without such modifications, disequilibrium will continue and family functioning is likely to become less effective and less efficient (Glasser and Glasser, 1970, p.6).

The time frame of family crisis is less than clear in the literature. Caplan said crisis is self-limiting with individuals, lasting from four to six weeks (Aguilera, Messick, and Farrell, 1974). Similarly, Kaplan (1973) specified that coping responses of parents informed of their child's leukemia would be evident within one to four weeks. Other writers have said that the duration of the disorganized state is dependent upon variables such as family organization (Hill, 1965) and family members' ability to communicate (Smilkstein, 1975).

There are two types of crises:

> Developmental crises are transition points, the periods that every person experiences in the process of biopsychosocial growth and development and that are accompanied by

> changes in thoughts, feelings, and abilities (Murray and Zentner, 1975, p.208).

This concept is not incompatible with the maturational changes relevant to family systems. Families experience stages of development characterized by developmental tasks. For example, the task in the child-rearing stage is the satisfactory development of mother-father roles (Tomm, 1977a). Families are likely to experience some disorganization at each stage of development (Solomon, 1973).

> The situational crisis is an external event or situation, one not necessarily a part of normal living, often sudden, unexpected, and unfortunate ...(Murray and Zentner, 1975, p.209).

Caplan identified this type of crisis as one "...precipitated by life hazard...accompanied by heightened demands on the individual..."(Caplan, 1964, p.35). In their list of examples of situational crises, Murray and Zentner list illness and hospitalization (Murray and Zentner, 1975, p.210).

ILLNESS AS A FAMILY CRISIS

> ...illness is an event experienced by people that manifests itself through observable and/or felt changes in the body, causing an impairment of capacity to meet minimum physical, physiological, and psychosocial requirements for appropriate functioning at the level designated for the person's age, sex, and development, or handicapped state (Wu, 1973, p.23).

An individual's behavioral responses to the changes are directly related to his perception of his illness (Wu, 1973). Illness can be viewed by the patient as a challenge, an enemy, punishment, weakness, relief from responsibilities, an interpersonal strategy, irreparable loss or damage, or a value because it makes health more appreciated (Lipowski, 1970).

Certain aspects of illness can have different meanings as well.

> The meaning to (each) patient of his symptoms, lesion, diagnostic lable, loss of function, doctor's statements, and so forth, is determined by multiple factors, internal and external (Lipowski, 1970, p.1198).

The temporal aspects of illness (onset, course, and duration) will also assume character and meaning from past experiences, cognitions, and understandings (Wu, 1973).

Illness and phases of illness have also been viewed in terms of adaptive tasks. Murray and Zentner (1975) identify the adaptive tasks of convalescence as reassessment of life's meaning, reintegration of body image, and resolution of role changes or reversals. Moos (1977) says serious illness or injury sets forth seven adaptive tasks: dealing with pain and incapacitation, dealing with hospital environment and treatments, developing adequate relationships with professional staff, preserving emotional balance, preserving a satisfactory self-image, preserving relationships with family and friends, and preparing for an uncertain future.

Moos notes, "...family members and friends, as well as patients, are affected by the crisis (of illness), (and) encounter many of the same or closely related adaptive tasks..."(Moos, 1977, p.8). It would seem that when the perceived challenge or threat of illness exceeds the coping capabilities and resources of an individual or family, illness constitutes a crisis.

> The family system may become massively disrupted when a member becomes seriously ill with an organic disease, and the family's response to the illness may drastically affect the outcome for the sick member...(Olsen, 1970, p.237).

Livsey says, "Serious illness in an individual creates a family crisis" (Livsey, 1972, p.237). She stresses the interrelationship of illness and family even further, "Stress in human relationships is believed to precipitate and/or intensify somatic illness" (Livsey, 1972, p.238).

EFFECT OF ILLNESS ON FAMILY STRUCTURE

"Family structure" includes factors which define the family through its membership and the nature of its connections across the family boundary. Family membership specifies the composition of the family; who is and is not a member, the alignments and splits among members. Family connections with the environment include the quantity and quality of relationships with other institutions such as

workplace and school, with their social network, and the family's socio-economic and geographic position in the community (Tomm, 1977a).

Illness can alter family household membership in different ways. The ill person may have to leave the household to obtain treatment (Livsey, 1972). The separation may be lengthy and the distance great. If a parent is hospitalized it may be necessary for children to leave the household to be cared for by friends and relatives. It may be necessary to have individuals join the family to provide assistance (Parsons and Fox, 1968).

Members may realign when there is illness in the family. For example, when a father becomes ill, an older son may align with his mother as another adult-parent (Olsen, 1970). Family members might align against the ill member because of his/her demands for attention (Livsey, 1972).

Hill (1965) describes family connections with community institutions:

> ...the closed nature of the family is selectively opened for tran-acting business with other agencies, including kin and professionals... agencies can be ranked on their accessibility to the...family: immediate kin highest, family friends and neighbors next, the family phy-cian,...pastor,...and so on... Other agencies enter the family with greater difficulty and often through ...family members who act as liaisons for the family: the school, the employer, the health clinic, the case-work agency, and other such formal agencies (Hill, 1965, p.33).

Illness can alter these connections. For example, connections with school and workplace might decrease while connections with health and social service agencies might increase.

Hill goes on to note that families have changed.

> Once a self-contained economic and social unit buttressed by kinship supports, the family now has interdependent relationships with many other associations in working out its problems (Hill, 1965, p.34).

Parsons and Fox (1968) say the family is especially vulnerable to the effects of illness because today's families are isolated from kin relationships and therefore must become more dependent on social institutions. MacVicar and Archbold say, "The number of persons available to provide assistance...is an indicator of potential hardship imposed by illness" (MacVicar and Archbold, 1976, p.187). They agree with Parsons that assistance from kinship systems is usually neither stable nor permanent. Further support for the importance of family connections within the community is given by Yokes in his discussion of patients with myocardial infarction:

> Those families who have close ties within the primary family, with relatives and with members of the local community, seem to have a cushion of absorbtion of the emotional and sometimes financial shock experienced when a family member has an acute myocardial infarction (Yokes, 1973, p.395).

Illness can also drain family financial reserves.

Reduced financial reserve and consequent altered life style add to the adjustments required from the family with an ill member (MacVicar and Archbold, 1976).

In the literature, reactions to the crisis of illness tend to be described in terms of the patient or family subsystems. A common approach has been to look at the reactions of spouses. In a study of patients with chronic illness and their spouses, it was found that 56% of spouses noted an increase in tension during the illness of the other. The interpersonal tension from illness in one member led to psychophysiologic distress (symptoms) in both partners (Klein, 1967). In another study looking at reactions of spouses, Silva (1977) reports that 23 out of 36 presurgical spouses scored higher on the State Anxiety Inventory than did the preoperative patients themselves.

Skelton and Dominian (1973) studied the reactions of 65 wives of myocardial infarction patients during the husband's hospital stay, then three, six, and twelve months following discharge. Within the first three months after discharge, 25 wives reported feelings of tension, anxiety, depression, and sleep disturbance. They were distressed because of their "loss" of a "strong" husband and fear of recurrence. They found their husbands dependent and irritable which contributed to feelings of tension and sometimes hostility.

In a similar more recent study, 82 wives of myocardial infarction patients were interviewed while their

husbands were in hospital, and again at two months and twelve months after discharge (Mayou, Foster, and Williamson, 1978). During the first few weeks after discharge 80% of the wives experienced anxiety, depression, fatigue, irritability, poor concentration, and insomnia. "In the first few weeks the men were very dependent...the men had to modify their jobs...more often than the wives had foreseen..."(Mayou, Foster, and Williamson, 1978, p.700).

The marital subsystem (husband and wife) has been the focus of two studies. Kaplan (1973) assessed families' coping behaviors by assessing the coping mechanisms observed in parents of leukemic children. Unfortunately, the article does not reveal the methodology of the study except to say it was a clinical review of 50 families from the day of confirmed diagnosis until two months after the child died. The marital subsystem was also the focus of a study of burn patients. Patients and their spouses were asked to discuss their post-hospital experiences in a group with other burn patients and their spouses (Granite and Goldman, 1975). Their discussions centred on concerns about family relationships, work, recreation and integration into the larger community.

Some articles appear to have generalized individual member reactions to family reactions. The reactions are usually identified as feelings, defence mechanisms or other emotional responses. For example, Epperson (1977) found that families in the acute crisis stage, when first coming to a

critical care unit to see an injured family member, demonstrate periods of high anxiety, denial, anger, remorse, grief, and finally reconciliation. She goes on to say that families may eliminate stages and different members may be experiencing different stages at the same time. Hence, the stages have little predictive value. Similarly, Williams and Rice (1977) list hostility, anger, guilt, and grief as possible reactions of families of intensive care unit patients.

It is not clear that the studies by Epperson (1977) and Williams and Rice (1977) have, in fact, identified family affective or emotional responses to acute illness situations. Perhaps more correctly, they have identified common affective or emotional responses in individual family members.

EFFECT OF ILLNESS ON FAMILY FUNCTIONING

> Family functioning is concerned with the details of how individuals actually behave in relation to one another in the process of fulfilling the needs and goals of the family and its members...functioning refers to routine activities of daily living involved in survival...and in the procurement and use of goods and services...(functioning also) refers to the emotional, communicative, problem-solving, and control behaviors of family members (Tomm, 1977a, p.3).

