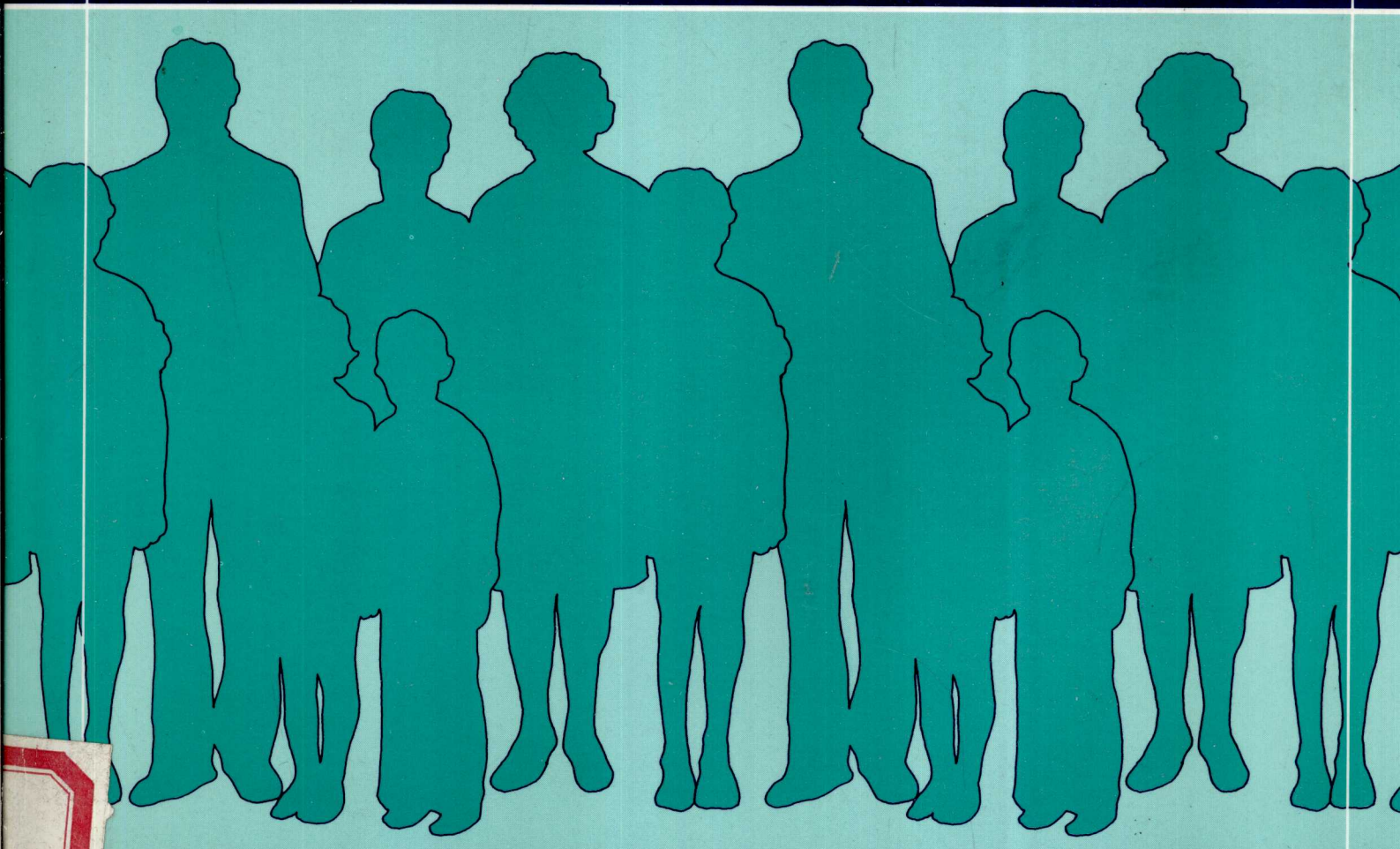
FAMILY NURSING

Second Edition

Theory and Assessment



Marilyn M. Friedman

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Second Edition

Theory and Assessment

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To my family of past and present

