

**FAMILY CENTERED CRISIS INTERVENTION
IN SITUATIONS INVOLVING LIFE-THREATENING
ILLNESS**

By



KAY MARIAN STEWART

**A Practicum Submitted to the Faculty of Graduate Studies
of the University of Manitoba in Partial Fulfillment of the
Requirements of the Degree of**

Master of Social Work

Winnipeg, Manitoba

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ABSTRACT

The diagnosis of any life-threatening illness in an adult partner has an impact upon the whole family system as well as each individual member of the family.

This practicum provided social work involvement with fourteen families. In eight of these families, services were provided from the time of diagnosis for approximately six months. In the other six families, services were provided primarily during the crisis phase.

The practicum concentrated on the role of social work in sustaining the family's adaptation process and development of the student's skills in family crisis intervention.

Assessment was based on an ecological framework and utilized the Double ABCX model of analysis of family crisis. Intervention incorporated crisis theory, grief therapy and a family-centered approach. Emphasis in family counselling was in effecting changes in communication and role performance.

Evaluation by means of a consumer satisfaction questionnaire demonstrated the interventions to be helpful.

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KAY STEWART

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TABLE OF CONTENTS

	<u>Page</u>
Abstract	i
Acknowledgements	ii
Table of Contents	iii
List of Figures	vi
 <u>SECTION I</u>	
INTRODUCTION	1
 <u>CHAPTER 1</u>	
LITERATURE REVIEW	
Crisis Theory and Crisis Intervention	4
Grief Work	11
Family Crisis Intervention	13
Stress and Coping	21
The Ecological Perspective & Adaptation	25
Family-Centered Practice	29
Family Crisis Intervention and Family Theory	31
Family Crisis Intervention and Illness	36
Summary	43
 <u>CHAPTER 2</u>	
DESIGN OF THE PRACTICUM	
Setting	44
Clients	44
Intervention	45
Termination & Evaluation	49

	<u>Page</u>
<u>SECTION II</u>	
<u>CHAPTER 3</u>	
THE PRACTICUM EXPERIENCE	
Overview	54
Family Case Studies	
"X" Family:	
Reorganization to Adapt to Life-Threatening Illness	58
"A" Family:	
The Crisis of Cancer as an Impetus to Change	75
"B" Family:	
Adaptation Versus Change	89
"C" Family:	
Reorganization in the Later Stages of Life	100
"D" Family:	
Family Reorganization after the Death of a Parent or Spouse	111
"E" Family:	
Adaptation to Loss of a Spouse in Later Life	125
"F" Family:	
An Illustration of Entry Difficulties	136
Overall Adaptation	147

CHAPTER 4

EVALUATION

Evaluation of Service to Clients	151
Critique of the Model of Service	157
Recommendations	165
Evaluation of Personal Objectives	168

BIBLIOGRAPHY

Bibliography

APPENDIXES

Appendix 1 - FAM III

1. Authorization to Copy FAM III, Dr. Harvey Skinner
2. FAM III Questionnaire
3. Interpretation Guide

Appendix 2 - Consumer Questionnaire

1. Authorization to Adapt and Copy Consumer Questionnaire
2. Consumer Questionnaire
3. Responses to Consumer Questionnaire

Appendix 3 - Beck Depression Inventory

Appendix 4 - Support Network Questionnaire

LIST OF FIGURES

	<u>Page</u>
1. The Double ABCX Model of Family Adaptation	16
2. Genogram: Family X	59
3. Illustration of Double ABCX Model in Case of Family X ...	65
4. Eco-map: Family X, pre intervention	67
5. Eco-map: Family X, post intervention	68
6. Genogram: Family A	76
7. Illustration of Double ABCX Model in Case of Family A ...	81
8. Eco-map: Family A, pre intervention	85
9. Eco-map: Family A, post intervention	86
10. FAM General Scale: Family A	88
11. Genogram: Family B	90
12. Illustration of Double ABCX Model in Case of Family B. ...	93
13. Eco-map Family B, pre intervention	97
14. Eco-map Family B, post intervention	98
15. Genogram: Family C	101
16. Illustration of Double ABCX Model in Case of Family C. ...	104
17. Eco-map: Family C, pre intervention	107
18. Eco-map: Family C, post intervention	108
19. Structural Map: Family D, pre intervention	114
20. Illustration of Double ABCX Model in Case of Family D ...	116
21. Eco-map: Family D, pre intervention	119
22. Eco-map: Family D, post intervention	120
23. Eco-map: Family D, post death	121
24. FAM General Scale: Family D	124
25. Eco-map: Family E, pre intervention	127
26. Eco-map: Family E, post intervention	134
27. Eco-map: Family E, post death	135
28. Genogram: Family F	138
29. Structural Map: Family F	140
30. Eco-map: Family F, pre intervention	144
31. Eco-map: Family F, post intervention	145

SECTION I

INTRODUCTION

As the social worker attached to a surgical ward and an intensive care unit of a general hospital, I see many patients in the early stages of diagnosis and treatment for cancer and at the time of sudden admission to intensive care for myocardial infarction (heart attack). It is well known that heart disease and cancer are the two leading causes of death in North America today. It is not surprising, therefore, that a diagnosis of cancer and myocardial infarction is commonly perceived by patients and their families as a threat to their continued existence or as a threatened loss of loved ones. Although there are certainly differences between the experience of myocardial infarction and a diagnosis of cancer (notably the shorter onset phase and the more immediate threat to life created by myocardial infarction), both diseases do constitute a life-threatening illness.

In spite of the differences in onset, the time of diagnosis of serious illness is a time when the reality of the situation for patient and family seems overwhelming, often resulting in feelings of extreme anxiety, panic and helplessness. Cohen and Wellisch (1978) state that the time of diagnosis represents the first order of crisis because it signals the threatened and perhaps actual loss of significant relationship for members of a family.

This practicum has grown out of my experience in the fields of medical social work and psychosocial rehabilitation. I have worked with individuals and

families from a variety of treatment approaches and have come to the realization of the following:

1. illness in one member of a family impacts on all family members;
2. open communication between family members enhances the adjustment process;
3. engagement of families in psychosocial treatment in a secondary setting requires special attention and skill;
4. comprehensive assessment utilizing the ecological approach is the key to offering appropriate intervention; and
5. because of the ecological approach's emphasis on the transactions between individuals and environments (and its focus on improving the goodness-of-fit between person and environment), it is well suited to medical social work practice.

My own personal learning objectives in this practicum were:

1. to develop expertise in working with families where an adult partner is diagnosed with a life-threatening illness, i.e. either myocardial infarction or cancer;

2. to develop skills in the engagement of clients in a secondary setting (where families often do not request service and/or may be resistant to social worker intervention);
3. to increase my knowledge of an ecological systems perspective and enhance my assessment skills using an ecosystems model; and
4. to enhance my skills in family-centered social work practice.

CHAPTER 1

LITERATURE REVIEW

Serious illness in an individual represents a family crisis. Therefore the review of literature concentrated on crisis theory and family crisis intervention. Hill's (1958) theory regarding the variability of family response to crisis and the Double ABCX model of family crisis (McCubbin & Patterson, 1983) are discussed. Central to this model are the concepts of coping and adaptation. Therefore theories of coping and adaptation to stress were also researched.

An ecological family-centered approach to practice was found to fit well with the family crisis intervention model. Discussion of an ecological perspective and principles of family-centered practice are included in this literature review.

This chapter closes with a discussion of some family intervention models that are relevant to and influence practice with families facing illness. These include communication theory, the life cycle perspective, and structural family therapy.

CRISIS THEORY AND CRISIS INTERVENTION

Golan (1978) identifies five components of crisis. The first being the hazardous event which may be an external blow or internal change; anticipated or unanticipated. This is the beginning of a process of increasing disequilibrium. The diagnosis of life-threatening illness, either of cancer or myocardial infarction, can represent such a hazardous event which is experienced as an

external blow to the family system, disrupting the family's previous state of balance.

The second component is vulnerable state. This refers to the subjective reactions as people attempt to deal with the effects of the hazardous event. The threat of sudden death from myocardial infarction or perceived terminality of life with a diagnosis of cancer contribute to the high anxiety level observed in patient and family during the initial stages. The individual fears the possibility of his own death and the family fears the possibility of loss, through death, of one of its members. During this period of vulnerability, people attempt to deal with the situation through the use of their usual and emergency coping strategies.

The third component involves a precipitating factor. This is seen as the final blow that propels the individual and/or family into a state of active crisis. The precipitating factor may coincide with the initial hazardous event, i.e., "the initial event may be of sufficient force to overpower immediately the person's homeostatic balance and send him into a state of active crisis" (Golan, 1978, p.66). This may be the case for some families when told that the patient has suffered a myocardial infarction or is diagnosed with cancer. This blow may be so overpowering that it holds potential to produce the maximal disequilibrating effect.

The fourth component, active crisis, is characterized by shock, psychological and physical turmoil, followed by painful preoccupation with events leading up to the crisis. This is followed by a period of remobilization, renewed activity and readjustment. Golan discusses both "shock crisis" and "exhaustion crisis", with "shock crisis" referring to a sudden traumatic event for which the person has no

prior preparation. "Exhaustion crisis" refers to ongoing stresses which tax the person's usual coping capacities beyond a level that they can handle and thus, after exhausting all their resources, propels them over the edge into an active crisis state. Myocardial infarction or cancer both hold the potential of creating either states of crisis. A sudden massive myocardial infarction (M.I.) in which the onset phase of illness lasts only minutes and the person and his family are thrust almost immediately into the acute illness phase, can easily overwhelm their available coping mechanisms and precipitate a shock crisis (Golan, 1978, p.191). Also, admission to hospital for routine surgery may reveal a diagnosis of cancer and come as a shock to patient and family. On the other hand, the family who have sat anxiously by the bedside for days while the coronary care team struggle to stabilize the M.I. patient's condition, may succumb to a state of exhaustion crisis if the patient's condition remains critical for too long. Similarly, a patient whose health has deteriorated gradually over a long period of time, and a diagnosis of cancer suspected and finally confirmed, may too experience exhaustion crisis.

The final component is that of reintegration or restoration of equilibrium. This stage is really an extension of the active crisis state, as the tension and anxiety gradually decrease, some form of reorganization of the family's functional ability occurs. The state of imbalance during active crisis cannot continue for long, so some form of adjustment, either adaptive or maladaptive must occur. It is towards ensuring that the patient and his family adjust in an adaptive and integrative manner that intervention is directed.

Parad and Caplan (1960) set out a framework for studying families in crisis which is useful for analyzing the crisis of life-threatening illness. The perceptual

meaning of the crisis to the family influences its impact. "The loss of body integrity and how this loss is perceived by the individual patient and his family is pivotal" (Williams, 1979, p.27). The stressful event of life-threatening illness poses a problem which is by definition insolvable in the immediate future. The stress of illness and hospitalization is beyond the control of the family. They have no way of knowing the length or outcome of the illness.

Secondly, the problem overtaxes the psychological resources of the family since it is beyond their traditional problem-solving methods, resulting in a feeling of helplessness. People whose usual problem-solving mechanisms are avoidance, denial, suppression, and masking feelings, are massively overtaxed because the problem of being hospitalized with a life-threatening illness is difficult to push out of awareness.

Thirdly, the situation is perceived as a threat or danger to the life goals of the family members. The threat of sudden death of one of its members is a reality the family of the myocardial infarction or cancer patient faces.

Fourthly, Parad and Caplan (1960) define the crisis period as characterized by tension, which rises to a peak and then falls. As the peak approaches, tension rises and stimulates the mobilization of previously hidden strengths and capacities.

Finally, this framework identifies the crisis situation as awakening unresolved key problems from both the near and distant past. Examples of this may be wide and varied, i.e., the patient may have experienced severe separation anxiety during a childhood hospitalization that now surfaces and compounds the

patient's extreme panic in the hospital; the family may have lost a previous member through death and now the threatened loss of another family member awakens the unresolved grief of the past.

Parad and Caplan (1960) also discuss reaction to crisis. The initial response may be to defend against the emotional implications of the problem, denying their anxiety and pain. Individuals may attempt to relieve unexpressed tension through focusing hostility and anxiety on something else, i.e., scapegoating another family member by blaming him for having caused the patient's heart attack.

In the second stage, individuals begin to confront their feelings. They begin to talk to each other about the danger and threatened loss. They show overt signs of anxiety, they cry, are unable to sleep, and begin to support and comfort each other. The increasing danger to the patient's life overpowers the family's defensive denial of the problem. At this stage, the tension is released through expression of anxiety, mutual support and reassurance and the strengths of the family are mobilized.

As the patient improves, tension relaxes in day to day family functioning. The intensity of the emotional burden is reduced and previous ineffectual handling of problems gradually consolidates. The family continues to express feelings of anxiety and longs openly for the patient's continued recovery. They gain comfort from mutual support at this time.

Golan (1978) discusses four phases of the crisis of illness: the onset phase, where the illness is developing and being diagnosed; the acute phase of

treatment, including hospitalization and surgical procedures; the recuperation phase, which encompasses the gradual recovery of normal functions; and the post-hospital restoration phase including adjustment to new limitations and disabilities and re-establishment of systems' relationships.

The onset phase may last only moments with myocardial infarction thrusting patient and family almost immediately into the second acute phase. With cancer, the onset of disease may often be more gradual with the patient experiencing a longer sense of developing illness prior to diagnosis. However, the goal of intervention at the time of diagnosis is similar: 1) to help the patient and family begin to clarify the meaning of the diagnosis and its implications; and 2) to encourage them to express their fears and other feelings of loss or threat (Golan, 1978).

Intervention must address two task areas faced by the family: 1) family members must deal with the anxiety and disruption arising from the recent threat of death and the sudden hospitalization of one of its members; and 2) they must prepare for an uncertain future in which they have to adjust to the realities/limitations/implications of the illness (Mooney, 1984).

Parad (1971) states that the first goal of crisis intervention is to alleviate the immediate impact of the disruptive stressful event. The second goal is to help mobilize the psychological capacities and social resources needed for coping adaptively with the stressor.

During the acute phase the patient is in severe physical and emotional trauma. The family is going through a parallel phase of serious upset and with a life-

threatening illness, may have to deal with the very real possibility that the patient may not survive. The perceptual meaning of the crisis to the family influences its impact.

When the immediate threat to survival is past, the individual questions whether he can continue to fulfill previous roles; he feels he has lost a valued part of himself, i.e., strength, energy, or independence. Family members, too, must deal with the same uncertainties about the future (Mooney, 1984). The family needs to make necessary adaptations to re-integrate the patient into the family. To accomplish this the patient and family must work out patterns of communication in which all members' needs will be met.

Golan (1978) identifies tasks in the recuperation period as helping patients and families face their current situation, work through their feelings and set up realistic adjustment and post-discharge plans. The intervention should focus on family interaction and dynamics, i.e., attitudes, communication, and patterns of coping with emphasis on helping the family retain its integrity and function.

In the recuperation phase, patients' sudden confrontation with death makes them aware of their own feelings and awakens the realization that they will be different now. They must cope with their own changed self-image and their fears of dependency and of changed lifestyle.

In the restoration phase, according to Golan (1978), the patient and family begin to grapple with the fact that illness may have left permanent damage and limitations. With myocardial infarction this may mean the individual is restricted in his/her physical activity or ability to return to work. For the cancer patient, it

may mean body image changes as a result of surgical treatment, (i.e., amputation, colostomy, mastectomy) and an inability to return to work while undergoing chemotherapy treatment. Coping tasks during this phase revolve to a large extent around adjustment to the major realignments in the family roles and to the provision of material and emotional support.

It is with these tasks of role realignment, working through feelings of loss, adopting patterns of communication in which all members' needs can be met, and adjusting to an altered reality and establishing a new balance, that intervention is directed.

GRIEF WORK

Life-threatening illness represents a crisis involving loss. This kind of experience does not allow all family members to return to things the way they were before; they need to establish a new balance for themselves.

The individual patient may feel that his/her life may never be the same again and he/she may react with depression and bitterness. The patient faces multiple losses, i.e., loss of health, possible loss of job and family roles, loss of sense of self as they were prior to the illness, and possible loss of life.

Smith discusses three generic tasks on which we should base our treatment plan for crisis involving loss: 1) the patient needs to recognize the loss and express how they feel about it; 2) they need to explore, with the therapist, how

the loss can be compensated; and 3) the patient needs to implement some activity that will compensate for the loss (Smith, 1978, p.403).

Worden (1982) addresses similar issues as he discusses the four tasks of mourning: 1) experience the emotion of grief; 2) accepting the reality of the loss, i.e., accepting the diagnosis and its implications; 3) adjusting to an altered environment without that which has been lost, i.e., adjusting to an altered sense of self; and 4) reinvesting in life, i.e., reinvesting in altered lifestyle and adjusted life goals.

Loss threatens the continuity of who we are and where we are going in life. Grief work is essentially re-establishing a sense of continuity, purpose and meaning. The individual must feel free to mourn their former healthy state. Intervention on this task can be done by modelling open discussion of difficult issues and presenting the grief process as part of the adjustment.

The first task in the grief work phase is to allow emotions. Intervention should be directed towards helping the patient experience and express a wide range of emotions. He/she may feel anger and depression that this illness has happened to him/her. He/she may experience a sense of loss that he/she is not the same person that he/she once was, and harbor a fear of dependency or invalidism.

The family also need to mourn for their former healthy state. They need to experience and express the emotions associated with this loss. They may experience anger, depression, fear, sadness, anxiety. They may feel anger at the patient, or external sources, or feel guilt and self-recrimination, feeling in some way they contributed to the person's illness.

The sense of loss experienced at the diagnosis of a life-threatening illness has many of the same features as normal mourning, i.e., denial, anger, bargaining, depression, and finally acceptance. The therapist can help the patient and family deal with the mourning process by encouraging expression of painful feelings and emotions such as sadness, grief, loss, fear of death, etc.. "Family members may be encouraged to share their effective experiences and react empathically to each other" (Worden, 1982). The therapist may also help by normalizing and universalizing these feelings and the grieving process.

FAMILY CRISIS INTERVENTION

Hill (1958) cites four areas of family function that help us assess what resources the family has to respond to the crisis: 1) family integration; 2) adaptability; 3) organization; and 4) expressiveness. Use of this framework helps us to understand the impact the event has on a particular family and assess resources the family brings in dealing with this impact.

The first of these, family integration, refers to a sense of cohesiveness or belonging to one another in a meaningful way.

The second resource is adaptability. Families in crisis must either regain their previous equilibrium or find a new balance. A family with rigid behavior patterns will have a more difficult time.

A third resource is organization. A family clear about family rules, responsibilities and structure can better develop necessary plans to cope with the crisis.

A final resource is expressiveness. This refers to the opportunity to express thoughts and feelings. The ability to deal with conflict by open discussion is crucial to the task of crisis resolution.

We also need to be concerned with how the patient copes with stress, their strengths and vulnerabilities, what supports they can depend on, how they have coped with previous life stresses, whether financial concerns exist, and how they think the illness will affect their work and their family. As Williams stated, "assessment of the individual's capacity of adaptation and the environmental supports available to him/her is of vital importance" (Williams, 1979, p.27).

It was Hill, some thirty years ago, who developed the ABCX Family Crisis Model in an attempt to explain and understand the variability of family response to any crisis (McCubbin and Patterson, 1983). How vulnerable a family is to crisis depends on the interaction of the stressor (A factor) with existing resources (B factor) and with family perception (C factor). The X factor represents family crisis. Therefore, one family faced with a diagnosis of M.I. or cancer in one of the marital partners (the stressor) may perceive it as a challenge and as an opportunity to grow (C factor). Inner strengths may be mobilized to deal with the crisis and friends and relatives may be called upon to give support (B factor) so that the family unit is strengthened by the event (A factor). Another family faced with a similar diagnosis may define it as a catastrophe (C factor) and feel overwhelmed by the stresses. They may lack personal or family resources (B

factor) so that they cannot support each other. This can lead to crisis for the family where family members become disorganized, routines disintegrate, and family stability is threatened. Coping is the central process used by families as they seek to adapt and adjust to new demands. It involves an interaction of resources, perception and behavioral responses.)

McCubbin and Patterson (1983) extend the Hill ABCX Model, calling it the Double ABCX Model. This adds post-crisis variables to the existing pre-crisis variables of the original model in an effort to describe additional life stressors faced by the family and new resources which the family must call upon in order to achieve a satisfactory resolution of the crisis.

Insert
Figure 1
about here

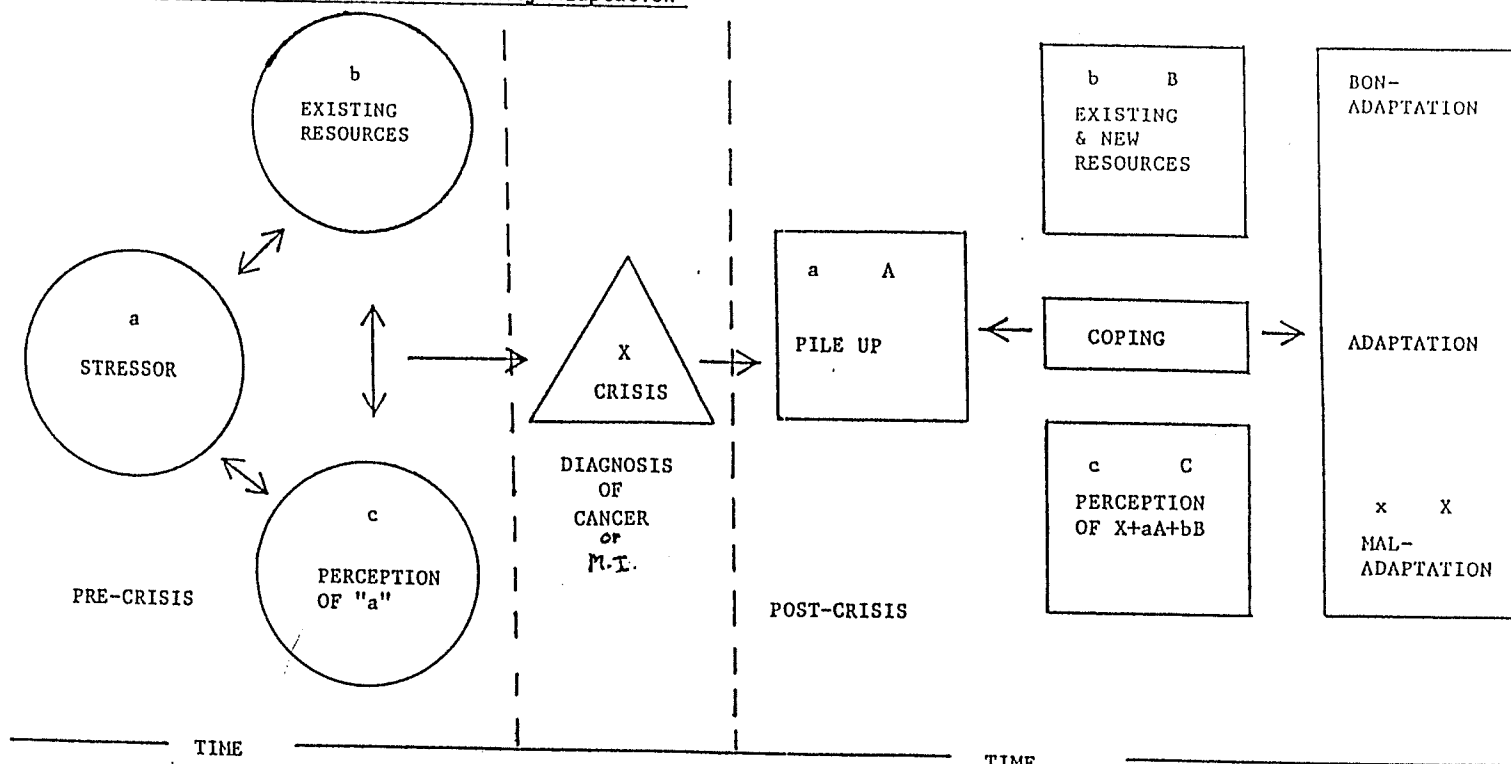
1. The aA Factor: "Pile up" of Family Demands

McCubbin (1983) suggests that families are seldom dealing with a single stressor but rather they are experiencing a pile up of demands (aA factor). He outlines five broad types of stressors contributing to this pile up in the family system faced with a crisis.

- i) the initial stressor and its hardships;
- ii) normative transitions;

Figure 1:

The Double ABCX Model of Family Adaptation



Adapted from: McCUBBIN AND PATTERSON (1983)

- iii) prior strains;
- iv) the consequences of family efforts to cope; and
- v) ambiguity both intrafamilial and social.

2. Factor bB: Resources

"Resources are the psychological, social, interpersonal, and material characteristics of individual family members, of the family unit and of the community which are used to meet demands and needs" (Patterson and McCubbin, 1983, p.29). There appears to be two general types of resources used by a family in response to life-threatening illness in one of its members:

1. existing resources already in the family's repertoire, which help the family deal with the crisis; and
2. new resources which are strengthened and developed in response to new demands.

3. Factor cC: Perception

In the face of a diagnosis such as life-threatening illness, the family must struggle to give it meaning and redefine the situation. At first the family may see the illness as hopeless, shameful, overwhelming and beyond

their ability to manage. "Family efforts to redefine a situation as a challenge, as an opportunity for growth, or to endow the situation with meaning appear to play a useful role in facilitating family coping and eventually adaptation" (Patterson and McCubbin, 1983, p.30). The ability to perceive a situation in a positive way is of course affected by the nature of the stressor and the characteristics of the family.

4. Coping Strategies

"Pile up" of family demands, resources and perceptions are all critical components of coping strategies. "Coping includes the behavioral responses of family members as well as the responses of the family unit, in an attempt to manage the situation. Coping is their ability to acquire the resources needed for family adaptation" (Patterson and McCubbin, 1983, p.30).

Patterson and McCubbin identify three difference styles of coping. Each copying style is made up of several coping behaviors.

- i) maintaining family integration, co-operation and an optimistic definition of the situation;
- ii) maintaining social support, self-esteem and psychological stability; and
- iii) understanding the medical situation through communication with other patients and families and consultation with the medical staff.

One of the primary strategies used by families to cope is by obtaining information from medical staff and books in order to reduce feelings of uncertainty, fear and anxiety, as well as to gain a better understanding of the diagnosis.

5. The xX Factor: Adaptation

The outcome of these coping efforts by the family to achieve a new balance results in what McCubbin and Patterson (1983) term adaptation, or Factor xX. Adaptation is on a continuum from "bonadaptation" to "maladaptation" and reflects the outcome of family efforts in to major areas: 1) the balance in capabilities and demands between individuals and the family unit; and 2) the balance between the family and the larger community. This may be clarified by referring to Table 1 on the following page.

Table 1

Range of Outcomes of Family Efforts to Balance Functioning

MALADAPTION ----- BONADAPTATION

- | | |
|--------------------------------------------|--------------------------------------------------------------|
| - deterioration in family integrity | - family integrity strong |
| - individual development curtailed | - member development enhanced |
| - family unit development curtailed | - family unit development enhanced |
| - loss of family independence and autonomy | - family independence and control of environmental influence |

(Source: McCubbin and Patterson, 1983. p.13)

STRESS AND COPING

Moos (1986) identifies five major sets of tasks in managing a life crisis:

1. establish the meaning and understand the personal significance of the situation;
2. confront reality and respond to the requirements of the external situation;
3. sustain relationships with family members and friends, as well as with other individuals who may be helpful in resolving the crisis and its aftermath;
4. maintain a reasonable emotional balance by managing upsetting feelings aroused by the situation; and
5. preserve a satisfactory self-image and maintain a sense of competence and mastery.

Learning to cope and adjust to a change event is largely determined by the individual's perception of the event in relation to himself and to others, and completing certain adaptive tasks and learning to use various coping strategies. Lazarus and Cohen (1979, p.230-233) and Moos and Tsu (1979, p.9-17) postulate that cognitive and situational appraisal factors are central to determining the impact of the stressful event and will determine the individual's ability to cope. The three types of appraisals they identify are:

1. harm/loss - which are events that refer to damage that occurred;
2. threat - which includes events referring to anticipated harm or loss; and
3. challenge - which involves internal issues of control.

The focus of challenge is placed positively on potential gain, growth or mastery of potential risks (Lazarus and Cohen, 1979, p.219). Facilitating a shift from an appraisal of loss or threat, towards that of challenge is a worthy social work goal.

Coping efforts result from completing certain adaptive tasks. These "tasks" need to be dealt with in order to allow for satisfactory adjustment to occur (Moos, et al, 1979 and Lazarus, et al, 1979). Sohor (1987), integrated work of Moos and Lazarus as it pertained to adaptive tasks and coping skills. A summary of Sohor's integration of this work follows:

1. **To reduce harmful conditions in the environment to advance prospects of recovery.** The coping skills of denial or minimizing the seriousness of the illness is a self-protective reaction. The coping skills of denial, humor, and avoidance behavior are used to alleviate anxiety and reduce demands of the stressor. Information seeking skills can be useful in restoring a sense of having some control.
2. **To tolerate or adjust to negative events and realities.** The coping skills involve, again, self-protective and information seeking skills

which can be useful in coping with significant losses and to help prepare for an uncertain future.

3. **To maintain a positive self-image.** The coping skills involve: a) self-care techniques to maintain a sense of mastery and competence; and b) goal setting skills such as helping to re-establish future goals for patient and family, help to define limits of independence and role changes.
4. **To maintain an emotional equilibrium.** The coping skills involve self-sustaining skills such as adopting a healthy lifestyle, developing a positive attitude, feeling hopeful and exploring alternative views of present circumstances. Being able to see the illness as a challenge helps the individual derive meaning from the event.
5. **To continue satisfying relationships with others.** This involves the ability to develop relationships with health care professionals and maintain relationships with family and friends; maintaining or adding to one's support network. The coping skills required are emotional support seeking skills that involve sharing feelings of joy and frustration to deal with tension and stress. Patient and support system need reassurance and information (Sohor, 1987, p.39-42).

Barbara Lilliston (1985) discusses how the experience and response of an individual who incurs a traumatic physical loss is influenced by his unique characterological, cultural and biological self. She states it is not the severity or nature of the illness alone that determines the psychological response of the patient, but rather it is the person, his environment (meaning the social, physical

and biological environment) and the ecological fit between them that determine behavior. She identifies four groups of effective/perceptive responses to physical loss of functioning:

1. disruption of body image and body ego;
2. orientation to time/subjective experience of time;
3. grief and depression; and
4. fear, anxiety, guilt, rage.

For the patient to adapt to the abrupt change and emotional discomfort created by the sudden state of illness, the individual employs a variety of coping responses. Lilliston refers to Caplan's views of coping as two related tasks. One task is to respond to the external situation and the other is to respond to one's feelings about the situation (Caplan, 1976, cited in Lilliston, 1985).

Lilliston refers to the work of Weissman (1974), who defines fifteen coping strategies used by cancer patients and the application of these same coping patterns by Stewart (1977) to other types of illness (cited in B. Lilliston, 1985).

1. rational/intellectual: seek additional information regarding stressful situations;
2. shares concern: talk with other about problems;
3. reversal of affect: laugh it off;
4. suppression/isolation/passivity: don't worry, close off feelings, wait and see;
5. displacement: distract yourself with activities;

6. confrontation: take positive concerted actions based on present understanding;
7. rationalization/redefinition: accept, rise above it, make an adventure out of it;
8. fatalism: accept stoically, prepare to accept the worst;
9. acting out: do something (ambiguous, impartial, reckless)
10. repetition: use plans made in similar situations in the past;
11. tension reduction: eat, smoke, use drugs;
12. stimulus reduction/avoidance: withdraw socially, get away;
13. projection: blame others, externalize;
14. compliance of authority/role modelling: do what you are told; and
15. masochistic surrender: seek blame, atonement, sacrifice.

Some of these techniques are more adaptive/maladaptive than others. One would not want to encourage a maladaptive coping pattern but Lilliston (1985) believes that intervention must take into consideration the observable effective responses of the patient and/or family and preferred patterns of coping used by these people. This may be accomplished by ascertaining what were the formerly preferred coping techniques and encouraging their utilization in the present situation.

THE ECOLOGICAL PERSPECTIVE AND ADAPTATION

The ecological perspective is concerned with the growth, development and potentialities of human beings and with the properties of their environments that support or fail to support the expression of human potential. By clarifying the

structure of the environment and the nature of its adaptive influence, the perspective appears to be well suited to the task of developing concepts and action for intervening in the environment (Germain, 1979). In an ecological view of social work, practice is directed toward improving the interaction between people and environments in order to enhance adaptive capacities and improve environments for all who function within them. To carry out this professional purpose requires a set of environmental interventions and a set of interventions into the transactions between people and environments to complement the sets available for intervening in coping patterns of people (Germain, 1979).

In this model, two concepts are important:

1. Adaptation: the active effort of individuals over the life span to reach "goodness of fit" with their environment; and
2. Environment:
 - a) physical aspects - the natural and built world; and
 - b) social environment - the network of human relations at various levels of organization.

An ecological perspective suggests that our social purpose is to improve the quality of transactions between people's adaptive potential and environmental qualities. Therefore, social work efforts should be directed to supporting and enhancing the adaptive capacities of people and to influencing the immediate environment to be more responsive to human needs. Our practice domain must be the interface between coping behaviors of people and qualities of the impinging social and physical environment (Germain, 1977).

"The strength of the ecological approach to social work is its 'vantage point'. Its emphasis is not on the identification of pathology or maladaptation, but on developing an appreciation of the variance of adaptive responses possible" (Jensen, 1985, p.337). It does not require a delay of social work's entry into the helping network until problems in psychosocial functioning develop. It allows for the use of social work's skill and knowledge for increasing potential of the system to realize its goals for survival and growth. It provides opportunity for understanding and building on the strengths and competencies of clients. In this manner, the ecological approach is particularly suitable to health care social work practice.

The ecological perspective, focussing attention on transactions between individuals and environments, helps to underline the need for social work services for clients facing disease and disability. "In the short term, the client's coping behaviors and environmental resources must be mobilized to meet the challenge of the current health crisis. In the long term, significant changes in the client's coping capacities, environmental resources, and the transactions between them will be necessary to maximize the client's potential for survival, for affiliation, and for growth and achievement" (Monkman et al, 1982, p. 155).

Intervention to assist clients with the impact of illness must consider the concepts of stress and coping, as previously discussed in this literature review. The stress of illness or disability represents a transactional process between inner and outer events that disturbs the goodness-of-fit between person and environment. Coping refers to capacities and skills people use to handle stress,

i.e., motivation, cognition and problem-solving skills, anticipation, self-confidence, defense against anxiety and depression (Germain, 1977, p.68).

Interventions using this perspective may be directed to the person, the family, the environment, or the interaction among them. Interventions directed to the person or family may include procedures to increase self-esteem, reduce psychic discomfort, strengthen adaptive patterns, teach coping skills or provide information.

However, social work must focus not only on coping behaviors but also consider environmental factors required by patients for effective coping with the stress of illness and disability such as:

1. . opportunities for taking action, exercising judgement and making decisions to the degree allowed by the nature of the illness;
2. staff behaviors and patient services that support patients' self-esteem and reward patients' coping efforts;
3. organization procedures and policies that respect patients' lifestyles, cultural values and social supports; and
4. the provision of information in the appropriate amount at the appropriate time (Germain, 1977, p.69).

In summary, interventions directed to the environment include providing opportunity for action, decision making and mastery, and restructuring situations for a better adaptive fit.

FAMILY-CENTERED PRACTICE

There is strong research support for the important role played by the family at every stage of illness in enhancing or inhibiting the rehabilitation process (Adams and Lindemann, 1974, cited by Caroff and Mailick, 1985). The functional capacity of the family to make adaptive changes required by the illness of one of its members is a critical determinant of outcome.