Almost all aspects of family functioning can be viewed as formal and informal role allocations.

> A role can be defined as the pattern of wants and goals, beliefs, feelings, attitudes, values and actions which members of a community expect should characterize the typical occupant of a position (Robischon and Scott, 1962, p.52).

Informal roles refer to prescribed patterns of behavior idiosyncratic to particular individuals in certain settings. Formal roles are those broadly agreed upon within the community. Examples include the roles of mother, policeman, student (Tomm, 1977c). Roles commonly determined by age and sex are uniquely defined within each family system (Anderson and Carter, 1974). By mutual consent, family members can be breadwinners, nurturers, disciplinarians, and clowns.

Roles exist in paired positions. An individual can not adopt a "victim" role unless another member adopts the reciprocal role of "persecutor" (Robischon and Scott, 1969). Alteration of one role requires alteration of the other.

Although mutually agreed upon at some level of awareness, it is possible for a role to exist, such as scapegoat, which is functional for the family but disfunctional for the individual (Bell and Vogel, 1968).

Nye and Gecas identify eight parental roles in their review of family literature: provider, housekeeper, child care, child socialization, sexual, recreational, therapeutic, and kinship (Nye and Gecas, 1976, p.13).

Role change is listed as a very common family

occurrence following illness of a family member. Anthony (1970) studied families in which one of the parents was mentally or physically ill.

> There is no doubt that illness brings about a disequilibrium within the family and a change in complementarity of roles (Anthony, 1970, p.60).

Anthony (1970) pointed out that the family must acclimatize initially to illness and then to the "wellness" of the patient.

Shellhase and Shellhase (1972) state that the necessary reorganization of family objectives following physical disability of a member often results in changes of roles. They go on to say:

> Established patterns of decision-making activities are no longer workable if they had depended upon the able-bodied presence and participation of the now-disabled member. In addition to the earlier purpose of the family ...the family is now required to devise and implement an accommodation to the reality of the disability within the family group (Shellhase and Shellhase, 1972, p.549).

Besides role changes, another noticeable area of change following illness of a family member may be in a family's patterns of interaction. Families establish patterns of interaction to organize family functioning into a reasonably stable system. These patterns identify what is acceptable and not acceptable regarding how, when, and to whom to relate in a wide variety of content areas (Watzlawik,

Beavin, and Jackson, 1967). Jackson (1964) coined the term "family rules" to identify these governings of family life. Repetitive patterns of interaction among family members define family rules which, in turn, govern patterns of interaction.

Haley (1962) said the focus of a family study should be on the total family and the interactions between family members rather than the interactions between family members and the interviewer or tester. But rarely is reference made to interactional changes as a response to illness of a family member. Shellhase and Shellhase (1972) report that, in response to traumatic injury of a family member, "...the full range of activities and transactions which contribute to the maintenance of the family as a group undergoes extensive change" (Shellhase and Shellhase, 1972, p.549).

EFFECT OF FAMILIES ON ILLNESS

Families have an effect on the course of illness and rehabilitation. Power (1976) observed chronically ill patients and their families and determined that the feelings and attitudes of the patient's family are a vital factor in the adjustment to illness. This was strongly supported in a two year study of patients, their families, and rehabilitation problems (Peck, 1974). Problems in rehabilitation were most frequently a sign of uncooperative family strategies such as undermining the experts or

controlling the patient's initiative.

The variable of time probably has an effect on the importance of family to patient progress. The low significance in the relationship between family solidarity and rehabilitation in Litman's (1966) study is most likely due to the early, critical stage of the orthopedic injury when it is feasible that family solidarity would have little effect on early training of the patient. Closer to the end of the fifteen-month period of training it was found that the family did play an influential role in the patient's convalescence. Litman concluded that, "It appeared that therapy may be enhanced if performance is conceived in terms of re-entry into an established family constellation rather than an individual or personal matter" (Litman, 1966, p.216).

Using a questionnaire, Levinson (1976) determined that the family resources of religious belief, education, and income were more significant than marital satisfaction in reducing stress and increasing coping ability in the crisis related to having a mentally retarded child. A methodological shortcoming was this project's retrospective approach to the study of the coping process.

Family factors predicting home placement of severely disabled polio patients were the kinds and degree of role changes which the disability imposed. Where large differences existed in pre and post-illness family roles, the patients were more likely to remain in hospital (Deutsch and Goldston, 1960).

The family also has an effect on illness susceptibility.

> The family contributes not only to genetic predisposition but also to the actual etiology of specific diseases through the transmission of social values, the socialization process of the child, and the family pattern of daily living and behavior (Murray and Zentner, 1975, p.229).

SUMMARY OF LITERATURE REVIEW

Family systems attempt to maintain a steady state but can experience crisis. Caplan's definition of crisis as an experience of affective change and disorganization of function appears to be widely accepted (Aguilera, Messick, and Farrell, 1974, p.6).

However, the study of families in crisis is complicated by two factors. The focus of the early development of crisis theory was the individual. Attempts to directly apply crisis theory to family systems ignores the complexity of a system comprised of many individuals. Secondly, investigators and writers have used numerous approaches and points of view in their attempts to understand the family. Consequently the phases, characteristics, and temporal aspects of crisis in families are difficult to determine from the readings.

The literature supports the view that illness can constitute a crisis in a family. The family's response to

the crisis has an effect on the course of illness and implications for the family's integrity.

The literature most frequently describes family reactions in terms of an individual or family subsystem. This is especially true in the studies describing affective or emotional responses. Other responses to illness have been described as changes in family structure, roles, and occasionally as changes in patterns of interaction.

Using existing knowledge of family dynamics and crisis, this study then, is designed to further explore the family's responses to illness of a family member.

III. METHODOLOGY

The first purpose of this study was to describe reactions that occur in families when fathers who have experienced their first myocardial infarction have been home from hospital for one to three weeks. The second purpose was to describe what people and services these families report to be helpful during this one to three week period. This information could be added to existing knowledge about how families experience crisis and how nurses can give effective care to patients and their families as they cope with the crisis of illness. The purposes of this study and the lack of significant research in the area directed the investigator to an exploratory descriptive research design (Brink and Wood, 1978). This chapter describes the various aspects of the methodology used to carry out this study. Discussed in the following pages are sample selection, data collection, and data analysis.

SAMPLE SELECTION

The convenience sample was selected from a population of coronary patients (non-surgical) in two large urban

general hospitals. In both settings the patients spend one to seven days in a coronary acute care area before being transferred to the post acute coronary care units where they remain until discharge. The head nurses on both post acute units (8 and 18 beds respectively) reported that their bed occupancy was almost always 100%.

For purposes of homogeneity of developmental stage, the 10 families in the sample had at least one child living at home. Other criteria of eligibility were:

- the father had recently experienced his first known myocardial infarction
- the family lived in the lower mainland, and was accessible for a home visit
- parents and children nineteen years or older would be able to read and respond to the letters of consent

Each week this investigator spoke with the head nurses of both units to get a list of eligible patients about to be discharged from hospital. The investigator visited each eligible patient in the hospital. The content of the letter of consent was discussed and consent was sought to participate in the study and to approach other family members (See Appendix A). Telephone verbal consents were sought from other family members and an appointment made for a home visit. Written consents were obtained on the occasion of the home visit before the interview began (See Appendix B).

One patient refused to participate in the study. He was very anxious in hospital and about discharge in

particular. He asked to have two weeks to "take it easy" and then he would consider it. (When contacted by the investigator, all family members agreed to participate.)

The method of sample selection did not provide a random sample hence the results of the study are not generalizeable beyond the families of the study.

It is assumed that variables such as previous learning experiences, individual personality factors, and socioeconomic levels influence the response of the family system to illness. The effects of these extraneous variables were not controlled except for the variable of previous learning experience. This study specifies that the patient will have experienced his first known myocardial infarction. Since the focus of this study was on qualitative data rather than proving or disproving a hypothesis, this limitation was not a major concern.

DATA COLLECTION

The method chosen for collection of the data was a semi-structured interview to avoid restriction of responses but to ensure that comparable data were collected (Brink and Wood, 1978). A combination of open-ended and closed-ended questions and scale items was used as advised by Kerlinger (1973). Five content areas were covered by the interview schedule. Four content areas were related to family reactions in the realms of affect, interaction, roles and

structure. The fifth content area was related to what people and services the family perceived to be helpful.

The interview schedule was examined by thesis committee members and revised. It was submitted to two experts (a member of the nursing faculty and a nurse clinician in a community mental health centre) for review. Adjustments were made to eliminate ambiguities and inadequate wording. The revised interview schedule was pretested with two eligible families and minor final adjustments were made. The interview schedule in its final form is presented in Appendix C.

One to three weeks after the father had been discharged from hospital, each family was interviewed once in their home. This provided them with a familiar and comfortable setting. It also provided opportunities for the investigator to observe interactions, non verbal cues, and environmental factors which validated family responses. The investigator used the interview schedule with each family. The interviews were tape recorded and the content of the tape recordings was compared to notes written during the interview to ensure that the written data were complete and accurate. Additional notes of observations were made immediately after each interview.

Members of the thesis committee monitored random sections of tape recordings with the interview schedules to ensure validity of the investigator's judgements. Objectivity of the participant investigator was fostered

by the thesis committee's monitoring of tape recordings and interview schedules, the use of a standard interview schedule, and the investigator's self-scrutiny.