Preface

Since I wrote the first edition of this text there has been a noticeable increase in both the number of texts available in family nursing and the number of baccalaureate and graduate courses entitled "family nursing." Moreover, there appears to be, at least among authors of family nursing texts, a growing recognition that family nursing is conceptually and empirically distinct from nursing of family members. Due to the heavy influence of family therapy, family nurses are beginning to "think interactionally" in their writings about the family.

I continue to be struck, however, by the contrast between what is promulgated in the nursing literature, and what actually exists in practice. A family-centered approach remains a stated ideal rather than a prevailing practice—not only in inpatient but also community and clinic settings. A recent literature review which surveyed the literature with respect to the extent to which family assessments were being completed by nurses from various areas in nursing confirmed that the focus is still on the individual (Temple, 1983). Nevertheless, in Temple's study (1983) where she sampled 99 nurses in community, school, inpatient and outpatient settings she found that nurses who were more educated and who had completed courses in which family assessment was taught incorporated family assessment into their nursing practice to a greater extent.

My ardent belief is that health professionals, regardless of the setting must broaden their commitment so that they serve families as units, as well as family subsystems (e.g., parental subsystems) and individual family members. One of the primary obstacles to providing family health care is a lack of substantive knowledge. Vast amounts of literature are available on the family—in the fields of sociology (family sociology), social psychology, anthropology (cross-cultural family studies), family therapy, social work, and nursing. But what do we teach in nursing that actually enables a nurse to work with families? Even though we see growing interest, many schools of nursing do not include adequate family theory in their curriculum to provide the necessary foundation for family-centered practice. In all the health professional programs, there is an enormous concentration on the individual client or patient, with little focus on the family system. No one would negate the importance of studying the client comprehensively, but because the family is greater and different from the sum of its parts, both the familial and individual level of assessment and intervention must be nursing's focus. Sweeney (1970) expresses a similar conviction:

> The difference between philosophy and practice in public health nursing will be reconciled only when the public health nurse internalizes family concepts in relation to the needs of individuals and the needs of the family as a whole. (p. 170)

Not only is there a paucity of knowledge provided in many nursing and other health curricula, but in the nursing literature there is also a serious lack of systematic, comprehensive family assessment tools. Several community health texts have included a family data collection instrument as part of their text, but little related theory or indepth exploration of the related assessment areas.

A comprehensive family assessment tool, based on a structural–functional, family developmental and systems theoretical framework is presented in Part II. Each chapter contains both a theoretical and applied perspective related to one of the assessment areas.

The family assessment process and much of the family theory presented in this textbook represent the product of my teaching of family and community health nursing as well as a graduate seminar in family nursing. I first started out with a very rudimentary tool. Gradually, as the result of insights gained from usage and student and faculty feedback, the family assessment tool grew into a series of self-learning modules which have been incorporated in much of the content within this book. The learning objectives and study questions have been retained from these original modules to assist students with their own learning. The study questions (evaluation) at the end of the chapter test the objectives, and upon successful completion of the study questions the learner will have mastered the chapter objectives.

The assessment content and process presented in the following chapters has proved to be a valuable teaching–learning tool in both undergraduate and graduate courses. One obvious limitation to its usage in its pure form is that it is quite detailed and elaborate, precluding use in everyday practice. I believe, however, that a detailed approach is initially necessary to learn family nursing meaningfully. Once the content and skills are grasped, a more practical, attenuated assessment process may be initiated.