It is because serious illness in an individual impacts on the entire family system that I intended to adopt a family-centered approach to intervention in this practicum. "Family-centered practice is a model of social work practice which locates the family in the center of the unit of attention or the field of action. Based on a systems framework, this approach to helping is based on the premise that human beings can be understood and helped only in the context of the intimate and powerful human systems of which they are a part. One of those powerful systems is the family of origin which has deep and far-reaching effects on all its members. Another is the current family system or network of intimate relationships as it exists in the present and which plays a vital role in the lives of most people" (Hartman and Laird, 1983, p.4). Consistent with a systems perspective, the family system itself has an environment and must be seen in that context, and therefore the model of practice adopted in this practicum is "concerned with transactions among person, family and environment and with a

wide range of strategies for assessment and intervention which may strengthen or change those transactions" (Hartman and Laird, 1983, p.4).

The domain of family-centered practice is consistent with Bertha Reynolds' point that "social casework is not to treat the individual alone nor his environment alone, but the process of adaptation which is a dynamic interaction between the two" (Reynolds, 1933, p.337 cited in Hartman and Laird, 1983). Family-centered practice is restricted neither to families and their members nor to those larger environmental systems which affect the nature of family life. Its focus is those transactions among person, family, and environment which affect individuals, families and even the larger social forces and systems in which families are involved (Hartman and Laird, 1983).

Hartman and Laird (1983) rely on the metaphor of ecology in their conception of family-centered practice, which helps to: focus on the interface between families and the larger environment. They identify the primary mission of the family-centered practitioner as the enhancement of the quality of life, of the adaptive balance between human beings and their ecological environments. This enhancement may come through change in individual or family functioning, in the larger systems on which the family depends for nurturance and growth, or in the transactions among these systems (Hartman and Laird, 1983, p.6).

Ecological Principles of Practice: Ecology as a metaphor suggests certain principles for practice (Hartman and Laird, 1983, p.72-73):

1. Problems or difficulties that come to the social worker's attention are better understood as lacks or deficits in the environment, as dysfunctional transactions between systems, as adaptive strategies, or as results of interrupted growth and development, rather than as disease processes located within the individual.
2. Problems are seen as outcomes of the transaction of many complex variables. A feedback model of change is initiated in which interventions are made and tested through the continued monitoring of the system's response. Interventions that redefine and thus alter the family's relationship system are evaluated in terms of outcome.
3. In applying an ecological metaphor to practice, life experience is seen as the model for and primary instrument of change, i.e., strategies are devised which, insofar as possible, make use of natural systems and life experiences and take place within the life space of the client. Further, the family itself is a natural helping system and thus can be not just the arena, but the instrument of change.
4. Change in one part of the system has an impact on all other parts of the system (Hartman and Laird, 1983, p.73).

FAMILY CRISIS INTERVENTION AND FAMILY THEORY

The objective of family crisis intervention is to resolve the crisis in as short a time as possible (Walsh, 1981). The goals and time frame do not allow for

indepth restructuring of family relationships. Intervention must be congruent with the family's skills and goals. Bonnefil & Jacobsen (1979) argue that the goal of crisis intervention is not crisis resolution but the most adaptive resolution given the inner and outer resources of the individual and family.

There are aspects of systems theory, communication theory, family structure and life cycle theories that seem particularly relevant in influencing intervention with families facing the crisis of illness. These concepts , many of them borrowed from the literature on family therapy are discussed here.

Communication

Bateson's work on general systems theory further developed into communication theories with the work of Satir, Haley, Jackson and Weakland (Goldberg & Goldberg, 1985). In general systems theory, the system can be described as a whole and that its components and their characteristics can be understood as function of the total system. Components must be understood in terms of the transactional processes between them.

General systems theory is concerned with communication. It observes feedback which is considered positive or negative. According to this theory, families enter therapy because they are experiencing some form of breakdown in their usual feedback processes. As communication becomes blocked or damaged, breakdown of dysfunction occurs.

Therapies based on communication theory aim to facilitate congruent communication between family members, constantly checking out with other

members to be sure that each has understood the intent of the communication. The intervention is directed at helping family members see that they are misreading messages. If congruence characterizes most of the communication most of the time in a family, it is likely that messages and consequently roles, rules and relationships will be clear. If there is a high level of incongruence, confusion and conflict result (Laird & Allen, 1983).

Family Organization and Structure

Structural family therapy places family organization and structure at the center of attention. The concept of the family as an organization with a hierarchy of authority is of prime importance. While developing from systems and communication theories, structural family therapy adds a new view of organizational power.

Structure of the social system in relation to its functions provides the framework by which the therapist measures the family's adjustment (Aponte, 1976). Structural dimensions of transactions most often identified in structural family therapy are boundary, alignment and power. Boundary of a subsystem refers to the rules defining who participates and how (Minuchin, 1974). Aponte (1976) speaks of alignment as the joining of opposition of one member of a system to another carrying out an operation. Power can be defined as the relative influence of each family member on the outcome of an activity (Aponte, 1976). Dysfunctional structures in families are best classified according to the structural dimension to which they are most closely related, whether that be boundary, alignment or power.

The idea of life stages is central to the structural focus. The family is faced with the task of reorganizing in times of transition; new subsystems and new alliances may be made. Power and hierarchial arrangements may be altered and members may have to assume new roles or give up others as the family passes through successive life stages and faces new developmental tasks (Laird & Allen, 1983).

Change is seen as occurring through the process of the therapist's affiliation with the family and his restructuring of the family so as to transform dysfunctional transactional patterns (Minuchin, 1974). Minuchin envisions the therapist as a boundary maker, clarifying diffuse boundaries and opening inappropriately rigid ones. Therapy is directed toward repairing or modifying the family structure so that it can more effectively carry out its functions of "support, regulation, nurturance and socialization of its members" (Minuchin, 1974, p.14).

Life Cycle

The family life cycle perspective views symptoms and dysfunctions in relation to normal functioning over time. It frames problems within the course the family has moved along in its past, the tasks it is presently trying to master, and the future toward which it is moving (McGoldrick & Carter, 1982).

McGoldrick & Carter (1982) identify six family life cycle stages with emotional tasks associated with each transition and the changes required in family status to allow the family to proceed developmentally. These stages are identified as:

1. the unattached young adult;
2. the newly married couple;

3. the family with young children;
4. the family with adolescents;
5. launching children and moving on; and
6. the family in later life.

Carter & McGoldrick's (1980) view of the normal family includes a vertical axis which involves patterns of relating and functioning that are transmitted down the generations, and a horizontal axis which represents the stresses on the family as it moves forward through time, coping with the changes and transitions of the family life cycle; both predictable developmental stresses and unpredictable events, such as illness.

The therapist must assess not only the dimensions of the current life cycle stress but also its connections to family themes, triangles and labels passed down in the family over time.

Family life cycle passages are concerned with shifting membership over time and the changing status of family members in relation to each other. Dysfunctional families characteristically confuse shifts in status, exits and functions. This occurs by the family pretending to have more power over membership than it actually has, i.e., parents pretending children are not growing up, a mother who refuses to accept a daughter-in-law in order to pretend her status with her son is unchanged (McGoldrick & Carter, 1980).

Family stresses which are likely to occur around life cycle transition points frequently create disruptions of the life cycle and produce symptoms and dysfunction. In this view, assessment of life cycle passages are significant to the

therapist's intervention with the family. For example, Haley (1973) viewed family stress as highest at the transition points from one stage to another of the family developmental process, and symptoms as most likely to appear when there is an interruption in the family life cycle. Symptoms indicate that the family is having difficulty making the transition to the next phase and therapeutic efforts need to be directed toward remobilizing the family life cycle so that normal developmental progress can continue.

FAMILY CRISIS INTERVENTION AND ILLNESS

The occurrence of illness in an individual can be viewed from the point of view of how such illness effects the family and what changes take place to cope with its occurrence. Serious illness in a family member presents an acute and chronic crisis and produces disruption and disorganization of the family's previous equilibrium (Livsey, 1972), i.e., the family's interactions, plans and needs become unbalanced.

The family therapist must assess the family as to:

1. its developmental level;
2. its unique style; and
3. the patterns of interaction and their flexibility in times of stress.

Therapy also needs to consider what stage of the life cycle the family is in. Expectations change in each stage and illness will affect each group differently (Cohen & Wellisch, 1978).

Lipowski (1970) discusses coping styles, i.e., an individual's enduring attitudes that are put in operation when he is ill. It may be postulated that a patient's coping strategies are both influenced by and affect his family relationships. One may also speak of coping by the family as a unit. Each family's coping style is built upon years of experience with one another in ways of resolving problems or avoiding resolution of them. Thus (illness) is not so much a separate problem in family process as it is an accent upon the usual mode of functioning (Cohen & Wellisch, 1978).

Coping refers to the mechanisms by which the family adapts itself to and deals with the changes resulting from the illness of one of its members. The ability of a family to function successfully may be affected by conflicts that impair coping and disturb the sick member (Livsey, 1972).

Olsen (1970) stresses adaptive and successful coping and lists the following characteristics of families that make good adaptation to serious illness: a clear separation of generations; flexibility within and between roles; direct and consistent communication and tolerance for each individual's development. Family intervention needs to address family organization and structure, opening up rigid boundaries to enable role sharing, addressing the power hierarchy to promote clear separation of generations and to facilitate clear, direct and open communication between members.

Patient and family both being affected by the onset of illness requires that family needs, too, be addressed in treatment. Minuchin (1974) suggests that facilitation of adjustment to chronic illness requires modification of the patient's

extrapsychic, as well as intrapsychic environment; which includes minimizing family pathology. Minuchin is particularly concerned with enmeshment, overprotection, rigidity and lack of conflict resolution in the family (Rustad, 1984).

Although the stress of illness may create dysfunction and cause the family's regression to ineffective behavior patterns, or be more difficult to cope with because of pre-existing family pathology, crisis also presents the family with an opportunity to grow through adaptive strategies. For example, role realignment or the re-establishment of boundaries can lead to a more equitable distribution of power, greater independence of family members, and a greater sense of family loyalty (Goldberg & Goldberg, 1985).

Structural family therapy theory also recognizes the importance of life stages and the task of reorganizing in times of transition. New subsystems and alliances are formed, power arrangements altered, and members assume new roles or give up others as the family passes through life stages. Illness represents a stress on the family as it moves through time and it is an unpredictable event in the family life cycle. Illness alters the power and hierarchical arrangements in the family as role adaptations and realignments are made. Structural family therapy intervention can assist in helping the family make necessary adjustments by modifying the family structure to adapt to the illness by clarifying diffuse boundaries and opening inappropriately rigid ones.

Strain & Beallor (1978) set as goals for family adaptation to an ill member the following:

1. family acceptance of physical and mental regression;
2. ability to help patient ward off stresses secondary to illness;
3. ability to tolerate the patient's expression of feelings and fears;
4. ability to enlist patient's trust yet support autonomous functioning; and
5. the ability to mobilize outside support (cited in Rustad, 1984).

The disparate and strong needs of the patient and the family during the process of adjustment may bring them into serious conflict, and as Minuchin (1974) has pointed out, resolution of these conflicts can be important if an adequate adjustment is to be reached. Unfortunately, even families who maintained relationships reasonably well before the onset of illness may find they lack the skills needed to deal with the conflicts and problems which arise as an outgrowth of the disability. When there is commitment to the relationship and some desire and capacity for change, new skills may be taught in the process of family intervention (Rustad, 1984).

Families operate generally to keep the emotional tension down and the equilibrium stabilized. Life threatening illness disrupts the family equilibrium; family members often react by distancing themselves from the emotional turmoil. Thus, at a time when open relationships can be most beneficial to the resolution of life crisis and to the emotional functioning of the family, these forces often render the family incapable of dealing openly with the crisis. Family members attempt to protect one another from the stress by denying the severity of the illness and the accompanying emotional upset, and communication becomes blocks. The serious illness of a family member leads to disruption of family equilibrium. The degree of disruption is affected by: 1) timing of illness in

the life cycle; 2) nature of the illness; 3) openness of the family system; and 4) family position of the seriously ill member (Herz, 1980).

Serious illness or death at any other than an elderly stage in the life cycle phase is considered an incomplete life in that it does not follow the normal expected course of life.

Serious illness in the prime of life is the most disruptive to the family...it is at this phase in the life cycle that the individual has the greatest family responsibilities. Illness at this stage may prevent the family from completing its life cycle tasks. Serious illness or death of an adult family member interferes with opportunity for the marital partners to begin enjoying each other with fewer family responsibilities. Serious illness of a patient with children still at home may result in the family not resolving tasks of these life stages. The adolescent may be needed at home to help with siblings and care of the ill parent. For the spouse, it means added emotional, domestic and financial burden.

"The intense stress of long-term illness is difficult for any family to deal with on a continuing basis. It is difficult to achieve a balance between living and dying. Often the family and the dying individual, acting to protect each other from the intensity of the anxiety, close down communications and relationships. The resulting inability to deal with the tension creates distance and further tension is manifested in a variety of symptoms."

Herz, 1980, p.230

This can easily be the scenario that develops with either the illness of cancer or myocardial infarction. At the point where cancer treatment is no longer successful in checking the spread of the disease, the patient and his family

move into a stage of terminality. This can also be the case with myocardial infarction for the patient who has sustained significant heart damage and, if not a candidate for bypass surgery, patient and family live with the knowledge that at any moment their life may suddenly end or he/she may gradually enter a phase of end-stage cardiac disease. The long-term stress of living with dying may result in serious family dysfunction. Family intervention to facilitate communication and help family members remain emotionally open to one another can reduce the tension and prevent or remediate family dysfunction.

Herz utilizes Bowen's theory of the openness of the family system as being dependent on two interrelated criteria, i.e., degrees of differentiation of family members and level of family stress. She notes that Bowen defines openness in the family system as the "ability of each family member to stay non-reactive to the emotional intensity in the system and to communicate his/her thoughts and feelings to the others without expecting the others to act on them" (Herz, 1980, p.231). The more differentiated individual is able to define his position on the basis of thought or principle and can hear other's thoughts and feelings without over-reacting.

The second criteria in determining openness of the family system, level of family stress, is crucial to the development of family symptomology.

A family can be undifferentiated but remain symptom free because they have little stress. There is greater likelihood of emotional problems when family members are unable to deal openly with one another. The ability to remain open, express feelings and remain non-reactive to other's anxiety depends on the intensity and the duration of the stress. Life-threatening illness creates

intensive stress for all family members and therefore places the openness of the family system under considerable strain.

The family position of the ill member is also an important contributing factor. The more emotionally significant the member, the greater disruption in family equilibrium and the greater denial of family dependence on that member. The significance of a member can be understood in terms of their functional role and the degree of emotional dependence of the family on that individual. For example, the threatened loss of a parent through serious illness, to a young child, means loss of breadwinner and nurturer; to a couple with extreme marital fusion, threatened loss of spouse represents loss of self (Herz, 1980).

Herz believes intervention must be directed at opening up the family emotional system, with the goal of preventing family dysfunction by assisting the family in dealing with the stress of serious illness. Herz advocates for several interventive strategies, including: 1) modeling open discussion of factual information re: severity of illness, and 2) establishing at least one open relationship within the family. By this, she does not mean therapist with a family member, which would only serve to close the family further by lowering anxiety enough to prevent family from dealing with each other or inviting dysfunction by creating a triangle. In order for family members to gain from open discussion of the threat of death or emotional impact of serious illness, it must occur in the context of the intimate family relationship.

SUMMARY

This literature review provides evidence that the diagnosis of life-threatening illness imposes many stresses on the family. The family may also be facing concurrent stresses related to illness such as marital dysfunction or normative individual or family transitions. The negative consequences of a cancer/M.I. diagnosis are obvious; however, there may also be positive consequences which promote family growth and well-being. Families employ many active strategies to cope with stresses, gain understanding of the situation, and relieve tensions. We need to give these families much empathic support during the time of crisis. More importantly, we need to take the opportunity to help these families to expand their coping repertoire, to keep family lines of communication open, to improve problem solving abilities, and to enhance overall interpersonal relationships, so that they can grow with the demands of the illness.

CHAPTER 2

DESIGN OF THE PRACTICUM

SETTING

The setting for this practicum was Misericordia General Hospital. This is a 409 bed acute care general hospital. Patients are admitted through the Emergency Department and by physicians who have admitting rights to the hospital. The delivery of medical services is provided to the patient by the physician in charge and/or by specialists on consultation, and by nursing staff on the unit where the patient is confined. Other health care team members consisting of social worker, pastoral care visitor, home care co-ordinator, dietician, and occupational or physiotherapists provide services as needed. The student was well oriented to this setting having been an employee at Misericordia for four years. The student's familiarity with the setting facilitated introduction of the practicum and access to clients, as the student was already known to many physicians and head nurses, through whom most referrals came.

CLIENTS

The clients consisted of families with a diagnosis of life-threatening illness, either myocardial infarction or cancer, in one of the adult partners. Referrals were identified from my own caseloads on surgery and the intensive care unit, as well as sought from head nurses, physicians and other social workers in Misericordia General Hospital.

Meetings with the family took place weekly or more frequently during the crisis phase, immediately following diagnosis, and during hospitalization. Frequency of post discharge meetings depended upon need, but for the most part, were every two or three weeks for the duration of the practicum. Seven families were seen over a four to six month period. Seven families were not seen past the crisis/hospitalization phase.

INTERVENTION

This practicum consisted of a plan of intervention with families for the first three months following the diagnosis of myocardial infarction or cancer in an adult partner. Intervention began in the crisis stage at the time of diagnosis and continued through the hospitalization phase of treatment and initial recovery, with post-discharge follow up expected to continue up to three months after onset of illness. Intervention was based on an ecological systems assessment and was consistent with a family-centered model of practice. As discussed in the preceding literature review, intervention with patients and families consisted of an assessment, crisis intervention, grief therapy, and family-centered counselling to enhance coping strategies.

1. Assessment

An assessment of the family was done using an ecological framework. Also the Double ABCX model explained in the literature review was an additional assessment tool with which to identify stresses, resources, and

family perception, effecting coping ability. Components of life cycle development and family structural theory contributed to the assessment of family functioning.

2. Crisis Intervention and Grief Therapy

Diagnosis of life-threatening illness creates a disequilibrium in the family's normal steady state, so initial intervention efforts were directed at "cushioning the impact of the stressful event by offering immediate environmental first aid and to strengthen the person (and the family) in his/her coping and integrative struggles through on the spot clarification and guidance through the crisis period " (Golan 1978, p.71).

The diagnosis of life-threatening illness by its "threatened" loss of a loved one can set up a process of anticipatory grief for the family. As well, the loss of "previous state of health" for the patient and family also comprises a crisis of loss for which patient and family may need to mourn. This process and the intervention of helping the family to operationalize the mourning process by encouraging the expression of painful feelings and emotions was discussed in the earlier literature review on grief work (p.12-14). The practicum intervention followed that as outlined in the grief work section.

Encouragement of the ventilation of feelings is a basic procedure in the early stages of crisis intervention. It can help the family come to terms with the diagnosis. The social worker needed to normalize and universalize family feelings. Families were helped to identify their own coping mechanisms that they could use to gain control of their situation.

Practical tasks were also discussed and planned for, such as financial matters, transportation and other resources that could be utilized to relieve initial stresses.

Golan (1978) presents six operational objectives in working with families in crisis:

1. relief of symptoms;
2. restoration to pre-crisis level of functioning;
3. some understanding of the relevant precipitating events which have led to the state of disequilibrium;
4. identification of remedial measures which patient and/or family can take which are available through community resources;
5. connecting current stresses with past life experiences and conflicts; and
6. initiating new modes of perceiving thinking and feeling, and developing new adaptive and coping responses which can be used beyond the immediate crisis situation (Golan, 1978, p.71).

These were the objectives toward which intervention was directed.

3. Family-Centered Counselling

Contact was maintained throughout the practicum period with members of seven families, in hospital and/or in their own home. Contacts were made at the time of crisis of diagnosis, during the treatment phase in hospital and in the post discharge adjustment phase with additional

family sessions at each stage as warranted by the family's needs and/or desires. The focus of these family sessions arose from issues identified from the assessment and which related to family functioning, interfamily relationships, communication, support systems, past illness and crisis in the family, the present course of illness and coping strategies. Emphasis was placed on encouraging open communication and enhancing coping strategies with a view to helping the family to problem solve and reorganize after a crisis.

Essentially, this approach could be summarized as family-centered crisis intervention. Crisis intervention has just been described in some detail but to summarize, family intervention during the acute stage of illness were directed towards two goals: 1) reducing anxiety and 2) minimizing the social disruption , for the family, caused by life-threatening illness. This involved recognizing the impact on the family system and helping family members identify their emotional responses, encouraging expression of feelings, providing re-assurance and support, information giving and provision of practical assistance.

During the convalescence stage, intervention was directed toward: 1) preparing the family for the patient's discharge from hospital and 2) toward re-organization post discharge to adapt to the continuing effects of the illness. This involved education as to what to expect, anticipatory problem-solving, encouraging of open communication between family members, discussion of role changes, and linkage to community resources.

TERMINATION AND EVALUATION

Intervention with the practicum families was maintained until such time as family members felt the major adjustments required of them to accommodate illness, had been made. For most families, this was around a five to six month period after onset on illness. At this point most issues were resolved or families felt able to cope with their changing circumstances without outside help and mutual agreement for termination of service was reached.

Evaluation of progress towards goals was undertaken with each client family. These goals were determined through a process of ecological assessment and involved change in the adaptation and/or functioning of individual patient and/or family members, in the interaction between family members, or involved changes in the environment to achieve a better adaptive fit.

Three methods of evaluation were utilized to measure effectiveness of intervention: These are as follows:

1. Eco-maps were used pre and post intervention, as an evaluative measure. "Eco-maps can be used to evaluate outcomes and measure change. A comparison of eco-maps done at outset and at termination can help clients and workers measure the changes that have taken place. As such the maps can become an important device in maintaining accountability" (Hartman, 1978).
2. The Family Assessment Measure (FAM III) either the general scale or brief form (Appendix I), were presented to families as a pre and post

intervention tool. Four of the practicum families agreed to complete one of the questionnaires but only one family completed both a pre and post intervention test.

The FAM is a self-report instrument that provides quantitative indices of family strengths and weaknesses. The basic concepts assessed by FAM include: task accomplishment, role performance, communication, affective expression, involvement, control, values and norms. The general scale used in the practicum focuses on the family as a system. The FAM may be used as a clinical diagnostic tool, or as a measure of therapy outcome.

The concepts measured by the FAM also provide a framework for family assessment and are elaborated upon in the following text. Task accomplishment, i.e., the family's achievement of basic, developmental and crisis tasks, as control to its life as a group. The process by which tasks are accomplished include: problem identification, exploration of solutions, implementation of selected approaches, and evaluation of effectiveness. Task accomplishment involves the performance of various roles. Role performance requires allocation of specified activities to family members, agreement to assume assigned roles and carrying out the prescribed behaviors. The process of communication is essential to role definition and task accomplishment. The goal of effective communication is the achievement of mutual understanding. A vital element of communication, affective expression impedes or facilitates task accomplishment and role integration. Effective communication is most likely to become blocked in times of stress, such as illness. Similarly

the affective involvement which refers to the degree and quality of members interest in one another, can thus help or hinder task accomplishment. Types of affective involvement range from the uninvolved to the enmeshed family. Also the ability of the family to meet the emotional and security needs of family members, and the flexibility to provide support for family members' autonomy of thought and function are critical elements at a time of family illness.

Control is the process by which family members influence each other. The family needs to be capable of successfully maintaining ongoing functions and adapt to shifting task demands, if they are going to make a successful adaptation to the crisis of illness. Values and norms provide the backdrop against which all basic processes must be considered. It is important whether family rules are explicit, the scope allowed members to determine their own attitudes and whether family norms are consistent with the broader cultural context (Skinner, et al 1983).

The norms for the FAM III are based on a heterogeneous sample of 475 families (n=933 adults, n=502 children) that were tested at various health and social service settings in the Toronto area. There is moderate to high internal consistency reliability for each subscale (.65-.87 for adults and .62 to .87 for children) and high internal consistency for the overall rating (.93 for adults and .94 for children) of the general scale (Skinner, et al, 1983).

3. A third means of evaluation used was a consumer feedback questionnaire. Evaluation researchers consider consumer feedback an

important source of information on treatment and such questionnaires usually include enquiries into satisfaction with the therapist, with access to services, with the treatment modalities offered, and with the changes that did (or did not) occur as a consequence of service (Trute, 1985).

The consumer feedback questionnaire used is contained in Appendix 2 and based on questions pertinent to hospital social work and this practicum, adapted from Powell (1987).

4. The Beck Depression Inventory, short form. This was used in only one case as a pre and post intervention evaluation measure. The Beck Depression Inventory, short form, is a 13 item questionnaire measuring probable severity of depression. The reliability and validity of studies of the original BDI were based on a sample of 598 patients in the psychiatric and outpatient services of the Philadelphia General Hospital and the Hospital of the University of Pennsylvania. The split-half reliability was 0.93, which is highly significant. The short form correlated 0.96 with the total BDI score (Beck & Beck, 1972). A sample questionnaire is found in Appendix 3 which was published in Post Graduate Medicine, Dec. 1972.
5. Support Network Questionnaire. A sample questionnaire is found in Appendix 4. This questionnaire was developed by Trute (1988) and modelled after approaches of Hirsch (1980) and Kazak & Wilcox (1984). The Support Network form identifies family, friends, and professionals who provide help or assistance and in what form; e.g. with tasks, social activities, personal worries, decisions, emergencies and/or information.

The questionnaire also asks the family to identify negative influences in their support network that block change. The questionnaire was completed by two practicum families.

SECTION II

CHAPTER 3 THE PRACTICUM EXPERIENCE

OVERVIEW

During the practicum period a total of 14 families were seen by the student. In each case an adult family member was diagnosed with a life threatening illness, either cancer or myocardial infarction. Of the 14 cases, the breakdown in diagnosis is as follows:

Table II
Breakdown in Diagnosis

<u>Diagnosis</u>	<u>No. of</u> <u>Patients</u>	
myocardial infarction	3	
breast cancer	3	} 11 cancer patients
lung cancer	5	
bone cancer	1	
liver cancer	1	
uterine cancer	1	

During the practicum period 4 patients died, all of them cancer patients, although 1 cancer patient died suddenly as a result of an M.I. having a previous history of heart disease. Of the other 3 cancer patients, 1 was diagnosed as terminal at the point of my entry to the case; the other 2 received a brief period of treatment.

The amount of involvement with each client varied. All clients and/or families were seen a minimum of twice, with 5 clients fitting into this level of contact. These were clients who for the most part, declined involvement past the hospitalization phase. It was necessary to include a greater number of families in the practicum in order to achieve a sufficient number of families willing to be involved with the student over a longer period of time, i.e. the initially proposed period of 3 months from time of diagnosis.

The maximum number of interviews with a family was 12 with 2 families receiving this level of treatment. The remaining families were seen at varying levels of frequency between 3 to 10 interviews. A total of 8 families were seen for 2-4 interviews and 6 families for 6-12 interviews.

Table III represents the breakdown of client families according to age and diagnosis of patient, number of sessions and family members seen.

Table III
Demographic Breakdown of Client Group

<u>Age of Patient</u>	<u>Sex</u>	<u>Diagnosis</u>	<u>Family Members Seen</u>	<u>No. of Interviews</u>
50	M	lung cancer	pt. only	2
75	F	breast cancer	husband and pt.	2
41	F	breast cancer	husband and pt.	2
78	M	bone cancer	pt. only	2
43	F	breast cancer	pt. and mother	4
55*	M	lung cancer	wife and pt.	2
30	F	uterine cancer	pt. only	3
63*	M	liver cancer	pt. only	3
80*	M	lung cancer	wife and pt.	6
79	F	M.I.	pt., adult son/daughter	8
55	M	M.I.	wife and pt.	6
49	M	M.I.	pt., wife and 19 yr old son	12
48*	F	lung cancer	pt., husband son 28 years, two daughters 26 and 16	12
68	F	lung cancer	pt. and husband	8
***	-	deceased		

As this table reflects, there was an even split between male (7) and female (7) patients. There were 4 patients under 50 years of age, 5 patients between 50-65 years, and 6 patients 65 years and over. Six families had children still living at home. All but one client, who was widowed, were living with a spouse.

All the families resided in Winnipeg. Eleven of the families were Caucasian, one family was Asian, and two families were native.

Twelve of the families could be described as of the middle socio-economic class. One was working class and one was on partial social allowance. All of the patients, both male and female, of working age (eight families) were employed at the time of diagnosis of their illness. Of their partners, one wife was a full time homemaker and one husband was on disability leave. Six families were retired. All but one family consisted of a marital couple, the other was a widow. Six of the families had children living at home, seven families had adult children no longer at home, and one family had no children.

The six cases that are discussed in this section were chosen because they were cases where I had the greatest involvement and in most cases the family engaged on such a level as to be willing to complete the FAM assessment measure. Also each case was chosen for the particular issues that it illustrates, i.e. dysynchrony of family members in coping with terminal illness, the crisis of cancer as an impetus to change or family re-organization after the death of a parent. A seventh case is added to demonstrate entry difficulties.

One case (X) is discussed at length being representative of much of my work with practicum families. The remaining six cases (A to F) are discussed in slightly less detail.

FAMILY CASE STUDIES

"X" FAMILY

REORGANIZATION TO ADAPT TO LIFE THREATENING ILLNESS...

The "X" family consisted of Mr. X, 55 years and Mrs. X, 44 years. This couple had 3 adult children living away from home. A daughter, 27 years, in Winnipeg with a 3 year old child, a son, 24 years, living with this sister, and a second son, 21 years, living and working in Thunder Bay.

Both Mr. and Mrs. X's parents were deceased, as were the majority of their brothers and sisters. Those who are living, are in North Western Ontario except one of Mr. X's sisters, who lives in Winnipeg, not far from the X family. The family constellation is diagrammed in Figure 2.

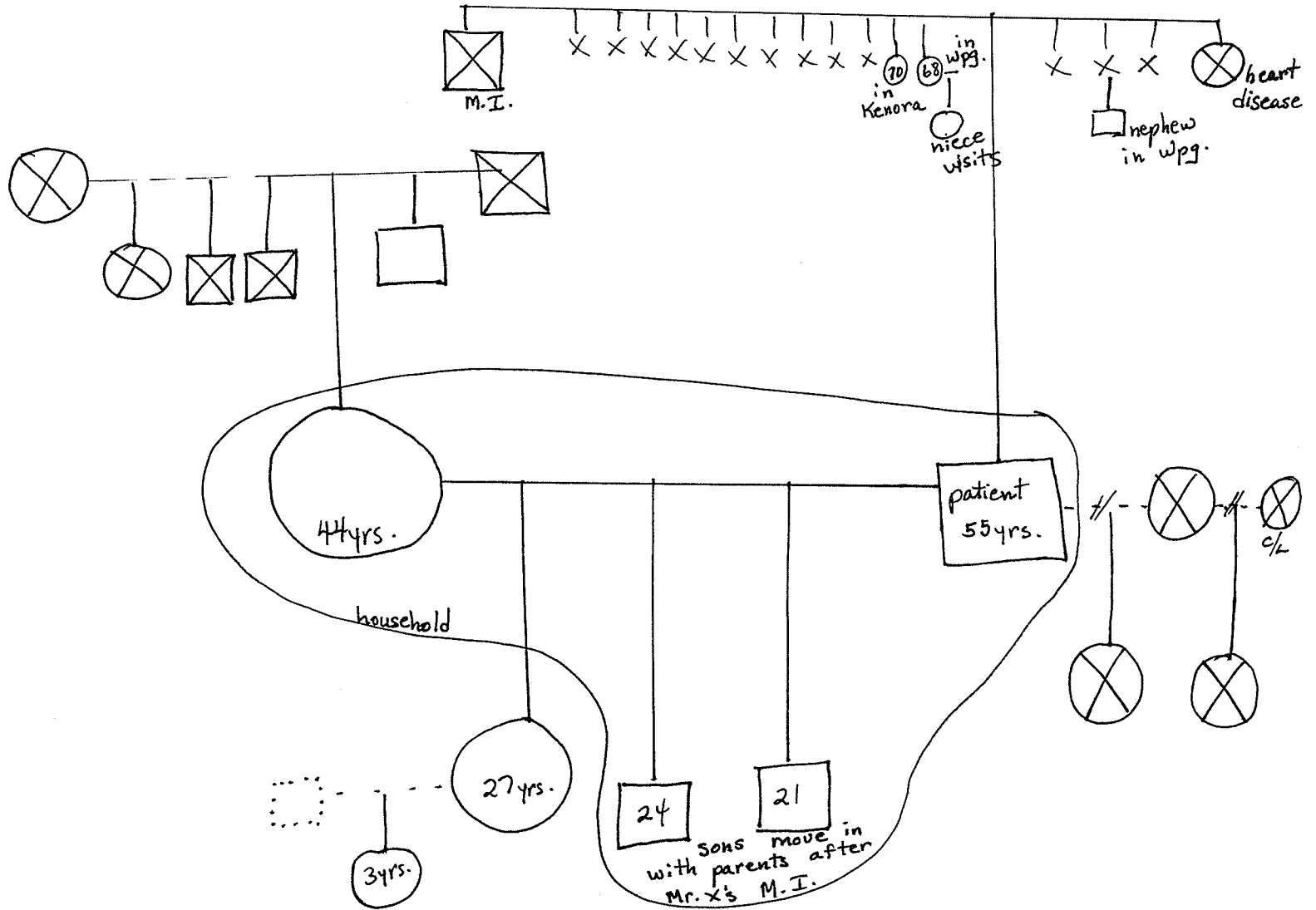
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Figure 2
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Reason for Referral:

Mr. and Mrs. X were referred to the Social Work Department in Feb '88 while Mr. X was a cardiac patient in the Intensive Care unit of the Misericordia General Hospital. Mr. X had suffered a myocardial infarction (heart attack), and was concerned about his recovery time and ability to continue employment. Mrs. X

Figure: 2

Genogram: Family "X"



was concerned about her husband's serious condition and feared for his survival. This couple were seen for 6 sessions over a four month period, from February to June, 1988.

History of Previous Family Functioning:

The couple had been managing well prior to Mr. X's heart attack. They had a prior history of problems with alcohol abuse dating back to pre-1980. Mrs. X had been so seriously ill at one point from cirrhosis of the liver, that she was not expected to recover. However, she did survive after extensive treatment, and had now been free of any alcohol use for 8 years. Mr. X had not been as successful in achieving total sobriety, but had not had any serious drinking binges for the past two years. The couple had separated at one point in 1976 due to alcohol abuse, but subsequently reconciled. After Mrs. X's recovery from liver disease, the couple entered alcohol treatment programs together. Mr. and Mrs. X's history with Mrs. X's serious illness reveal that this couple were experienced in coping with critical illness. In fact, they survived intact as a family, and emerged from the experience strengthened in their relationship and personal functioning, capable and committed to overcoming their alcohol dependency problems.

Family Assessment:

The X family are a native family. Developmentally this couple are in the life cycle stage of launching children and adjusting to their regained couple status.

Mr. X makes his living from traditional Indian skills as a guide at a fishing camp. As usually the case in native families, they are close to extended family and boundaries between nuclear and extended family are not distinct.

Mr. and Mrs. X function in traditional roles, with Mrs. X being the homemaker and Mr. X the breadwinner. Communication is generally clear with husband and wife discussing issues together. They are mutually supportive of one another but external stresses have at times created conflicts. They have had previous experience with serious illness and their experience has created a belief in the ability to recover if medical advice is followed.