The interviews ranged from 30 to 60 minutes with the average being approximately 50 minutes. The total time spent with each family was about 75 minutes. All interviews took place in the family home, 8 in the evening and 2 in the afternoon. Only one family member, an 11 year old, reported feeling self conscious with the tape recorder once the interview had ended.

DATA ANALYSIS

Descriptive analysis was planned for the data since the purposes of the study were to describe reactions and people and services perceived to be helpful. The information from the study would be added to existing knowledge. Descriptive analysis was also appropriate since, without a random sample, the conclusions of the study refer only to the study sample (Brink and Wood, 1978).

The abundant data from the semi-structured interviews were summarized into categories and descriptive statistics such as frequency distributions were used. This approach is defined by Holsti as content analysis.

> Content analysis is any technique for making inferences by objectively and systematically identifying specified characteristics of messages (Holsti, 1969, p.14).

IV. RESULTS

The first purpose of this study was to describe reactions that occur in families when fathers who have experienced their first myocardial infarction have been home from hospital for one to three weeks. The second purpose of the study was to describe what people and services families report to be helpful during this period. This chapter will describe the sample and report the findings of the study.

DESCRIPTION OF THE SAMPLE

As shown in Table 1, the sample consisted of 10 families and included 41 family members. Fathers ranged in age from 40 to 58 years, mothers from 34 to 55, and children from 2 to 23.

All of the fathers in the sample were on partial or full salary at the time of the interview. Two wives worked part-time (up to three days a week), and three wives worked full time.

TABLE 1

Ages of Household Family Members

	Age in Years		
Family	Father	Mother	Children
1	40	39	11, 17
2	40	34	2, 8
3	43	42	8, 12, 17, 21
4	46	44	15, 19, 21
5	44	41	6, 7, 9, 15[a]
6	44	42	15
7	50	48	9
8	58	55	23
9	52	49	17, 23
10	43	39	8

[a]Lives in household but was not available for interview.

The number of days fathers spent in hospital ranged from 8 to 15. The length of time between date of discharge and the family interview ranged from 8 to 19 days (See Table 2).

TABLE 2

Duration of Hospitalization and Number of Days After Discharge That Interview Took Place

	Number of Days		
Subject	Acute Care	Post Acute Care	After Discharge
1	3	10	11
2	1	12	8
3	6	9	10
4	3	11	19
5	4	8	14
6	1	11	9
7	2	6	11
8	4	11	8
9	7	7	12
10	1	12	8

Eight fathers were being visited by home care nurses twice a week at the time of the interview. One father was attending a physiotherapy program.

FINDINGS

The literature review suggested that families experiencing illness of a family member would manifest reactions or changes in family roles, patterns of interaction, affect,

and structure. Items 1 through 4 of the interview schedule were designed to gather these data. The 10 families interviewed described changes in all 4 areas, as shown in Table 3.

TABLE 3

Areas of Change Described by Families

	Changes			
Family	Role	Interactions	Affect	Structure[a]
1	X	X	X	X
2	X	X	X	X
3	X	X	X	X
4	X	X	X	X
5	X	X	X	X
6	X	X	X	X
7	X	X	X	X
8	X	X	X	X
9	X	X	X	X
10	X	X	X	X

[a]Includes changes in Social Contact and Family Membership but excludes reduced contact with father's co-workers.

More details regarding these areas of change are described in subsequent sections of this chaper.

Changes in Roles (Item 1)

Table 4 shows the changes in roles in descending order of frequency. Of the 10 families, one reported changes in 4 roles, 5 reported changes in 3, one reported changes in 2, and 3 reported changes in one role.

TABLE 4

Changes in Roles Described by Families

	Family									
Roles	1	2	3	4	5	6	7	8	9	10
Household chores (1a)	X	X	X	X	X	X	X	X	X	X
Financial (1f) management	X	X	.	.	X	.	.	.	X	X
Looking after feelings (1e)	X	.	X	.	X	.	.	.	.	X
Disciplining children (1b)	X	X	.	X	.	.	.	.	.	.
Decision making (1d)	.	.	.	X	.	.	.	.	X	.
Initiating (1c) social activities	.	.	.	.	.	.	.	.	.	.

The roles included were those identified by Nye (1976) except for the sexual role which was not explored by the investigator nor mentioned by family members.

All 10 families experienced changes in household

chores. The changes were minimal in some families:

> Dad didn't do anything (before the heart attack) anyway. The only change is Mom did some gardening one day and the boys usually do it.

One mother said:

> I'm doing less because I'm spending time with him, but it (housework) is still my responsibility.

Nevertheless, all 10 families reported that wives and children were doing more work to reduce father's workload around the house. However, 4 fathers assumed new household responsibilities:

> (Father's) doing more around the house because he's home and it's easier because he has lots of time.
>
> Dad is helping more with dishes and cooking because he's bored.

One father assumed reponsibility for waking his wife and daughter "...to get her to school on time. Usually Mom sleeps in." And children reported of their father, "He makes us snacks now for after school."

Five families reported changes in the financial management of the family. In all 5, the wives had increased their participation from no involvement to "...doing more leg work" and to "...going to start paying the bills and doing the banking."

Four families reported changes in who looks after people's hurt feelings and concerns. One mother said she had less time to provide relief for her children because

she had to be nurse-companion to her husband. In the other 3 families, the children reported going to Dad less than they used to.

The changes reported by 3 families in regards to disciplining the children were varied. One mother reported:

> I'm doing 100% now to ease the stress for Dad.

One father reported having increased involvement with the children:

> I can't put up with the screaming and yelling. I'm forever putting the children in their rooms.

And the youngest (15 years) of 3 boys in a family reported:

> Dad yells less now. I'm doing some yelling now - keeping (older brothers) in line.

Only 2 families reported a change in decision making roles. In one family, the boys described the usual family pattern:

> Usually we let Dad do the worrying and let Mom go hysterical.

However, in a recent episode when the youngest child was believed to be lost, the oldest boy "took over" and mother calmed the father. In the second family, the wife got a driver's learner permit without discussing it with her husband and this was a change. Families who hadn't experienced having to make a major decision as yet did not anticipate a change in the decision making in the family.

None of the families reported a change in the role of initiating social activities in the family.

Another role that emerged in the interviews was one which 7 wives identified. They reported activities and concerns related to their perceived health care worker responsibilities. Some typical comments made were:

> It takes me a long time to shop because the diet has changed for everyone and I know I have to get it right.
>
> I'm nagging more...Don't do this. Leave that alone.
>
> I'm trying to keep the kids quiet, stop them from acting up while he's home - but it's hard.
>
> If he's having aches or pains or problems, I sink right down.
>
> At first I babied him too much. Now I'm afraid he'll get into the habit of lying around. It's hard to know what to do.
>
> Last week I slept lightly in case he needed something.
>
> I feel more responsibile for making him feel O.K.

Changes in Patterns of Interactions (Item 2)

Table 5 shows that of the 10 families, 9 reported changes in the amount of talking they were doing, and all 10 reported changes in the kinds of things they talked about. Data yielded from item 2c of the interview schedule were redundant and omitted from the analysis.

TABLE 5

Changes in Patterns of Interaction
Described by Families

Patterns of Interaction	Family									
	1	2	3	4	5	6	7	8	9	10
Amount of Talking (2a)	+	+	-	+	-	+	+	.	V	-
Topics (2b)	X	X	X	X	X	X	X	X	X	X

Note. V indicates differing responses from family members

In 8 families discussion of stressful topics was reduced. Children required less direction and were obedient quickly. There was less arguing between siblings, parents, and parents and children. In 2 of these families parents avoided talking about financial matters and in one family, financial matters were the one "serious" topic they did discuss. Very frequently, it was the wife who was editing subject matter in the family:

> Don't bug father with that right now or he'll get upset.

Only one father reported withholding information to control stress levels of his wife.

> I don't tell her if I'm not feeling well. I try to hide it.

Six families reported that they were talking more about health-related topics: diet, weight, exercise. Only

4 families reported that the father's heart attack per se had been discussed in the family but this question was not asked of all families.

In one family there was more joking and loving looks exchanged between the parents than had been the case before the heart attack, and one father said he was talking about school with his children more than he had before.

In terms of the amount of talking being done, 5 families reported they were talking more than they had before the father had had his heart attack and 3 families reported talking less than they used to. In one family 3 members said the family was talking the same amount and one member said the family was talking less.

While discussing changes in patterns of interaction, 4 families commented on new perspectives the heart attack had brought about in the family:

> ...more aware that life is really short. Don't waste precious time arguing about silly things.
>
> I've done lots of thinking that I've never done before...things are better now, more like they used to be (more loving, time together).
>
> (Husband) I used to be strong, steadfast, a rock. I feel closer and more intimate towards (my wife). I'm much more conscious of how much I need her. (Wife) It's been the same for me. I appreciate him a lot more...He's more important to me than I thought.
>
> The family isn't quite as permanent as I thought.

> Perhaps we were drawn closer together when Dad had this heart attack. Makes you forget the little things and we try to get around it rather than get on each other's nerves. We don't take anyone for granted anymore.