Learning about family theory and assessment has additional benefits. Reiss (1976) believes that the study of family theory and research should help students increase their understanding of human interaction since "the reality of human social interaction is a complex phenomenon, and simple truisms and common sense will not be sufficient to understand it" (p. 399). Robischon and Smith (1977) strongly emphasize the need for nurses to become skilled in family assessment as a requisite for family nursing intervention. With the increasing emphasis in nursing on the nursing process and with assessment being the foundation for practice, I believe that family assessment will grow in importance as has the assessment of individual clients. This is not to suggest that assessment alone provides sufficient knowledge and skill for family health care. Education in family nursing must include discussion and practice in the other nursing process components—diagnosis, planning, intervention, and evaluation.

This book is subdivided into three broad areas. Part I includes four introductory chapters that discuss the family's importance and family definitions; family nursing goals and roles; nursing process; and the basic approaches used in family analysis. The chapter on family nursing roles covers the new thrust of health care—health promotion, wellness training, and prevention of illness and dysfunction. This positive approach to health care is not new. Community health and nursing have been advocating its primacy for a number of years. But because of the present recognition that life style and the environment are the major determinants of disease and illness, and because of the rising costs of crisis-oriented medical care, health promotion and preventive modalities are receiving renewed enthusiasm from both health providers and consumers.

Part II introduces the reader to the actual family assessment model (tool), which forms the core of this text. I have integrated pertinent theory and content within each of the assessment chapters. The large areas of assessment are identifying data including sociocultural data, developmental stage and history, environmental data, family structure, family functions, and family coping. Family structural dimensions are crucial to family assessment since they cover family dynamics consisting of the power structure and role structure, communication patterns and processes, and family values. The affective function, socialization function, and health care function are three essential family functions discussed under family functions. Chapter 18 explains cultural differences among Chicano and black families.

The appendices contain the complete family assessment tool, a family de-

scription (case history), and two family assessments to give students an opportunity to retest themselves on the significant areas of family assessment.

In the second edition of this text, each chapter has been updated and carefully edited—hopefully improving the recency and clarity of the content. One of the major changes in the second edition is in the theoretical framework for the family nursing assessment model. In rethinking my use of a structural–functional theoretical framework (adopting some of the central notions of this framework from sociology)—I shifted to a more eclectic framework. Actually the focus and content areas of the assessment model have changed little. Nonetheless, the conceptualization of the theoretical bases has been altered. I have now broadened the conceptual–theoretical framework to include three major theoretical perspectives: family development theory, general systems theory, and structural–functionalism. By acknowledging these three theoretical bases, a more accurate and clear identification of the theoretical underpinnings for family assessment is obtained. Chapter 4 discusses the text's theoretical bases, as well as the extent to which nursing theories inform family nursing theory and practice.

Discussion regarding the role of the family nurse in health promotion and in assisting families in their own family self-health care has been enlarged in Chapters 2 and 3. And in Chapter 7 (Systems Approach) a description of the holistic paradigm which the systems approach reflects has been added.

Sociocultural theory and assessment has also been elaborated on and is now included as a separate chapter (Chapter 8)—as a basic foundational assessment area. The last chapter in the text, as in the first edition, still applies cultural concepts and assessment content to the black and Chicano families. This chapter underwent a major content revision which involved an updating of relevant family research findings and dispels some of the common stereotypes we have about black and Chicano families.

Communication principles and the functions and importance of conflict and conflict resolution has been added to the communication chapter (Chapter 10). The values chapter (Chapter 13) also underwent a major overhaul reflecting the changing nature of society and our values. In the socialization chapter, a greater emphasis was placed on research findings and the difficulties parents face in rearing children today. And lastly, much attention and care was given to the modification of the family coping chapter (Chapter 17). Since I recently completed research in the area of family coping and ethnic differences in family coping, my enthusiasm and interest in this area and, I hope, its relevancy for family nursing will be apparent to the reader. Both theoretical and research developments in family coping are briefly presented here.