Mr. X holds the value that work gives purpose and independence. Both Mr. and Mrs. X define family as very important. The quality of emotional relationships in this family is good. They participate in mutual decision making and reach out to resources for help when conflicts and problems cannot be resolved internally. They make good use of resources and maintain a good relationship with their support system. They turn typically to extended family, i.e. adult children for assistance when needed.

In looking at the "X" family from the point of view of crisis theory, (Golan 1978), the diagnosis of myocardial infarction was a disruption to the family's previous state of balance. Both Mr. and Mrs. X demonstrated behaviors that were indicative of an active crisis state. Mr. X was shocked by the diagnosis and had a need to repeat several times the events leading up the actual experience of his heart attack. Mrs. X's shock and anxiety were demonstrated by her emotional state, as she sat by her husband's bedside, expressing fear for his survival.

Problems Addressed:

The "X" family began to re-organize themselves from the crisis as the planning for discharge was discussed. The couple began to address life-style changes, i.e. diet, exercise, time off work, and how these factors would be integrated into their daily lives. Mrs. X also raised concern for her husband staying alone at home when she was to enter hospital in a few weeks time, for upcoming knee surgery.

Different goals were set at each stage of Mr. X's illness. During the crisis stage while Mr. X was in the intensive care unit, the goals were:

1. to alleviate Mr. and Mrs. X's anxiety regarding the patient's survival; and
2. to strengthen their coping capacities.

During the recovery phase, while still hospitalized but out of intensive care the goals of interventions were:

1. to prepare for Mr. X's discharge; and
2. to obtain financial support while Mr. X was unemployed.

In the post discharge phase, goals were established as follows:

1. secure household management resources to meet family's needs while Mr. X was unemployed;
2. facilitate emotional adjustment to temporary (possibly permanent) loss of employment;
3. facilitate adjustments to role changes as a result of illness; and
4. facilitate couple communication to ensure all members emotional needs are met.

Intervention:

Intervention during the time of initial crisis focussed on two goals: 1) alleviating the immediate impact of the disruption and stress of Mr. X's heart attack on the couple; and 2) mobilizing their psychological capacities and social resources to enhance adaptive coping with the stress of life-threatening illness (Parad - 1971). Achievement of these goals was undertaken by providing opportunity for Mr. X and his wife to vent their fears and shock at the news of Mr. X's heart attack. Also network building interventions ensured Mrs. X had support when visiting her husband in ICU, by suggesting she have family or friends accompany her, or by my own presence some of the time.

Exploration with Mr. and Mrs. X of their previous coping strategies, during past times of crisis, specifically during Mrs. X's own critical illness, served to re-

assure this couple of their emotional strengths and capacity to survive an emotionally difficult time.

Once the immediate threat to survival seemed past, Mr. X began to question his return to work. Mr. and Mrs. X were receiving assistance with City Welfare at the time of Mr. X's heart attack, but the family generally supported themselves by Mr. X's employment through the spring and summer months as a guide at a fishing camp in North Western Ontario. He had been due to leave for camp in 3 weeks time when he had suffered this heart attack. The rest of the year the couple managed on his saved earnings and some city assistance through the winter months.

The impact of this crisis on the future i.e. work, was a major issue for Mr. X. Mr. X's work was very important to him, giving him a sense of purpose and capability in which he took pride. It also gave them as a family, freedom from dependence on public assistance. As it eventually proved impossible for Mr. X to return to this type of work, intervention helped him mourn the loss of a valued part of himself.

The "X" family was assessed utilizing McCubbin & Patterson's Double ABCX model (1983).

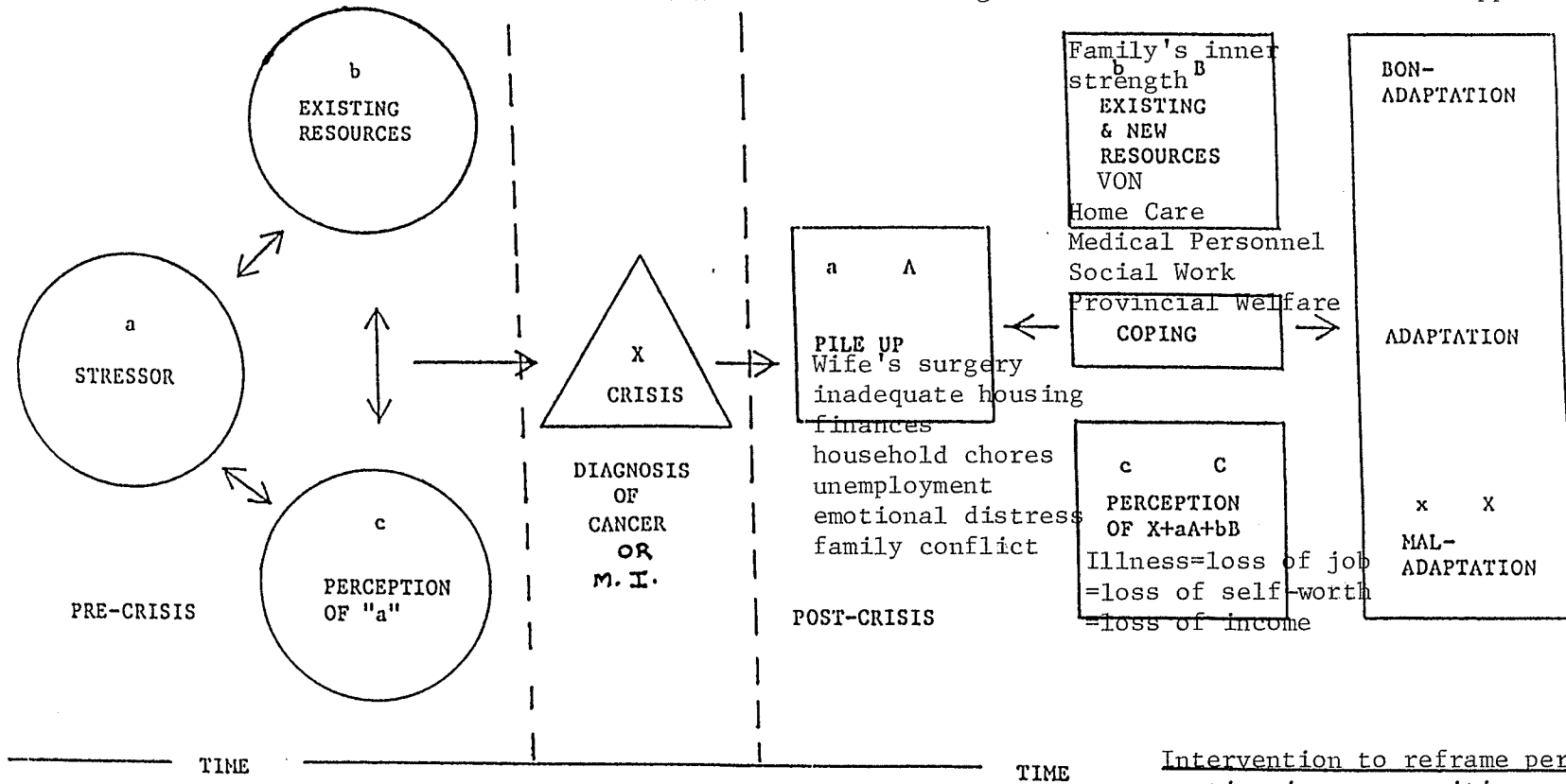
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Figure 3
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Figure 3:

The Double ABCX Model of Family Adaptation in Life Threatening Illness

Intervention to reinforce couple's coping ability and open communication to resolve conflicts.

Intervention to increase community & social supports.



Adapted from: McCUBBIN AND PATTERSON (1983)

Intervention to reframe perception in more positive terms.

McCubbin suggests that families are seldom dealing with a single stressor, but rather they are experiencing a "pile up" of demands. The "X" family were dealing with the stress of Mr. X's myocardial infarction and treatment, lifestyle changes, Mr. X's hospitalization, resulting unemployment and dependence on City Welfare resulting in lower income. In addition, Mrs. X's orthopedic problems required surgery very soon after Mr. X's heart attack. Her immobilization after surgery added stress to the family. Their housing, with stairs, was inadequate. Mrs. X could not negotiate the stairs herself. Mr. X could not assist his wife because of his heart attack. Also, during Mrs. X's hospitalization, the additional stress of Mr. X potentially being left alone at home was of concern to Mrs. X. Household chores as well became a problem after Mrs. X's surgery, as Mr. X was not well enough to take over her role in heavy household chores.

A second factor in the Double ABCX model is resources. The X family had some good psychological and interpersonal resources, but would require additional new resources to meet the new demands placed upon them. The Eco-maps, before and after intervention illustrated the increased input of resources to the family.

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Figures 4 and 5
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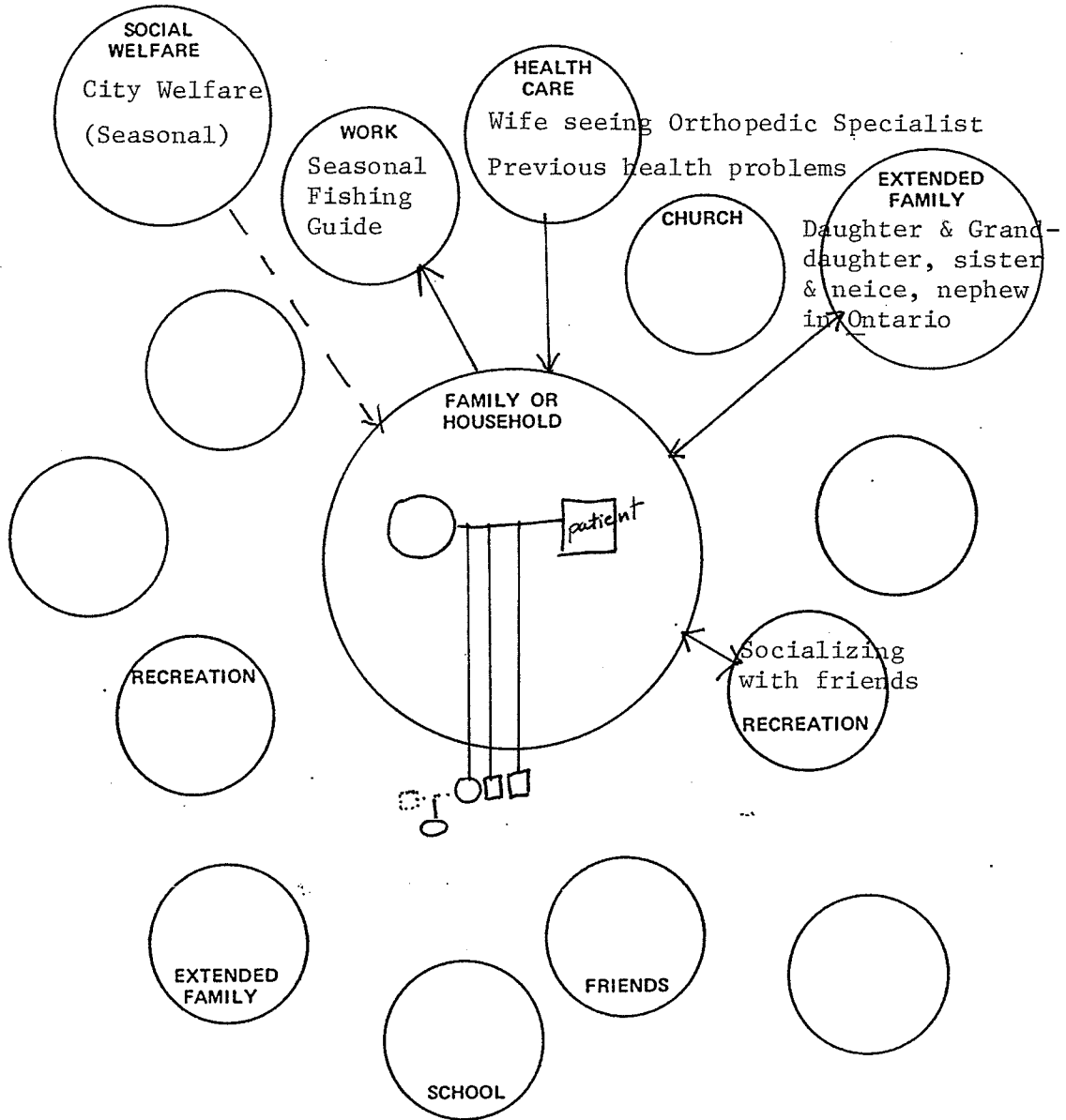
Referrals were made to Victorian Order of Nurses and Home Care for nursing and housekeeping services for both Mr. X and his wife. Contacts were made

Diagrammatic assessment of family relationships

Figure 4

ECO-MAP

Name Family "X"
Date Feb/88 (PRE)



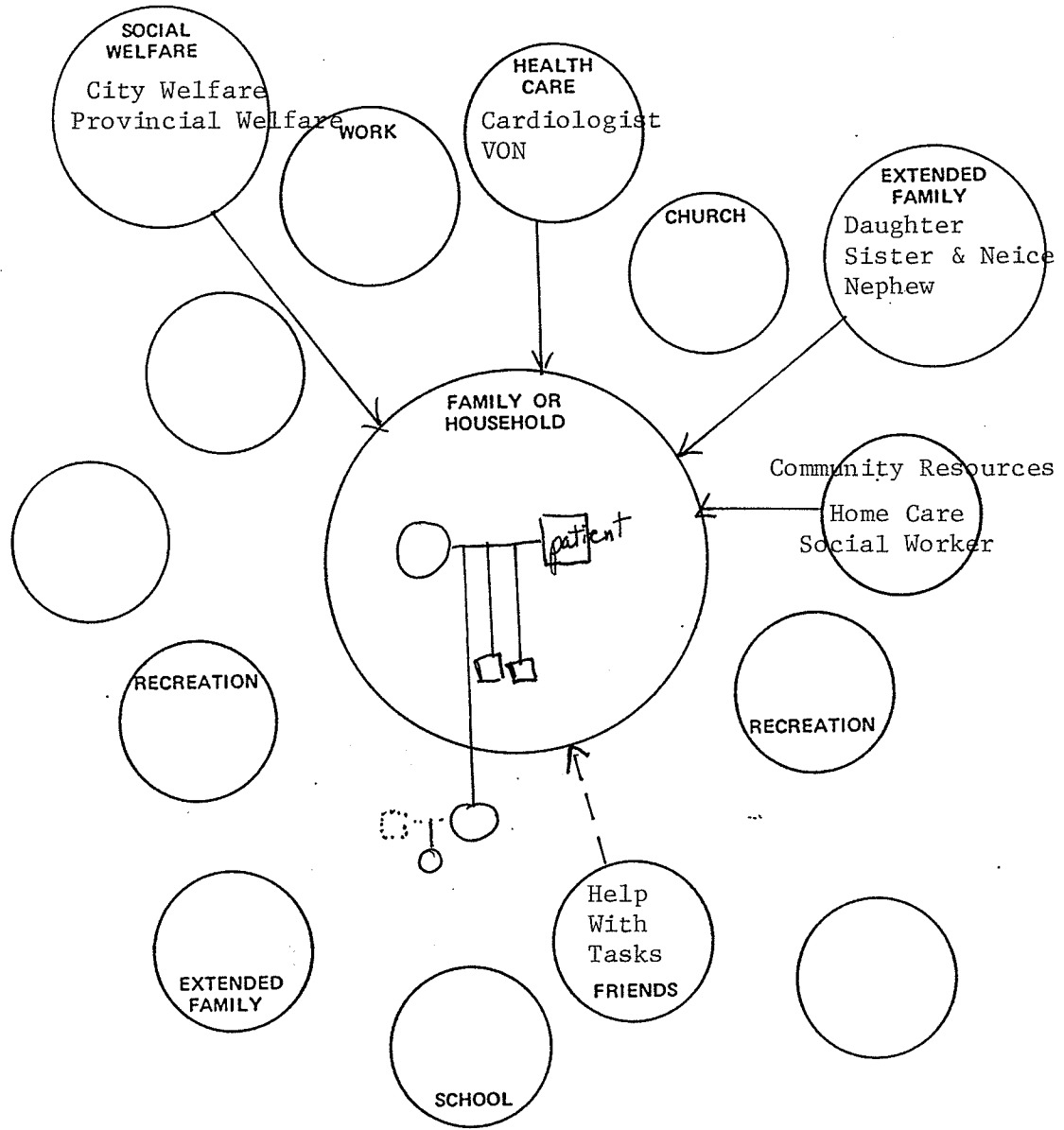
Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, + + + + + for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

Diagrammatic assessment of family relationships

Figure 5

ECO-MAP

Name Family "A"
Date June/88 (POST)



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines:
 ————— for strong, - - - - - for tenuous, ++++++ for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

with City Welfare to maintain the family on assistance until Mr. X's ability to return to work could be determined. This also required my intervention on the family's behalf advocating with Mr. X's physician to clarify the length of time he would be off work and whether he could return to his former type of employment.

Intervention to help this couple in their adaptation process by mobilizing their social resources involved advocating with and referring to appropriate community supports to meet certain needs, and problem solving with the couple around personal resources and utilization of their social support system. The couple decided to request increased temporary support from their children, to assist them through the first difficult months of adaptation. While Mrs. X was hospitalized, the eldest son moved home so that Mr. X would not be left alone. The younger son, who had been working in Thunder Bay returned to Winnipeg and found work here. The family decided that the two sons live with the parents and assist with the running of the household and needs of their parents during Mrs. X's convalescence from knee surgery. Although this plan worked well for the family, there is concern that the adult children could potentially become stalled in their developmental tasks of leaving parents and establishing themselves independently. Even though the family saw this as a temporary arrangement until Mrs. X was able to resume her normal activity level, a useful intervention may have been to meet with the entire family to ensure this issue was clear. It was not of particular concern to the family and was seen as a natural solution possibly because of the not uncommon blurring of boundaries between nuclear and extended family in native culture.

It was a concern from the start, that Mr. X would not be able to resume the physically demanding duties of his employment as a fishing guide. Intervention on this issue began early in the convalescent period with Mr. X exploring the meaning to him of his work, his perception of himself in relation to work, exploring other roles he performs in the family and his overall importance to the family. The majority of conflicts between Mr. and Mrs. X during this time were over Mr. X attempting to do too much in order to prove to himself that he could return to work. Such attempts at physical labour resulted in Mr. X experiencing angina, and his wife becoming distressed that he would have a second, possibly fatal, heart attack. Mr. X also threatened to return to work in response to City Welfare's threats to cut off assistance. The family had to repeatedly justify to City Welfare why he was not working. If he was ill City Welfare expected a medical report that would enable them to transfer the family to Provincial assistance. Mr. X's physician was reluctant to predict Mr. X's work potential beyond two month periods at this time. Mr. X's threats to return to work were made out of frustration and his reinforced negative feelings of loss of independence. The fear on Mrs. X's part that her husband might actually return to work caused considerable conflict between the couple. Resolution of this problem required intervention with City Welfare and Mr. X's physician, as well as in the communication processes between the couple.

Intervention consisted of opening up and clarifying communications between the couple. My purpose was to reframe Mrs. X's anger at her husband as a concern for his well being, while at the same time, enabling Mr. X to be heard by her as to the importance to him of being a capable head of the household. With this clarification, and assistance in communicating, Mrs. X was able to express her fears to her husband as well as provide him with information as to other

important roles he played in the family regardless of earning money i.e. companion, father, decision-maker; important roles that she cared much more about than loss of financial income or financial independence. Mr. X did have a sense of himself as more than a wage earner, and the verbalization and legitimization of these other roles by his wife did much to help him adjust to the possibility of not returning to work. Mr. X ceased "overdoing" physical activity and began looking at developing hobbies within his abilities.

Evaluation:

Several evaluative instruments were used with the "X" family to assist in determining the effectiveness of the intervention:

1. Eco-maps, pre and post intervention;
2. Support Network questionnaire;
3. FAM III, Brief form - pre and post intervention;
4. Beck Depression Inventory, pre and post intervention; and
5. Consumer Satisfaction questionnaire.

The Eco-maps (Figures 4 and 5) illustrate the increased social support network subsequent to intervention which assisted the family in acquiring necessary additional community resources to meet their needs. i.e. Home Care, Welfare,

VON, and family. It also illustrates the change in reciprocity of the flow of supports i.e. prior to Mr. X's M.I., the family were engaged in a more mutual give and take process with their support system. Now they are primarily receiving support.

A second evaluative tool, the support network questionnaire, was basically found to be redundant. It provided information similar to that of the Eco-map, showing an increase in formal support systems and greater reliance on informal supports subsequent to the illness. It did also reveal that Mr. and Mrs. X depended on family for instrumental and affective tasks and supplemented instrumental task performance with formal community supports.

The FAM III (brief form) was administered at the time of the first meeting with the family after hospital discharge, approximately 3 weeks after Mr. X's M.I. The first 2 weeks of hospitalization were seen as a time during which the couple were reacting to the crisis of Mr. X's M.I., and not an appropriate time to request they complete the questionnaire. Thus, it was administered during the first home visit after discharge. The brief form was utilized because of reluctance on the couple's part to complete the longer form, citing lack of education and poor reading skills as a barrier. They were co-operative with the short form and Mr. X also agreed to complete the Beck Depression inventory. Both Mr. and Mrs. X's pre-intervention scores on the brief FAM III fell within the normal range. However, their answers did indicate weakness (though still within normal) in the areas of expression of emotions and conflict in role expectations. These are the areas that were addressed in interventions with this couple. A post intervention FAM (brief form) was received four weeks after termination of treatment. The couple's scores continued to be in the normal range. Previous disagreement

over role function ("family duties are fairly shared") was resolved. Their response to "we tell each other about things that bother us", changed from "disagree" to "agree". Their pre-intervention response may have reflected a desire to protect one another and a fear that upset feelings might cause Mr. X cardiac stress. Their post-intervention response seems to indicate no concern in this area and an increased openness in communication since intervention. Disagreement remained on two questions but their overall scores fell well within the range of normal family functioning and seemed to reflect slight positive changes subsequent to intervention.

Mr. X's answers on the Beck Depression inventory scored him as experiencing "none to minimal" depression. In fact, the only area in which he acknowledged any concern was in the section under "pessimism", indicating he did feel discouraged about the future. Two other areas that I would have expected acknowledgement of concern , were under "work difficulty" and "fatigability", as the question of whether Mr. X would be able to return to previous employment was raised by him right from the time of diagnosis. Possible explanations of this seeming inconsistency is that the statements on the Beck questionnaire regarding work difficulty and fatigue do not provide enough range to express Mr. X's experience or that he was not willing to admit to limitations of his M.I., still practicing some denial at this time regarding the significance or permanence of his cardiac disability.

The post-intervention "Beck" revealed no depression, Mr. X no longer reporting any pessimism about the future. None of his other responses changed.

Interventions with this family were many in the instrumental area, referring to and arranging for support services to enable the family to manage Mr. X's recovery at home. Intervention in the affective area focussed on handling feelings of anxiety in relation to Mr. X's illness and on opening of communication between the couple to assist in Mr. X's adaptation to the loss of his work role. Evaluation of the clinical work reveals progress on all specified objectives and the pre and post test instruments support the intervention as successful.

"A" FAMILY

THE CRISIS OF CANCER AS AN IMPETUS TO CHANGE...

The "A" family consists of Mrs. A, 30 years, and her husband, 28 years, and 4 children, 3 from a previous marriage. Mrs. A comes from a large family as the attached genogram illustrates (Figure 6). Nothing is known about Mr. A's family. Mrs. A's family live close by in the same reserve community.

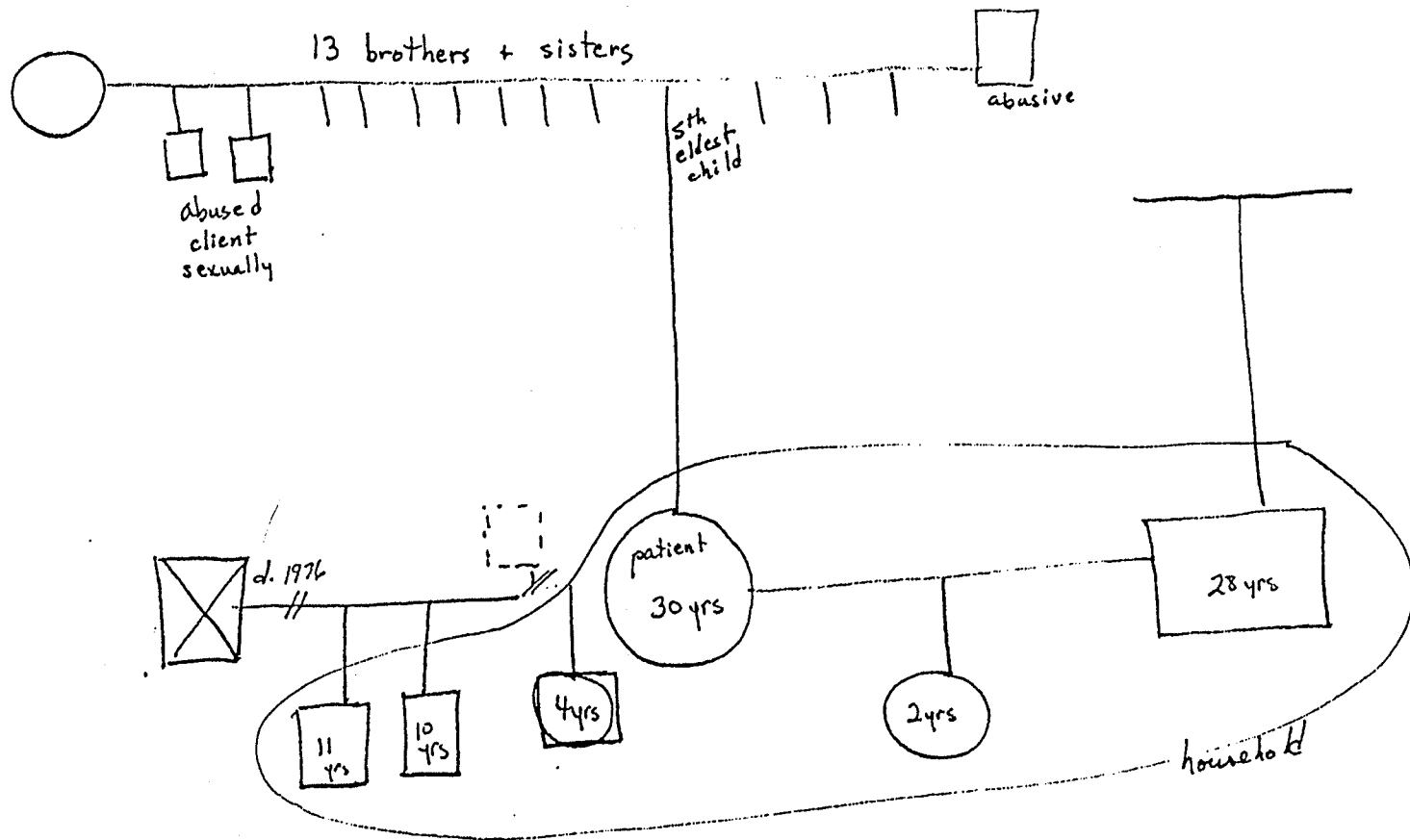
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Figure 6
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Reason for Referral:

Mrs. A was referred to the Social Work Department of the hospital by her program trainer, because of marital problems. Mrs. A was working as an alcohol counsellor trainee on her reserve and was scheduled to come into Winnipeg for surgery, for cancer of the uterus. As she had to come into Winnipeg for periodic 6 week training sessions, there would be opportunity for continued counselling if she wished. Mrs. A was seen for 3 sessions during her 10 day hospitalization in Feb. '88. Though further sessions were offered, Mr. A did not choose to continue counselling post discharge.

Figure: 6

Genogram: Family A



History of Previous Family Functioning:

Mrs. A is in her second marriage, her husband drinks heavily and is abusive. Her first marriage ended in 1976, with the death of her husband in an alcohol related drowning accident. She had 2 sons from this marriage, now 11 and 10 years of age. After her husband's death, Mrs. A indulged in much alcohol abuse, and as she described it, did not want to admit that alcohol had been responsible for her husband's death. After 5 years of this self-destructive behavior, Mrs. A decided she wanted to straighten her life out and provide a stable home for her children. She returned to the reserve and quit drinking. During this time, she had a 3rd child, now 4 years old. In 1984, she met and married Mr. A., a new comer to her reserve. They have one daughter, 2 years of age.

Mrs. A was a victim of sexual abuse by her father and several of her brothers when she was a child. Having been victimized for much of her life, she has difficulty believing that she deserves better.

Family Assessment:

This couple are developmentally in the stage of the life cycle, concerned with tasks of raising young children. They represent a blended family and they face additional psychosocial tasks of integrating a step-parent and step-children into one family unit. They are a native family, living on a reserve. Mrs. A holds

traditional Indian values and her culture and the welfare of her people are important to her.

Mrs. A. functions in the role of both wage earner and homemaker. Her husband only recently became employed. Mr. A functions in the power position of the family and maintains control by intimidation and abuse. Mrs. A reports she and her husband have different styles of communication, she tries to talk out problems, while her husband tends to be non-communicative and displays a limited range of emotion. Having not seen Mr. A, it was not possible to observe family communication patterns.

Mrs. A holds the belief that it is important for her children to have a father, that marriage is sacred and that she has a responsibility to make the marriage work. According to his wife, Mr. A clearly believes that the man should be in charge of the family and Mrs. A feels her husband resents her position in the community.

The quality of emotional relationships in this family is poor. There is lack of trust on the part of both partners as well as jealousy and intimidation from the husband. Mrs. A's family of origin holds a poor quality of emotional responsiveness for Mrs. A because of her victimization in childhood from sexual abuse.

Mrs. A attempts to engage in joint decision-making with her husband but he does not respect her as an equal partner. There is poor conflict resolution in this family, often resulting in violence. Mrs. A has some resources she can reach out to in an emergency and is becoming more capable in asking for and receiving

help. Mr. A has limited social supports other than his wife and "drinking buddies".

Presenting Problems:

Mr. A drinks excessively and abuses his wife emotionally and physically. She identifies problems between them as:

1. finances - up until recently, he was unemployed and she was sole support of the family;
2. sex - she expressed complaints that her husband forces sexual encounters upon her even though intercourse is presently painful for her due to the tumor pressing on her cervix; and
3. jealousy - that her husband does not trust her with other men, accuses her of "sleeping around" when in Winnipeg on training sessions, follows her and generally intimidates her.

Mrs. A, because of her desire to make this marriage work, is ambivalent about leaving her husband. She always feels let down by her husband, but seems to think something is wrong with her and that she does not deserve anything better. The diagnosis of cancer of the uterus has brought the situation to a crisis point for her. She has reached a point of reflecting on the difficult life she had had and herself states "now on top of everything else, at 30 years of age, I have cancer".

Although Mrs. A's prognosis is very good, her cancer having been eliminated by surgery (hysterectomy), the diagnosis of a potentially life-threatening illness has forced her to confront the problems in her marriage. She describes herself as being at a crossroads in her life and having to make changes.

In addition to the problems in the marital relationship, Mrs. A is experiencing considerable stress and abuse in her work situation. Her co-worker in the alcohol counsellor program has had an affair with her husband, has physically beaten up Mrs. A because she reported her co-worker as having a drinking problem, and the sponsors of the training program have been slow to respond to Mrs. A's complaints. These factors in the job situation further frustrate Mrs. A's efforts to improve herself and reinforce her victimization.

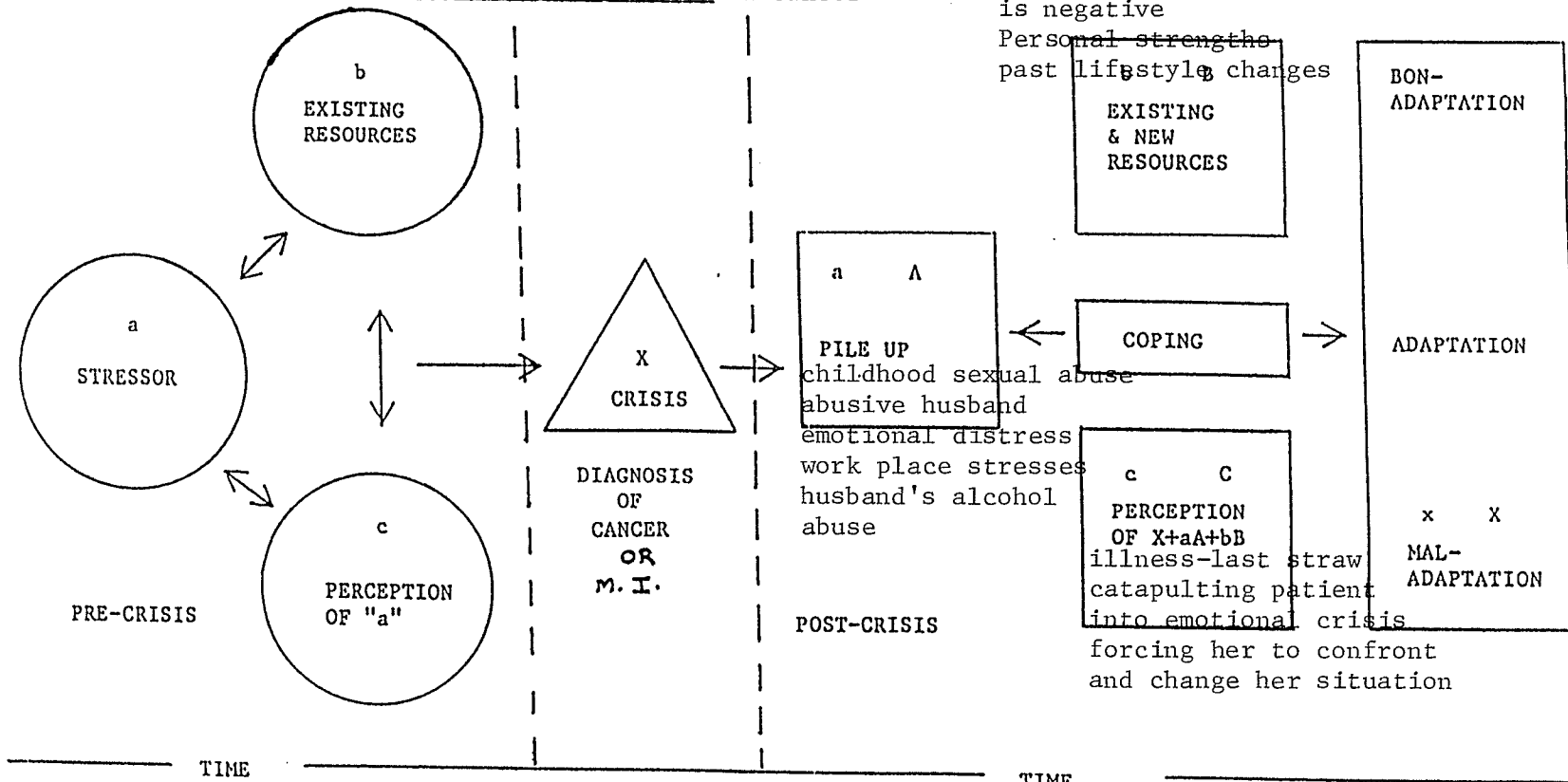
Mrs. A is clearly experiencing a pile up of stresses. In order to facilitate adaptation, intervention was directed toward increasing and creating a more positive support system, and toward reinforcing her perception of the crisis of this cancer diagnosis as an impetus toward change; i.e. reframing the illness as an opportunity to make positive changes in her life.

Insert
Figure 7
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Intervention focus on increasing positive supports ie. counselling services, abuse victim's groups, literature re; victimization.