Changes in Affect (Item 3)

Table 6 shows the changes in affect in descending order of frequency. Six families reported changes in all 5 areas of affect, 3 families reported changes in 4 areas, and one family in one area of affect. With the affects of "impatience", "hopefulness", "fearfulness", 9 families reported changes. With the affects of "happiness" and "nervousness", 8 families reported changes.

TABLE 6

Changes in Affect Described by Families

	Family									
Affect	1	2	3	4	5	6	7	8	9	10
Impatience (3b)	-	V	V	V	V	-	V	.	V	V
Hopefulness (3c)	+	V	V	V	+	+	.	V	+	+
Fearfulness (3e)	+	+	+	V	+	V	.	V	V	+
Happiness (3a)	V	-	.	+	-	V	.	V	V	+
Nervousness (3d)	V	+	+	V	V	V	.	+	.	V

Note. V indicates differing responses from family members.

In 7 of the 9 families experiencing changes in "impatience," family members reported trying to be nicer, more relaxed and tolerant of one another. As one child-sibling put it:

> Our family is more subdued, less reactive, less boisterous.

In one family the 4 children reported that this more patient behavior occurs, "...only when Dad's around." Increased impatience with diet and activity restrictions was reported by 4 of the 7 fathers. In the 2 families where less impatience was reported overall, some family members reported increased impatience with the children. In one of these families, the father thought he was "bitchier" but the mother thought he was the same. In one family, the oldest son reported increased impatience with his father's infraction of diet and activity limits.

Of the 9 families reporting changes in "hopefulness," 5 families said they were feeling more hopeful. In the remaining 4 families, there were differences expressed. Fathers expressed hopefulness while mothers and children were less hopeful.

> (Father) I'm more hopeful. I feel stronger every day. (Mother) I'm still insecure, especially if he's not feeling well.

> (Father) At the end, I'll be back to normal. (Mother, Children) We're still nervous about it.

> (Father) When I was in hospital I thought, "What will happen next time?" But now I'm just thinking about getting better. (Mother) It happened. Things can't be the same. (Son) Expect the unexpected but don't dwell on it.
>
> (Father) Make the best of it. The worst is behind us. (Mother) It might happen again. I guess that feeling will wear off.

Family members in 9 families said the family was more fearful than it had been before the heart attack. One father said:

> No one can tell you when it's going to happen again...if it's going to happen.

In 4 families where mothers expressed increased fearfulness, differing views were presented by other family members. One son expressed the view of father and two of the children:

> Think of it as a one shot deal. It won't happen again.

But the third son in the family said:

> Sometimes you forget he had one (heart attack). Everything's fine and dandy. Then I remember, something could happen.

In response to his wife saying she was more fearful, a husband responded:

> I wouldn't say I'm more afraid. All I can say is I'm more aware of what's going on around me.

Earlier in the interview, this same father had said about activity:

> The physical strength might be there but I'm afraid to use it.

Another father said:

> I disagree. There's no change (in fearfulness).

Another father said:

> I know they're (wife and son) more fearful but I couldn't say for myself. I'd have to think on it.

Of the 8 families reporting a change in happiness 2 families reported being less happy and 2 were more so. In 4 families there were varying responses from family members. Wives and children reported more happiness because, "He's here with us," and positive changes in family relationships and health habits had taken place. In these families one wife expressed her ambivalence about happiness:

> It's hard to generalize until the doctor says he's O.K.

Two fathers said there hadn't been any change in family happiness and one father said the family was less happy because of the restrictions on everyone. In this last family, the 2 children said there was no change in happiness.

Three families reported an increase in nervousness and 5 families reported varying responses. In these 5 families, the mothers reported increased nervousness due to having to manage the children's problems alone, reduced finances, father's health, and other new responsibilities. As one woman said:

> There's more pressure and strain to do things. And there are deadlines.

In these 5 families, 2 fathers and their children reported no change in nervousness, 2 fathers reported less nervousness, and one son said, "There's less tension because it goes away a lot faster now."

Of 43 responses in regards to changes in affect, 24 were varied responses where family members stated different opinions on more, less, or no change.

There were other expressions of affect in relation to adjustment to the illness. One father clearly expressed a sense of loss:

> You have to give up everything (food, cigarettes, activity) all at once. I've had to give up a helluva lot!

And another father expressed anger towards himself:

> I'm really mad. I should have done it (stop smoking, diet) earlier.

Only one marital pair said the husband's increased dependence on the wife was "...something new for both of us ...not frustrating, just inconvenient."

Some children were demonstrating marked changes in behavior. In one family, the 15 year old son did not come home for the evening interview. His parents thought he was deliberately avoiding the discussion. They described him as:

> ...changed completely. He used to run around a lot (before the heart attack). Something's bothering him. He's much quieter, settled down. The school counsellor called but (the son) won't confide in him.

In another family where the father and daughter reportedly never got along, the daughter felt unable to argue with her

father about keeping a part time job that was very important to her. Uncharacteristically, she complied and gave up her job without argument. In another family, the daughter planned to stop seeing her boyfriend because her father had disapproved of him. She had been dating the boy for several months and her father had not mentioned it since coming home from hospital. The daughter thought she should do it "...to make Dad happy."

Statements of shock and disbelief were expressed by 4 fathers during interviews that took place on the eighth, tenth, eleventh, and fourteenth days post discharge:

> Why me? I had only one on the risk scale - heredity.
>
> The biggest thing was the shock. I never get sick. I never miss work. Nothing could happen to me!
>
> I have a mental block. I'm only 44 years old. I shouldn't be here.
>
> I've never been sick. I still can't believe it...I've always been so healthy.

Of these 4 fathers, 2 had experienced difficulties in the first week home from hospital. One father reported:

> I had a sort of flu for four days: nausea and vomiting, headache, shakes, and crying jags. I still have an eye inflammation and a headache.

One son reported and all members agreed:

> In the first few days Dad was picky, edgy, almost explosive. Now he's a lot quieter.

Changes in Family Contact (Item 4)

The parameter of family structure has two aspects. The first is family contact with outside groups and the second is family membership. Table 7 shows that of the 10 families, one family experienced changes in the amount of contact they had with 6 groups, 5 families with 4 groups, and 4 families with 2 groups. Table 7 shows the changes in contact in descending order of frequency.

TABLE 7

Changes in Family Contact with Groups

	Family									
Groups	1	2	3	4	5	6	7	8	9	10
Friends (4ai)	+	+	-	+	-	+	+	+	+	-
Community Agency People (4avii)	+	+	+	+	+	+	.	.	+	+
Family Members (outside household) (4aii)	+	+	NA	NA	+	.	.	+	+	+
Neighbors (4aiii)	+	-	.	+	+	.	.	.	.	+
Clergy (4avi)	.	.	.	.	-	.	.	.	-	.
People from school (4av)	.	.	.	.	+	.	.	.	.	.
People from work (excl. father) (4aiv)	NA	NA	NA	-	NA	.	-	.	.	NA

Note. NA indicates not applicable. Families did not have extended family in Canada or family members, other than fathers, who worked.

By group, 10 families experienced changes with friends, 8 with community agency people, 6 of 8 families with extended family members experienced changes, 5 experienced changes with neighbors, 2 with clergy, one with people from school, and 2 of 5 families with working members other than fathers experienced changes.

All 10 families experienced changes in the amount of contact they had with friends. In 7 cases, friends had been seen more. In 2 of the 3 families where friends had been seen less, the families remarked that friends seem to be "hesitating - afraid to tire him (father) I guess."

Eight families had contact with home care nurses. Of these 8, 2 had contact with a dietician, and one had contact with a physiotherapist as well. Bank managers had been seen by 2 of these families.

Two families did not have other relatives in Canada. Of the 8 remaining, 6 families had increased contact with extended family members and one family said the heart attack had brought the whole family "closer."

Half of the families reported no change in the amount of contact they had with neighbors. "We never saw them anyway." "I doubt that they even know Dad had a heart attack." Of the 5 families reporting a change in contact, 2 said they didn't know the neighbors but the neighbors had asked how the father was feeling.

Similarly, 5 families reporting no change in the amount of contact with clergy remarked that they didn't have

any contact anyway. Two families reported less contact because of inability to get to church services. One wife continued to attend church as before. Two families reported no change and made no further comment.

Only one school counsellor contacted the parents about their son's behavior and possible adjustment to the father's illness. The most frequent comment made by the family in response to the question was, "No change. I doubt they (teachers, counsellors) even know (about the heart attack)."

Of the 5 families where someone other than the father was employed, one member reported having less contact with people from work and this was related to her having changed the shift she worked. Another member took a leave of absence from work to be home with her husband.

In relation to the amount families were going out of the home, (Item 4b), 6 families reported they were going out less. In 3 families, this was due to father's limited physical activity and mother's inability to drive the family car. With 4 families, mothers and children reported "sticking closer to home." In one family, fathers and some children were going out less while mothers and some children were going out the same amount. In one family parents were going out less and their child was going out the same amount as before the heart attack. This question prompted 4 families to say they planned to spend much more time together once father was well.

Only one family experienced a change in family membership (Item 4c). The two children had spent a few days with relatives "...to give the kids a break."

Family Perceptions of Help (Item 5)

Table 8 shows the families' reports of the amount of help they received since the father was discharged from hospital.

Table 9 shows which person(s) families perceived as offering the most help to the family since father had been discharged from hospital.