A special thanks go to Dr. Barbara Artinian from Azusa Pacific College, Azusa, California who offered important theoretical suggestions for revising this text. Dr. Ruth Wu, Dean, School of Health and Human Services, California State University, Los Angeles, was also most helpful in assisting me with the writing of Chapter 2. Maxene Johnston, De Ann Young, and Barbara Bailey also need to be gratefully acknowledged for their authorship of Chapters 15 (Johnston) and 10 (Young and Bailey) in the text's first edition. Although in the second edition these chapters were substantially revised, a large part still remains their work. And lastly, my husband continues to support (and tolerate) my writing. He deserves a special "spot in heaven" for his understanding.

Contents

APPENDICES

PART 1

INTRODUCTORY CONCEPTS AND APPROACHES

1

Introduction to the Family

☐ LEARNING OBJECTIVES

1. *Describe the basic purposes the family serves for society, the individual family member, and the health care provider.*
2. *Define:*
   a. *family*
   b. *nuclear (conjugal) family*
   c. *extended family*
   d. *family of orientation or origin*
3. *Describe how family and society mutually affect each other.*
4. *Give examples of how the family influences the health status of its members and how the family is influenced by illness or injury of one or more of its members.*
5. *Define variant family forms and give examples of several types of traditional and nontraditional (experimental) family forms.*
6. *Identify several stressors commonly found in single-parent and step-parent families.*

INTRODUCTION

One of the most important aspects of nursing is the emphasis placed on the family unit. Empirically we realize that the quality of family life is closely related to the health of family members. Up until only recently, remarkably little attention has been paid to the family as an object of systematic study in nursing curricula. Apart from simple evaluative labeling of families with terms such as "good," "problem," "multiproblem," or "disorganized," nurses were generally unable to describe objectively the families they see. Today the study of families and the clinical specialty—family nursing—in baccalaureate nursing programs has grown significantly. Nevertheless, too little research has been devoted to examining the relationships between the family—its structure and functions—and the health and development of its individual members (Brown, Tanner and Patrick, 1984).

This chapter will attempt to set the stage for a systematic study of the family theories and family nursing assessment by describing basic purposes of the family, basic family definitions, how the society and family mutually influence each other, and, most importantly, the salient interrelationship between the health status of family and the health status of its individual members.

Because the family forms the basic unit of our society, it is the social institution which has the most marked effect on its members. This basic unit so strongly influences the development of an individual that it may determine the success or failure of that person's life.

The family serves as the critical intervening variable (or as some authors term it, "buffer" or "bargaining agent") between society and the individual. In other words, the basic purpose of the family is *mediation*—taking the basic societal expectations and obligations and molding and modifying them to some extent to fit the needs and interests of its individual family members. At the same time the family provides new "recruits," preparing children for assuming roles in society (William and Leaman, 1973).

Each family member has basic physical, personal, and social needs. The family must serve to mediate the demands and wishes of all the individuals within the unit. A family is expected to be concerned with the needs and demands of parent(s) as well as children, making it a difficult task to assign priorities to diverse individual needs at any particular time. On the other hand, society expects each member to fulfill certain obligations and demands. Hence, the family has to mediate the needs and demands of the family member with those of society.

Although a number of groups have a mediating function, the family is of central importance in that it is *the* primary group for the individual. Each fam-

ily member belongs to a number of groups, but usually only the family is concerned with the total individual and all facets of his or her life. The highest priority of the family is usually the welfare of its family members. Other groups such as co-workers, church, school, and friends do not have this concern for the complete individual, but usually limit themselves to one facet of the individual's life; for example, cooperation and friendliness at work, sincerity and involvement in church affairs, or productivity and achievement in school. This is not to say that other groups cannot serve as, or even replace, the family. In communes, monasteries, custodial hospitals, kibbutzim, or various rooming situations, nonfamily primary groups may provide this same critical mediating function.

A difference, however, which is not substitutable between these primary groups and the family is that the family still retains the replacement or reproduction responsibility. The other primary groups do not generate new members in order to guarantee the survival of the community.