Figure 1:

The Double ABCX Model of Family Adaptation in Cancer



Much of informal support system is negative
 Personal strengths past lifestyle changes

EXISTING & NEW RESOURCES

BON-ADAPTATION
 ADAPTATION
 x x
 MAL-ADAPTATION

a A
 PILE UP
 childhood sexual abuse
 abusive husband
 emotional distress
 work place stresses
 husband's alcohol abuse

c C
 PERCEPTION OF X+aA+bb
 illness-last straw
 catapulting patient into emotional crisis
 forcing her to confront and change her situation

COPING

TIME

TIME

Adapted from: McCUBBIN AND PATTERSON (1983)

Intervention focus on supporting her need to make a change; problem solving.

Goals:

1. to empower Mrs. A to take steps to free herself from an abusive relationship; and
2. to assist her in formulating a plan concerning work problems.

Intervention:

Intervention was limited because of Mrs. A's short hospitalization and inaccessibility post discharge. Contact was limited to Mrs. A as her husband was not in Winnipeg and she did not want to include him in counselling as she did not feel safe discussing the abuse in his presence. Individual therapy was conducted with Mrs. A from a systemic perspective; i.e. by effecting Mrs. A to make changes that would alter the marital and family relationships. Mrs. A was seen for 3 sessions during her 10 days hospital stay. During the first interview, contact consisted of exploring Mrs. A's concerns, making a problem list, and gathering family history.

Intervention provided validation for the horror of the tragedies she has suffered, gave her a cognitive framework of how she had been victimized, and offered support and reinforcement for her emotional strength and the positive changes she had made in her life.

In the second interview, further attempts were made at cognitive restructuring around her sense of herself as a victim, through providing information on

resources such as the Manitoban Committee on Wife Abuse (which was still in operation at the time of this practicum) and reading materials to educate her about wife abuse and victimization from childhood sexual assault. Intervention also focussed on what she wanted in her life. Attempts were made to empower her to feel capable to taking charge of her life.

In the third and final interview, Mrs. A had still not come to any decisions regarding her marriage or work situation. This interview was spent strategizing as to how to handle her complaints of the job and to whom in authority she would direct these complaints. As Mrs. A intended to return home to her husband, at least temporarily, intervention focussed on a protection plan for herself and what resources there were in her community to help her.

Designing a protection plan involved discussion of the signs Mrs. A. could identify in her husband's behavior that usually precipitated violence and which could serve as a warning signal for her to put her protection plan into action. The second step involved her leaving the home and going to a neighbour upon whom she could rely for help, and who had a telephone so she could call for assistance. This meant re-considering a family move to a new home on another part of the reserve but where she did not have the ready support of reliable neighbours available to her. A final step in the protection plan if she was unable to get out of the house before violence occurred, was for her to attempt to get to the bedroom, this being the room she identified as the least dangerous or having the least lethal objects in it.

Intervention was essentially delivered in the crisis stage as the client was not seen subsequent to hospital discharge.

Evaluation:

The following evaluative tools were utilized with Mrs. A:

1. eco-maps - pre and post intervention;
2. support network questionnaire; and
3. FAM III - administered at initial interview.

The eco-maps were useful in identifying what community and social supports the patient had, what resources were positive, which were conflictual and what supports could be relied upon for additional support. The post intervention eco-map, adds additional resources that were provided to Mrs. A by way of counselling resources, reading material and development of a protection plan.

Insert
Figures 8 and 9
about here

The support network questionnaire gathered very similar information. It confirmed that Mrs. A relied primarily on professionals for both instrumental and affective tasks and that family and community members, specifically husband, extended family and clients, whom she did not want to abandon by leaving her job, were a block to change.

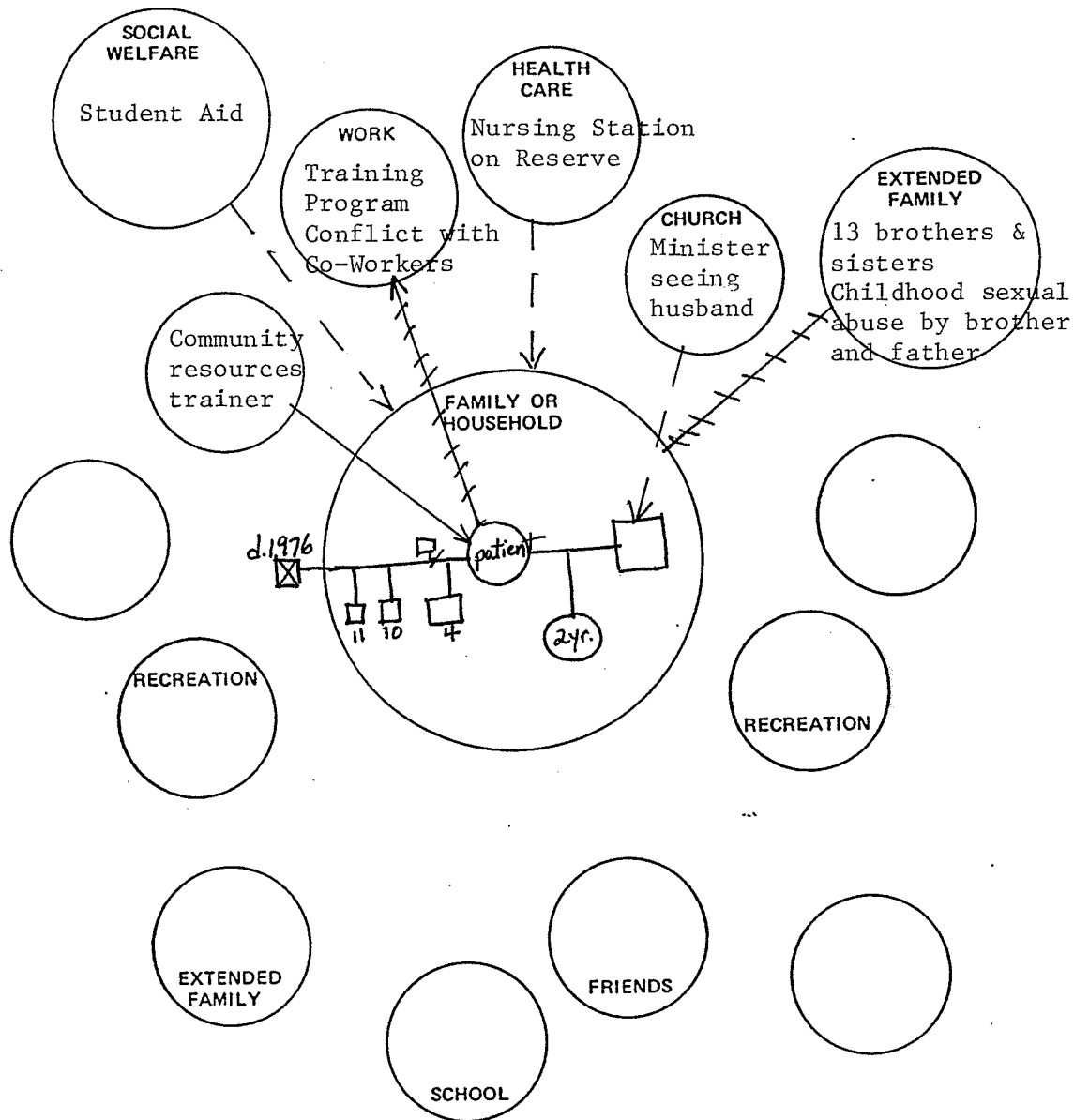
Diagrammatic assessment of family relationships

Figure 8

ECO-MAP

Name Family "A"

Date PRE



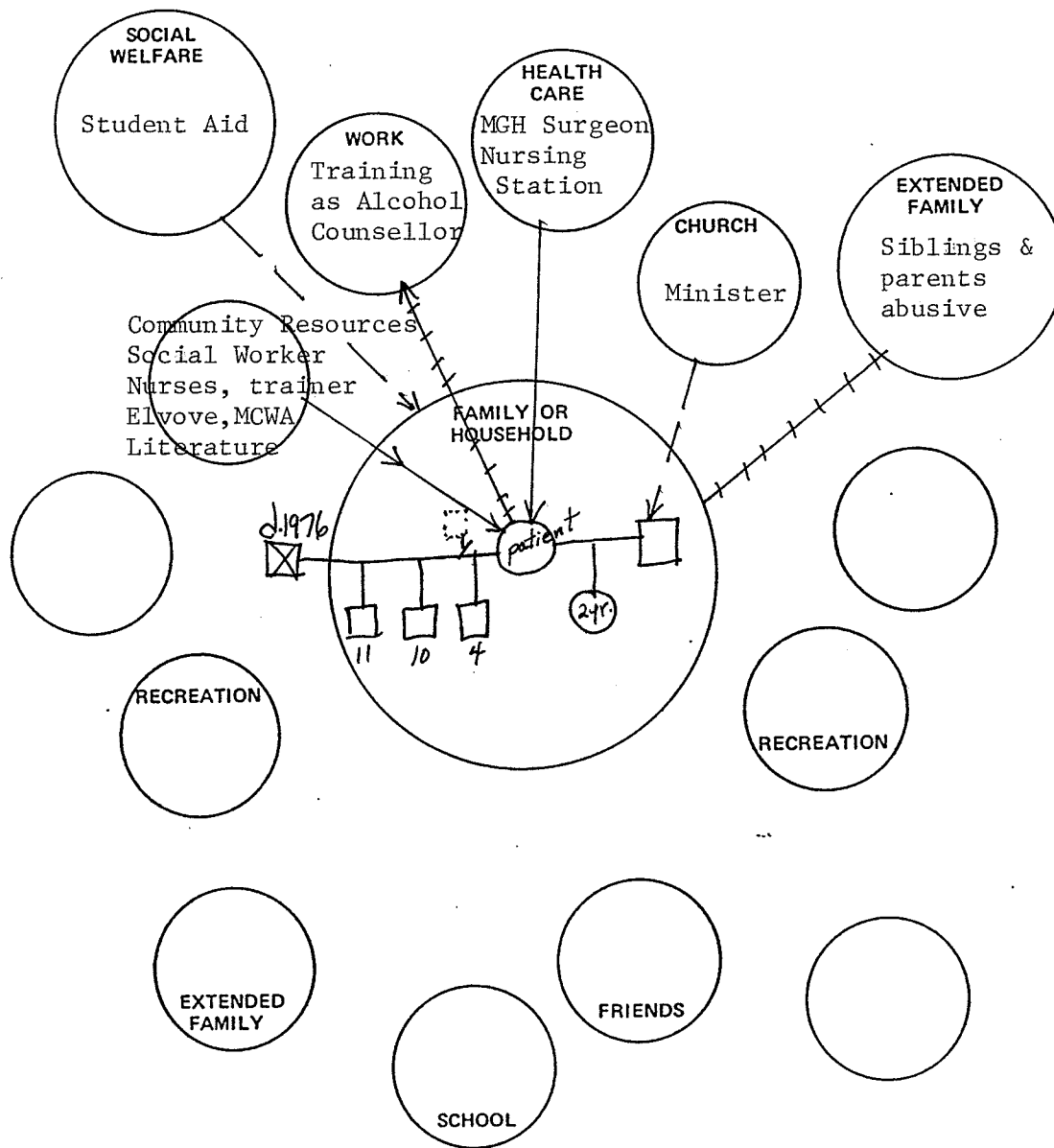
Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, ++++++ for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→→
 Identify significant people and fill in empty circles as needed.

Diagrammatic assessment of family relationships

Figure 9

ECO-MAP

Name Family "A"
Date Post



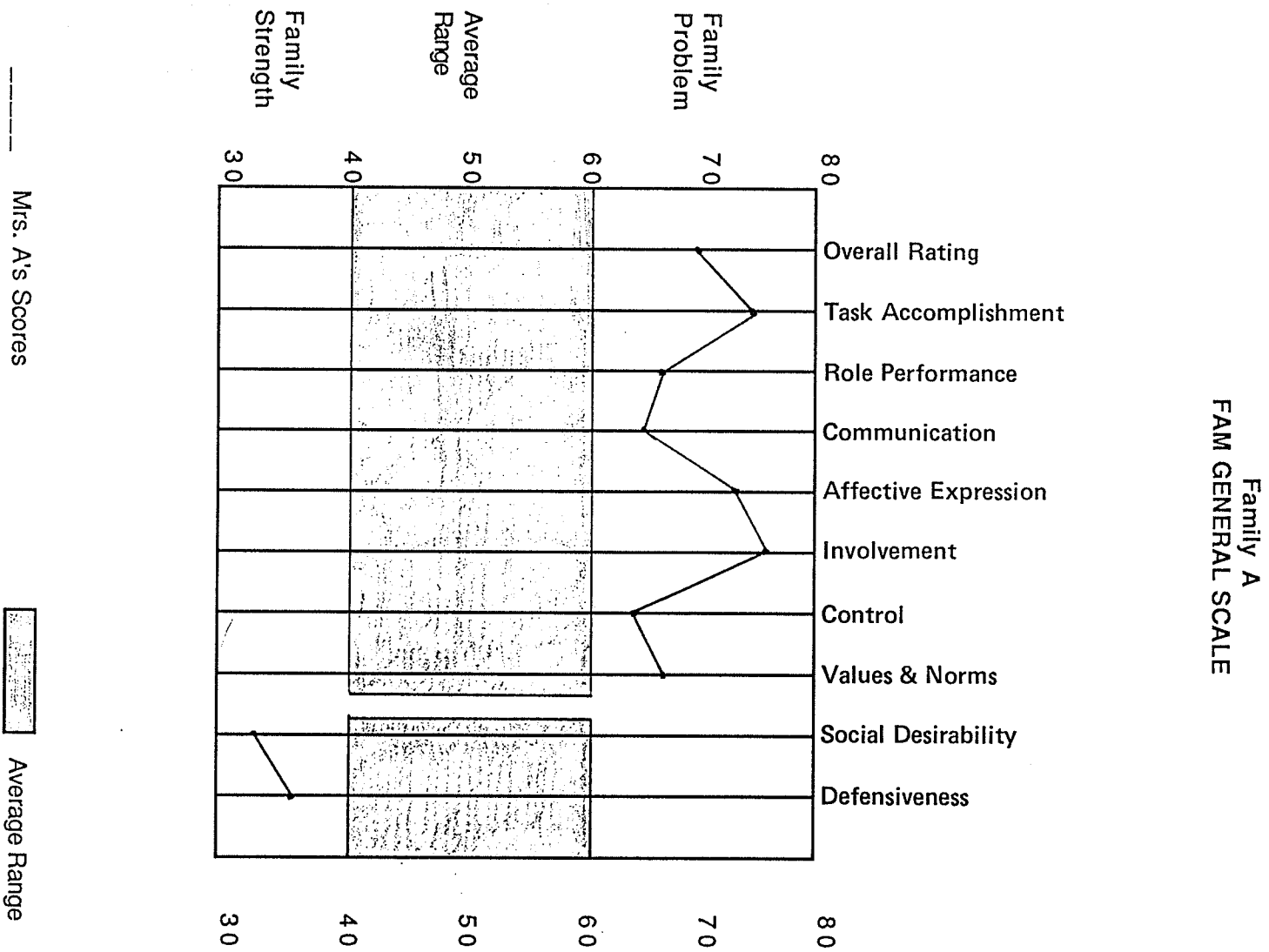
Fill in connections where they exist.
Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
———— for strong, - - - - - for tenuous, ++++++ for stressful.
Draw arrows along lines to signify flow of energy, resources, etc. →→→
Identify significant people and fill in empty circles as needed.

Mrs. A was asked to complete the FAM III general scale after the initial contact with me. The results are represented in Figure 10. As can be observed from the graph, all of Mrs. A's responses fall in the problem range. The social desirability and defensiveness scales are scored below 40. This pattern is characteristic of high levels of anxiety. It is a signal that the respondent is reaching out for assistance. Considering the number of significant stresses confronting this woman, it is not surprising she is seeking help at this time.

Insert
Figure 10
about here

Attempts to reach Mrs. A post discharge were unsuccessful and a post intervention FAM questionnaire was not returned. Mrs. A did write a letter of thanks to the student, when leaving hospital, for the counselling sessions. This would seem to indicate some level of satisfaction on the part of the client with the intervention. Without follow-up contact it is not possible to evaluate the efficiency of the intervention but based on qualitative evaluation of Mrs. A's verbal responses in the last interview, she had gained a new perspective of her situation and the knowledge of alternatives available to her.

Figure 10



"B" FAMILY

ADAPTATION VERSUS CHANGE...

The "B" family consisted of Mr. B, 49 years and Mrs. B, 43 years and their 3 sons all living at home, ages: 21, 19 and 15 years. Mr. B has no relatives in Canada. Both his parents are deceased. Mrs. B has a brother and sister in Winnipeg and both her parents are also living. Her father is terminally ill with cancer. She is the primary support to her parents. The family relationships are diagrammed in the genogram, Figure 11.

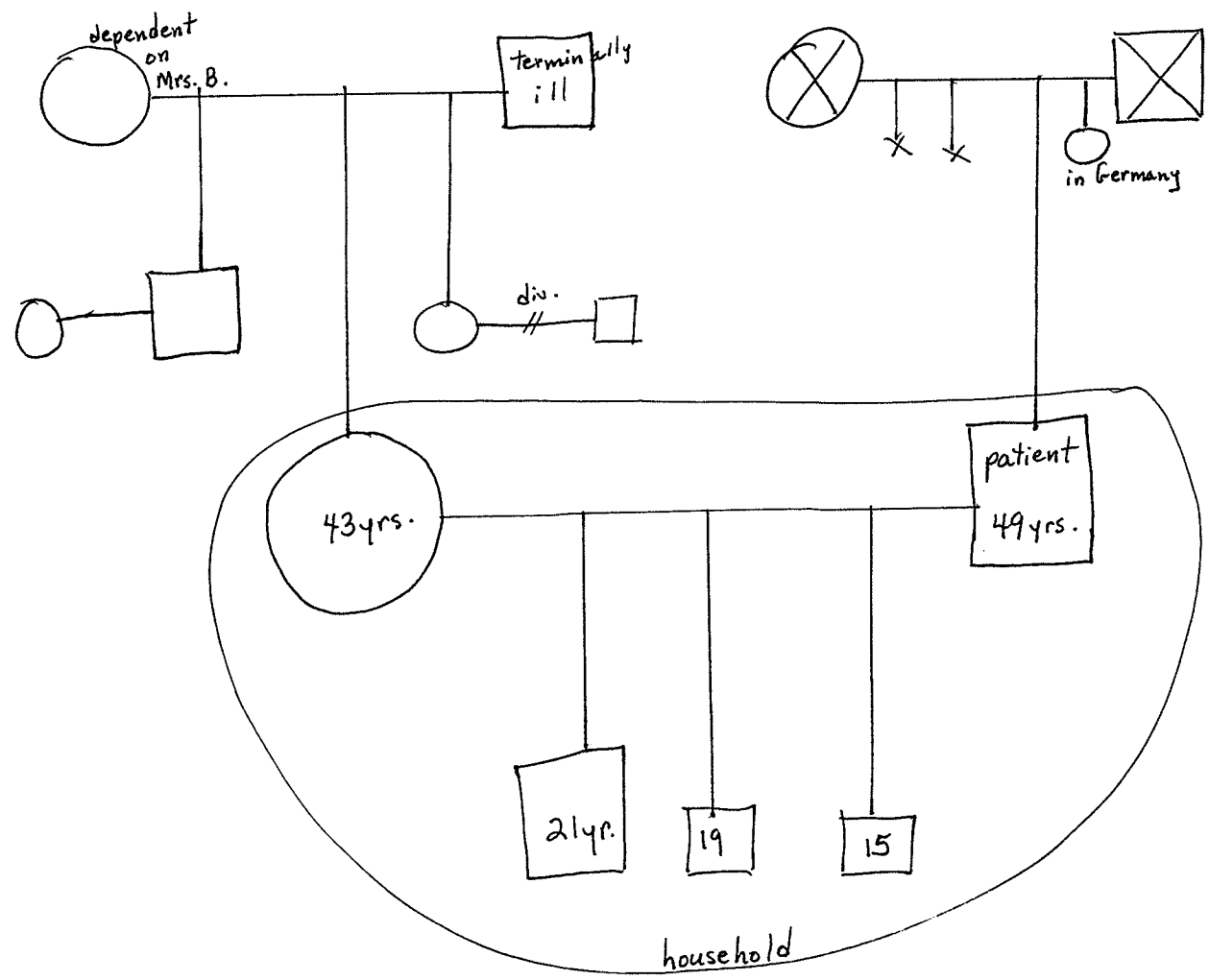
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Figure 11
about here

Reasons for Referral:

Mr. B was referred to the Social Work Department in April '88 while he was a patient in the Intensive Care unit of the Misericordia General Hospital recovering from a myocardial infarction (M.I.). He was referred by the head nurse because of anxiety and worries he expressed about his wife and children. Mr. B was particularly concerned about how his wife would cope with his illness as she suffered depression and was under psychiatric care. He also had concerns for his sons, two of whom were unemployed. The patient and/or his

Figure: 11

Genogram: Family "B"



family were seen for a total of ten sessions, over a five month period from April to August '88.

Assessment:

Pressures and conflicts existed in this family prior to Mr. B's heart attack. Mrs. B's depression often created stress between the couple, though Mr. B felt he had learned to live with her mood swings, accepted this as an illness and tried to be supportive and understanding. There was also a fair bit of conflict between Mr. B and the 19 year old son over his unemployment. He had been unemployed for one year, his unemployment insurance had run out and Mr. B, in the past, blamed his son's long hair as preventing him from getting hired. The son, an amateur musician in a rock band hoped to make a career for himself in the music world and was resistant to his father's suggestions that he should seek further training. Mrs. B felt herself to be particularly close to her youngest son (15 years old) and found him a big support to her. The eldest son, recently laid off, was not in conflict with his father but was a concern for Mr. B as he saw both sons as victims of the present day economy and worried about their future. In addition, the oldest two sons were, at this point, financially dependent on the family. Mr. B would not consider either son applying for social allowance.

Consistent with crisis theory and the Double ABCX model, Mr. B's M.I. represented a "pile up" in stressors. The family had already been dealing with a number of major stresses (unemployment, and wife's depression) in their pre-crisis state. The crisis of Mr. B's heart attack represented an additional burden that created more stress than could be managed by the family resulting in a

state of "pile up". Mr. B was looking for social work intervention to regain control over the stresses, by resolving some issues and thus putting the family back into balance.

The Double ABCX model as it applies to this case is illustrated in Figure 12.

Insert
Figure 12
about here

This desire for adaptation vs. change became clear in the course of my work with the family. Once problems were dealt with sufficiently to restore a sense of balance/control, Mr. and Mrs. B had no desire to work further on pre-existing issues (i.e. conflicts with sons, marital conflicts and wife's depression). Improvement in family functioning was not their goal; rather they saw restoration to pre-crisis functioning as adequate. The service provided was basically family crisis intervention.

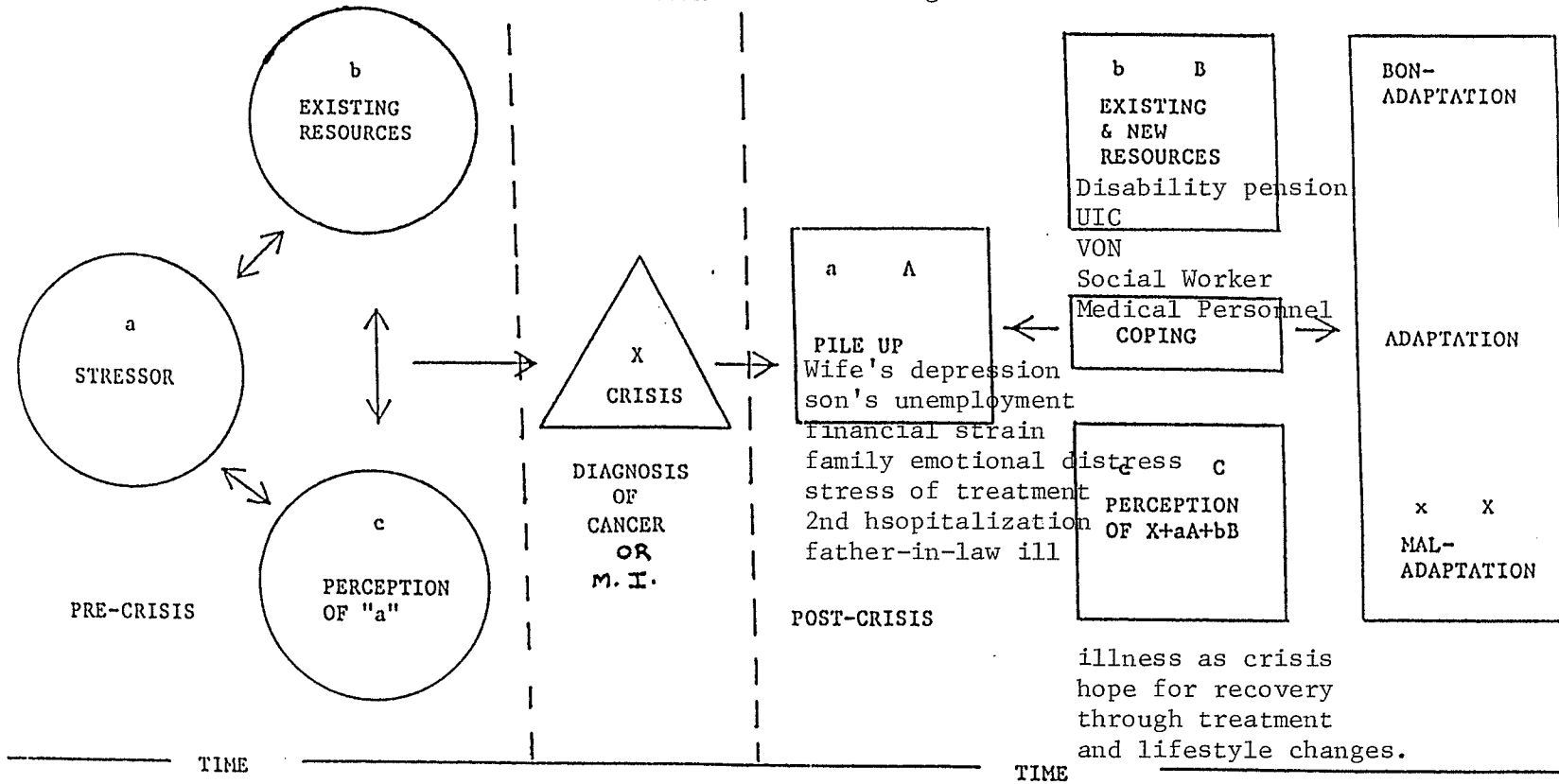
Intervention:

Mr. B's first need was to vent his feelings and worries regarding his family and himself. He expressed surprise at his heart attack as he considered himself physically fit and the heart attack had happened during a time of relaxation, in fact on return from vacation. He was impressed with how his wife had coped with the crisis and had gotten him to the hospital quickly. With the immediate

Intervention to increase resources in patient's environment.

Figure 12:

The Double ABCX Model of Family Adaptation Life Threatening Illness



Adapted from: McCUBBIN AND PATTERSON (1983)

illness as crisis
hope for recovery
through treatment
and lifestyle changes.

Intervention to regain sense of control and mastery of the situation.
Family crisis intervention..

threat to his survival past, Mr. B's concerns turned toward the troubles in his family. His anxiety about his wife and his sons was the next need to be addressed as these worries were hampering his recovery by increasing his tension level, interfering with his sleep. Crisis intervention was provided giving him some sense of control over these issues by:

1. expressing them and venting his feelings;
2. creating, with the student's help, a problem list which served to externalize the problems, i.e. get them on paper so that he no longer needed to mull them over in his head;
3. agreement with the patient that he would not dwell on these problems - that they would be dealt with in conjunction with the student;
4. assurance to patient that some of the problems on the list could be effectively resolved and how I would intervene to do so, i.e. student will advocate on 21 year old son's behalf with UIC to obtain his payments; student will meet with patient's wife to provide emotional support for her during this crisis (in light of her depression); student will meet with patient's 19 year old son to discuss youth employment programs and refer appropriately to assist him in job finding; and
5. that when feeling stressed, he will use relaxation tapes to alleviate tension.

This intervention with the patient did much to alleviate his anxiety in intensive care and on the ward. Meetings with the wife and son provided employment referral and emotional support. A meeting was also held with patient, his wife and 19 year old son to clarify Mr. B's illness and treatment and open communication and express caring between them. There was a sense of regret and guilt on the part of each of these family members because of past conflicts. The student was able to assist the older son in obtaining his UI benefits and the second son (through his own resources) found employment. By the time Mr. B was discharged from the hospital, he had regained a sense of control over his social environment and was able to concentrate on his recovery progress.

Post hospital follow-up focussed on role adaptation and communication to accommodate Mr. B's illness. The sons picked up some of the heavier chores that Mr. B used to perform. Financially Mr. B had a good disability plan and was not concerned with time missed from work.

Unfortunately, Mr. B was re-admitted to hospital four weeks after discharge. Although this created much initial anxiety and stress for patient and family, being worried it was a second heart attack, it proved not be cardiac related. During the process of assessment and diagnosis patient and wife were seen for supportive counselling allowing them the opportunity to vent their feelings and concerns at the point of this discharge. Mrs. B was coping effectively with her husband's illness and there was less conflict between Mr. B and his sons. Mr. and Mrs. B felt they were managing satisfactory and thus social work contact was terminated.

Evaluation:

Upon initial discharge after Mr. B's heart attack (14 days after M.I.), both Mr. and Mrs. B were asked to complete the FAM general scale and the Beck Depression inventory. Although initially agreeing to do so, at the next meeting Mr. B explained they did not want to complete the forms. Mr. B indicated that he found the FAM "too depressing". He felt the questions pointed out too many negatives in their relationship and they preferred not to go through that process. I believe that this illustrates an important point. This family's desire was to adapt to a crisis, in this case illness, sufficiently successfully to restore a previous manageable level of stress versus a desire to enter family therapy to change and improve family functioning. My contract with the family was not for family change, but rather to intervene to problem-solve and reorganize after a crisis. I experienced problems in gaining the family's co-operation because I was attempting to shift from a role of crisis intervention to that of family therapy.

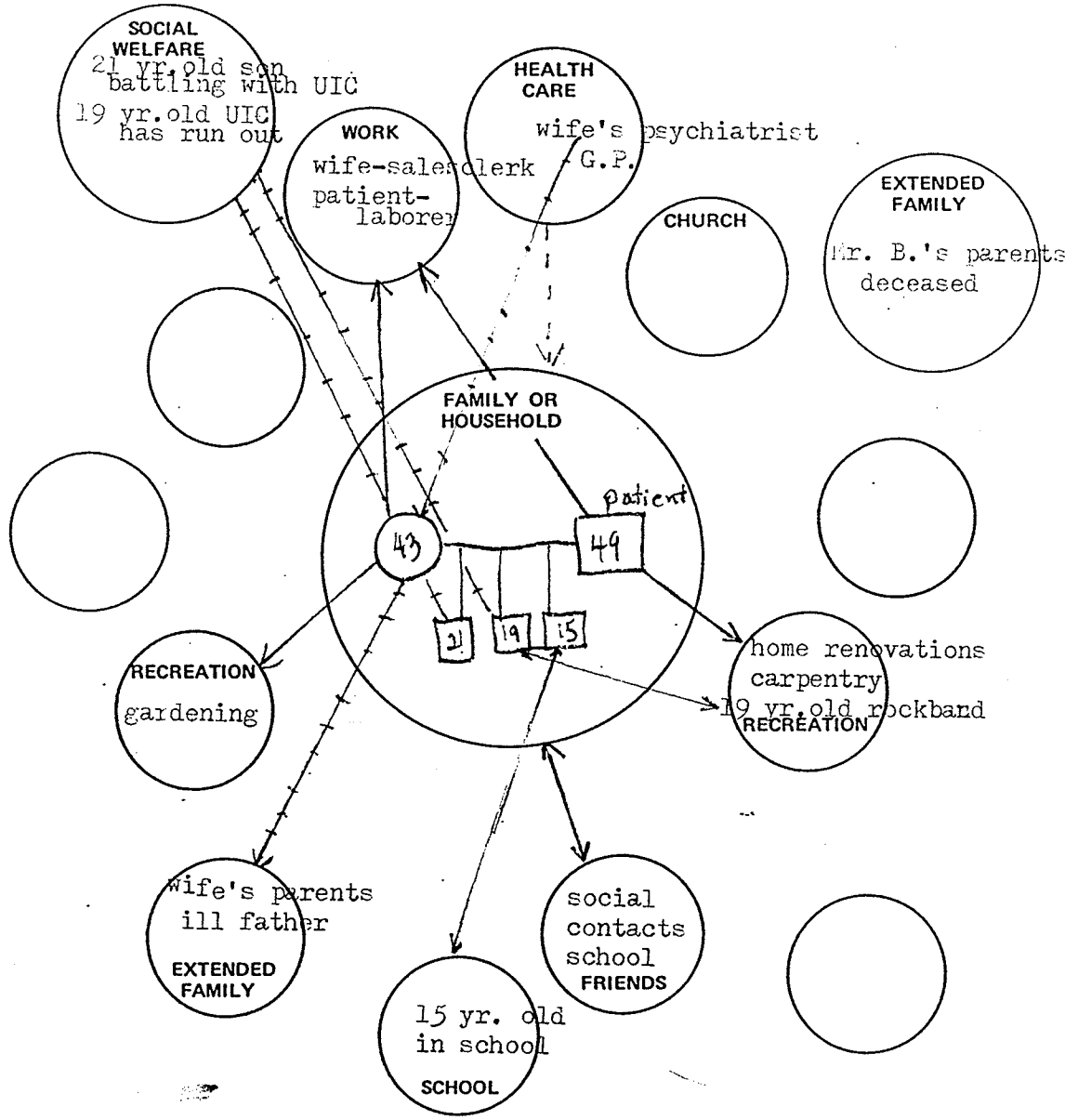
The eco-maps, pre and post intervention illustrate the tensions for the family that existed prior to Mr. B's heart attack and the resources that were effective in alleviating some of these stresses during the intervention phase.