TABLE 9

Person(s) Offering the Most Help to Families

	Family									
Person(s)	1	2	3	4	5	6	7	8	9	10
Friends (5ai)	X	.	X	X	.	X	.	X	X	.
Relatives (5aii)	.	.	NA	NA	X	.	.	X	.	.
Clergy (5aiii)	.	.	.	.	.	.	.	.	.	.
Nurses[a] (5aiv)	X	X	X	.	.	X	.	.	X	X
Doctors (5av)	.	X	.	.	.	.	.	.	.	.
Community (5avi)	.	.	.	.	.	.	.	.	.	.
Others (5avii)	.	.	.	.	.	X[b]	.	.	.	.

Note. NA indicates not applicable. Extended family members were not in Canada.

[a]Families 1-6, 9, 10 had home care nurses twice a week.

[b]Dietician.

TABLE 8

Amount of Help Received by Families

Family	No Help	Very Little Help	Some Help	Quite A Bit of Help	A Great Deal of Help
1	...	...	...	...	X
2	...	X	...	...	...
3	...	...	X	...	...
(4)[a]	X	X	...	...	...
5	...	...	...	...	X
(6)	...	...	...	X	X
7	X	...	...	...	...
8	...	X	...	...	...
(9)	...	...	X	...	X
10	...	...	...	...	X

[a]Families in parentheses indicate differing responses from family members.

Of most help to families during this period (Items 5b, 5c, 5d) was information and someone to listen and reassure family members. Seven families said getting information was the most helpful or would have been the most helpful service. Of these 7, 3 families said it would have been helpful if the information they received from the nurses, cardiologist, and general practitioner had been less conflicting and more understandable.

Being reassuring, cheerful, a good listener, a calming effect was listed by 5 families as being helpful. Two families specifically identified that it was helpful to have someone to reassure and support mothers.

Just knowing that help had been offered and was available was reported by 3 families as helpful. Financial assistance was identified by 2 families as being helpful. Specific services such as transportation, babysitting, and providing meals were mentioned by 3 families.

Four families made statements indicating and valuing the family's independence.

> Help's been offered but I've never accepted.
>
> We didn't need it. We're pretty self-sufficient.
>
> We don't ask for help. We're independent.

V. ANALYSIS

All 10 families described changes that had occurred in the areas of family roles, interactions, affect and structure since the father had returned home from hospital. In terms of the help they perceived receiving during this time, one family reported "no help," 2 families reported "very little help," one reported "some help," and 3 reported "a great deal of help." A difference of opinion among family members occurred in 3 families reporting "no help - very little help," "quite a bit of help - a great deal of help," and "some help - a great deal of help." Friends and home care nurses were most frequently seen as the persons offering the most help to the families. Receiving information and reassurance were seen as helpful during this time.

This chapter contains the discussion of these findings and their relationship to the conceptual framework and existing knowledge. The chapter concludes with implications and recommendations for nursing practice, education, and research.

INTERPRETATION OF FINDINGS

This study was of an exploratory nature using a convenience sample of 10 myocardial infarction patients and their families. Hence, the findings are not generalizeable beyond the families in the sample. Considering these limitations, discussion of the possible meanings of the findings will be organized under the headings family focus, family reactions, family perceptions of help, and illness as a family crisis.

Family Focus

Many authors in nursing and medicine suggest that a family evaluation should be an integral part of any patient assessment (Olsen, 1970; Livsey, 1972; MacVicar and Archbold, 1976; Eichel, 1978). The findings of this study support a family focus in health care. Families had indeed experienced changes in response to the father's heart attack. The families were also very actively involved in father's convalescence. The findings of Mayou, Foster, and Williamson (1978) concur. They advise that the whole family be given advice and help throughout the convalescence of the myocardial infarction patient.

It is to be expected that most families focus on the ill member, expending time and energy in that direction. But it seems clear that other family members may need extra support during this difficult time as well. In this study,

mothers appear to be very stressed with concerns about the father and the pressures of added responsibilities. Many wives (38%) in the study conducted by Skelton and Dominian (1973) had also found the period after discharge very stressful. Consider the son who was reportedly demonstrating marked behavior changes and did not participate in the interview. What of the daughter unable to vent her feelings of anger towards her father and her feelings of loss about the part time job? In the near or distant future, these members' reactions may influence their health, the current patient's health, and the health of the family system.

A concern often accompanying a proposal for a whole family system study is, "Family members won't be able to express themselves with everyone present." Willingness to engage in a family interview is indicated by the fact that only one patient declined when approached by the investigator. Families willing to participate in such a study probably have the ability to express their thoughts and feelings to some extent. They may also be seeking this opportunity because they perceive it may be helpful to the family. These motivations to participate are similar to those for individuals consenting to participate in an individual focused study. Further, the limitations inherent in interviewing families are not dissimilar to those of interviewing individual respondents. In both, the subjective data are fallible but continue to be important sources of

information. The most telling argument for the family members' ability to express themselves in a family interview is the richness of the data in the previous chapter.

Although willing to participate in a family interview, some families needed a catalyst to be able to talk together as a family. Four families had discussed the heart attack and subsequent events only when visitors had asked about it. It was through such visits that many family members gained this information. Yokes (1973) suggests that interpersonal relationships may suffer if family members do not talk with the patient about the heart attack. The data collection interview was also helpful to some families. Only one wife had expressed surprise that the entire interview would take place with all family members. She said she wouldn't be able to discuss her annoyance with her husband for "maybe getting too used to doing nothing." She admitted being unable to express annoyance towards him even when he wasn't ill. Her difficulty was manifested in her alternating overprotectiveness and withdrawal from her husband. She was also nervous about asking him how he was feeling. During the interview the husband spoke of his fatigue, his fearfulness, and determination to comply with the doctor's orders to "take it easy." Both wife and daughter asked him questions and all three talked about the degrees of overprotectiveness demonstrated in the past two weeks. The wife said later of the interview, "It was good. I really enjoyed it once we got into it." Given the opportunity, family

members can participate in a family discussion, expressing themselves and clarifying perceptions.

Children were active and valuable participants. Parents seemed to welcome the opportunity to hear their children discuss their observations and reactions. In response to the opening question, "What changes have you noticed in the family in the past two weeks?," it was a 6 year old who said, "Dad can't smoke and eat much anymore. Mom cries a lot. And we don't have much money." To think of children as unaware and unable to report is a gross underestimation of their capabilities. The attentiveness and participation of all family members indicate the potential need for families to have opportunities to discuss their changed situation together.

There were many opportunities to validate interview content with direct observations. A father who had reported feeling impatient with his children lifted and carried his 2 year old daughter to her room because she had changed her position in the sitting arrangement. Another family with 3 sons had reported that all family members were helping around the house. The house was immaculate, the diet cookies served had been baked by the 15 year old, and the oldest son talked from the kitchen while making lunch for his evening job.

Family members do not always agree. Disagreement can range from healthy individuation of members to pathological conflict (Satir, 1967). Differences of opinion are

often based on different perceptions. These perceptions are influenced by available information, individual needs, and previous experiences. This was the situation when family members were asked to identify changes in patterns of interaction and affect and asked to score the amount of help they had received. The occurrence of differences of opinion was normalized in the opening comments of the interview. During the interview, differences of opinion were explored and individuals were asked to clarify their views. Family members either agreed or disagreed with views presented and the investigator continued the interview. Opportunities to gain new perspectives were utilized but each member's view was accepted.

Family Reactions

Changes in Roles. All 10 families experienced role change as a response to illness of a family member as defined in this study.

The major impetus for the adjustment in roles was the family's attempts to limit physical activity and control levels of stress for the fathers. This was expressed in the role changes for household chores, financial management, looking after feelings, disciplining children, and decision making. All family members perceived these limitations as necessary for keeping father well and all members were involved to some extent.

Another motivating factor could be the wives'

realization of their dependence on a husband who might not always be there. One woman who was becoming more involved in the family's financial management said:

> When I was single I was really independent...took care of bills, insurance, all that stuff. Ever since we've been married I've left all that to him. Everything, everything in my life, decisions, I've just let him take care of everything in my life. I realize I have to stand on my own two feet. It's really hard...a big change. I have no confidence left.

Another woman who hadn't worked for 22 years said:

> I wish I was working now...for the money and the independence.

This attempt to reduce dependence on the husband prompted this woman to get her driver's learner permit.

> I'm learning to drive and that's a big step for me...We had talked about it before but nothing was firm...I kept putting it off until now.

The father's sick role in itself necessitated the development of a corresponding health-care worker role in families. Most wives and many children shared this responsibility for monitoring the diet, observing father's condition, reminding him to do and not do things, creating a therapeutic environment.

None of the families reported a change in the role of initiating social activities. In fact, most families were experiencing a marked decrease in social activities and the resumption of same was seen as something for the

future. One man said he couldn't answer the question because he didn't know how social activities were initiated in the family. He was unable to anticipate how it would be done in the future. His lack of awareness of this particular pattern of interaction is contrasted with his son who felt they did very little together as a family, and his wife who said she initiates the activities and would continue to do so.

Although some couples spoke of feeling closer to one another, none of the families mentioned limitations on sexual activity. The question had been purposely omitted because of possible parental discomfort with children present. It is also possible that, like social activities, sexual activity was not a priority for these couples during the time of this study.