To restate the family's role, the family unit occupies a position between the individual and society; its functions here are twofold: (1) to meet the needs of the individuals in it; and (2) to meet the needs of the society of which it is a part. These functions, which are fundamental to human adaptation, cannot be fulfilled separately. They must be joined in the family.

For society, the family, through its procreation and socialization of new members, functions to fill a vital need. It forms a grouping of individuals that society treats as an entity; it creates a network of kinship systems that help stabilize a society, even in its industrialized state; and it provides status, incentives, and roles for its members within the larger social system (Lidz, 1963).

The family also functions to meet the needs of its members. For the spouse or adult members it serves to stabilize their lives—meeting their affectional, socioeconomic, and sexual needs. For the children, the family provides physical and emotional care, and concomitantly directs their personality development. The family system is the main learning context for an individual's behavior, thoughts, and feelings. The family's mediating function also protects individuals from direct contact with society.

Parents are the primary "teachers," since parents interpret the world and society to children.* The environment—outside forces—is important mainly as it affects parents, since parents are the ones who are translating to the children the major meanings these outside forces have.

The family has a crucial influence on the formation of an individual's identity and feelings of self-esteem. Minuchin (1977), a noted family therapist, so beautifully summarizes the dual role that the family plays:

> The family, then, is the matrix of its members' sense of identity—of belonging and of being different. Its chief task is to foster their psychosocial growth and well-being throughout their life in common . . . The family also forms the smallest social unit which transmits a society's demands and values, and thus, preserves them. The family therapist, therefore, must see the family as the link between the individual and larger social units. The family must adapt to society's needs while it fosters it's members' growth, all the while maintaining enough continuity to fulfill its function as the individual's reference group. (p. 3)

An individual is the repository of group (especially primary group or family) experience. His or her identity is both individual (intrapersonal experiences) and social (interpersonal experiences). A person's intrapsychic experiences are largely developed from his or her interpersonal experiences, e.g., through the parent-child relationship. It has been repeatedly found that a meaningful conception of an individual's mental health status can be achieved only as we relate the functioning of the individual to the human relation patterns of that person's primary group or family.

Why Work with the Family?

In the preface it was noted that family-centered practice has been promulgated by community health nursing for quite some time. Why has there been the emphasis on working with families? Tinkham and Voorhies (1977) believe that the family provides the critical resource for delivering efficacious health services to people. They refer to the family as being the community health nurse's "patient," with the major focus being family health needs and their resolution.

The following are the most cogent reasons why the family unit needs to be focused on:

1. There is the belief that in a family unit, any dysfunction (illness, injury, separation) which affects one or more family members may, and frequently will, in some way affect other members and the unity as a whole. The family is a closely knit, interdependent network where the problems of an individual "seep in" and affect the other family members and the whole system. If a nurse assesses only the individual and not the family, she or he may be missing the gestalt needed to gain a holistic assessment. One of the important tenets of family therapy is that the symptoms of the identified patient (the family member with the overt behavioral

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* *The interpretation parents give of the world and society is naturally based on their experiences and their "reality." If they have been discriminated against or lived in a crime-ridden community, they may see the world as being "dangerous," "hostile," a place to avoid, and thereby impart these perceptions to their children. If, on the other hand, the world has provided stability and security for them, this perspective will be transmitted to their children.*

problems or psychosomatic illness) are indices of family pathology.
2. There is such a strong interrelationship between family and health status of its members that the role of the family is crucial during every facet of health care, from preventive strategies through the rehabilitative phase; thus assessing and rendering family health care is critical for assisting each family member to achieve an optimum level of wellness.
3. Through family health care that focuses on health promotion, "self-care," health education, and family counseling, significant inroads can be made to curtail risks which life style and environmental indiscretions create. The goal is to raise the level of wellness of the whole family, which should then significantly raise the wellness level of each of its members.
4. Case finding is another good reason for providing family health care. The presence of health problems in one member may lead to discovery of disease or risk factors in other family members; this is often the case when visiting families with chronic health problems or communicable disease. The family-centered nurse works through the family to reach individuals.
5. One can achieve a clearer perspective of the individual and his or her functioning when the person's family is also assessed. This enables the nurse to view the individual in his or her primary social context.