Insert
Figures 13 and 14
about here

Figure 13

ECO-MAP

Name B. family
 Date pre-intervention



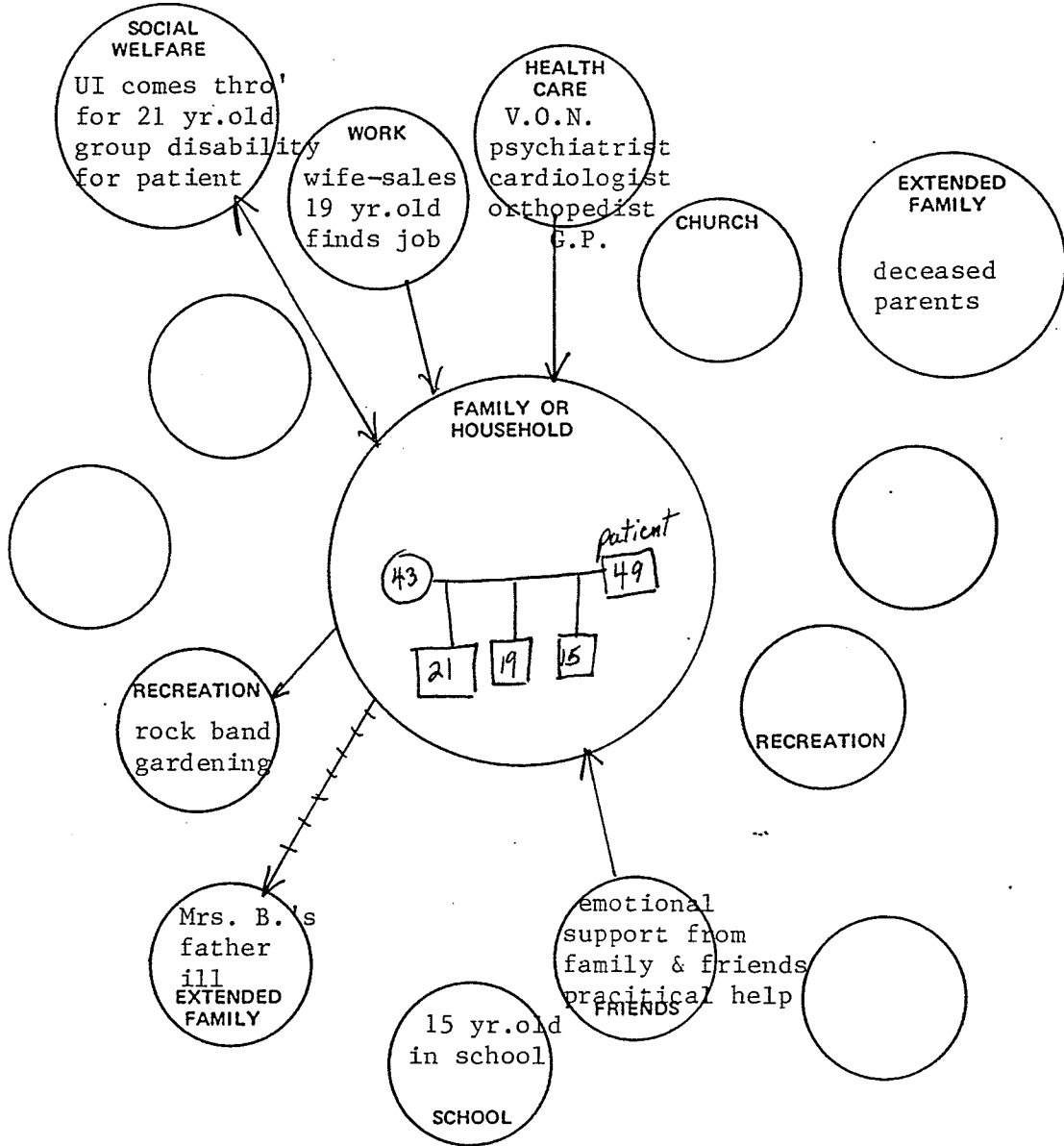
Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 _____ for strong, - - - - - for tenuous, + + + + + for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

Diagrammatic assessment of family relationships

Figure 14

ECO-MAP

Name B Family
Date Post-Intervention



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, ++++++ for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

The consumer questionnaire was issued and returned 8 weeks after termination of contact. The family found social work intervention helpful, cited the 2 problems of 1) wife's depression and 2) son's unemployment as the two major issues addressed and that these problems had improved. This family indicated a possible desire to meet with a social worker again, in the future, if the need arises, which would seem to indicate satisfaction with the effectiveness of intervention.

"C" FAMILY

RE-ORGANIZATION TO ACCOMMODATE LIFE-THREATENING ILLNESS IN THE LATE STAGES OF LIFE ...

This family consists of Mrs. C, 68 years and her husband 75 years of age. Mr. and Mrs. C have been married 42 years. Mrs. C is a homemaker and her husband is a retired railway worker. They have 2 adult children living away from home, a married son 38 years with 2 young children, and a daughter 34 years of age. The genogram in Figure 15 illustrates the family constellations.

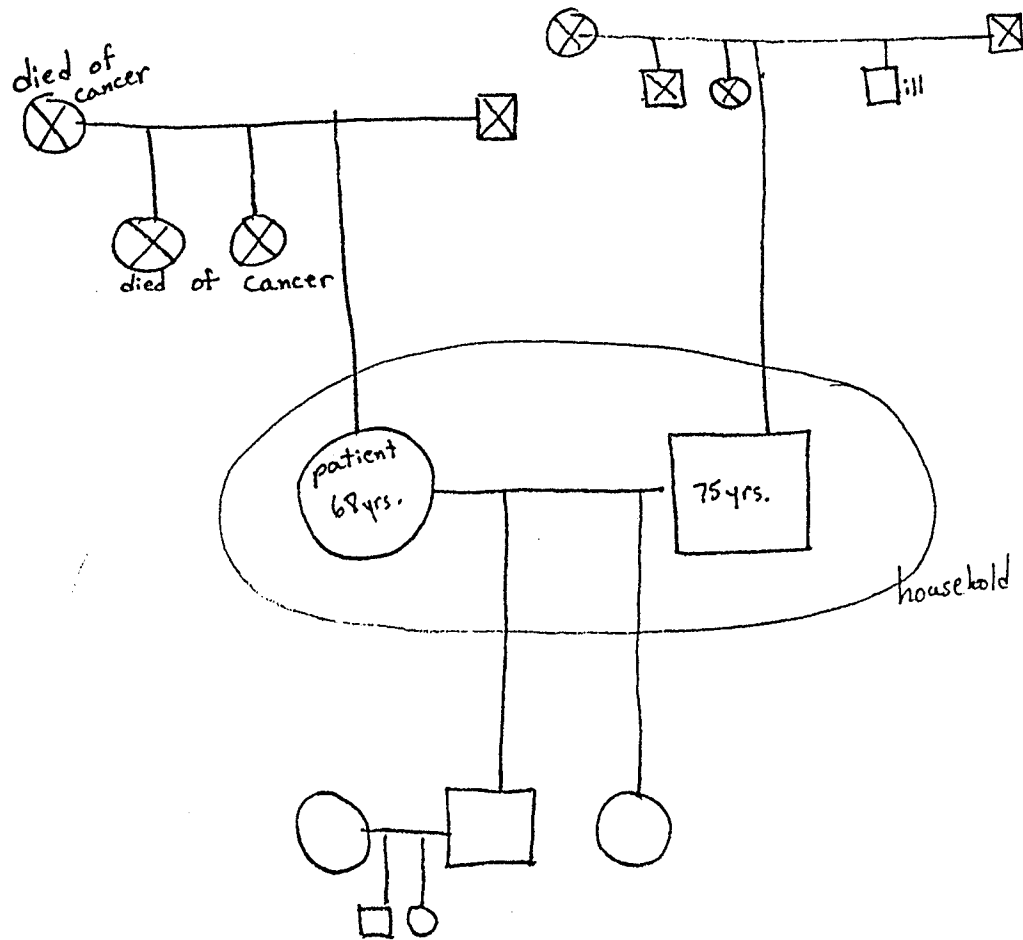
Insert
Figure 15
about here

Reason for Referral:

Mrs. C was referred to this student's practicum because of a diagnosis of lung cancer with a guarded prognosis, and having an ill husband was anticipated to have concerns for how the family would adapt to her illness. Social work contact was initiated with Mrs. C during her hospitalization and continued with herself and her husband post discharge during her receipt of chemotherapy from June to December, 1988.

Figure: 15

Genogram: Family C



Family Assessment:

Mr. and Mrs. C have a very close and supportive relationship. They exhibit a lot of strengths in their marriage and in their caring of one another. Mr. C. has had a number of health problems over the years. He had a colostomy 20 years ago for cancer of the bowel; he also has cataracts and arthritis. Although he has been managing his colostomy for 20 years, this continues to represent a significant handicap from the family's point of view.

Both adult children are supportively involved with their parents. The unmarried daughter provided care to her father while Mrs. C was hospitalized. The son helps out with practical chores and transportation when possible. Mrs. C also expresses worries about her son as he suffers from Chron's (chronic bowel disease) and will soon be undergoing colostomy surgery himself.

Mrs. C has assumed most household maintenance tasks since Mr. C's retirement. She did all the housekeeping as well as the outdoor chores. With the advent of her illness, one of her worries has been who will manage these tasks when she is too ill to carry on and who will look after her husband, as she does not feel he is capable of being on his own.

Communication in this family is generally clear and direct. Decisions are made mutually and conflicts are talked out to find resolution.

Mrs. C. holds a rather pessimistic attitude toward illness. Her mother and two sisters died of cancer and she believes she will suffer the same fate. She feels

illnesses in her family have been a heavy burden to bear. Mr. C. attempts to maintain a more optimistic outlook to his wife's illness, maintaining hope as his primary coping strategy.

Other than their children, the C family have a limited support system. Though they have relatives and neighbours who would show emotional concern, most of them are elderly or distant and cannot provide practical assistance.

This family exhibited a sense of "pile up" as they tried to cope with Mrs. C's illness; her fear of treatment, it's side effects, management of household tasks, and the emotional stress of three ill family members, all contributed to the pile up of stressors for this couple. A significant contributing factor to this "pile up" was Mrs. C's perception of cancer as hopeless. She equated cancer with death and disfigurement and feared the loss of her hair and other side effects of treatment.

The Double ABCX model illustrates these issues in Figure 16.

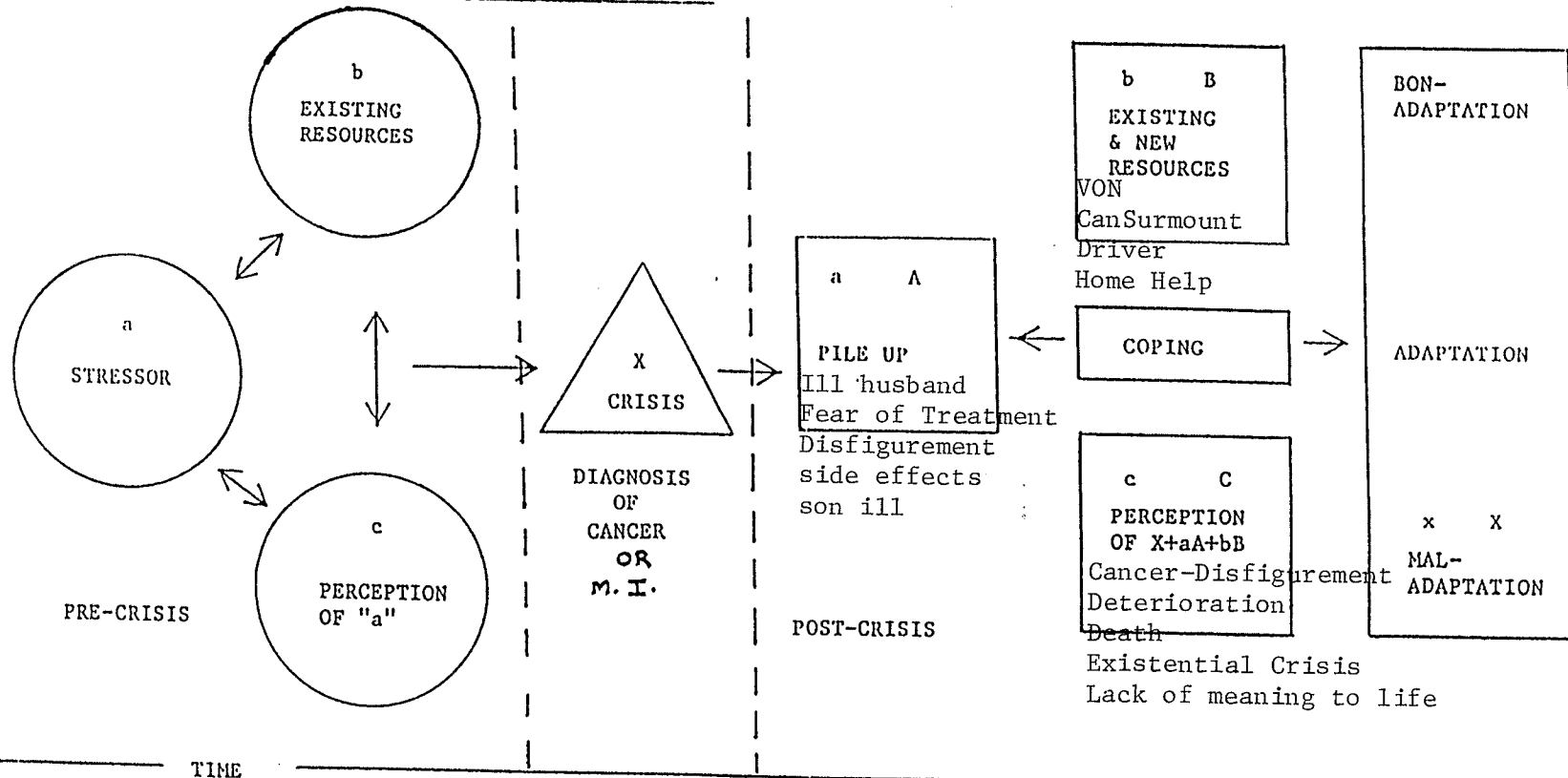
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Figure 16
about here

Problems Addressed:

1. patient's anxiety at news of diagnosis;

Figure 16

The Double ABCX Model of Family Adaptation



Adapted from: McCUBBIN AND PATTERSON (1983)

Intervention: increase in family's community supports.
 Re-organization of role performance.
 More shared tasks between spouses.

Intervention: directed toward giving patient emotional time-out skills; grief counselling.

2. conflict between patient and family regarding acceptance of treatment;
3. enable Mrs. C to make a decision regarding treatment acceptable to her and her family;
4. network building to provide practical assistance and emotional supports; and
5. Mrs. C's perception of her illness and development of effective coping strategies.

Intervention:

Initial intervention with Mrs. C was directed at providing emotional support at the news of diagnosis. This represented a crisis for Mrs. C and her family. She had been told she had cancer and that chemotherapy would give her a 20-30% chance of recovery. She saw her life as over, did not want treatment, fearing that it might make her worse and hasten her death. She was on one level hoping the diagnosis could be wrong and basically using denial as a way of coping at this point.

The crisis for Mrs. C's family was accentuated by her refusal of treatment. They saw this as "giving up without a fight" and resigning her to certain death, whereas they felt treatment would at least give some hope. This conflict with her

family was a critical issue for Mrs. C with which she asked for assistance from the student. Intervention with Mr. and Mrs. C focussed on trying to help each partner to communicate and understand the other's reasons for wanting/not wanting treatment. Each alternative and its consequences were examined and attempts made to offer Mrs. C some means of remaining in control, if she accepts treatment, such as to control how long she remains in treatment. As a result, Mrs. C basically consented to treatment because of her family's concern.

A number of interventions directed at the social environment were necessary to ensure maintenance of instrumental tasks and support social functioning. The eco-maps represented in Figures 17 and 18 depicting this family's social environment, pre and post intervention, indicate the increase in community and health services.

Insert
Figures 17 and 18
about here

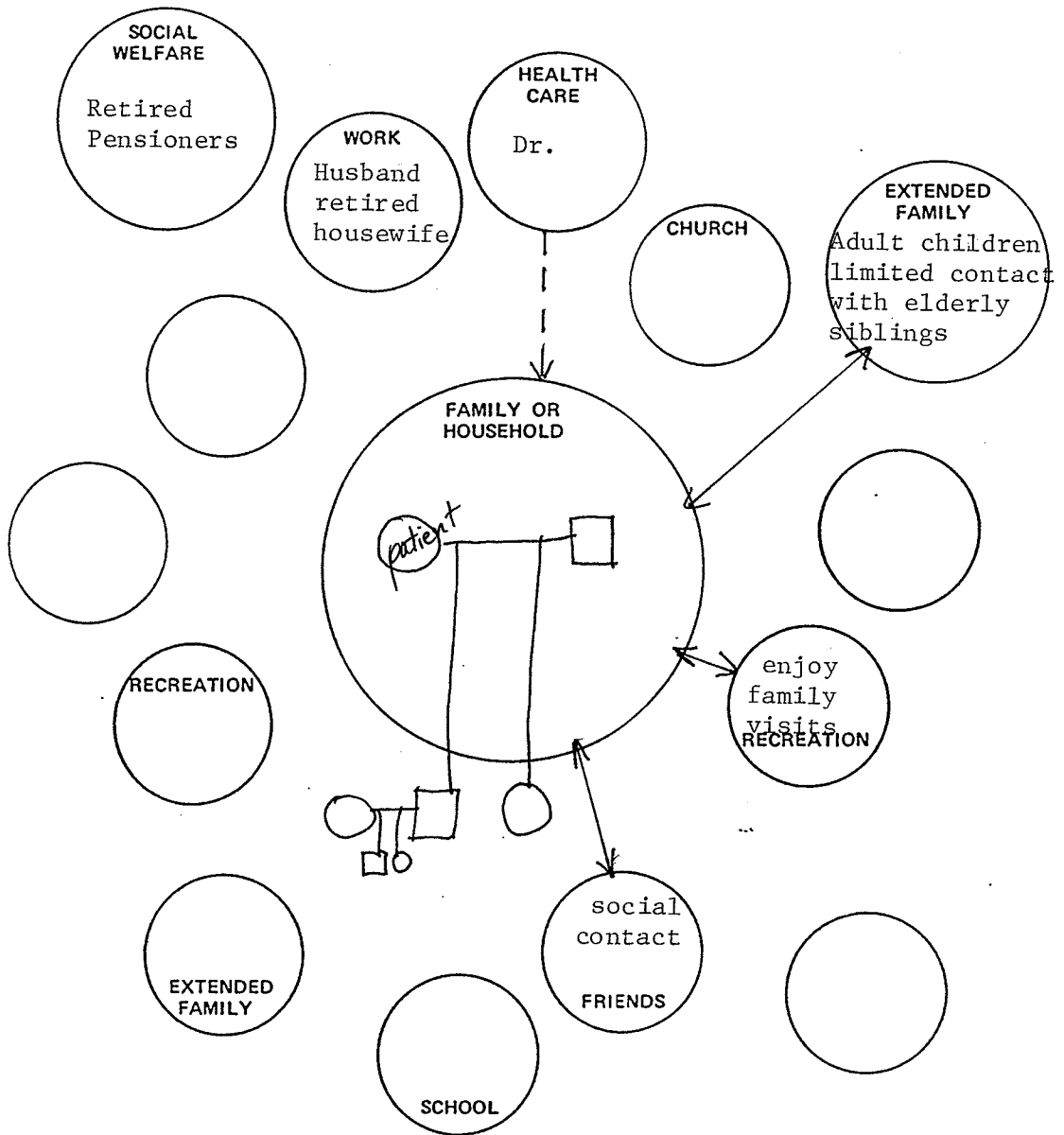
The student referred to VON for health monitoring, arranged for a Cansurmount visitor to provide emotional support and information from personal experience with chemotherapy, referred to Community Home Services for assistance with heavy household chores, arranged for a volunteer driver to treatments, arranged for a pastoral care visitor for emotional support during Mrs. C's first treatment, and assisted the family to problem-solve around role performance and task performance. The couple found they could manage most daily household chores by Mr. C. performing tasks under Mrs. C's supervision.

Diagrammatic assessment of family relationships

Figure 17

ECO-MAP

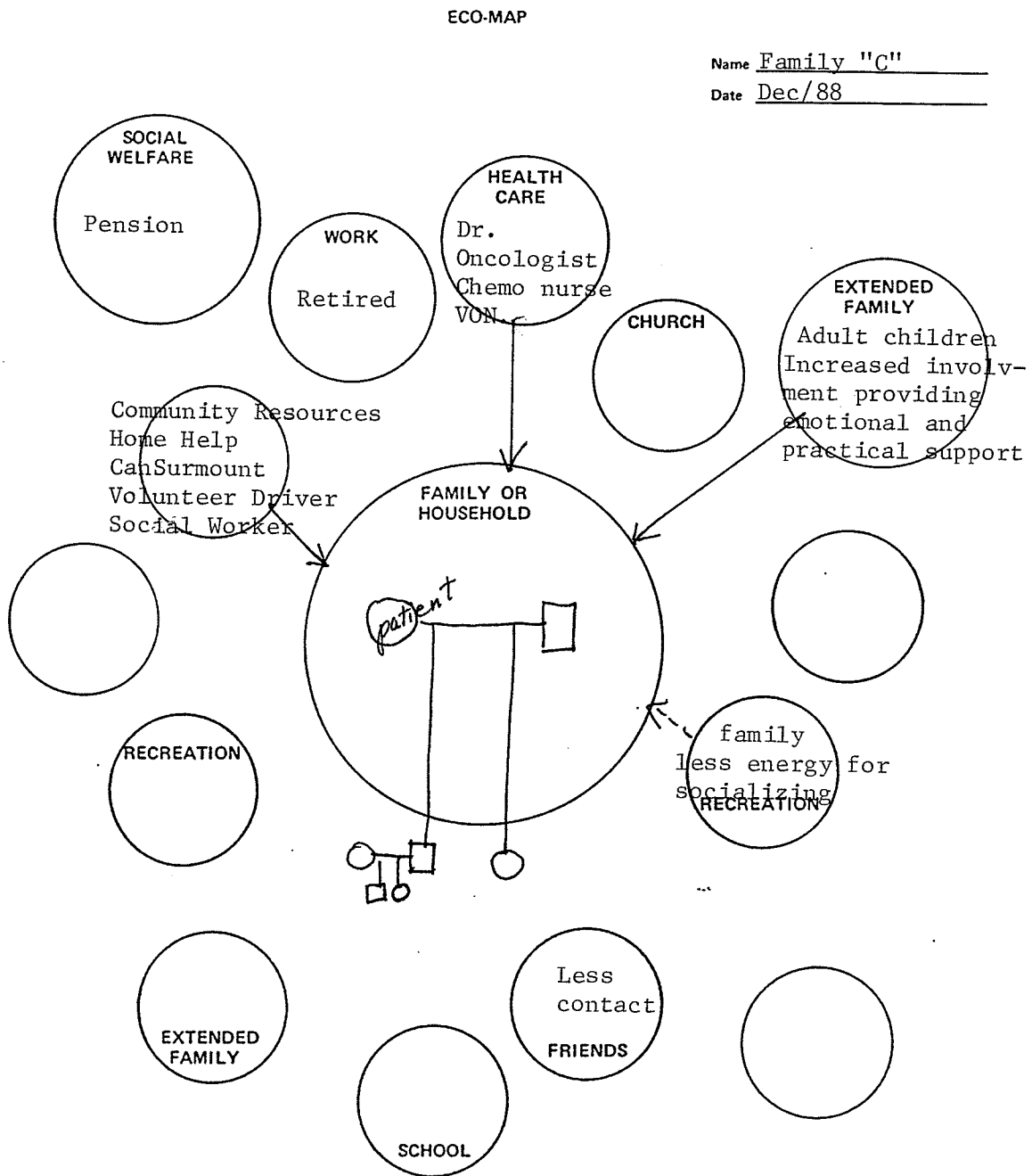
Name Family "C"
Date June/88



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, + + + + + for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. → → →
 Identify significant people and fill in empty circles as needed.

Diagrammatic assessment of family relationships

Figure 18



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 _____ for strong, - - - - - for tenuous, ##### for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

Intervention in affective areas explored Mrs. C's perception of her illness, and its emotional impact on her, giving her opportunity to vent her feelings of sadness and fear. The student has also worked on skill building tasks with Mrs. C to give herself emotional breaks from the stress of her illness, i.e. ways to pamper herself, activities that absorb her mind. This intervention was directed toward trying to help Mrs. C maintain some quality of life and as a means of coping with loss of function/disfigurement, which are two of the significant psychosocial tasks facing terminally ill patients (Moynihan, et al. 1988).

Evaluation:

Mrs. C continues to struggle with the existential crisis of her illness. She finds little meaning in life and sees life as primarily a series of hardships and disappointments. Intervention on psychosocial tasks of confronting existential and spiritual questions and planning for surviving friends and family, have not met with much success. Attempts to intervene by drawing out any joys of her past have also been unsuccessful. Although she identifies moments of happiness she feels these are outweighed by the multitude of sufferings they have endured as a couple. As Mr. C wants to remain hopeful about his wife's recovery/prolongation of life, he is resistant to discussions of planning for his own needs beyond his wife's survival.

At the point of first contact with Mr. and Mrs. C as a couple, they were asked to complete the FAM III questionnaire. The brief form was used because Mr. C was unable to read the questionnaire himself and found the 50 question scale

overwhelming. The results of the brief form indicated normal family functioning. Mrs. C's score was 28 ($x = 27.3$) and Mr. C's score was 18, which, lower than the mean for normal families would seem to indicate family strength in the areas questioned. Mr. C's answers tended to be in the extreme, perhaps suggesting some projection on his part of wanting to be seen as a good and loving family. However, the clinical data supports the results of basically healthy family functioning.

The couple declined completing a repeat FAM questionnaire, post intervention, feeling their answers would not change.

Progress has been made on all problems addressed. Crisis intervention was effective in alleviating Mrs. C's initial anxiety over diagnosis and supportive intervention enable her to keep her anxiety, during chemotherapy treatments at a manageable level. Facilitating communication between Mr. and Mrs. C regarding treatment enabled Mrs. C to reach a decision to accept treatment in a way both partners could accept. Network building, as evidenced in pre and post intervention eco-maps, was effective in enabling the family to maintain instrumental tasks and social functioning. Mrs. C's perception of her illness remains negative and she continues to struggle with the crisis of a potentially terminal illness. Some level of success has been achieved in enhancing Mrs. C's coping strategies. Her primary style of coping is through distraction and interventions to sustain coping have enabled her to keep her anxiety under control.

"D" FAMILY

FAMILY REORGANIZATION AFTER THE DEATH OF A PARENT OR SPOUSE ...

This family consisted of Mr. D, 52 years old and Mrs. D, 48 years old, their 16 year old daughter, a 26 year old daughter and her 7 year old child, and twin sons, 28 years old, married and living away from home. Mrs. D was diagnosed in March with cancer of the lung with metastasis to the brain. The elder daughter who had been living away from home in B.C. when her mother fell ill, came home to provide support to her parents.

Reasons for Referral:

This family was identified as a potential candidate for the student's practicum because of the severity of Mrs. D's illness, the sudden deterioration in her health and the adjustment this would require of her family.

Mrs. D was receptive to social work contact, welcoming assistance to discuss her illness with her family, particularly her youngest daughter. She also requested assistance with financial concerns, having been cut off Worker's Compensation when admitted to hospital.

The family were seen over a 5 month period from March to July, 1988. Mrs. D died in mid April, 1988. The father and youngest daughter continued in counselling to assist in their re-organization as a family after Mrs. D's death.

Family Assessment:

During the course of assessment with this family, the following patterns of functioning were apparent:

- emotional distance existed between husband and wife;
- conflict existed between father and teenage daughter;
- mother functioned as placater and ran interference between the children and dad;
- father's style of parenting was autocratic; and
- conflicts arose quickly between the 16 year old and father while Mrs. D was in hospital.

Basically this family was experiencing difficulty prior to Mrs. D's illness. The husband was disengaged from the rest of the family. Mrs. D aligned herself with her 16 year old daughter against dad. Developmentally, this family was in the stage of raising adolescent children but parenting roles were not evenly shared. This responsibility fell primarily to Mrs. D and her threatened death had obvious

negative consequences for continued survival of the family unit. The structural map in Figure 19 depicts the power, boundary and alignment issues in this family.

Insert
Figure 19
about here

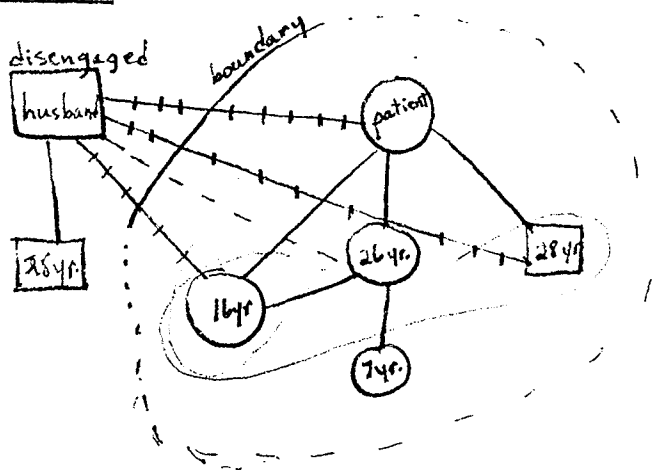
There was little communication between Mrs. D and her husband. Communication between Mr. D and the children was primarily conflictual. Mrs. D functioned in roles of nurturance and support for the family as well as a wage earner. Mr. D's primary function was a wage earner and disciplinarian. Parents did not share a common view or style of raising children. Mrs. D tended to be more lenient and laissez-faire with the children.

Conflicts were often unresolved in this family and issues avoided as a means of dealing with conflict.

My intervention in this family began with Mrs. D, exploring her understanding of her illness and her view of its impact upon her and her family. Mrs. D was aware of the severity of her illness, and did not see her family being able to care for her at home in her present state of health. She was unable to walk or do most daily activities without assistance.

The diagnosis of cancer and the severity of Mrs. D's condition represented a crisis to this family disrupting their previous state of balance. They made efforts

Structural map

Figure 19

- - - - - conflict
 ——— strong relationship
 - - - - - weak relationship

Boundary between husband and rest of family.

Alignments of 16yr. with mother & brother.

Conflict between father and most family members.

to re-organize by having an aunt come to stay temporarily with the family while Mrs. D was hospitalized. An elder daughter returned from B.C. to relieve the aunt and take over management of the household. Mr. D reacted with a great deal of anger toward the doctors about the length of time it took to diagnose his wife's cancer.

Pre-existing conflicts between the teenage daughter and Mr. D resulted in her going to stay with a brother, further fragmenting and disrupting the family.

With the multiple stressors of Mrs. D's illness (and later her death), the parent-child conflicts, loss of income and disruptions in family organization, this family was experiencing a "pile up".

The Double ABCX model as it pertains to this family is illustrated in Figure 20.

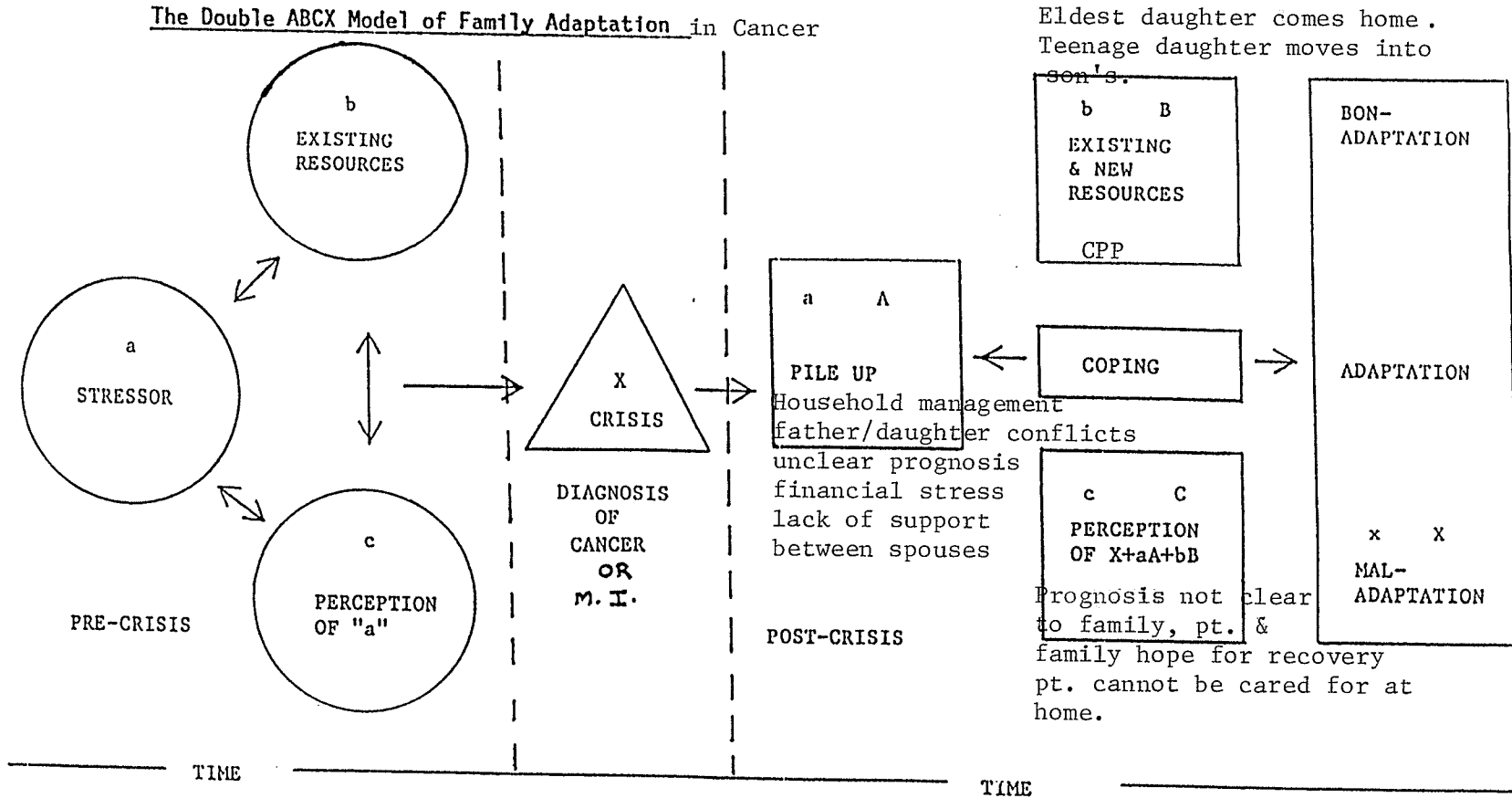
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Figure 20
about here

Their perception of the illness as treatable impeded them from preparing for Mrs. D's death. As the stresses piled up, the family drew on the extended family resources to cope with the crisis. In the short term, this enabled them to cope with the demands of Mrs. D's illness. In the long term, intervention was directed at helping them use existing resources differently and find new ways of relating to one another.

Intervention to use family resources differently and develop new patterns of family interaction.

Figure 20

The Double ABCX Model of Family Adaptation in Cancer



TIME

Adapted from:

McCUBBIN AND PATTERSON (1983)

TIME

Eldest daughter comes home.
Teenage daughter moves into
son's.

b B
EXISTING
& NEW
RESOURCES
CPP

BON-
ADAPTATION

ADAPTATION

x X
MAL-
ADAPTATION

a A
PILE UP
Household management
father/daughter conflicts
unclear prognosis
financial stress
lack of support
between spouses

COPING

c C
PERCEPTION
OF X+aA+bb
Prognosis not clear
to family, pt. &
family hope for recovery
pt. cannot be cared for at
home.

Intervention to explore family's perception of prognosis, direct to medical team for information, introduce seriousness of patient's condition.

Problems Addressed:

1. Mrs. D and family's understanding of her illness and its prognosis;
2. Financial issues due to Mrs. D's unemployment;
3. Father - daughter conflicts; and
4. Decisions after Mrs. D's death as to where the 16 year old would live.

Intervention:

Initial interventions with Mrs. D involved exploration of her feelings and understanding regarding her diagnosis, discussion of her optimism about treatment, and her concerns for her family. In subsequent meetings, Mrs. D acknowledged how ill she was but hoped that the chemotherapy treatment would improve her condition, to the point where she could leave hospital. Interventions were brief (but regular) because of Mrs. D's weakened condition. They consisted of practical assistance i.e. C.P.P. disability forms, relaxation therapy with use of tapes to alleviate anxiety around treatment, and discussion of her concerns for her family. Mrs. D requested assistance for her family to

cope with the illness, but did not feel she had the energy to participate in this process.

Intervention with the family was directed toward the impact of this crisis on the future of the family.

As Mrs. D's prognosis was poor, attempts were made to help the family obtain this information i.e. they were advised to meet with Mrs. D's doctors so that they would be more able to deal with the reality of her condition and its consequences. Unfortunately, Mrs. D's condition worsened rapidly and she died very shortly after my first meeting with the family.

Eco-maps represented in Figures 21 and 22 depict the changes in family organization before and after intervention, and the changes in connection to support resources. Figure 23 reveals how the family is helped to re-organize and use supports in new ways to achieve a new balance after Mrs. D's death.

Insert
Figures 21, 22 and 23
about here

Subsequent to Mrs. D's death, contact was maintained with the family to provide grief counselling. Encouragement to vent their feelings of loss and anger was provided and the normalcy of their feelings stressed. Assistance to help them re-organize as a family was also provided.