The variance in the number and degree of role changes among families is most likely related to the variance between pre and post illness roles in each family. In 3 families only one role change was reported - household chores. In one of these 3 families, the father's role was characterized by relatively little involvement and few role responsibilities. He appeared somewhat passive and compliant in contrast to his wife who was very dominant during the interview. These characteristics are similar to those of a sick role hence illness of the father in this family may produce minimal changes (Wu, 1973). In another family, the father's pre-illness role was largely that of being an ample wage

earner and having the "final word" in major decisions. Illness had affected neither of these roles thus far and the family did not anticipate changes.

The third family reporting only one role change points out the influence of the family's readiness and ability to realistically acknowledge the father's disability - its nature, extent, prognosis, consequence. The father frequently said:

> I've had a heart attack but there's no drastic change in our lives.

This family's report contained several contradictions suggesting their own perceptions were confused and contradictory. The father denied being more fearful but reported taking nitroglycerine on several occasions for chest pain. He drove the car after being told it was not safe for him to do so. He said he was on holiday time not sick time so he would have been home anyway. Maintaining pre-illness functions as much as possible seemed important in this family and the illness-imposed changes were minimized in their report more than in fact.

Changes in Patterns of Interaction. Alterations in patterns of interaction occurred in all 10 families. The major factor again appeared to be the family's attempts to control the levels of stress experienced by the father. As one mother said:

> I know stress can bring on a heart attack. I bite my tongue and think, "Is it really worth it?"

A son said:

> We're more aware of when we're doing something wrong. This is going to kill my Dad.

Before the father returned home from hospital, mothers of younger children had already impressed upon them the need to be cooperative, obedient, and quiet. With older children there was also a conscious effort to be helpful and less argumentative. It would seem that all family members assume some responsibility for father's health during this period of time.

Members were also involved in the convalescent regime. They monitored father's diet and exercise. These seemed to be tangible things over which members could exert some control to keep father well.

The life-threatening nature of the illness in this study also prompted a re-evaluation of family values and goals. The quality of relationships and having time together were two values which also influenced patterns of interaction in the direction of reducing conflict. There was a realization for most families that their time together was not unlimited.

Changes in Affect. Affect changes were experienced by all 10 families. Of the 5 affect areas explored, 9 families reported changes in 4 or 5 of them.

The one family that reported having only one affect change originally said they hadn't experienced any affect change. The father later said he was getting more impatient

to go out, go bowling, go to work. Several factors may have influenced this lack of reaction to the father's illness. The father's involvement in the family was limited even before the heart attack. Both parents worked different shifts and the wife seemed to be the main force in the family. Another factor was the sense of disbelief that the father had had a heart attack. He is lean, a non-smoker, and hadn't had health problems. His wife is an obese smoker who has had a series of illnesses in the past 10 years. Her illnesses, which included a myocarditis, may have fostered family adaptive skills which manifested themselves as marked non-reactiveness to illness. "His heart attack is just one more thing." All of these factors: similarities between father's sick role and well role, disbelief and possible denial, and previous experiences may have influenced their non-reactiveness to father's heart attack.

The families' attempts to control levels of stress to prevent father's relapse and their renewed appreciation of one another contributed to their sense of being "less impatient" with one another. But fathers experienced impatience and a sense of loss regarding the imposed changes in their life style and their self-image. This was even more difficult for fathers who were feeling quite well. They looked well, felt quite well, but were limited in what they could do.

All family members, including the youngest children, seemed to be sharing a responsibility for making father

better and preventing him from dying. The extremes of affect were no longer acceptable in the family - no arguing, "mustn't let my fearfulness hurt him," "can't run in from school and yell 'Hi, Dad!," no teasing. Family members tolerated little deviation from the valued "good" behaviors. Unfortunately, these expectations are difficult for children to meet all of the time. Their normal developmental needs continue to exist at a time when a parent's needs seem greater and parental resources are less available.

Compliance with the convalescent regime was also highly valued in the families. They expressed pleasure about new health habits which would prevent recurrence of a heart attack. Compliance was remarked upon. Deviation from the regime was a source of strain in families.

It was father's life that had been threatened and it was important for him to see a future for himself and his family. Hence, fathers expressed more optimism and hopefulness than did mothers. Mayou, Foster, and Williamson (1978) also found wives to be more distressed than husbands in their study of wives of myocardial infarction patients. Fathers also seemed to have more difficulty saying they were afraid of having another heart attack.

Mothers experienced the pressures of an increased workload. They were having to attend to all others' needs and assumed added responsibility when their own support system was diminished. They were also experiencing concerns for their husbands' lives. Skelton and Dominian (1973)

suggest wives receive alternative reliable sources to help them express their feelings. The more dependent the wife had been, probably the more frightening the prospect of being left to deal with matters alone.

This one to 3 week period following hospital discharge seems to be a time of affective ambivalence and contradiction. Family members can be happy and fearful, hopeful and afraid, happy and impatient. A family member's life has been threatened. He is home recuperating. Convalescence is characterized by limitations to previous lifestyle. He might have a heart attack without warning. It is a time of exploring limits. How far can I walk? How much can I do? Can I get angry? Am I expecting too much? Where are the limits? What is O.K.? One daughter reported:

> I saw Dad reach up to cut a lilac. He didn't say anything but I know it hurt him.

A father discovered limits.

> I thought I'd load the dishwasher to help out. And it really tired me. I mean, I couldn't believe it, you know?

And one mother who is still unsure said:

> They (father and son) kid each other and I'm afraid they're getting too rambunctious. It's not like (my son) would hit his father in the chest or anything. But now I don't bug (father) 'cause I figure he should know.

Changes in Structure. Five families experienced changes in the amount of contact they had with more than 50% of the groups mentioned.

All families experienced changes in the amount of contact they were having with friends. Most families (80%) had increased contact with community health care practitioners while 75% of the eligible families had increased contact with their extended family.

This study indicates that families are somewhat isolated from their neighbors. Even information was not readily shared with neighbors. Few families in this study had regular contact with religious institutions either. The children's school was another relatively closed system with which families had little contact.

These data suggest that friends, family, and community health agencies have much more access to the families than do neighbors, clergy and people from school. It can be expected that the openness of the family system to certain groups will also define the family's support system.

Since the families are going out of the household less than they used to, the increased contacts are occurring in the family home. Although several families mentioned that the increased number of visits from friends could be tiring, they were pleased that people visited. It provided diversion for the relatively home-bound family and was seen as a demonstration of caring.

Family households appear to cope with illness of a family member without altering family membership. For some families having help by altering membership would diminish their independence. Other families couldn't call on friends

or family for help because they were perceived as being too busy with their own lives and concerns.

Family Perceptions of Help

Most families (6) reported they had received at least some help. There was no apparent correlation between families who had made statements asserting their independence and those who had received very little or no help.

Three families had members who differed in their opinions of the amount of help received. The differences of opinion related to differences in circumstances and individual need. One father found the home care nurses very helpful but other family members had not met them. One wife found the nurses very helpful in providing her with information. It was information the husband had received in hospital so he perceived the nurses as less helpful. One father perceived the offer of help as helpful while other family members did not.

Most families indicated friends and nurses were the most helpful and this concurs with services identified as being most helpful: reassurance and information. This also correlates with the increased contact families reported having with friends and community agencies (home care nurses). Although contact with relatives had increased for 6 of the 8 families with relatives in Canada, only 2 families perceived family as being very helpful. Perhaps extended family

members were too anxious themselves about the ill member to be of much support to the household family.

Illness as a Family Crisis

The findings clearly indicate that illness as defined in this study affects the family. All families experienced some change in their roles, interactions, affect, and structure. Inasmuch as these changes are a period of disequilibrium and disorganization of function, the changes indicate that illness is a crisis.

Caplan (1964) also defined crisis as an affective change, a period of increasing tension and anxiety. Affect changes did occur in 10 families. But within the limitations of this study it seems doubtful that a "family mood" or affect can be measured if it exists at all. From 40-100% of the affect changes reported by each of the 10 families included differing responses from individual family members. Their perceptions of other family members and the events, and their own personal needs governed their own affective responses. The multiplicity of variables affecting each family member makes it unlikely that the family, that is all family members, could report the same affect at the same time.

Without a measureable entity of family affect, is there such a phenomenon as family crisis? More research is required. This study indicates that crisis theory as developed for individuals may not directly apply to family

systems. Literature describing family emotional responses to situations must be read critically. To date, the best definition for a family crisis may be the simplest as recorded by Rapoport (1965, p.24):

> Crisis in its simplest terms is defined as 'an upset in a steady state'...

Findings are inconclusive and more research is required to identify the characteristics and phases of family crisis. Several families suggested that each week after the father returned home was becoming easier - people becoming more settled and relaxed. Routines had been established, resources were known, roles were enacted, and some limits had been tested. Two families anticipated slipping back into pre-illness patterns soon. This implies that families experience the most disequilibrium and disorganization closest to the time of the imposed change - father returning home.

Negotiating new family rules and roles appears to be one of the family's adaptive tasks when a member becomes ill. The sooner these negotiations are completed to the relative satisfaction of all members, the sooner the family returns to some level of system stability. Families may require assistance identifying and calibrating necessary changes. Assistance may be in the form of facilitating a change in family cognition, affect, or behavior. These necessary recalibrations are, in fact, the opportunities for families to enhance their interactions, learn new skills, gain new perspectives. The converse is also true.