THE FAMILY-SOCIETY INTERFACE

As the basic unit in society, the family shapes and is shaped by the external forces (community, large social systems) surrounding it. Most sociologists would agree that the influence of society on the family is greater than that of the family on society, although the family exerts an effect on the society also. In spite of the greater impact society exerts on the family, the family should not be considered a passive, reactionary agent in the process of social change. Throughout history the family has demonstrated tremendous resiliency and adaptiveness, just as political, educational, and other societal institutions have shown their ability to change as need dictates. Moreover, the forces operating in society and in the family are continually intervening, interacting, and changing.

Tinkham and Voorhies (1977) point out that tacit sanction by society of the communal form of group living, for instance, has modified socialization patterns of the family. The adulation of youth by society has completely altered the function of the family relative to its role in assisting parents and grandparents. Society, with its beliefs, values, and customs pervades every facet of family life such as the age at which children may go to work and the age at which they are legally given adult status. Society also sanctions illness definitions, sick role behaviors, and the appropriateness of treatments.

On the other hand, the family influences society, which in turn may alter social norms. Tinkham and Voorhies (1977) again cite a case in point by explaining that when families socialize their children to settle disputes and conflicts by nonviolent means, the use of war as a means for handling disputes becomes a less acceptable strategy. Also the egalitarian roles which women have assumed in family life have made drastic changes in the way society now views women and their roles and capacities.

The controversies over family planning services and, later, abortion laws exemplify the way in which the family exerts pressure on society to change. With rising expectations and economic strain, families have pushed for health legislation and funding for birth control services.

The great forces of a modern industrial nation, with its emphasis on individual achievement and autonomy, have been effective in shaping family patterns in such a way that the atomistic nuclear family has emerged. Its organization is more geared to the needs of a complex, urban, industrialized society (Goode, 1964).

The nuclear family structure, however, is not unique to this postindustrial society; apparently the nuclear family has been the predominant kinship structure in the past (Laslett, 1971). Despite the long-standing belief associated with a nostalgic view of the family in agrarian, preindustrial times, that many kinfolk lived together, the nuclear family—a group composed of parents and their children only—was the most common type of domestic unit. Given the high mortality characteristic of these societies, the number of persons that lived long enough to become grandparents and share a household with their married children and grandchildren was extremely limited. In addition, families were larger, so that there were not enough grandparents to spread around to the grandparents' offspring. The extended family households that did exist—those which included kin beyond the nuclear family—were likely to be among the rich, who had sufficient resources to support additional family members.

HEALTH STATUS OF FAMILY AND FAMILY MEMBERS

Health and illness behavior are learned, and the family is the primary source for health education. In one way or another, the family tends to be involved in the decision making and therapeutic process at every stage of a family member's health and illness, from the state of being well (when promotion of health and preventive strategies are taught) to diagnosis, treatment, and recuperation. The process of becoming a "patient" and receiving health services

encompasses a series of decisions and events involving the interaction of a number of persons, including family, friends, and professional providers of care. Generally speaking, the role the family plays in the process varies over time depending on an individual's health, the type of health problem, i.e., whether it is acute, chronic, severe, etc., and the degree of familial concern and involvement. Six stages of health/illness* will be presented to further illustrate the family's major involvement.