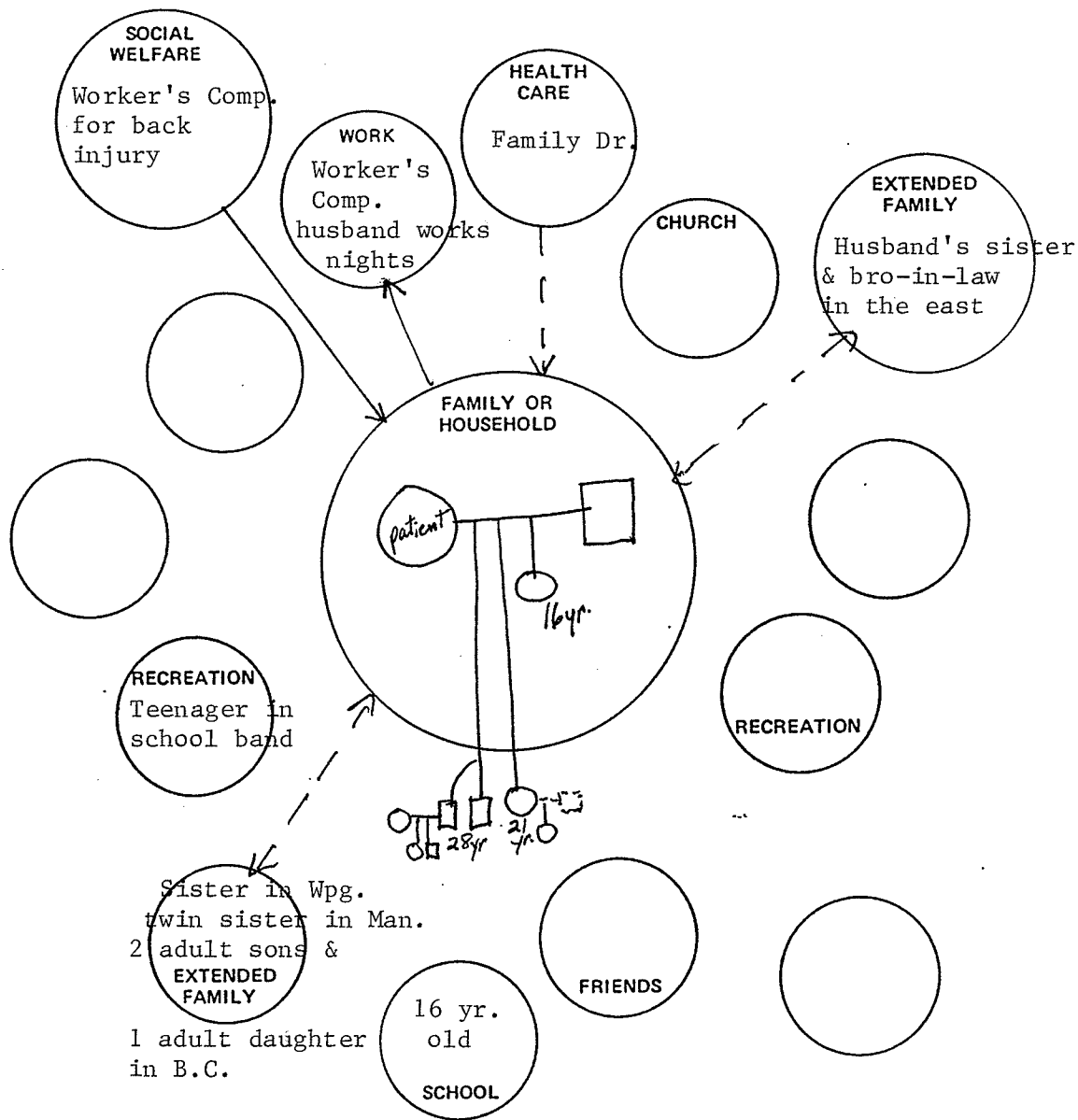
Diagrammatic assessment of family relationships

Figure 21

ECO-MAP

Name Family "D"

Date Pre



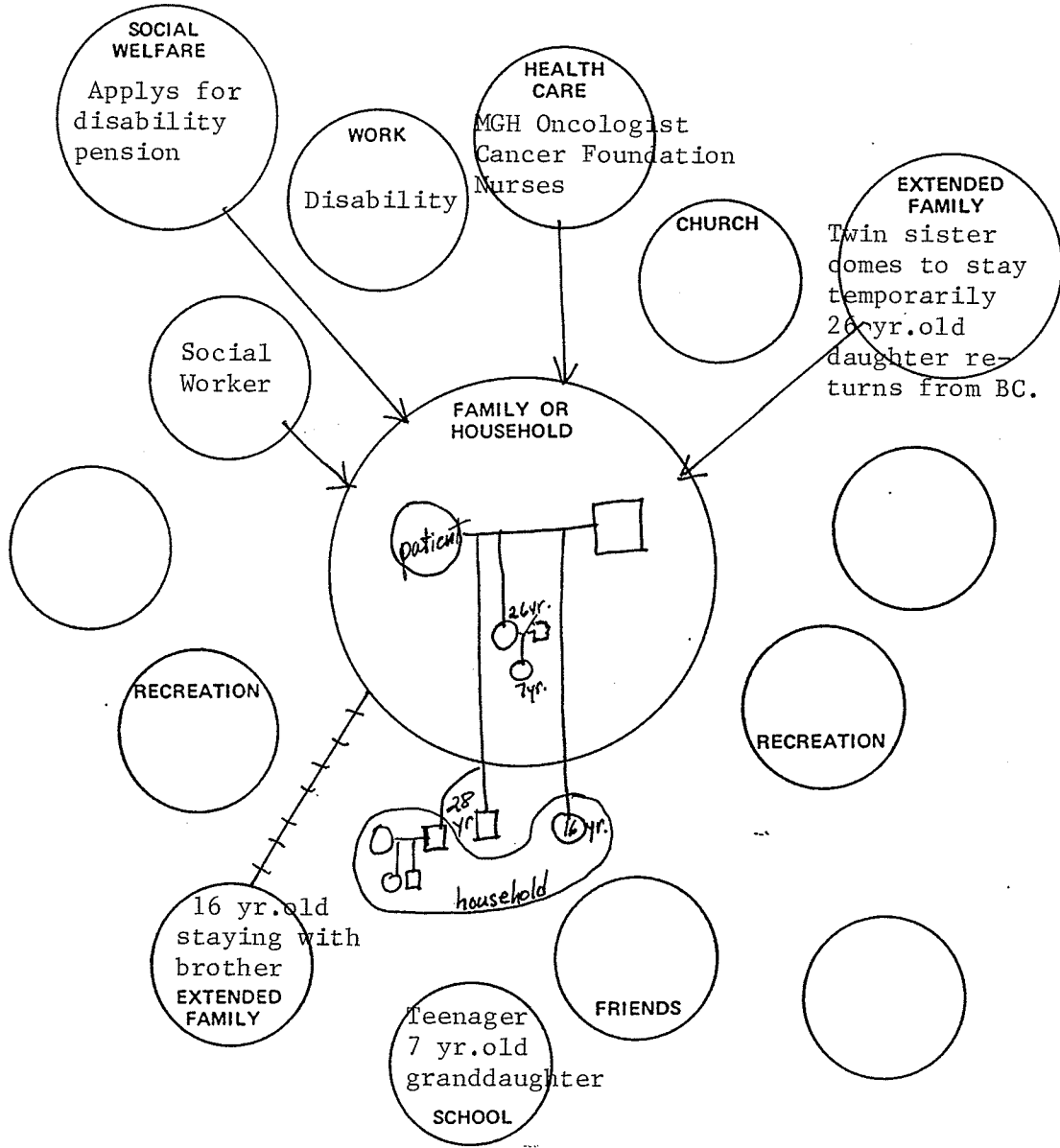
Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 _____ for strong, - - - - - for tenuous, + + + + + for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

Diagrammatic assessment of family relationships

Figure 22

ECO-MAP

Name Family "D"
 Date Post



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 _____ for strong, - - - - - for tenuous, + + + + + for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

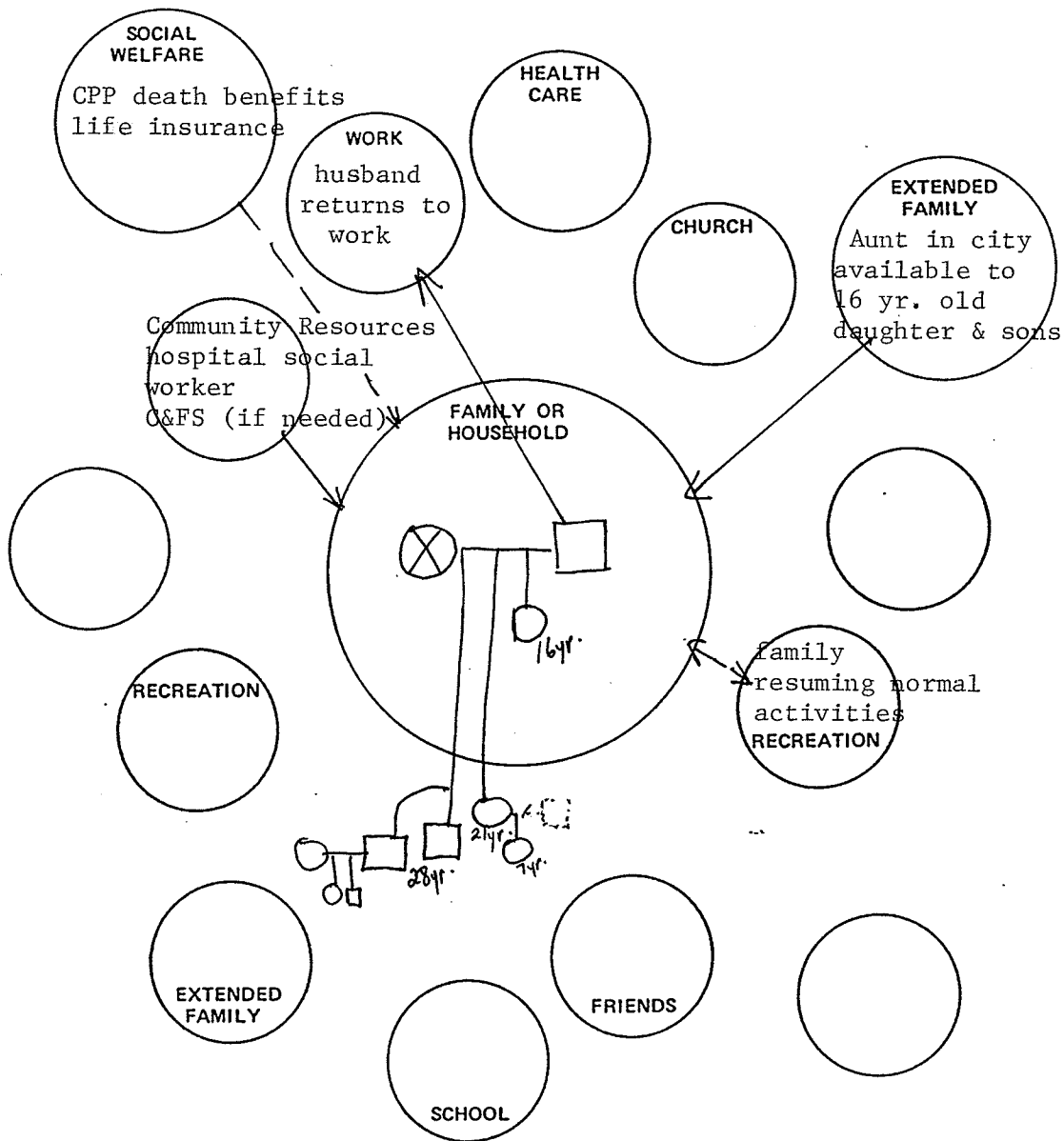
Diagrammatic assessment of family relationships

Figure 23 After Intervention following Mrs. "D"'s death

ECO-MAP

Name Family "D"

Date _____



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines:
 ————— for strong, - - - - - for tenuous, + + + + + for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

Mr. D, the son and teenage daughter were receptive to joint counselling sessions to work out where this girl was going to live, and how she was going to re-enter the family. Interventions consisted of clarifying communication between father and daughter, and addressing issues of authority.

During this process with the family, father and daughter were asked to complete the FAM III general scale. The daughter did complete the questionnaire, the father refused. The results of the daughter's FAM questionnaire are represented in Figure 24. The areas falling most seriously in the problem range are affective involvement, role performance, communication and task accomplishment. The affective involvement item was seriously elevated to a score of 83, indicating absence of involvement among family members, or narcissistic involvement to an extreme degree, and that family members exhibit insecurity and lack of autonomy. Problems in other areas cited above are consistent with family interviews that identify much of the daughter - father's struggles are over tasks, roles and that they are unable to clearly communicate with one another. A social desirability scale below 40 (this one being 39), does not guarantee the validity of the other scales. However, as the score is very close to 40 and the defensiveness score is in normal range as well as the clinical data supporting these areas is problematic, I believe the results are reasonably valid. The extremely high score of affective involvement, I believe is a result of some projection on the daughter's part, of her father not allowing her any autonomy, and her interpretation of his behavior as acting only out of self-interest.

Insert
Figure 24
about here

Evaluation:

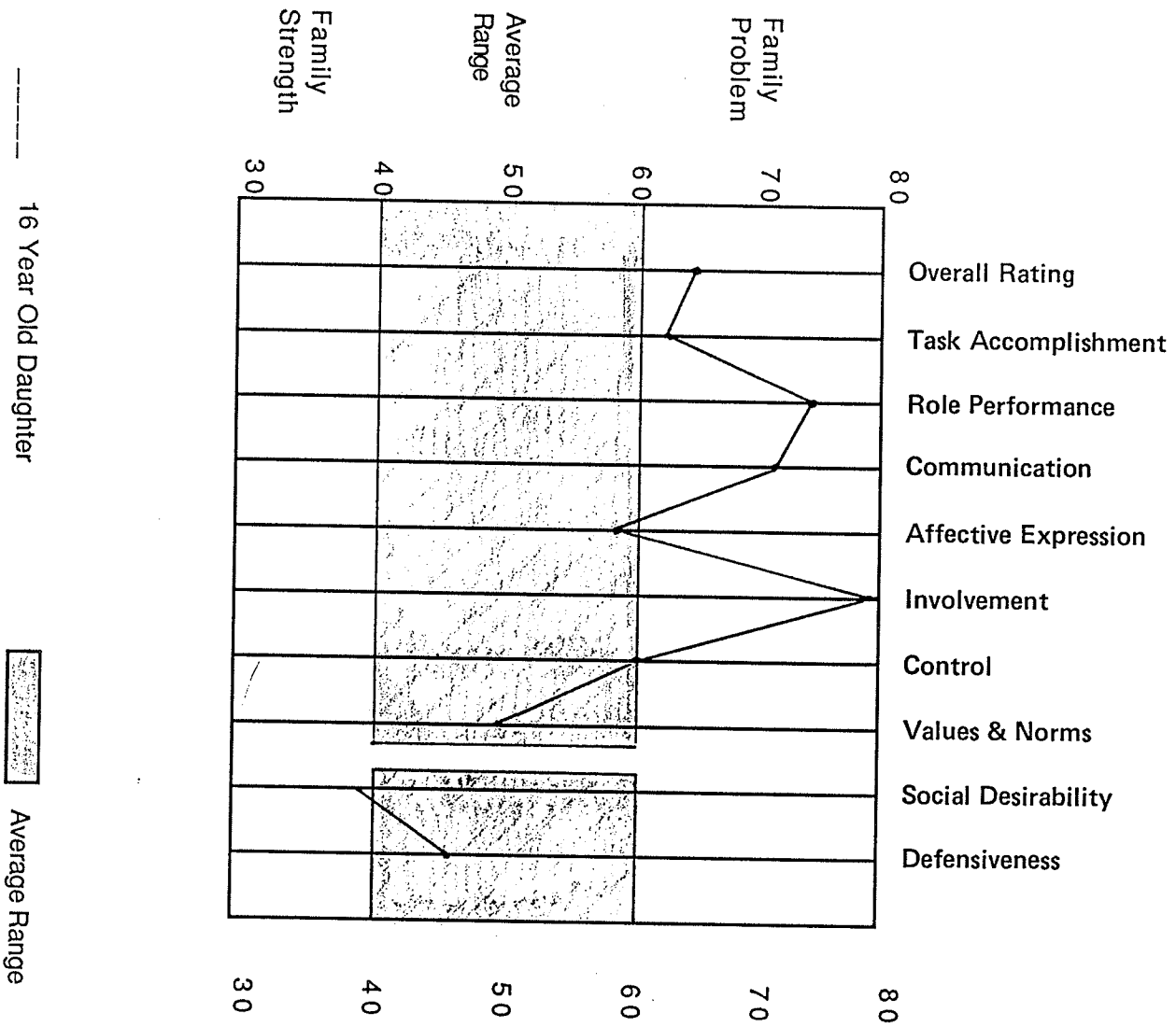
The outcome of my involvement with this family can be considered a partial success. Conflicts continued between father and daughter and they discontinued treatment before all issues were resolved but the 16 year old did return to her father's home. Mr. D, who had exhibited much ambivalence about whether he wanted the responsibility of parenting this girl, and had been wrestling with what to do with the rest of his life now that his wife was dead, ultimately made a decision to parent, return to work, and wanted his daughter home. Although conflicts continued between himself and his daughter, he was consistent in his message to her that he wanted her around. He was also helped to recognize that often a "cooling off" period before dealing with conflicts would enable him and his daughter to communicate more effectively.

The daughter was looking for support and validation for the efforts she was making to cope with the loss of her mother, and to reconcile with her father. In retrospect, I feel I could have provided her more nurturing and support in this area. My interventions also were directed at ensuring she had supports she could turn to if needed, and these were identified with her, specifically her sister, a brother, an aunt, and the Child & Family Services agency if needed.

The family refused to complete a post intervention FAM questionnaire.

Figure 24

Family D
FAM GENERAL SCALE



"E" FAMILY

ADAPTATION TO LOSS OF A SPOUSE IN LATER LIFE ...

Basic Information:

Family members - Mr. E - 80 years (cancer patient)
Mrs. E - 81 years

There were 3 sessions conducted with Mr. E, 3 conjoint family sessions and 2 sessions conducted with Mrs. E.

Reason for Referral:

The patient was initially referred in hospital in Jan. '88 when lung cancer was diagnosed because he seemed distressed at the diagnosis. He was seen for supportive contact during January and February, 1988. Referral was again initiated in May, 1988 at the time of discontinuation of chemotherapy. The couple was seen from May to August, 1988 (until patient's death) and Mrs. E was seen until October, 1988.

The Presenting Problem:

Mr. E was referred to social work as a potential client for student's practicum as he was showing signs of being distressed with the diagnosis. He had had cancer of the bowel 5 years ago, was treated surgically, now having a colostomy, and had believed after 5 years that he was cured. The recurrence of cancer in the lung came as a shock and disappointment. Mr. E. though initially despondent was optimistic about treatment, feeling having recovered once from cancer, he could do so again.

The crisis for this family did not come at the time of diagnosis but rather at the time of discontinuation of treatment in May, 1988.

The family consisted of Mr. E, 80 years of age and his wife 81 years of age. They have been married 58 years. Their only son died in 1960 at age 24, in a motor vehicle accident. All their own siblings have died excepting one of Mr. E's sisters in Austria. Mrs. E has several nieces and nephews living in Thunder Bay who do occasionally visit. The initial eco-map (Figure 25) shows a rich support system in spite of few close relatives.

Insert
Figure 25
about here

Family Assessment:

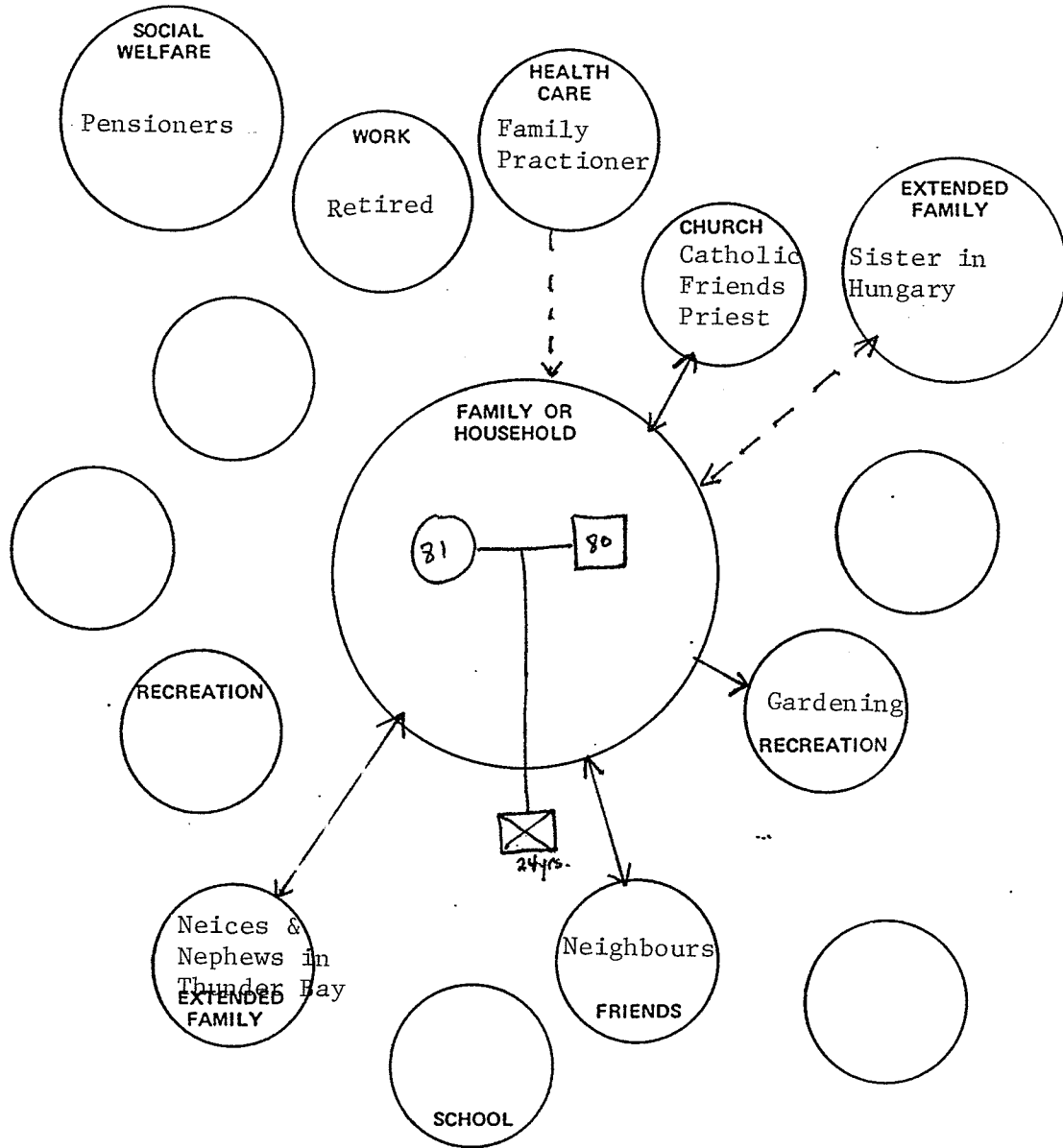
This is a family dealing with the developmental tasks of the family in later life (McGoldrick & Carter, 1982). The emotional stages associated in this stage of

Diagrammatic assessment of family relationships

Figure 25

ECO-MAP

Name Family "E"
Date Feb/88



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, +++++ for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

the life cycle include coping/managing the effects of aging and preparing for death. Mr. and Mrs. E have managed the effects of aging by sharing household tasks, Mr. E performing more physically demanding tasks (prior to his illness) such as gardening and vacuuming. Mrs. E suffers with arthritis but is able to manage the lighter household chores and meal preparation. With the assistance of neighbours she does the family grocery shopping. Their division of labor demonstrates complimentary roles and good problem solving and adaptation to accommodate their needs and abilities as they age.

This family are of Hungarian background and hold a strong Catholic faith. The church is an important and central part of their lives. They spend time each evening in prayer and attended church regularly together, prior to Mr. E's illness.

Communication in this family is clear and direct. They openly discuss most things, including Mr. E's illness. Mrs. E accompanied Mr. E to doctors appointments when there was new information or when decisions had to be discussed. There was a change in Mr. E's willingness to discuss his illness once the treatment stopped. Mrs. E observed her husband as being depressed.

The rules and norms in this family can be summarized in the following statements: The marital partners support and help each other, they look to experts for advice, faith carries them through and they have a close emotionally satisfying relationship. Decisions are made through discussion though ultimately Mr. E has the final say. They maintain mutually supportive relationships with friends and neighbours and can rely on them for help when needed.

Problems Addressed:

The problems addressed in this case were as follows:

1. Mr. and Mrs. E's need for information to understand the reason for termination of medical treatment;
2. Mrs. E's concern regarding her husband's depression;
3. Mr. E's depression;
4. household management in light of Mr. E's deteriorating health;
5. resources to enable Mr. E to stay at home through the terminal stages of his illness; and
6. Mrs. E's bereavement.

Intervention:

Initially intervention was with Mr. E only, at the time of diagnosis. The intervention involved acknowledgement of his feelings regarding a recurrence of his cancer, validation of his feelings of disappointment and unfairness that the cancer had recurred. As Mr. E adjusted to the diagnosis and focussed on

the role of chemotherapy, the student supported his optimism and hopefulness that treatment would help. The practitioner also arranged resources to assist Mr. E in the treatment process, i.e. volunteer driver. Periodic supportive contact was maintained with Mr. E during the phase of chemotherapy treatment, to explore any concerns that might arise and make the opportunity available should Mr. E have a need for further social work services.

The crisis came for Mr. and Mrs. E at the point that medical treatment was discontinued and the student became actively re-involved. Mrs. E was very upset and Mr. E was depressed. Conjoint family counselling was initiated to explore the couple's concerns. One of their greatest immediate needs was to understand why treatment was stopped. Both Mr. and Mrs. E had many questions about this and its implications. Thus, Mr. and Mrs. E were assisted by the practitioner to make a question list for the oncologist, and encouraged to talk openly about their concerns. The student also intervened to help Mr. and Mrs. E talk together about their worries for Mr. E. This couple who had normally been open in their communication were having a difficult time with the emotional content of this issue. Mr. E was depressed and uncertain as to how much information he really wanted from his doctors. He also wanted to be protective of his wife and not worry her. By the student's exploration of the medical questions this couple had, it became clear to Mr. E that his wife was already very worried, and that his lack of communication with her regarding his illness was not protective of her feelings but rather served to worry her more. The student clarified with Mr. E whether he was willing to let Mrs. E accompany him to medical appointments and acquire information about his illness.

The student's intervention also explored Mr. and Mrs. E's feelings regarding the discontinuation of treatment and encouraged the expression of these feelings, serving further as an enabler to get communication back into the open between Mr. and Mrs. E. issues around role adjustment were also addressed as well as management needs to care for Mr. E during the terminal stages of his illness. Much of this activity involved resource counselling and referral to necessary support services, i.e. VON, Community Home Services.

After Mr. E's death, two sessions were held with Mrs. E for bereavement counselling. This involved acknowledgement of her loss and her feelings of grief, encouragement of use of her support system and the ultimate adjustment to an altered life.

Evaluation:

Mr. and Mrs. E declined to complete the FAM III and Beck Depression inventory when approached in the early stages of the practicum. Mrs. E did complete the consumer evaluation questionnaire. She reported the family sessions as helpful in "providing opportunity to discuss questions about Mr. E's diagnosis and treatment and to talk over feelings". The two main concerns she cited as discussed with the practitioner were: 1) household help and 2) husband illness and death. She reported the concerns over "household help" (i.e. role change adjustments necessitated by husband's illness and death) to be "somewhat better", whereas she identified concerns over husband's death to have "remained unchanged". She was finding the death of her husband harder to cope with as she settled into a routine again, feeling his absence with greater

acuity. She did not however feel a need to go on with counselling but indicated she would call upon the practitioner as needed.

An audiotaped interview and supervisor's critique was another evaluative measure used in this case. From this interview the student was able to become more effective in helping this couple discuss their fears of Mr. E's death.

An eco-map was used as a pre and post test instrument to determine whether any changes occurred after the intervention which had clinical significance. Special attention was paid to ensuring an adequate social network to support the couple through the process of caring for a terminally ill family member.

As illustrated by comparing Figures 25, 26 and 27, the major changes in Mr. and Mrs. E's support network came in terms of the direction and intensity of contact. Although neighbours and friends were supportive in the pre-intervention phase, they increased their involvement as Mr. E's health failed. Also the reciprocity of flow of energy between the couple and their support network changed significantly with the E's primarily being the recipients of support. The other significant post intervention change as seen in Figure 26 is the expansion of the couple's network from totally informal supports to heavy reliance on formal support networks.

Insert
Figures 26 and 27
about here

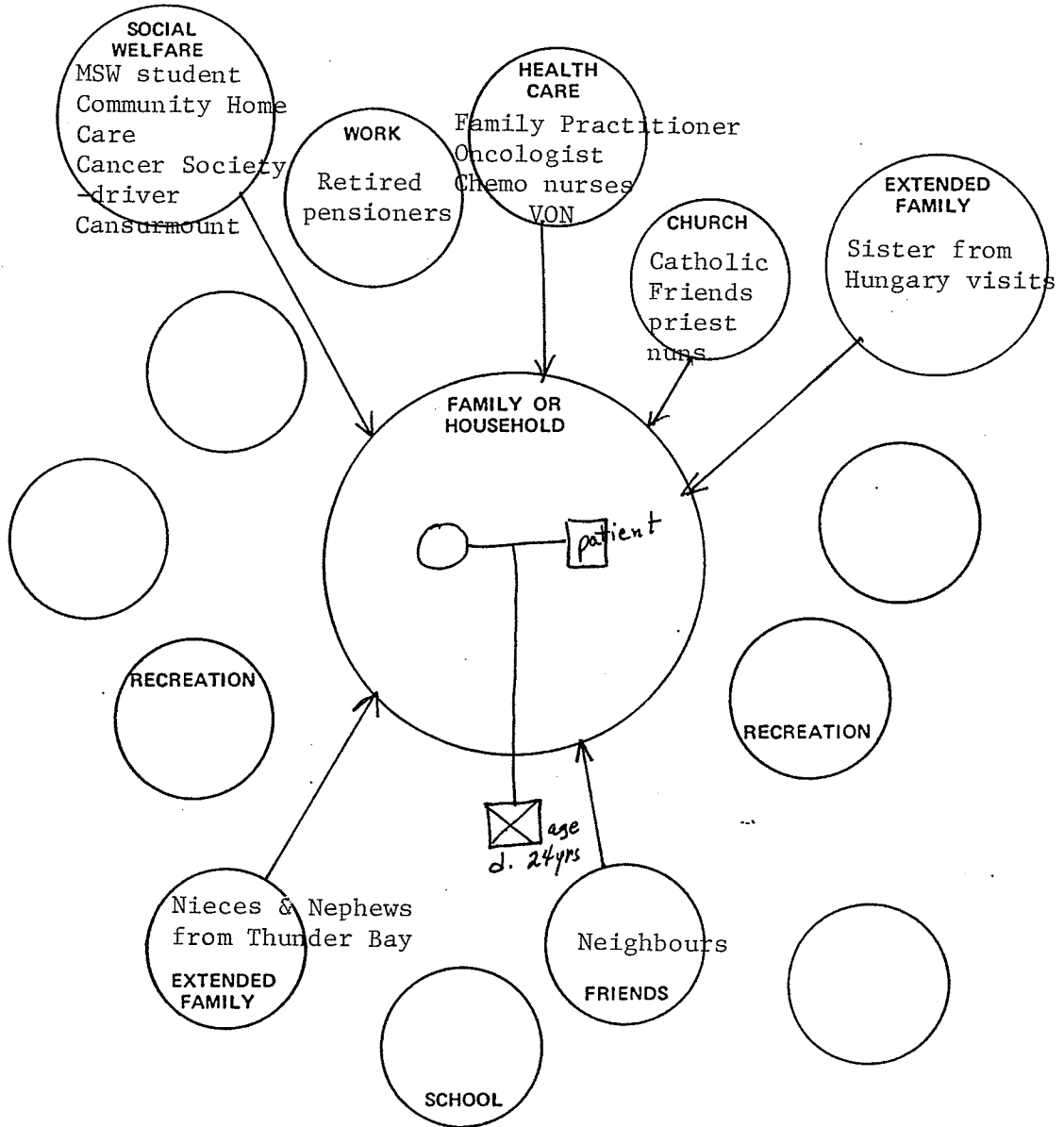
I have included a third eco-map, Figure 27 to illustrate Mrs. E's social network at termination, after her husband's death. As illustrated there is a return to greater reciprocity, or lessening of reliance on formal supports, though not totally and an increase in intensity with informal supports.

Diagrammatic assessment of family relationships

Figure 26 "E" Family

ECO-MAP

Name "E" Family
Date August 1988



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines:
 ————— for strong, - - - - - for tenuous, ++++++ for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

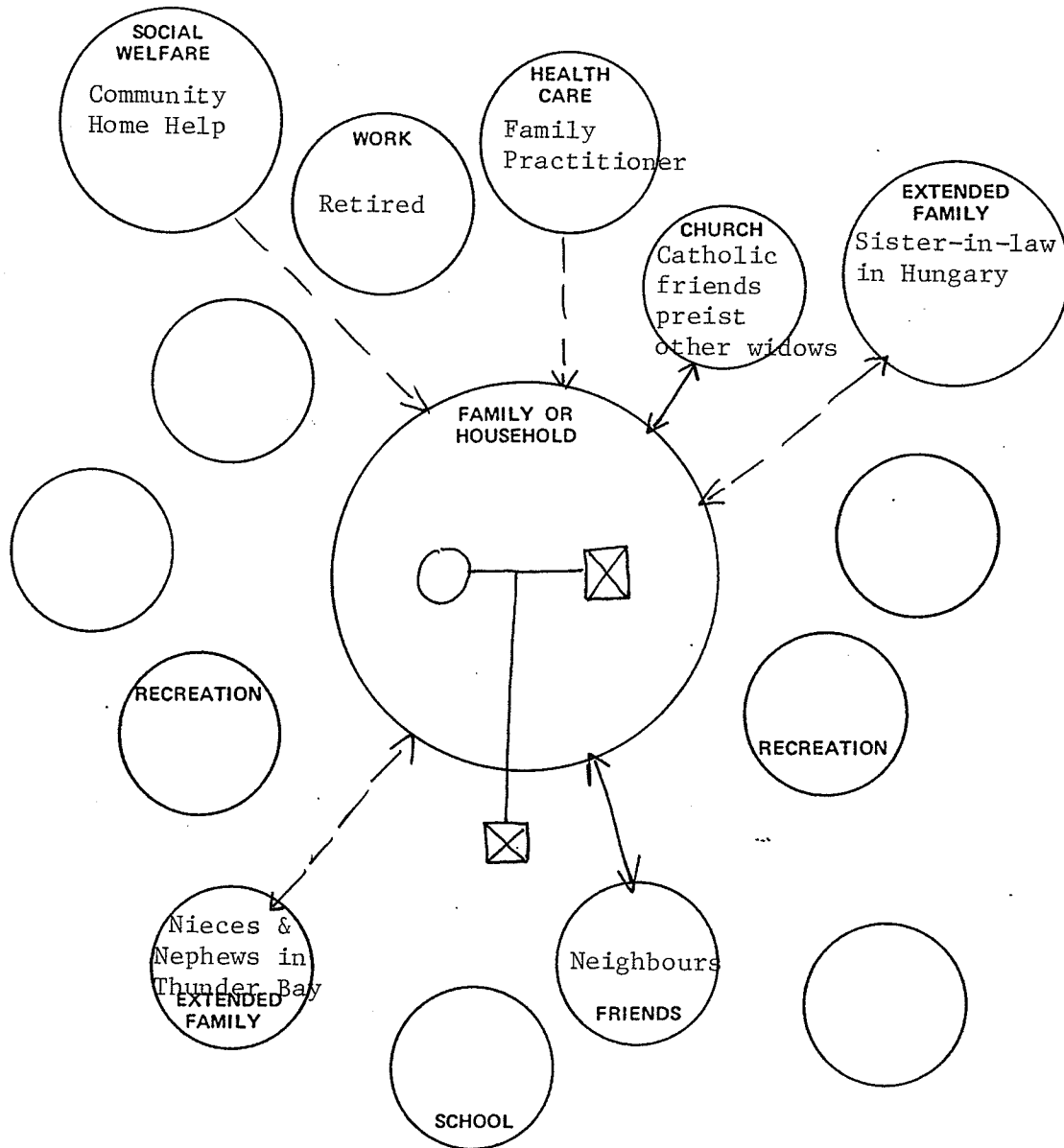
Diagrammatic assessment of family relationships

Figure 27 "E" Family

ECO-MAP

Name "E" Family

Date Oct. 1988



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, ++++++ for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

"F" FAMILY

AN ILLUSTRATION OF ENTRY DIFFICULTIES ...