Dysfunctional families may respond to the demands of illness with increased rigidity and inflexibility. Old rules and roles are perpetuated, innovations and risk are not tolerated, and the cost to family and family member health is high. For the families in this study, it could be assumed that the father's transition to "wellness" (as defined and perceived by the family) will necessitate negotiation and recalibration of family rules and roles again. For some families this might constitute a crisis and one can speculate about its effect on the compliance behaviors characteristic in this study. Similarly, how would the family's progressive non-compliant behavior (children begin to argue, wife asks for support) affect father's transition to "wellness?"

IMPLICATIONS

Although the design of the study is such that the findings can only be considered tentative, they strongly suggest that the family is an integral part of the patient's illness and as such, will affect and be affected by the illness. This study holds some implications for nursing practice, education, and research.

Nursing Practice

In all health care settings the nurse should complete a family assessment regardless of which family member

is the current identified patient. The assessment should include the baseline data of pre-illness family structure, developmental stage, and levels of functioning. Family members should be asked for their perceptions of the illness and their current situation. After determining family reactions to the current situation, the nurse should compare this data to the family's pre-illness state and its' reactions in other situations of change. The differences in these family situations are most valuable data. The greater the difference or change between the current situation and pre-illness state, the more help the family may need to cope with the adaptive tasks confronting it. It is also important to assess the family's perception of the quantity and quality of its' support system and resources.

Nurses should meet with family members regularly throughout the course of illness. Understandable information and explanation should be provided to the family as its' need and readiness to learn dictates. Family members should be encouraged to verbalize their thoughts and feelings and the nurse should be available to listen. The family members need to hear acknowledgement of their difficult tasks and support of their efforts. The nurse should facilitate interaction among family members to fully utilize their knowledge and support of one another. The nurse, patient, and family members should identify problems and goals together. Outside resources should be provided as necessary. The family is its' own specialist and best

resource in times of change. The nurse, as facilitator, can maximize change for the improved health of all family members.

Nursing Education

All levels of nursing education should include the appropriate levels of knowledge and skills related to a family focus in health care and the behavioral aspects of illness. This would include a progressive application of an expanded base of knowledge from the natural and social sciences and humanities. Included would be content related to the concepts of family dynamics, adaptation, role theory, interpersonal and communication theory, change theory, developmental theory. Nursing students would require supervised opportunities to interact with and assess families in various developmental stages and situations. They would also require opportunities to consider their own family experiences and coping processes.

Community and hospital nursing services conjointly with nursing education should prepare and make available to nurses in practice, a series of workshops designed to help them develop and apply a family focus in their care.

Nursing Research

This study raises many questions and leaves many unanswered. How do family responses observed in this study compare to their responses when the patient first came home?

What was it like for the family when father was first hospitalized? What will happen to these co-operative, health-conscious, compliant families when father starts to smoke, the teenagers begin to argue? Will it happen? When? How would data from this study compare to that from a sample of families in which the patient was a child with leukemia, a mother with a high-risk pregnancy, a grandparent with a broken hip, an adult with multiple sclerosis? How is it the same for families? How is it different? How can we account for the differences? What more can these studies tell us about family theory, family therapy, crisis theory, behavior and illness? What constitute good and bad family responses? How do they affect the course of illness?

The amount and the richness of the data in this study indicate that family system studies should include all family members. Given that a family system is greater than the sum of its independent elements it is not appropriate to present a family "score" which is the mean of family member "scores." There is a great need for the development of reliable and valid family study tools and approaches to analysis. Until then, it is probably still most appropriate to have family members "average" their own "scores" through seeking consensus or continue to report the differences among members. This latter approach is most representative of family functioning and retains potentially useful information. Depending upon the purpose of a study, it may be appropriate for a family system study

to include both the family system and individual family members as respondents.

In family system studies where family members are only interviewed individually, it is true that individual secrets may be revealed, that is, information that is not available to other family members. As secret information, the data have limited meaning and the family focus may be jeopardized because the investigator could not explore the effects of the "secret" on the family nor the effect of the family on the individual and his secret. At best, the investigator would have to hypothesize the effects in terms of family organization, interaction, values and goals.

The parameters of roles, patterns of interaction, affect, and structure were useful and could be used in other studies of similar design. The developmental stage of the family, the nature of the illness, the setting, and the timing of the study would presumably yield special categories and different data within these parameters.

The semi-structured approach of the data collection was useful. With specific open and closed-ended questions, the families were able to report concrete changes and less concrete changes related to feelings and interactions. Allowing families to relate anecdotes also yielded valuable data related to the interview schedule. The flexibility of open and closed-ended questions helped orient families to looking at themselves, was not restrictive, and yielded comparable data.

RECOMMENDATIONS

On the basis of the findings and implications of this study, it is recommended that:

1. Facilitating the effective coping of patients and their families be a unique and integral focus of nursing care in all settings.
2. All levels of nursing education include the appropriate knowledge and skills required for nurses to practice with a family focus.
3. Research be conducted with various stages of numerous illnesses in different settings to identify concepts relevant to relationships between family reactions and illness.
4. Longitudinal studies be conducted to effectively identify relationships of time, family reactions, and illness.

VI. SUMMARY AND CONCLUSIONS

This exploratory study was designed to elicit information about family reactions to the crisis of illness and what families perceive to be helpful during this crisis. The study focused on the family crisis of incorporating back into the family a father who had experienced his first myocardial infarction.

The study was conducted with a convenience sample of ten myocardial infarction male patients, their wives, and children living in the household.

A semi-structured interview schedule was used with each family one to three weeks following the father's discharge from hospital. The interviews took place in the family's home and averaged 50 minutes in length. The interview covered four content areas related to family reactions in the realms of affect, interaction, roles and structure. The fifth content area related to what people and services the family perceived to be helpful. The interview data were summarized into categories and descriptive statistics were used.

All 10 families described changes that had occurred in the areas of family roles, interactions, affect and structure since the father had returned home from hospital.

In terms of the help they perceived receiving during this time, one family reported "no help," 2 families reported "very little help," one reported "some help," and 3 reported "a great deal of help." A difference of opinion occurred in 3 families. Friends and home care nurses were most frequently seen as the persons offering the most help to families. Receiving information and reassurance were seen as helpful during this time.

Although the sample was small and not randomized, it is possible to draw some conclusions based on the data collected. When a family member is ill, families may experience changes in their roles, patterns of interaction, affect, and structure. The quality and quantity of changes are related to several factors. Of considerable importance is the family's perception of the nature of the illness - its character, extent, effect, and prognosis. These perceptions and the enactment of the sick role by the patient produce changes which may contrast markedly or minimally with the family's pre-illness state. Illness, especially life-threatening illness, fosters a review of individual and family values and goals. This review can also produce changes in family roles, patterns of interaction, affect and structure.

It is presumed that family reactions can have an effect on the patient's course of illness. The effect is dependent upon the family's perception of the illness and their perception of the amount and kind of controls they

can exercise. Also related are the personal needs of individual family members.

Family discussions of their changed situation can serve many purposes. New information can be shared. Individuals' needs may emerge. Perceptions can be shared, clarified, and altered. Members can positively reinforce each other's efforts and negatively reinforce deviance. Solutions to problems can be explored and agreed upon.

Family perceptions of the amount of help they receive and the people they find helpful are influenced by the needs and perceptions of individual family members. Most families in this study coped with illness of a family member without altering membership of their household.

Families find clear information and reassurance from other helpful when they are coping with illness of a family member.

More research is required to identify the characteristics and temporal aspects of family reactions to illness and family effects on illness. For these purposes innovative approaches to research design and methodology are required to ensure scientific theory development and continued appreciation of the complexity of family systems.

BIBLIOGRAPHY

Aguilera, D.; Messick, J.; and Farrell, M. Crisis Intervention. 2ed. St. Louis: C.V. Mosby, 1974.

Anderson, R., and Carter, I. Human Behavior in the Social Environment, A Social Systems Approach. Chicago: Aldine, 1974.

Anthony, E. "Impact of Mental and Physical Illness on Family Life." Am. J. Psychiatry 127 (August 1970):138-146.

Bell, N., and Vogel, E., ed. A Modern Introduction to the Family. New York: MacMillan, 1968.

Bertalanffey, L. "General Systems Theory - A Critical Review," in Modern Systems Research for the Behavioral Scientist. 11-30. Edited by W. Buckley. Chicago: Aldine, 1968.

Brink, P., and Wood, M. Basic Steps in Planning Nursing Research. North Scituate, Mass.: Duxbury Press, 1978.

Caplan, G. Principles of Preventive Psychiatry. New York: Basic Books, 1964.

Deutsch, C., and Goldston, J. "Family Factors in Home Adjustment of the Severely Disabled." Marriage and Family Living 22 (November 1960):312-316.

Eichel, Ellen. "Assessment with a Family Focus." Journal of Psychiatric Nursing 16 (June 1978):11-14.

Epperson, M. "Families in Sudden Crises: Process and Intervention in a Critical Care Center." Social Work in Health Care 2 (Spring 1977):265-273.

Ferreira, A. "Family Myth and Homeostasis," in A Modern Introduction to the Family. 541-548. Edited by N. Bell and E. Vogel. New York: MacMillan, 1968.

Fisher, L. "On the Classification of Families." Archives of General Psychiatry 34 (April 1977):423-433.