Prevention of Illness and Promotion of Health

The family can play a vital role in all forms of health promotion and prevention. Modern medical science has produced vaccines and suggested preventive behavioral measures such that many forms of illness can be avoided. Vaccines for poliomyelitis, measles, mumps, smallpox, and diphtheria are among the more common vaccines available to the public for preventive purposes. Smoking, lack of exercise, poor diet, high blood pressure, prolonged stress, and obesity have been well documented as factors influencing the occurrence of coronary heart disease and other major diseases, and preventive behaviors have been recommended to reduce their deleterious effects. Many other examples of recommended preventive practices could be cited, but these few suffice to make the point that many forms of health promotion and prevention exist. Whether a child gets a particular vaccine, whether a father is encouraged to get more exercise and eat less, or whether a mother receives proper prenatal care, all involve family decisions and participation to a great degree. *Public health begins in the family.* Wellness strategies usually require improvements in the life style of an entire family, and varying degrees of conflict may ensue because of the wider impact on the family. Moreover, an individual's body image and self-view—as either being healthy and active, or sickly and frail—are learned largely within the family context.

Symptom Experience Stage

The symptom experience stage begins when symptoms are (1) recognized, (2) interpreted as to their seriousness, possible cause, and importance or meaning, and (3) met with varying degrees of concern.

The family serves as the basic point of reference for assessing health behavior and provides basic definitions of health and illness, thus influencing the individual's perceptions. In the American family, the mother is frequently the major determiner of the health behavior in the family. Litman (1974) reported in family studies he conducted that the mother acted as health decision maker 67.7 percent of the time, while the father acted in this capacity only 15.7 percent.

Disease and socioeconomic status are interrelated. In general, there exists an inverse relationship between prevalence rates and socioeconomic status, resulting from the greater susceptibility of lower income groups to disease. This inverse relationship also reflects the fact that members of lower income groups are slower to respond to initial symptoms or may not recognize symptoms as signs of disease or as needing medical attention (Koos, 1954). The family exposes its members to health hazards and provides the basic interpretations of symptoms.

Families not only influence recognition and interpretation of symptoms of illness, but they may be the *genesis* of illness among family members. Family social disorganization often has negative health consequences for family members. A variety of specific health problems have been found more frequently in "socially disorganized families," among them tuberculosis (Holmes, 1956), arthritis (Scotch, 1962), mental disorders (Leighton, Harding, Macklin et al., 1963), hypertension (Harburg et al., 1973), coronary heart disease (Syme, Hyman, and Enterline, 1964), and stroke fatalities (Neser, 1975). The classic Newcastle-upon-Tyne studies (Spence, 1954) showed the pervasive influence of family on health. When deprivation, deficiency of care, and dependence on community were all present within a family, there was a higher incidence of infections, enuresis, short stature of children at age 3, convulsions, and strabismus. This study also showed a higher incidence of streptococcal infections and childhood accidents following an acute family crisis.

The Care-Seeking Stage

The care-seeking stage begins when the family decides that the ailing member is really sick and needs help. The ill person and family start to seek alleviation, information, advice, and professional validation from extended family, friends, neighbors, and other nonprofessionals (the lay referral structure). The decisions as to whether a member's illness should be treated at home, a medical clinic or hospital tends to be negotiated within the family. For example, Richardson (1970), in a study of low-income, urban households, found that about one-half of those with illnesses reported consulting another family member concerning what they should do about the situation. Knapp et al. (1966) also found that the family was the most frequently mentioned source of information concerning home remedies and self-medication.

Not only does the family provide the basic definitions of health, but family members may press the individual into this stage if they believe he is failing to react favorably. This process is extremely difficult for the family, particularly when a psychiatric disorder is the major problem. This is because it may mean that the family must label the person as mentally ill and isolate him and/or acknowledge their

* *The following six stages represent an adaptation of Suchman's (1965) five stages of illness and medical care.*

own feelings of guilt and shame. The problem is compounded when the affected person denies the disorder or blames the family (Vincent, 1970).

The Medical Contact Stage

This stage commences when contact is made with a health agency/professional. Studies have clearly shown that the family is again instrumental during this stage. The family (usually the mother-wife) will refer a family member to whatever type of service is felt appropriate. The family, serving in this capacity, is referred to as "the primary health referral agent" (Williams and Leaman, 1973).