Basic Information:

Family members - Mrs.F - 43 years (breast cancer patient)
Mr. G - 47 years
Second marriage for Mrs. F
2 children, one 15 year old son living at
home and 1 married daughter 21 years
with 3 year old daughter.
Genogram: Figure 28

Number of Sessions:

Number of sessions conducted with patient:	2
Number of sessions with patient's mother:	1
Number of sessions with patient and mother:	1

Reasons for Referral:

Patient referred after mastectomy while receiving chemotherapy in January '88;
concern expressed by nurses for patient's emotional functioning, weepy and

visibly upset during treatment. Contact was maintained over a six month period from January to July, 1988.

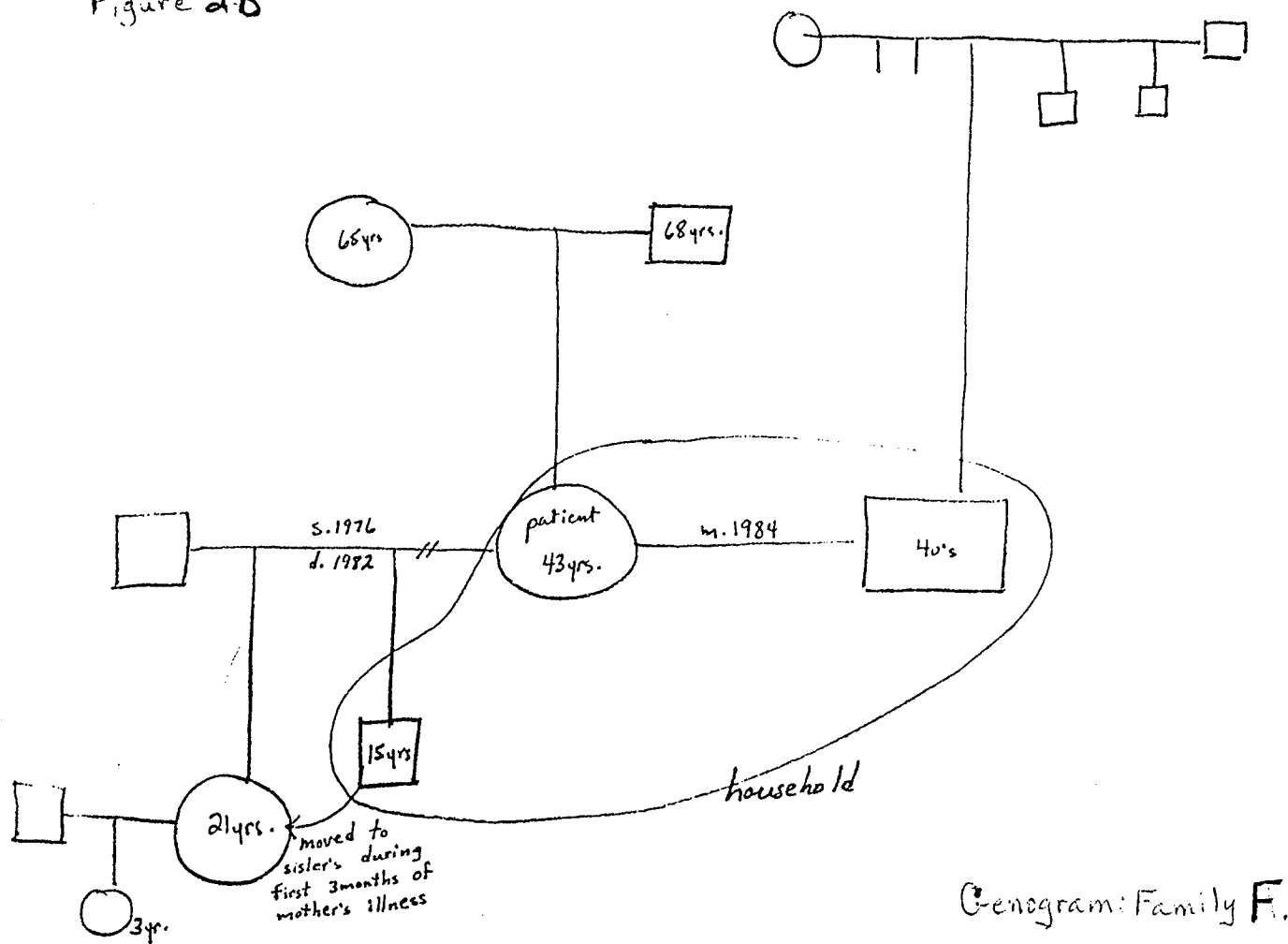
Insert
Figure 28
about here

Family Assessment:

This case is one of a re-married family. Mrs. F had been divorced from her first husband for nine years. She had two children from this marriage: a 15 year old son and a 21 year old daughter living away from home. She had been in this second marriage for four years. She had no contact with her first husband, nor did the children. She described this first marriage as abusive. Mrs. F reported that the relationship between her second husband and son was strained and in order to alleviate some of the stress during her illness she had sent her son to stay with his sister. The attached genogram illustrates the family constellation.

Developmentally this family needed to be getting on with the tasks of establishing themselves as a new family unit. The couple had begun to establish themselves as a unit with friends and family prior to Mrs. F's illness. However, Mr. F's entry into the family was complicated by the developmental stage of the son entering adolescence and beginning to rebel against parental authority. This interfered with the process of Mr. F being accepted as a father figure in the family.

Figure 28



Looking at this family from a structural point of view, a strong subsystem existed between Mrs. F and her mother. With the onset of Mrs. F's illness this subsystem was strengthened as Mrs. F turned more and more to her mother for support and sympathy as she felt less coming from her husband. The mother-daughter subsystem became the primary subsystem and the marital dyad weakened. It appears that the mother and daughter were always enmeshed and the illness accentuated its affects on family functioning. The following diagram illustrates the family structure. I have placed the mother in the highest position of power, both husbands are rather peripheral to the process and I place myself low and outside of the circle because Mrs. F did not allow me access into her family.

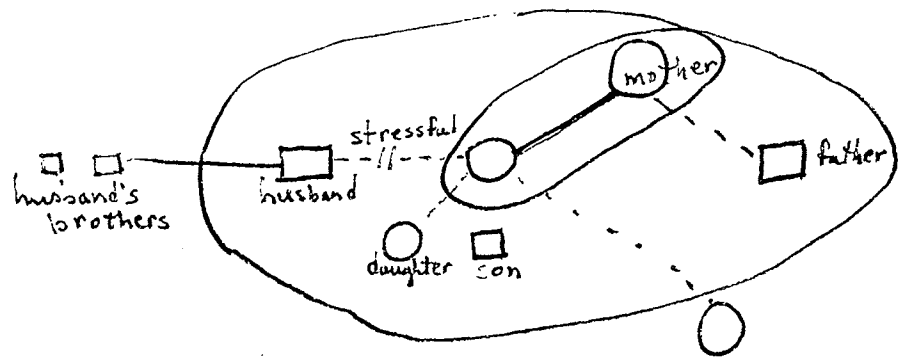
Insert
Figure 29
about here

As the diagram illustrates, Mr. F has as much power in the family as his wife, having control over whether the marriage continues or ends but the mother's power and enmeshment with Mrs. F erodes the connectedness of the marital system. The diagram also illustrates how the children (son in particular) are essentially left without an effective parent-child subsystem and the son forms a sibling subsystem with his sister as a parental substitute. Also the boundary around the family indicates that outsiders are not welcomed into the family. Mrs. F's extended family are central to the family but Mr. F's brothers are kept outside the family's boundaries. Finally Mrs. F's father maintains his connectedness

Figure 28

Family F

Structural map



with his daughter through his wife and maintains a weak marital dyad by accepting and supporting her position.

As only the patient and her mother were ever seen by the student it was not possible to observe patterns of communication between the couple. But by her reports, her husband was unsympathetic and uncaring about her illness. She reported conflict between them and expectations on her husband's part that she maintain the household even when she felt ill and not to expect any assistance from him. She felt negatively about his continuing to socialize with his brothers and friends when she was too ill to participate in social gatherings. Mrs. F turned to her mother for emotional support, practical assistance and help with parenting and decision-making.

Goals:

Mrs. F was resistant to family and individual counselling from the time of referral. Entry to the family was attempted through provision of instrumental resources to which Mrs. F was receptive. For this reason only some goals of intervention were made explicit and others were covert. Three goals were stated explicitly to Mrs. F:

1. to strengthen her coping capacity;
2. to help her reframe her perception of her illness to a more hopeful stance; and

3. to provide community resources that provide practical assistance.

Covert goals were:

1. to strengthen the marital dyad and weaken the mother-daughter subsystem;
2. to weaken mother's influence on Mrs. F; and
3. to dilute Mrs. F's dependence on mother by provision of community resources.

Intervention:

As Mrs. F was resistant to counselling, entry to the family system was attempted through provision of practical assistance resources to which she expressed interest. Specifically this involved referral to Victorian Order of Nurses (VON) for supportive health monitoring after her mastectomy and to Home Care for household assistance. Her mastectomy had been performed at another hospital 3 weeks prior and she had not been referred to these services. Attempts were also made to re-connect her with a mastectomy visitor for emotional support and to offer a more optimistic view of breast cancer but she was reluctant to accept this as she did not want to discuss her illness. Attempts were made to explore with Mrs. F her coping mechanisms. She identified her means of coping as to "not think about it", "putting it out of her mind", but behaviorally she seemed to embrace helplessness as a way of being and accept her illness as catastrophic

and hopeless. This seemed a stance re-enforced by her mother. Attempts were made to join with Mrs. F by commiserating with her in hope of her getting "fed up" with this stance and becoming motivated to attempt change.

Offers were made to meet with Mrs. F and her husband, with the goal of strengthening the marital dyad, but Mrs. F remained resistant to this suggestion. One meeting was held with Mrs. F's mother to attempt to decrease her influence on Mrs. F. Direct suggestions were made to the mother that her weepiness was not helpful to her daughter and that having her daughter's best interests at heart she would not want to be a hindrance to her emotional well being. The mother felt she had no alternative because there was no one else Mrs. F could depend on and she couldn't help herself from feeling sad and scared.

Evaluation:

Attempts to engage this family in a therapeutic process were unsuccessful. Problems with marital conflict and an overly involved mother continue. Interventions were direction toward easing the family's experience of "pile up" (Double ABCX model) of stresses through provision of new resources (bB) and attempts to reframe Mrs. F's perception of her illness (cC). The attached eco-maps illustrate the community resources added in an attempt to lessen Mrs. F's dependence on her mother and alleviate some of the stress present in the home by ensuring instrumental tasks were performed.

Insert
Figures 30 and 31
about here

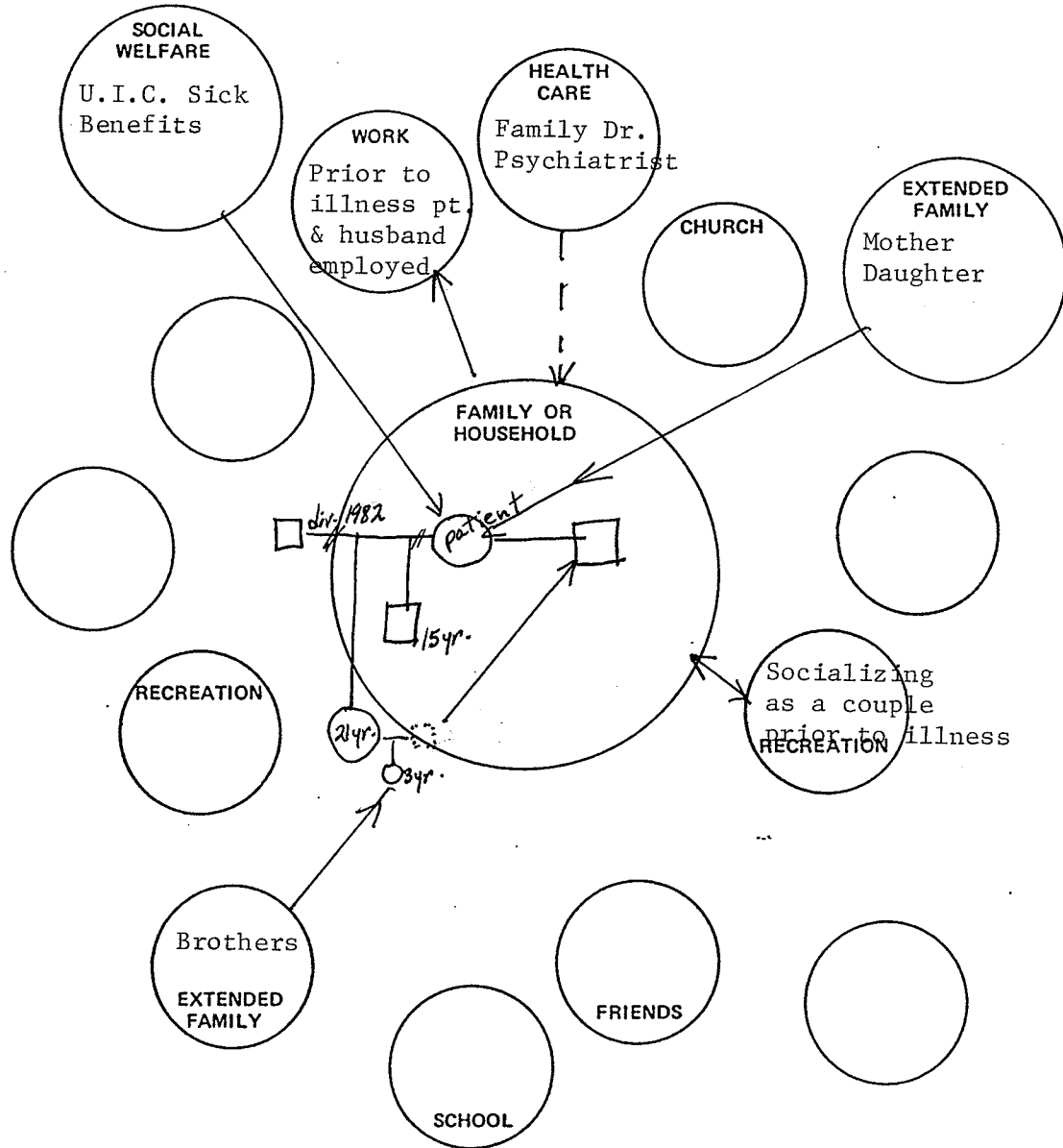
Diagrammatic assessment of family relationships

Figure 30

ECO-MAP

Name Family "F"

Date Pre



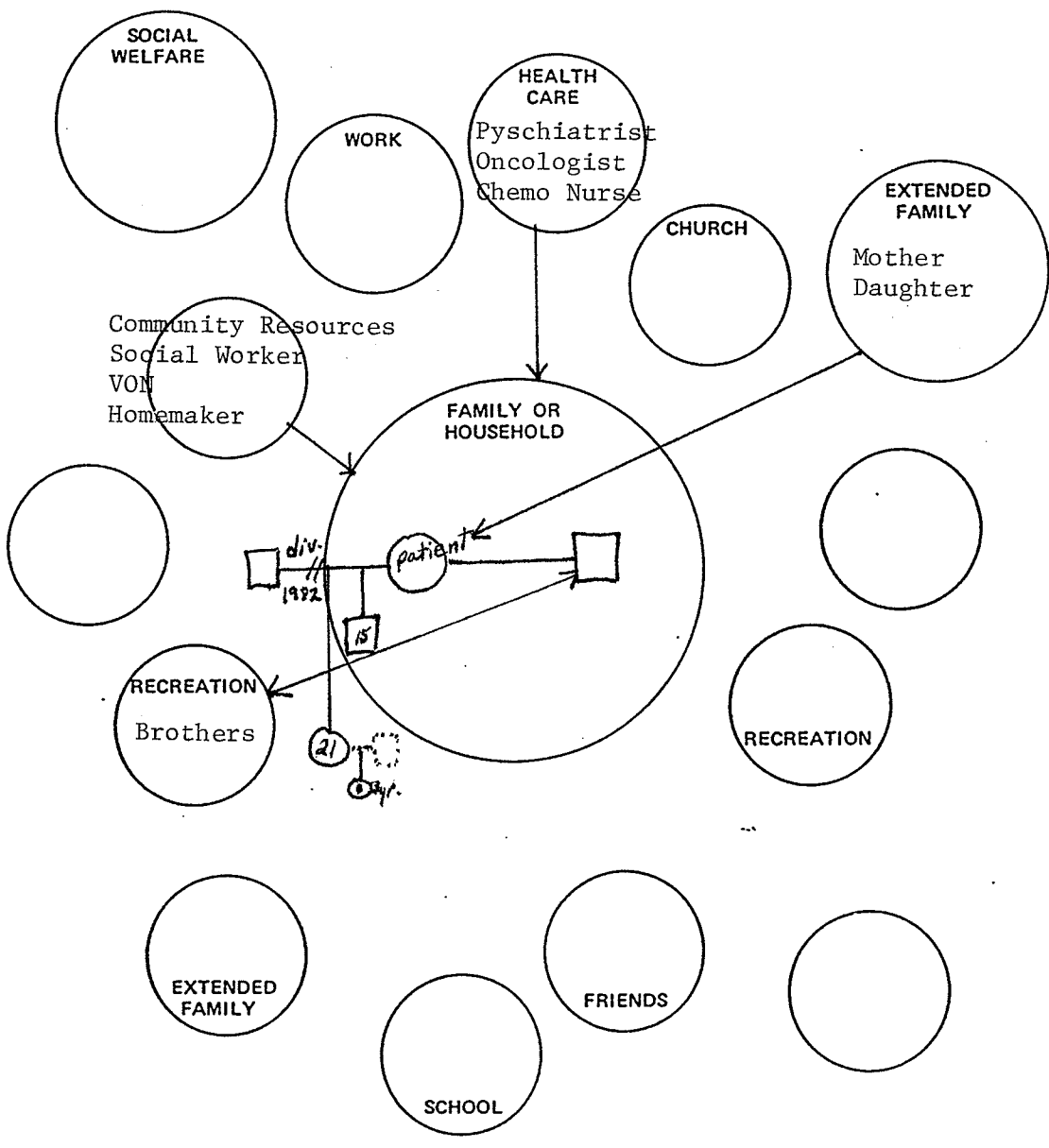
Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, ++++++ for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

Diagrammatic assessment of family relationships

Figure 31

ECO-MAP

Name Family "F"
Date POST



Fill in connections where they exist.
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines;
 ————— for strong, - - - - - for tenuous, + + + + + for stressful.
 Draw arrows along lines to signify flow of energy, resources, etc. →→→
 Identify significant people and fill in empty circles as needed.

Family interventions were unsuccessful in achieving the stated goals. In retrospect a less direct and more paradoxical intervention might have been more successful in achieving some change in the mother-daughter relationship.

It is interesting to note that although Mrs. F started the last interview saying she had tried to cancel it, that at the end of the session she reported feeling better having talked her feelings out. This would seem to indicate some level of satisfaction with services delivered on terms that she could accept.

Contact with this client was delayed three weeks beyond the crisis time of diagnosis of breast cancer and subsequent mastectomy. Entry might have been more successful if there had been opportunity for engagement at the time of crisis.

OVERALL ADAPTATION

A goal of this practicum was to assist each individual family to achieve a satisfactory adaptation to life threatening illness. However, some additional general comments, on the adaptation process of the whole practicum group of 14 families, may also be of interest.

Although the stresses associated with the illness itself were paramount, the sheer number of adjustments and their ongoing nature are important to mention. Husbands learned to share more parenting and homemaker responsibilities. Adult children moved back home to assist an ill and aging parent. Older couples sacrificed independence to meet the care needs of an ill member. Families re-organized their home environments to accommodate a dying spouse.

Additional external factors created further stresses for families such as financial losses when a wage earner was ill. For one family a spouse's terminally ill father created an additional care burden and forced her to split her energy between her husband and her parents. The raising of teenage children brings with it stresses at the best of times, which were accentuated when one parent was ill and less available to fulfill parenting responsibilities. This situation in four of the practicum families placed additional responsibilities on the remaining parent and/or older siblings.

In cases where there were pre-existing problematic relationships, the illness did nothing to improve the situation and non-supportive couple relationships made

the adjustment process more difficult. For several families the crisis of illness was intensified because of problematic family relationships, i.e. Family B where the wife was already depressed and the ill husband did not wish to burden his wife with his fears, or as in Family D, that was in danger of disintegrating when the mother died because the remaining parent had always been peripheral.

Perceptions about the illness often reflected past experiences with cancer and how the family of origin coped with the illness. Mrs. C had a negative outlook on any chance of recovery as her sisters and mother had all died of cancer. Mrs. F became helpless and hopeless as this "way of being" was promoted in her family of origin, during times of crisis. In spite of several families with problematic family relationships, all but two families had good support systems. In some cases, the support network was able to step in and aid the ill member or assist the family to continue to function when the primary relationships failed.

Although the fear of death was ever present, most families managed to reframe the situation to hold hope. Those who had negative thoughts had difficulty changing their perception of the future to be more optimistic.

A variety of techniques were used by families to cope with the illness, i.e. living day by day, seeking medical information, crying, denial and distraction.

The coping styles of most patients did not differ between male and female. Both used techniques such as seeking information and talking it out. Women tended to be slightly more visibly emotional, i.e. crying, focussing on feelings, whereas men tended to want to protect their families and not share their "upset" feelings with their spouse, but did so with the student.

The coping styles of spouses did differ between male and female. The wives tended to cry more, talk it out and seek support. The husbands used more techniques of denial, avoidance, and minimization with tendency toward maintaining a hopeful attitude.

There were also some interesting differences observed between M.I. patients and cancer patients and their families. Although both groups often coped by minimization of the illness, the difference seemed to be for the M.I. patient, the knowledge that death could come suddenly and thus distraction over the long run was less useful as a coping mechanism. Patients struggled instead to regain control over their environment through positive changes in life style and minimized the severity of their cardiac condition. Cancer patients tended to take a "one day at a time" stance, placing hope in the potential success of treatment, living with the fear/knowledge of possible death but as a less immediate threat, and distraction from their illness continued to be an effective coping mechanism.

At the three month point, when termination was expected, the practitioner found that three months was not enough time for complete adaptation to occur. There were ever occurring changes in health status of the practicum patients, as the disease or treatment progressed, thus altering the reality to which the family must adapt. For example with Family E, at the three month point, treatment was terminated and the family entered a new crisis with the terminal stage of illness. For Family X, at the three month point, Mr. X had not recovered sufficiently from his M.I. to return to work. It was uncertain from a medical point of view whether he ever would recover sufficiently to resume his previous employment. For

Family D, the patient died two months into my involvement with the family and at the three month point, not enough time had elapsed for the family to adapt and re-organize after the loss of a parent. My involvement thus with many of the families continued past the three month point until sufficient adaptation had been achieved to warrant termination of service. For most families, this point was reached between five and six months. With two families, I remain involved, at the point of writing, and am fortunately able to provide social work services to these families as the need arises as part of my ongoing responsibilities with the hospital.

CHAPTER 4

EVALUATION

This practicum was designed with the major objective of designing and implementing a comprehensive social work plan for families diagnosed with a life-threatening illness (either cancer or myocardial infarction) in one of its adult members.

The extent to which this objective was fulfilled is explored in this section. Recommendations for social work practice with such families, follows. The final section reviews the student's personal learning objectives.

EVALUATION OF SERVICES TO CLIENTS

The designing of an evaluation process presented some difficulty to the student. I did not feel comfortable in presenting questionnaires to the patient and spouse soon after they received a life-threatening diagnosis. Thus the presentation of questionnaires was generally delayed past the time of crisis. In some instances, families who had been willing to engage with the student in the crisis period were less receptive to continuing with service past this stage when presented with a family assessment measure. The introduction of the FAM represented a shift from crisis intervention to family therapy for which families had not contracted and understandably were, thus, resistant to the process.

Family functioning scales, i.e. FAM III General scale and FAM Brief form, were used as pre and post intervention evaluation tools. Problems were found in:

- the lack of families' willingness to complete questions on family function as they defined the problem as the illness;
- the lack of willingness of families to complete a second questionnaire as they did not feel their answers would change;
- the lack of willingness of families to complete the general scale because of the length and many of my older clients being unfamiliar with written forms and language barriers; as well as
- the lack of sensitivity of the brief scale to pick up changes over short periods of time, i.e. for families whose scores indicated normal family functioning before intervention, there was no perceived change after intervention.

On the positive side, I found the information gained from the FAM III, with those families who would complete it, to be an exciting and useful tool. It did reflect problems in family functioning in areas where I anticipated major shifts due to illness, such as in role allocation and performance, task accomplishment and control. The FAM is applicable to this client population as it emphasizes family health as well as pathology. Many of the families seen in this practicum were basically healthy functioning families coping with the additional stress of critical illness. A tool that emphasizes healthy functioning was successful in identifying these families as such, but served to highlight those aspects of family processes

that required reorganization or were perhaps reflecting the effects of stress from the demands of illness. However, it is not possible to be sure that identified problem areas did not pre-date the onset of illness. In some cases (Family B and Family D), the clinical data would support the fact that there were long standing problems in family functioning, whereas in Family X the interview data seems to indicate problems arose out of the changes necessitated by the illness. Secondly, the fact that the model emphasized neither total family system nor individual intrapsychic dynamics lends itself to the ecological approach with the practicum families, which were directed at individual coping ability, family adaptation and environmental systems. With families where there was a clear contract for intervention in family function there was more acceptance to complete the FAM III. This would seem to indicate with selected cases, the FAM III has applicability to this setting and population. However, because the majority of families seen in a medical setting are not seeking family therapy, but define their problems in terms of coping and adjustment, an evaluation tool that taps these entities would be more useful.

The Impact of Event Scale (IES) (Horowitz, 1979) which measures the stress associated with traumatic events would have been a more useful instrument. This IES measures two categories of experience in response to stressful events: intrusive experience, such as ideas, feelings or bad dreams; and avoidance, the recognized avoidance of certain ideas, feelings and situations. The Impact of Event Scale has been shown to be sensitive to change and thus would be an appropriate pre and post intervention instrument to monitor client's progress in treatment. Also the fact that it is brief, only 15 questions, makes it palatable for use with people with low energy due to illness or in a time of crisis.

The IES is a self-report measure which can be anchored to any specific life event, and it has a high internal consistency reliability (.79 - .92) on its subscales (Zilberg, et al, 1982).

Eco-maps were used as an assessment and evaluation tool to determine whether environmental changes were achieved. Eco-maps pre and post intervention were included in every case discussion and in Family D and E a third eco-map is added to depict changes after the death of the identified patient. These maps represent the changes in social environment and reflect the intervention to mobilize resources to meet client needs.

As I was successful in gaining co-operation of only one client to complete the Beck Depression Inventory, its usefulness cannot be fairly addressed. The issue for families seemed to be on unfamiliarity with questionnaires and having them presented at a time of illness, met with resistance. Co-operation was gained with some families to complete one questionnaire; having done so they were less inclined to complete a second.

In addition, evaluation of progress towards specified objectives was undertaken with each client family, based on clinical data obtained through open-ended interviews and client self-report. Some family problems were directly related to the illness, whereas others had their roots in former unresolved issues. In most cases families were successful in adapting to illness after brief and appropriately targeted help.

Also utilized with some families was the Support Network Questionnaire. The use of this questionnaire was found to be redundant as reported in the case

example of Family "X". The student found completing this questionnaire with families, after having already completed an eco-map drawing, to be questioning along all the same lines as information already obtained. In retrospect however, if this instrument had been introduced earlier, information could have been obtained about the family's social support network and who is available to assist with instrumental and affective tasks, from which the eco-map could have been drawn. An advantage of using the support network questionnaire would seem to be the systematic method of identifying and categorizing the client's network and the inclusion of who within the system is a negative influence or block to change.

A final evaluative measure adopted was a consumer satisfaction questionnaire which is contained in Appendix 2. Seven completed questionnaires were returned and their responses are compiled in Appendix 2. A summarized discussion of responses is included below.

Responses on the consumer evaluation questionnaire to the questions regarding the timing of social work contact re-affirmed the need for social work contact to be made with the client at or around the time of diagnosis. Clients for whom contact was delayed longer than one week from the time of diagnosis, felt this was later than they would have liked.

Overall responses indicated that the services were useful. Where home visits were made, the number was seen as sufficient for the majority of respondents and the number of contacts with the social worker was reported as "just right" in six out of seven cases. The counselling sessions were reported to be helpful by the majority of families who returned a questionnaire and to have included all

the topics they needed to discuss. The most commonly reported topics were: the illness itself, feelings of sadness and concerns for coping of the patient.

Nine of the fourteen issues, reported by clients as discussed in the sessions, were described as better after the intervention, while five reflected no perceived change. Those reported as "no change" were topics of the patient's physical condition i.e. health or inability to work. These were the two most frequent issues followed by concerns for spouse as the next major concern listed by respondents.

Five out of the seven families would recommend the service to other families in the same situation. The other two thought "perhaps" the service would be helpful to others. Half the respondents indicated they would like to meet with a social worker in the future "as needed" or "at any change in the medical condition of the patient". Of the three that responded "no", only one client responded "no" due to not finding the meetings helpful.

These responses would seem to indicate overall client satisfaction with the services offered, as do some of the additional comments added at the end of the questionnaire, e.g. "appreciated the care and compassion of the social worker when everything looked bleak", and "helped to talk over feelings".

CRITIQUE OF THE MODEL OF SERVICE

1. Family Centered Approach

This approach was chosen because of the student's initial hypothesis that illness in one member of a family impacts on the whole family system. The intent of the practicum was to adopt a family approach to treatment in order to assist in family adaptation to illness. From the point of view of the student, this approach was useful. It enabled me to gain a clearer understanding of family dynamics and interactions from which appropriate intervention and goals could be planned. It also provided the opportunity to intervene directly with patterns of family interaction, communication, and organization.

For the most part, family members who participated in family sessions found these helpful. However, there was reluctance on the part of many clients to engage in family sessions. Some of the reasons for this will be further discussed under the next section on engagement. At this point I want to discuss patients for whom family intervention would be premature. At the time of crisis of diagnosis with a terminal or critical illness a patient may not be ready to discuss some of the issues and implications of their illness with their family. At a time when they are feeling out of control it may be very important for them to maintain some control by determining how and when their family will learn of their diagnosis and prognosis. Because the patient and family may experience dysynchrony over the diagnosis, the patient may benefit from the opportunity to work through some of his initial feelings and reactions before he is willing to

engage in family sessions. It is important for the practitioner to be sensitive to this need and flexible in his/her approach to the client. Although direct intervention, in such a case, may be with the patient only, if done from a systemic perspective, the larger goal of improved family function and adaptation can still be achieved.

A final issue that became apparent to me in this practicum was to recognize the need, at times to involve adult children. In a couple of families adult children were part of the family sessions . However, there were two other families in which an opportunity to meet with adult children should possibly have been extended. In Family C the worries the patient held for her son's health and for her husband's care needs may have been more openly addressed by meeting with the children and parents together. In Family X where the sons returned home to care for the ill parents, a meeting with the parents and children may have been helpful to ensure that the children do not get "stuck" back in an earlier stage of family life cycle development.

2. Engagement

A second objective of this practicum was to examine the engagement process with clients in a secondary setting. My experience in this practicum has led me to identify the following observations as to the nature of the problem of engagement with this client population:

- a) The client defines the problem as medical. I found that some patients were not willing to engage at a therapeutic level because

they defined their problem as medical and perceived no need for counselling of either an individual or family nature. Individuals enter hospital because they perceive their symptoms in terms of medical care, not family counselling (Rehr, 1985);

- b) The client minimizes the illness as a way of coping with the emotional impact of diagnosis. I found two families who initially engaged as couples chose not to continue counselling past the hospitalization stage because they determined the illness to have been or being treated and "they would be fine". They preferred not to explore further the impact of the illness on their lives, emotions and relationships because their means of coping was to minimize the impact. Thus attempts to engage families by a desire to explore and assist them with the adaptation process was unsuccessful as families in their defensive struggle denied any need for significant adaptation; and
- c) The client copes with the invasiveness of the disease by not allowing others to invade their world. In several cases where treatment was complete, the client did not want any further social work contact. They wanted to forget their illness and return to normal life, and did not want to dwell on their illness. Their way of coping with the disease was to take control over not allowing others or negative thoughts to invade or become invasive in their world. Lewis, Haberman, & Wallhagen (1986) call this "refocussing control".

I found several factors that were most helpful in dealing with these issues and promoting successful engagement.

- a) Not being problem focussed: - The use of the Double ABCX model and an ecological approach enabled me to take a non-problem focussed approach with clients. Rather than, for example, identifying a problem in their coping, I could introduce a more preventative stance, i.e. to assist them as a family in their adaptation, not waiting for problems to develop, but discussing adjustments and changes they could make to deal with the psychosocial impact of the illness. As a pro-active stance, this also conveyed a sense of control to patients, a means of taking charge over the illness.

- b) Timing: - Another factor that enhanced successful engagement was timing. Being there at the time of crisis was important and often enabled me to make the most significant bonds with clients. This was exemplified in Family C when she received her diagnosis of cancer and did not want to receive treatment, also with Family E at the termination of treatment. This crisis intervention work with clients was the most effective means of engaging clients. It offered opportunity to alleviate initial emotional stress for patients and families and demonstrated to them the effectiveness of the student's skills.

- c) Offering instrumental assistance: - It was possible to engage some clients with instrumental tasks; i.e. some families required

assistance with financial aid due to illness or help in locating appropriate community resources (housing, transportation, etc.). However, at times some clients were willing to engage only at the instrumental level but not beyond.

- d) Having support of other members of the health care team: - In cases where the nursing staff introduced the student or where the physician advised the family to become involved with the social worker, engagement was made much easier. The support of other health care team members contributed positively to the family's view of social work as part of the treatment process, as having something to offer and as a normal event in adapting to illness.

3. Double ABCX Model

I found the Double ABCX model a useful theoretical framework, helpful to my understanding of the issues for this client population. The three units of analysis in this model, i.e. the individual family member, the family unit, and the community, and the interaction of these, emphasize the struggle to achieve a balance at both the individual-family and the family-community levels of family functioning. Family adaptation becomes the central concept in this model and describes the outcome of family efforts to achieve a new level of balance after a family crisis. The Double ABCX model suggests that coping is the central process describing families' efforts to adapt and achieve a new level of balance. Coping emerges from the pile up of demands on the family and involves an

interaction of recourses, perception and behavioral responses (Patterson & McCubbin, 1983).