Freedman, A.; Kaplan, H.; and Sadock, B. Modern Synopsis of Comprehensive Textbook of Psychiatry. 2ed. Baltimore: Williams and Wilkins, 1976.

Glasser, P., and Glasser, L. Families in Crisis. New York: Harper and Row, 1970.

Granite, U., and Goldmon, S. "Rehabilitation Therapy for Burn Patients and Spouses." Social Casework 56 (December 1975):593-598.

Haley, J. "Family of the Schizophrenic - A Model System." J. of Nervous and Mental Disorders 129 (1962): 357-374.

Hill, R. "Social Stresses on the Family," in Crisis Intervention. Selected Readings. 32-52. Edited by H.J. Parad. New York: Family Services Association of America, 1965.

Holsti, O. Content Analysis For the Social Sciences and Humanities. Don Mills, Ontario: Addison-Wesley, 1969.

Jackson, D. "Family Rules. Marital Quid Pro Quo." Archives of General Psychiatry 12 (June 1965):589-599.

Jackson, D. "The Question of Family Homeostasis." Psychiatric Quarterly Supplement 31 (1957):79-90.

Jackson, D. "The Study of the Family." Family Process 41 (March 1964):1-20.

Kaplan, D.; Grobstein, R.; Smith, A.; and Fischman, S. "Family Mediation of Stress." Social Work (July 1973):5-14.

Kerlinger, F. Foundations of Behavioral Research. 2ed. Toronto: Holt, Rinehart,and Winston, 1973.

Klein, D., and Bogdonoff, M. "Impact of Illness on the Spouse." J. Chronic Disease 20 (1967):241-248.

Langsley, D., and Kaplan, D. The Treatment of Families in Crisis. New York: Grune and Stratton, 1968.

Levinson, R. "Family Crisis and Adaptation. Coping with a Mentally Retarded Child." Dissertation, University of Wisconsin, 1976.

Lipowski, Z.J. "Physical Illness, the Individual, and the Coping Process." International Journal of Psychiatry in Medicine 1 (1970):91-101.

Litman, T. "The Family and Physical Rehabilitation." J. Chronic Disease 19 (1966):211-217.

Livsey, C. "Physical Illness and Family Dynamics." Advanced Psychosomatic Medicine 8 (1972):237-251.

MacVicar, M., and Archbold, P. "A Framework for Family Assessment in Chronic Illness." Nursing Forum 15 (1976):180-194.

Mayou, R.; Foster, A.; and Williamson, B. "The Psychological and Social Effects of Myocardial Infarction on Wives." British Medical Journal 1 (March 1978):699-701.

Moos, Rudolf. Coping with Physical Illness. New York: Plenum Medical Book, 1977.

Murray, R., and Zentner, J. Nursing Concepts for Health Promotion. Englewood Cliffs, N.J.: Prentice-Hall, 1975.

Nye, F. Role Structure and Analysis of the Family. Beverly Hills: Sage Publications, 1976.

Olsen, E. "The Impact of Serious Illness on the Family System." Postgraduate Medicine 47 (February 1970): 169-174.

Oppenheimer, J. "Use of Crisis Intervention in Casework with the Cancer Patient and His Family." Social Work 12 (April 1967):44-52.

Parad, H.J., and Caplan, G. "A Framework for Studying Families in Crisis," in Crisis Interventions. Selected Readings. 53-72. Edited by Parad. New York: Family Services Association of America, 1965.

Parsons, T., and Fox, R. "Illness, Therapy, and the Modern Urban Family," in A Modern Introduction to the Family. 377-390. Edited by N. Bell and E. Vogel. New York: MacMillan, 1968.

Peck, B. "Physical Medicine and Family Dynamics: The Dialectics of Rehabilitation." Family Process 13 (December 1974):469-479.

Power, P. "The Utilization of the Family in the Rehabilitation of the Chronically Ill Patient." J. Allied Health 5 (Spring 1976):42-50.

Quint, J. "The Case for Theories Generated from Empirical Data." Nursing Research 16 (Spring 1967):109-114.

Rakel, R. Principles of Family Medicine. Toronto: W.B. Saunders, 1977.

Rapoport, L. "The State of Crisis: Some Theoretical Considerations," in Crisis Intervention: Selected Readings. 22-31. Edited by H.J. Parad. New York: Family Services Association of America, 1965.

Robischon, P., and Scott, D. "Role Theory and Its Application in Family Nursing." Nursing Outlook (July 1969): 52-57.

Satir, V. Conjoint Family Therapy. Palo Alto: Science and Behavior Books, 1967.

Shellhase, L., and Shellhase, F. "Role of the Family in Rehabilitation." Social Casework 53 (November 1972):544-550.

Silva, Mary. "Spouses Need Nurses Too." The Canadian Nurse 73 (December 1977):39-41.

Skelton, M., and Dominian, J. "Psychological Stress in Wives of Patients with Myocardial Infarction." British Medical Journal 2 (April 1973):101-103.

Smilkstein, G. "The Family in Trouble - How to Tell." J. of Family Practice 2 (1975):19-24.

Solomon, M. "A Developmental Conceptual Premise for Family Therapy." Family Process 12 (1973):179-188.

Tomm, K. "A Family Assessment Model." Notes from class, "The Family in Health and Illness," February 1977a, University of Calgary.

Tomm, K. "Circular Pattern Diagramming." Notes from class, "The Family in Health and Illness, 1977b, University of Calgary.

Tomm, K. "Expressive Family Functioning Guide." February 1977c, University of Calgary.

Watzlawik P.; Beavin, J.; and Jackson, D. Pragmatics of Human Communication. New York: W.W. Norton, 1967.

Williams, C., and Rice, D. "The I.C.U. - Social Work Intervention with Families of the Critically Ill Patient." Social Work in Health Care 2 (Summer 1977):391-398.

Wu, Ruth. Behavior and Illness. Englewood Cliffs, N.J.: Prentice-Hall, 1973.

Yokes, J. "Family Rehabilitation: an Adult with Myocardial Infarction," in Family Health Care. 390-404. Edited by D. Hymovich. New York: McGraw-Hill, 1973.

APPENDIX C

Interview Schedule

Introduction:

1. Explain the purpose of the study.
2. Obtain consents to participate in the study and consents to record.

Engagement:

1. Speak to each member briefly in social conversation.

Opening Comments:

Your family has experienced a lot of changes during the past few weeks. A recent change is having Mr._____home from hospital. What I'd like to do is spend the next one to one and one-half hours hearing from all of you about the changes you've noticed in the family during the past_____weeks since Mr._____ came home. What is different in the family now as compared to how things were before Mr._____went into the hospital. Each of you might have different ideas on what the changes have been and that is to be expected. I'd like to hear everyone's ideas.

Body of the Interview:

1. When families experience major changes, they usually need time to reorganize the jobs and activities that keep a family running smoothly. What changes have you noticed in the sharing of jobs and responsibilities in the family?

   If necessary, clarify:

   1a) What changes have you noticed in the area of household chores?
   1b) .....of disciplining the children?
   1c) .....of initiating social activities?
   1d) .....of making important decisions?
   1e) .....of looking after peoples' needs for affection, their hurt feelings, concerns, etc.?
   1f) .....of looking after the financial needs of the family?

   Are there any other changes in the sharing of jobs and responsibilities that you would like to add?

2. All families have patterns of who talks to whom about what. These patterns change periodically depending on what is happening in the family. What changes have you noticed during the past_____weeks in how you talk to one another in the family?

   If necessary, clarify:
   - 2a) Has there been a change in the amount of talking that goes on? In what way?
   - 2b) .....in the kinds of things you talk about? In what way has it changed?
   - 2c) .....in who talks to whom? In what way?

   Are there any other changes in patterns of talking you'd like to add?

3. Families usually experience a change of mood or feeling tone when they find themselves in new situations. Have you noticed changes in the family's mood during the past____weeks?

   If necessary, clarify:
   - 3a) Would you say the family is more happy, less happy, no change?
   - 3b) ...more impatient, less impatient, no change?
   - 3c) ...more hopeful, less hopeful, no change?
   - 3d) ...more nervous, less nervous, no change?
   - 3e) ...more afraid, less afraid, no change?

   Are there any other mood or feeling changes you'd like to add?

4. When experiencing major changes, families sometimes notice changes in their own membership and the amount of contact they have with others.

   - 4a) In the past____weeks, have you had more or less contact with people other than family members?
     - i)...seen more or less of friends?
     - ii)...of family members outside of this household?
     - iii)...of neighbours?
     - iv)...of people from work?
     - v)...of people from school?
     - vi)...of clergy?
     - vii)...of community agency people?

   - 4b) How much are you going out of the home?
     - i) more
     - ii) the same
     - iii) less

4c) Has the membership of the family changed during the past_____weeks?

5. What amount of help have you received during the past_____weeks from people or agencies outside of the household?

1	2	3	4	5
no help	very little help	some help	a fair amount of help	a great deal of help

(All but #1)

5a) Who has been most helpful to your family in the past_____weeks?

i) friends
ii) relatives
iii) clergy
iv) nurses
v) doctors
vi) community agencies
vii) others

5b) In what ways were they helpful?

5c) What else would you have found helpful during this time?

(Received no help)
5d) What would have been helpful to your family during these past_____weeks?

Termination:

1. Express appreciation.
2. Give them recognition for their efforts.