In the 1950s Koos (1954) noted that while families may consult a different physician in special circumstances, the family doctor remains the one to whom they turn for all the family's ordinary medical needs. This pattern probably still exists among many inner-city, poor families due to the lack of availability of specialists. Most health data, however, show that emergency rooms are fast becoming the poor family's most common resource for initial medical care. Among working and middle-class families, there has been a growth in the number of families making use of group practice arrangements and medical clinics (Litman, 1971).

The type of health care sought varies tremendously. The folk practitioner, the unorthodox "healer," the holistic health practitioner (using sometimes esoteric modalities such as hair analysis and iridology), the superspecialist (such as a neurosurgeon), the independent nurse practitioner, and the primary care physician should all be considered as possible sources of health care (thus broadening antiquated definitions of medical care).

We know that families with higher income, families with children present in the home, and families who have resided in the community for some time usually have a regular physician or source of health care and that the reverse is often true—families not possessing one or more of the above characteristics do not routinely make use of the same care source (Wolfe and Badgley, 1972).

How do families decide what clinic or health provider to contact? While such variables as acceptability, appropriateness, perceived adequacy of service, and seriousness of condition are important, the proximity to a primary care facility seems to be a prime determinant of whom families contact. In other words, the closer the facility, the greater the usage factor (Abernathy and Schrems, 1971).

The Dependent-Patient Role Stage

As the patient accepts care of health practitioners, he or she surrenders certain prerogatives and decisions, and is expected to assume the patient role, characterized by a dependence on the health professional's advice, the willingness to comply with medical advice, and a striving to recover. Parsons (1951) coined this social state, "the sick role." How this role is further defined and enacted at home will be individually determined within each family. Some families exclude the sick member from all responsibilities and "serve and assist" to the fullest extent. Other families expect little change in the ill member's behavior, hoping that he or she can carry on as usual; this way of handling is seen frequently when it is the mother who is sick. Litman (1974) explains the difficulty mothers often have when sick:

> In view of both her rather pervasive and pivotal role as an agent of cure and care within the family setting, the mother may find it not only extremely difficult to fulfill her obligations to all the members of the household when one or more is ill, but she may experience considerable difficulty in maintaining her normal role and responsibility when she herself is the one who is ill. (p. 505)

Hence, mothers generally have a great deal of reluctance in accepting a patient role.

Thus the family unit plays a pivotal role in determining the sick member's patient role behaviors. The family is also instrumental in deciding where the treatment should be given—hospital, home, clinic, etc. Efforts to treat illness and promote good health may often conflict with family values and attitudinal patterns, making medical compliance problematic.

The Rehabilitation Stage

The presence of a serious, chronic illness in one family member usually has a profound impact on the family system, especially to its role structure and to the carrying out of family functions. The disruptive effect may, in turn, negatively affect the outcome of rehabilitation efforts. Can the patient reassume his or her prior (preillness) role responsibilities or is he or she able to establish a new, "workable" role in the family? The way in which this question is solved usually has to do with two factors: (1) the seriousness of the disability and (2) the "centrality" of the patient within the family unit (Sussman and Slater, 1963). When either the nature of the person's condition is serious (greatly disabling or progressively deteriorating) or the family member is a pivotal, crucial person to the family's functioning, the impact on family is much more pronounced.

Families play an important supportive role during the course of a client's convalescence or rehabilitation. In the absence of this support, the success of convalescence/rehabilitation decreases significantly.

In summarizing the six stages of illness and medical care, Haggerty (1963) highlighted the ways in which families influence the health of their members as being (1) a cause or the source of illness, (2) a factor affecting the outcome of illness once present, (3) a locus for spread of illness from one family member to another, and (4) a determinant of who is brought to the doctor and when.