The theory of "pile up" serves to demonstrate that families are seldom dealing with a single stressor-like life-threatening illness. Rather, as the Family X situation indicated, they face multiple changes and demands simultaneously. There are normative changes like the Family X's son leaving home, the adolescent-parent struggle in Family D, or additional demands on Family B due to illness in an aging parent.

Most families carry some residue of prior strain from unresolved hardships from earlier stresses, such as in Family A where there was domestic violence, or Family B where the spouse had suffered from depression for several years.

The original stressor of life threatening illness had its own accompanying hardships such as unemployment and financial problems as in Family X, or fear for survival which was present in all the case examples, or the unavailability to the children of care and nurturance of the sick parent as in the case of Family D.

The family's efforts at coping can itself result in consequences that add to the pile up of family stresses such as in Family X where the adult sons returned home to care for the ill parents, or Family E's erosion of a sense of independence by its increased dependence on external resources.

A fifth source contributing to the pile up theory is ambiguity. For all families there exists the ambiguity of prognosis; for Families B and X there was ambiguity

about the patient's ability to return to work; for Family D there was ambiguity as where the teenage daughter would live if and when the mother died.

These elements of pile up provided a useful framework for analysis of the stresses facing each family.

The second factor in the ABCX model - "resources", provides a means of identifying strengths and weaknesses and helps emphasize the need to strengthen or support existing resources or create and add new resources through network building. The third factor of the model, "perception", draws attention to the family's definition of the illness and illustrates how their perception becomes a critical component of family coping and a target for intervention.

4. Intervention

As discussed in Chapter 2, a family-centered crisis intervention approach was taken to assist families in achieving healthy adaptation to life threatening illness in one of its members. In the early stages at the time of diagnosis, crisis intervention and grief therapy was offered. Later interventions addressed family functioning, facilitating more open communication, opening boundaries between family systems and community, assisting families to address changes in role function and re-organize to maintain instrumental and affective tasks. Assistance with instrumental tasks was given and resource and network building was undertaken.

As discussed in the preceding section, the Double ABCX model proved useful in analyzing the stresses associated with life threatening illness and targeting areas for change to enhance coping. In addition, the ecological approach fit well with the Double ABCX model and was well suited to intervention with families with life threatening illness. The ecological perspective with its view of practice as directed toward improving transactions between people and environments to enhance adaptation lends itself well to health care intervention.

The ecological perspective defines adaptation as both changes in self to conform to environmental demands, as well as active changes in the environment so that it will conform to human needs (Germain, 1979). Thus my interventions were simultaneously directed toward strengthening internal coping mechanisms of individuals and the family unit, and toward ensuring the environment provided the external resources needed for successful coping. In this respect the eco-map proved to be a useful tool demonstrating supports available in the intimate and extended environment, the flow of resources, or lacks and deprivations, and bringing into consideration the relational and instrumental skills individuals must have to utilize their social environment and cope with its demands (Hartman, 1978).

RECOMMENDATIONS

Recommendations arising from this practicum are as follows:

1. that social work services be implemented at the time of diagnosis. Consumers indicated a preference for contact within a week from the time of diagnosis. Also the engagement process is enhanced by being available to the client at the time of crisis;
2. that the Double ABCX model be utilized to contribute to the assessment process. Assessment is a crucial component to determining the nature and intensity of intervention required. The Double ABCX model and theory of "pile-up" contributes to the identification of the indicators for intense social work involvement. Such indicators are: significant family and role changes, severity of illness, loss of job, prior strains, normative transitions and ambiguity of prognosis;
3. that in light of the significance of crisis intervention in enhancing the engagement process, the social worker who intervenes with the client at the time of diagnosis remain the same throughout the hospitalization;
4. that efforts be made to enlist the support of the health care team to facilitate the engagement process with clients;

5. that intervention be flexible and broad and based on an ecological perspective and providing individual and family counselling, practical assistance and network building;
6. that family-centered crisis intervention be recognized as an important component of the work with this client population;
7. that services extend beyond hospitalization to assist families in post-discharge adaptation. As this practicum demonstrated, many of the families continued to struggle with their adaptation to the impact of illness for five to six months after diagnosis. Presently no agency is servicing myocardial infarction patients and families from a psycho-social focus, nor do cancer patients, who are not receiving outpatient chemo/radio therapy, have access to social work services. This lack of community resources readily available to the patient and family post-hospitalization heightens the need for the extension of social work services to this outpatient population.
8. that hospital social workers receive training in work with the terminally ill and their families. As was the case in this practicum, the death of four of the fourteen patients with whom I worked, makes the need for training in counselling the terminally ill, readily apparent; and
9. home visits were found to be a valuable contribution for assessment purposes of understanding the client's life space and social environment. Although home visits were not necessary to the treatment phase, at least one home visit is recommended for assessment purposes when working,

over the long term, with families towards family reorganization and network development.

EVALUATION OF PERSONAL OBJECTIVES

This practicum was intended to develop my expertise in working with families with life threatening illness, through increasing my knowledge base, and examining theoretical frameworks that are useful in influencing practice with this population, and enhancing my skills in family-centered practice. In fulfilling these objectives, the practicum provided many challenges and opportunities.

The studying, organizing and integrating of relevant literature has contributed significantly to my learning. I have gained an increased understanding of family systems theory and examined approaches most effective with issues of illness in the family . The Double ABCX model provided me with a new framework for organizing information that I believed relevant, and helped me to target my goals for family crisis intervention.

The process of recruiting families to participate in my practicum has enabled me to utilize several different approaches to engagement and examine what factors I believe contribute to successful engagement. I feel I gained skills useful to the engagement process as the practicum proceeded and found I was more successful in engagement with families in the later months of the practicum.

Adopting a family-centered approach to practice provided me the opportunity to enhance my skills in working with couples and families. Most family interventions involved opening communication, helping couples reframe issues, mediating conflicts, and facilitating problem-solving regarding role changes and

instrumental tasks. Much of my work with these families could be considered family crisis intervention.

Due to the demographics of the population utilizing the community hospital, the majority of patients with whom I was involved were in later stages of life. Much of the family therapy literature is written from the perspective of families raising young children. In engaging and working with couples in their 60's, 70's and 80's, I found new challenges in adapting family theory and found the life cycle literature to be most helpful. Although only one of the families with whom I worked had young children (and I was not directly involved with the children), several families had teenagers. As I had previously only had very limited experience in working with adolescents, I found this to be a challenging and exciting learning experience.

This practicum did not provide the opportunity for me to be involved in depth with families sufficient to provide the family therapy learning experience I would have liked. Only one of the family's engaged at the level of wanting to make changes in family structure and organization. The majority of the families involved in this practicum were well functioning families who were dealing with the crisis of illness. The goals and time frame of family crisis intervention do not allow for indepth restructuring of family relationships. Intervention to support and strengthen the families' coping capacities and to ensure necessary environmental resources were present, was sufficient to enable them to make adequate family adaptation. Four out of the fourteen families had pre or co-existing problems in family functioning that warranted family therapy prior to the diagnosis of life threatening illness. Two of these families were only willing to engage at a minimal level, one did engage in therapeutic family change and the

other utilized family intervention only to the point of re-establishing their pre-illness balance. Although inter-relationship problems continued to exist in this family, the stressors of the husband's illness were alleviated to the point where the family could return to its previous level of functioning. My experience with this family was one of assisting them to achieve a successful adjustment versus making first order changes with pre-existing problems.

Although having chosen a client population facing life-threatening illness and aware of the potentiality of death, I basically designed this practicum with the intent of helping families adjust to living with a serious illness rather than dying with it. I soon found myself having to "shift gears" and reading in the area of terminal illness as my first client died suddenly, and rather unexpectedly, only one week after my beginning the practicum. During the course of this practicum, four of the patients with whom I worked died and my involvement included helping patients prepare for death and providing bereavement counselling to family members.

The use of assessment and evaluation measures demonstrated to me the value of such instruments and although not completely satisfied with the FAM III for this client population, I am interested in researching and designing ways to evaluate my ongoing work. I found the use of eco-maps useful to objectify changes needed following the patient's hospitalization. According to Hartman (1978) the use of eco-maps can help the client mourn interests and activities they had to relinquish by picturing their world before illness and recognizing sources of support and gratification that would continue, and identifying possible new resources to be tapped.

In summary, the organizing and integration of the literature and theoretical frameworks that I explored contributed greatly to my learning, as did the opportunity to work with these families over time and assist them in their adjustment process.

The challenge of working through and often struggling with this practicum has provided me the opportunity to refine my skills, broaden my knowledge and left me with an increased sense of professional self-confidence.

BIBLIOGRAPHY

BIBLIOGRAPHY

- Aguilera, D.C., and Messick, J.M., Crisis Intervention: Theory and Methodology, C.V. Mosby, St. Louis, 1982.
- Anderson, C. and Stewart, S., Mastering Resistance, New York: The Guildford Press, 1983.
- Aponte., H.J., "Underorganization in the Poor Family", in P.J. Guerin Jr. (ed), Family Therapy: Theory and Practice, New York: Gardner Press, 1976.
- Beck, Aaron T., & Beck, Roy W., "Screening Depressed Patients in Family Practice", Post Graduate Medicine, Vol.52, Dec. 1972.
- Bonnefil, M., & Jacobsen, G., "Family Crisis Intervention", Clinical Social Work Journal, Feb., 1979.
- Caroff, P. and Mailick, M., "The Patient has a Family: Reaffirming Social Work's Domain", in Social Work in Health Care, Vol. 10(4), Summer, 1985.
- Carter, Elizabeth A. and McGoldrick, M., The Family Life Cycle, A Framework for Family Therapy, ch. 1, New York: Gardner Press, Inc., 1980.
- Cohen, Marie M. and Wellisch, David, "Living in Limbo: Psychosocial Intervention in Families with a Cancer Patient", American Journal of Psychotherapy 32:4, October 1978.
- Dhooper, Surjit S., "Social Networks and Support During the Crisis of Heart Attack", Health and Social Work, Vol.9, No.4, Fall 1984.
- Germain, Carel B., "An Ecological Perspective on Social Work Practice in Health Care, "Social Work in Health Care, Vol.3(1), Fall, 1977.
- Germain, Carel B. (ed), Social Work Practice, Columbia University Press, New York, 1979.
- Germain, Carel B., Social Practice In Health Care, The Free Press, New York, 1984.
- Golan, N., Treatment in Crisis Situations, New York: The Free Press, 1978.
- Goldberg, I. and Goldberg, H., Family Therapy. An Overview, California, Brooks/Cole Publishing Co., 1985.
- Gurman, A.S. and Kniskern, D.P. (eds), Handbook of Family Therapy, New York: Brunner/Mazel Inc., 1981.

- Haley, J., Strategies of Psychotherapy, New York: Greene & Stratton, 1963.
- Haley, J., Uncommon Therapy, New York: W.W. Norton, 1973.
- Hartman, Ann, "Diagrammatic assessment of Family Relationships", Social Casework, Vol.59, No.8, Oct. 1978.
- Hartman, Ann and Laird, Joan, Family Centered Social Work Practice, The Fall Press, New York, 1983.
- Herz, F., "The Impact of Death and Serious Illness on the Family Life Cycle", in Carter and McGoldrick, The Family life Cycle, New York, Gardner Press Inc., 1980.
- Hill R., "Generic Features of Families under Stress", Social Casework (30) March, 1958, reprinted in Parad, 1975, pp.32-52.
- Hogman, Susan, Practician Report: Head-Injury Trauma, A family System Approach to Assessment and Intervention, University of Manitoba, Winnipeg, Manitoba, 1982.
- Horowitz, M.J., Wilner, N. & Alvarez, W., "Impact of Event Scale: A measure of subjective stress", Psychological Medicine, No.41, 1979.
- Jensen, Kathy, Cancer as a Chronic Illness: A Strength Oriented Approach to Social Work Practice, Practicum Report, U of M, 1985.
- Kazak, A.E., and Wilcox, B.L., "The structure and function of social support networks in families with handicapped children", American Journal of Psychology, 12, 1984.
- Kelmer, B., "Family Treatment in the Health Setting: The Need for Innovation", in Social Work in Health Care, Vol. 10(4), Summer, 1985.
- Laird, J. and Allen, J.A., "Family Theory and Practice" in Handbook of Clinical Social Work, Aaron Rosenblatt, D. Waldfazel eds. 1983 Jossey-Bass Inc. San Francisco, 1983.
- Lazurus, R. and Cohen, F., "Coping with the Stresses of Illness", in Health Psychology: A Handbook, by Stone, G.C. and Cohen, F. and Adler, N., Jossey Bass Publishers, 1979.
- Lewis, Haberman, & Wallhagen, "How Adults with Late Stage Cancer Experience Personal Control", Journal of Psychosocial Oncology, Vol. 4, No. 4, Winter, 1986.
- Lilliston, Barbara, "Psychosocial Responses to Traumatic Physical Disability", Social Work in Health Care, Vol. 10 (4), Summer, 1985.

- Lipowski, Z.J., "Physical Illness, The Individual and The Coping Processes". Psychiatric Medicine, (1), 1970, pp.91-101.
- Livsey, Clara, "Physical Illness and Family Dynamics", Advances Psychosomatic Medicine, 1972, Vol.8, pp. 237-251.
- McCubbin, H.I., Larsen, A.S. and Olson, D.H., "F-copes, Family Coping Strategies", Family Social Science, University of Minnesota, 1982.
- McCubbin, Hamilton I. and Patterson, Joan M., "Family Transitions: Adaptation to Stress", in Figley, C.R. and McCubbin, H.I. (eds), Stress and The Family, Vol. I: Coping with Normative Transitions, Brunner/Mazel, New York, 1983.
- McGoldrick, M. and Carter, E., "The Family Life Cycle", in Walsh, F., Normal Family Processes, New York: Guildford Press, 1982.
- Minuchin, S., Families and Family Therapy, Cambridge, Mass. Harvard University Press, 1974.
- Minuchin, S., Rosman, B. and Baker, L., Psychosomatic Families, Cambridge, Mass: Harvard University Press, 1978.
- Monkman, M. and Kagle, J., "The Transactions between People and Environment Framework: Focusing Social Work Intervention in Health Care", Social Work in Health Care, Vol. 8 (2) Winter, 1982.
- Mooney, Phyllis, Practicum Report, Myocardial Infarction: A Social Work Perspective, University of Manitoba, Winnipeg, 1984.
- Moore, Kathleen, "Training Social Workers to Work with the Terminally Ill", Health & Social Work, Vol.9, No.4, Fall 1984, p.268-273.
- Moos, R. and Schaefer, J., "Life Transitions and Crisis" in Moos, R. Ed., Coping with Life Crisis, New York, Plenum Press, 1986.
- Moos, R. and Tsu, V., Coping with Physical Illness, Plenum Publ. Corp., 1979.
- Moynihan, R., Christ, G., & Silver L.G., "Aids and Terminal Illness", Social Casework, June 1988.
- Olsen, H., "The Impact of Serious Illness on the Family System", Medicine 47, 1970, pp. 169-174.
- Parad, H.J., "Crisis Intervention", in Encyclopedia of Social Work, 16th issue, Vol. 1, pp.197-202, New York: NASW, 1971.
- Parad, Howard J. and Caplan, Gerald, "A Framework for Studying Families in Crisis", Social Work, July 1960.

- Patterson, J.M. and McCubbin, H.I., "Chronic Illness: Family Stress and Coping", in Figel, C.R. and McCubbin, H.I. (eds), Stress and Family Vol.II: Coping with Catastrophe, New York, Brunner/Mazel, 1983.
- Powell, Sue, Practicum Report, A Family Approach to Childhood Cancer, University of Manitoba, Sept. 1987.
- Rehr, Helen, "Medical Care Organization and the Social Service Connection", Health & Social Work, Vol. 10, No. 4, Fall, 1985.
- Rustad, Lynne C., "Family Adjustment to Chronic Illness and Disability in Mid-Life", in Eisenberg, et al, Chronic Illness and Disability Through the Life Span, New York: Springer Publishing Company, 1984.
- Satir, Virginia, Conjoint Family Therapy, Palo Alto, California, Science and Behavior Books, Inc., 1967.
- Sieburg, E., Family Communication: An Integrated Systems Approach, New York, Gardner Press Inc. 1985.
- Skinner, Harvey A., Steinhauer, Paul D., Santa-Barbara, J., "The Family Assessment Measure", Canadian Journal of Community Mental Health, (2) 1983, pp. 91-105).
- Skinner, H. A., Steinbauer, P.D., Santa-Barbara, J., The Family Assessment Measure Administration and Interpretation Guide, April 1984.
- Sohor, Sharon, Practicum Report, A Group Intervention for Myocardial infarction Patients and their Families, University of Manitoba, Winnipeg, 1987.
- Sokol, Bernice, "Intervention with Heart Attack Patients and Families", Social Casework, March, 1983.
- Smith, Larry L., "A Review of Crisis Intervention Theory", Social Casework, July, 1978.
- Trute, Barry and Hauch, C., "Social Network Attributes of Families with Positive Adaptation to the Birth of a Developmentally Disabled Child", Canadian Journal of Community Mental Health, Vol.7, No.1, Spring, 1988.
- Trute, Barry, "Evaluating Clinical Service in Family Practice Settings", Canadian Social Work Review, Canada, 1985.
- Ullmann, Alice, "Social Structure & Social Behavior in an Intensive Care Unit: A Social Worker's Response: Social Work in Health Care, Vol. 6, No. 2, Winter, 1980.

- Walsh, T., "Families in Crisis: Relating Vulnerability and Family Functioning to Treatment", Family Therapy, Vol.8, No. 2, 1981.
- Williams, Martha, "Crisis Intervention: A Social Work Method", Social Work in Health Care, Vol. 5, No. 1, Fall, 1979.
- Worden, J.W., Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner, New York: Springer Publishing Co., 1982.
- Zilberg, N.J., Weiss, D.S., and Horowitz, M.J., "Impact of Event Scale: A cross-validation study and some empirical evidence supporting a conceptual model of stress response syndromes, Journal of Consulting and Clinical Psychology, 50, 1982.

APPENDIX 1



Alcoholism and Drug

Addiction Research Foundation

Fondation de la recherche sur la toxicomanie

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October 19, 1988

Kay Stewart
435 Moray Street
Winnipeg, Manitoba
R3J 3A7

Dear Ms. Stewart:

You have my permission to use the Family Assessment Measure in your practicum research as a graduate student in the School of Social Work. Specifically, you have my authorization to reproduce the FAM test booklets for your thesis. Permission to microfilm is also granted.


Best wishes in your research. Obviously, I will be quite interested in learning of your findings.

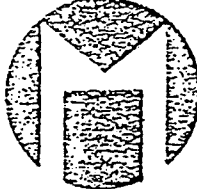
Sincerely,

Harvey A. Skinner, Ph.D.
Senior Scientist

HAS/rs

 Family

 Assessment

 Measure

BRIEF SCALE

Directions

The following statements are about your family as a whole. Read each statement carefully and decide how well it describes your family.

If you STRONGLY AGREE with the statement then circle the "4" beside the item; if you AGREE with the statement then circle the "3".

If you DISAGREE with the statement then circle the "2"; if you STRONGLY DISAGREE then circle the "1".

Please answer every statement.

Please circle one response (number) for each statement.

		STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1.	Family duties are fairly shared.	1	2	3	4
2.	My family expects me to do more than my share.	1	2	3	4
3.	We feel loved in our family	1	2	3	4
4.	When things aren't going well it takes too long to work them out.	1	2	3	4
5.	I never know what's going on in our family.	1	2	3	4
6.	We deal with our problems even when they're serious.	1	2	3	4
7.	When you do something wrong in our family, you don't know what to expect.	1	2	3	4
8.	We tell each other about things that bother us.	1	2	3	4
9.	It's hard to tell what the rules are in our family.	1	2	3	4
10.	My family tries to run my life.	1	2	3	4
11.	We take the time to listen to each other.	1	2	3	4
12.	Punishments are fair in our family.	1	2	3	4
13.	When someone in our family is upset, we don't know if they are angry, sad, scared or what.	1	2	3	4
14.	We are free to say what we think in our family.	1	2	3	4

Please do not write on this page.
Circle your response on the answer sheet.

26. My family tries to run my life.
27. If we do something wrong, we don't get a chance to explain.
28. We argue about how much freedom we should have to make our own decisions.
29. My family and I understand each other completely.
30. We sometimes hurt each others feelings.
31. When things aren't going well it takes too long to work them out.
32. We can't rely on family members to do their part.
33. We take the time to listen to each other.
34. When someone is upset, we don't find out until much later.
- ~~35. Sometimes we avoid each other.~~
36. We feel close to each other.
37. Punishments are fair in our family.
38. The rules in our family don't make sense.
39. Some things about my family don't entirely please me.
40. We never get upset with each other.
41. We deal with our problems even when they're serious.
- ~~42. One family member always tries to be the centre of attention.~~
43. My family lets me have my say, even if they disagree.
44. When our family gets upset, we take too long to get over it.
45. We always admit our mistakes without trying to hide anything.
46. We don't really trust each other.
47. We hardly ever do what is expected of us without being told.
48. We are free to say what we think in our family.
49. My family is not a perfect success.
50. We have never let down another family member in any way.

TABLE 3

FAM Interpretation Guide

1. TASK ACCOMPLISHMENT

LOW SCORES (40 and below) STRENGTH

- basic tasks consistently met
- flexibility and adaptability to change in developmental tasks
- functional patterns of task accomplishment are maintained even under stress
- task identification shared by family members, alternative solutions are explored and attempted

HIGH SCORES (60 and above) WEAKNESS

- failure of some basic tasks
- inability to respond appropriately to changes in the family life cycle
- problems in task identification, generation of potential solutions, and implementation of change
- minor stresses may precipitate a crisis

2. ROLE PERFORMANCE

LOW SCORES (40 and below) STRENGTH

- roles are well integrated: family members understand what is expected, agree to do their share and get things done
- members adapt to new roles required in the development of the family
- no idiosyncratic roles

HIGH SCORES (60 and above) WEAKNESS

- insufficient role integration, lack of agreement regarding role definitions
- inability to adapt to new roles required in evolution of the family life cycle
- idiosyncratic roles

3. COMMUNICATION

LOW SCORES (40 and below) STRENGTH

- communications are characterized by sufficiency of information
- messages are direct and clear
- receiver is available and open to messages sent
- mutual understanding exists among family members

HIGH SCORES (60 and above) WEAKNESS

- communications are insufficient, displaced or masked
- lack of mutual understanding among family members
- inability to seek clarification in case of confusion

4. AFFECTIVE EXPRESSION

LOW SCORES (40 and below) STRENGTH

- affective communication characterized by expression of a full range of affect, when appropriate and with correct intensity

HIGH SCORES (60 and above) WEAKNESS

- inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotions appropriate to a situation

5. AFFECTIVE INVOLVEMENT

LOW SCORES (40 and below) STRENGTH

- emphatic involvement
- family members' concern for each other leads to fulfillment of emotional needs (security) and promotes autonomous functioning
- quality of involvement is nurturant and supportive

HIGH SCORES (60 and above) WEAKNESS

- absence of involvement among family members, or merely interest devoid of feelings
- involvement may be narcissistic, or to an extreme degree, symbiotic
- family members may exhibit insecurity and lack of autonomy

6. CONTROL

LOW SCORES (40 and below) STRENGTH

- patterns of influence permit family life to proceed in a consistent and generally acceptable manner
- able to shift habitual patterns of functioning in order to adapt to changing demands
- control style is predictable yet flexible enough to allow for some spontaneity
- control attempts are constructive, educational and nurturant

HIGH SCORES (60 and above) WEAKNESS

- patterns of influence do not allow family to master the routines of ongoing family life
- failure to perceive and adjust to changing life demands
- may be extremely predictable (no spontaneity) or chaotic
- control attempts are destructive or shaming
- style of control may be too rigid or laissez-faire
- characterized by overt or covert power struggles

7. VALUES AND NORMS

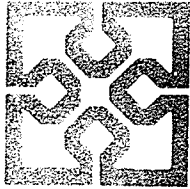
LOW SCORES (40 and below) STRENGTH

- consonance between various components of the family's value system
- family's values are consistent with their subgroup and the larger culture to which the family belongs
- explicit and implicit rules are consistent
- family members function comfortably within the existing latitude

HIGH SCORES (60 and above) WEAKNESS

- components of the family's value system are dissonant resulting in confusion and tension
- conflict between the family's values and those of the culture as a whole
- explicitly stated rules are subverted by implicit rules
- degree of latitude is inappropriate

APPENDIX 2



Health
Sciences
Centre

Dept. of Social Work
Children's Hospital

840 Sherbrook Street
Winnipeg, Manitoba R3A 1M4
Dial Direct (204) - 787-2482

February 7, 1989

Kay Stewart
Misericordia Hospital
99 Cornish Avenue
Winnipeg, Manitoba
R3C 1A2

Dear Kay,

I give you my permission to reproduce, to microfilm
and to xerox the "Consumer Evaluation Questionnaire" as
outlined in my Thesis.

Good luck.

Yours truly,

Susan Powell, MSW

SP/mb



APPENDIX 2

EVALUATION QUESTIONNAIRE

Your answers to the following questions will improve social work service to families within the hospital. Please check off the response which you think best answers each question below. A space for comments is provided in selected questions and at the end of the questionnaire. Thank you for your assistance.

1. How soon after the initial diagnosis was your first contact with the social worker?

At the time of diagnosis Within forty-eight hours
 Within one week One to four weeks
 Over four weeks

2. My first contact with the social worker after the diagnosis was:

Too soon Later than I would have preferred
 At about the right time

3. Did your social worker meet with you in your home as well as in the hospital?

Yes No

If yes, go to 3a; if no, go to 3b.

- 3a. Were the number of home visits:

Too many Not enough About right

- 3b. Would you have liked your social worker to visit your family at home?

Yes No

4. How helpful were the family meetings with the social worker?

Very helpful Helpful A little helpful

Not sure Not at all helpful *made things worse*

Please explain: _____

5. The number of contacts with my social worker were:

Just right Too many Not enough

6. Please examine the list below and place a check beside the topics that you discussed with your social worker:

- The illness itself
- The medical treatment
- The side effects of the treatment
- The long term prognosis of the patient
- Relationships with other family members
- Concerns about the behavior or coping of the patient
- Concerns about the behavior or coping of other family members
- Feelings of sadness
- Anger
- Feeling shocked
- Feelings of helplessness
- Job-related issues
- Financial issues
- Difficulties with sleeping, eating, health
- Relationships within the family
- Services from other agencies
- Other (please specify) _____

7. Please list two main issues or concerns discussed with your social worker:

- a) _____
- b) _____

How much change have you experienced in relation to item a)?

- It is much better It is somewhat better
 It is much the same It has become worse

How much change have you experienced in relation to item b)?

- It is much better It is somewhat better
 It is much the same It has become worse

8. Is there any subject listed above, or not listed above, which you would have liked to discuss with your social worker?

- Yes No

If yes, please specify: _____

9. Would you recommend family meetings as a help for other families facing your illness?

- Yes Perhaps No

10. Would you like to participate in further family meetings with your social worker?

- Yes Perhaps No

If you answered yes or perhaps, how often would you like the meetings to be held?

- As needed
 At any change in the medical condition of patient
 On a regular basis. If so, how often? _____

11. Any other comments you may have regarding the social work service you have received, or on social work services generally for hospital patients and families would be most welcome:

THANK YOU!

APPENDIX 2

RESPONSES TO CONSUMER SATISFACTION QUESTIONNAIRES

The following are the responses to the Consumer Satisfaction Questionnaires.

1. Of the seven returned questionnaires, four had contact with the social worker at the time of diagnosis or within one week. In the other three cases, contact was made with 1 - 4 weeks.
2. Those under one week indicated this to be about the right time and all those over one week felt this was later than they would have preferred.
3. In five out of seven cases, the worker also met with the family in their home. For those two where no home visit was made, both indicated no desire for a home visit. Of the five where home visits were made, four felt the number of visits was about right, one found the visits too many.
4. In response to how helpful the family meetings were, five indicated the meetings were "helpful" or "very helpful". One evaluated the meetings as "a little helpful" and one as "not sure".
5. The number of contacts with the social worker was reported as just right in six cases and too many in one case.

6. The topics covered in sessions with the social worker are reported in the family's returning questionnaires in descending order of frequency:

- the illness itself (6)
- feelings of sadness (6)
- the medical treatment (5)
- concerns about the behaviour or coping with the patient (5)
- difficulties with sleeping, eating, health (5)
- the long term prognosis of the patient (4)
- the side effects of treatment (3)
- relationships with other family members (3)
- concerns about the behaviour and coping of other family members (3)
- feeling shocked (3)
- job-related issues (3)
- financial issues (3)
- relationships within the family (3)
- services from other agencies (3)
- anger (2)
- feelings of helplessness (1)

7. Families were asked to list two major issues or concerns discussed with the social worker. The following issues were listed (their frequency is noted in parentheses):

- health problems (3)

- being unable to work (2)
- concerns for spouse (2)
- spouse's death (2)
- changes in self-image
- need for household help
- daughter's behaviour
- problems with unemployed son
- placement to meet care needs

In relation to the degree of change experienced by the families in the topics listed above, five issues were assessed as much the same, three as somewhat better and six as much better.

8. No topics other than those listed in questions 6 and 7 were identified by any families as issues they had wanted to discuss with the social worker.
9. Five families recommended that the family meetings would be helpful. The other two thought perhaps they would be helpful.
10. When asked if they would like to participate in further meetings, three families stated "no", one family replied "perhaps" and three responded with a "yes". Of the four families that responded with a "yes" to further meetings, three wanted them "as needed" and one "at any change in the medical condition of the patient".
11. Four families added comments in the space provided at the end of the questionnaire. These included:

- "appreciated the care and compassion of (the social worker) when everything looked very bleak";
- "helped to talk over feelings";
- "neither helped nor hindered"; and
- "was nice to know people are concerned".

APPENDIX 3

BECK - DEPRESSION - INVENTORY - SHORT - FORM

INSTRUCTIONS: This is a questionnaire. On the questionnaire are groups of statements. Please read the entire group of statements in each category. Then pick out the one statement in that group which best describes the way you feel today, that is, right now! Circle the number beside the statement you have chosen. If several statements in the group seem to apply equally well, circle each one.

Be sure to read all the statements in each group before making your choice.

A. (SADNESS)

3. I am so sad or unhappy that I can't stand it.
2. I am blue or sad all the time and I can't snap out of it.
1. I feel sad or blue.
0. I do not feel sad.

B. (PESSIMISM)

3. I feel that the future is hopeless and that things cannot improve.
2. I feel I have nothing to look forward to.
1. I feel discouraged about the future.
0. I am not particularly pessimistic or discouraged about the future.

C. (SENSE OF FAILURE)

3. I feel I am a complete failure as a person (parent, husband, wife).
2. As I look back on my life, all I can see is a lot of failures.
1. I feel I have failed more than the average person.
0. I do not feel like a failure.

D. (DISSATISFACTION)

3. I am dissatisfied with everything.
2. I don't get satisfaction out of anything anymore.
1. I don't enjoy things the way I used to.
0. I am not particularly dissatisfied.

E. (GUILT)

3. I feel as though I am very bad or worthless.
2. I feel quite guilty.
1. I feel bad or unworthy a good part of the time.
0. I don't feel particularly guilty.

F. (SELF-DISLIKE)

3. I hate myself.
2. I am disgusted with myself.
1. I am disappointed in myself.
0. I don't feel disappointed in myself.

G. (SELF-HARM)

3. I would kill myself if I had the chance.
2. I have definite plans about committing suicide.
1. I feel I would be better off dead.
0. I don't have any thoughts of harming myself.

H. (SOCIAL WITHDRAWAL)

3. I have lost all of my interest in other people and don't care about them at all.
2. I have lost most of interest in other people and have little feeling for them.
1. I am less interested in other people than I used to be.
0. I have not lost interest in other people.

I. (INDECISIVENESS)

3. I can't make any decisions at all anymore.
2. I have great difficulty in making decisions.
1. I try to put off making decisions.
0. I make decisions about as well as ever.

J. (SELF-IMAGE CHANGE)

3. I feel that I am ugly or repulsive looking.
2. I feel that there are permanent changes in my appearance and they make me look unattractive.
1. I am worried that I am looking old or unattractive.
0. I don't feel that I look any worse than I used to.

K. (WORK DIFFICULTY)

3. I can't do any work at all.
2. I have to push myself very hard to do anything.
1. It takes extra effort to get started at doing something.
0. I can work about as well as before.

L. (FATIGABILITY)

3. I get too tired to do anything.
2. I get tired from doing anything.
1. I get tired more easily than I used to.
0. I don't get any more tired than usual.

M. (ANOREXIA)

3. I have no appetite at all anymore.
2. My appetite is much worse now.
1. My appetite is not as good as it used to be.
0. My appetite is no worse than usual.

APPENDIX 4

SUPPORT NETWORK.

Using the attached form, identify family, friends and professionals from whom you can get help. Write each name beside the appropriate category and answer the next five questions about each person listed.

Under the column Near/Far, put a + if they live within 10 minutes from your home or a - if they are more than 10 minutes drive your home.

For each of the remaining questions, identify the various ways those person(s) assist you by placing an "X" across from their name under the appropriate headings.

1. Who has helped with tasks (i.e., cleaning, babysitting, shopping)?
2. With whom do you engage in social activities (go to a movie, invite home for dinner, go for a ride, talk, play)?
3. With whom do you talk about personal worries or daily stresses?
4. Whose advice do you consider in making important decisions?
5. From whom would you get needed emergency food, clothing or housing?
6. Who can get information, locate resources, introduce you to new friends or professionals?
7. Who keeps you from changing (makes you feel uncomfortable, influences you negatively, keeps you stuck)?

* Indicate those people with whom you have a close emotional relationship by placing an * by their name.

Professionals

Friends

Family

Professionals												Friends												Family												Names
																																				Relationship
																																				Sex
																																				How often are you in contact?
																																				How long have you known this person?
																																				Near/Far
																																				Tasks
																																				Social Activities
																																				Worries
																																				Decisions
																																				Emergency
																																				Information
																																				Blocks Change

Case Number

Family

Assessment

Measure

GENERAL SCALE

Directions

On the following pages you will find 50 statements about your family as a whole. Please read each statement carefully and decide how well the statement describes your family. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE with the statement then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

Please do not write on this page.
Circle your response on the answer sheet.

1. We spend too much time arguing about what our problems are.
2. Family duties are fairly shared.
3. When I ask someone to explain what they mean, I get a straight answer.
4. When someone in our family is upset, we don't know if they are angry, sad, scared or what.
5. We are as well adjusted as any family could possibly be.
- ~~6. You don't get a chance to be an individual in our family.~~
7. When I ask why we have certain rules, I don't get a good answer.
8. We have the same views on what is right and wrong.
9. I don't see how any family could get along better than ours.
10. Some days we are more easily annoyed than on others.
- ~~11. When problems come up, we try different ways of solving them.~~
12. My family expects me to do more than my share.
- ~~13. We argue about who said what in our family.~~
14. We tell each other about things that bother us.
15. My family could be happier than it is.
16. We feel loved in our family.
17. When you do something wrong in our family, you don't know what to expect.
18. It's hard to tell what the rules are in our family.
19. I don't think any family could possibly be happier than mine.
20. Sometimes we are unfair to each other.
21. We never let things pile up until they are more than we can handle.
22. We agree about who should do what in our family.
23. I never know what's going on in our family.
24. I can let my family know what is bothering me.
25. We never get angry in our family.