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FAMILY REACTION
TO STROKE IN
THE WORKING FATHER

by

JANET BERNICE BEREZOWSKY

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
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FALL, 1979

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "Family Reaction to Stroke in the Working Father" submitted by Janet Bernice Berezowsky in partial fulfilment of the requirements for the degree of Master of Education.

Supervisor

J.W. Vargo

Date Aug. 30, 1979

- Dedication -

To the memory of the late Dr. D.G. McKerracher who regarded those in his care first as people and then as patients.

Abstract

Relatively little research has been done into the effects of illness or disability on the family. Studies in the area have been largely retrospective. A major problem with this approach is that the effects on the family may not have been due directly to the disability but rather to family process in which the disability was but one factor. Another problem with many of these studies is that they failed to control for the time since disability onset. Consequently, the findings may represent an interim step in the adjustment to disability rather than the final outcome of disability.

This research was designed to study the reactions of families with dependent children to the occurrence of a stroke in the working father. The case study approach was employed in order to trace the process through which the families adjusted to the situation. A series of semi-structured interviews was conducted with two families in which the father had recently suffered a stroke. The data collection guide and guide for analysis of data employed in the study incorporated concepts from Montgomery's (1978) family crisis model, Parsons' (1972) sick role theory, and Wright's (1960) conceptualization of disability acceptance.

The objectives of the study were: (a) to determine whether the father's stroke precipitated a family crisis, (b) to identify the problems which families encountered subsequent to the father's stroke, (c) to describe the problem solving strategies which the families employed, and (d) to determine to what extent the families related to the father as a "sick man". In both families a stroke in the father did lead to a family crisis. In one family the crisis had been resolved, in the other it had not. Financial problems were experienced in both families. Health problems and relationship problems were also experienced by the family which had not resolved its crisis. Problem solving strategies were democratic in the family that resolved their crisis, whereas they were autocratic in the other family. The significance of the sick role was not demonstrated in either family. Family dynamics were considered to be a more significant influence in determining the role expectations which the families held for the disabled father.

The results are discussed in terms of the differences between the two families which might account for the successful crisis resolution by one and the continued struggling of the other. Implications of the findings for rehabilitation workers are presented and suggestions for further research are offered.

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J.B.B.

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All things change,
and we must change with them.

- Lothair, ca. 840 A.D.

CHAPTER I

INTRODUCTION

Although the effects of disability on the family have not been widely researched, it is generally recognized that illness of a family member tends to disrupt the family's customary pattern of functioning (Anthony, 1969; Kaplan, Smith, Grobstein & Fischman, 1973; Parsons, 1972). Moreover, the family's response may drastically affect the outcome for the sick member (Gordon, 1966; Litman, 1962; Olsen, 1970). This research is designed to study the way in which the family deals with the demands imposed upon them following a stroke in the working father.

Weiss (cited in Hodgins, 1964) describes well the complexity of the problem.

> Few situations in life [as a stroke] so disturb and disrupt a home. A man or woman previously considered healthy is suddenly helpless, paralyzed on one side, perhaps unable to speak, perhaps unconscious, and certainly confused or childish.
>
> The first question, of course, is sheer survival. In most instances the patient does survive, and then follows a trying period for everyone.... Gradually the responsibility for care must be shifted to the patient himself.
>
> I say gradually because this is the essence of the problem psychologically. Not only has the brain been damaged, but the patient undergoes psychological regression as the result of his illness. That means

> in some respects he becomes childish and overly dependent. Slowly he will have to become a mature person again - it is impossible to hurry these things - as independent as his incapacity or disability will permit. His wife must be staunch enough to assume responsibility in the beginning and yet be willing to shed it later on as an essential feature of her husband's recovery. (pp.189-190)

To gain an understanding of the impact of disability on the family, one can approach the study from several different perspectives. Disability is frequently conceived of as a loss (of a body function or body part) which initiates a process of mourning similar to bereavement (Janis & Levanthal, 1965; Parkes, 1972; Vargo, 1978; Wright, 1960). This perspective has been used primarily for studying the disabled individual's response to disablement, although it was recognized as early as 1953 that the family moves through a very similar process.

> The sharer suffers [also] , not only because the injured person suffers (sympathy) but because he also experiences a loss (personal and social loss). A wife may feel the loss of her husband's leg just as personally, just as deeply, as the husband himself. The sharer, therefore, has to accept the loss, just as does the injured person, before suffering may be overcome. (Dembo, Ladieu, & Wright, 1953, p.95)

The process of disability acceptance as described by Wright (1960) has been used as a framework for examining the family's response to stroke in the working father. This model builds on the classic work of Dembo, Leviton, and Wright (1975) which was first published in 1956[1].

---

[1] Dembo, T., Leviton, G.L., and Wright, B.A. Adjustment to misfortune - a problem of social psychological rehabilitation. Artificial Limbs, 1956, 3(2), 4-62. (Original publication.)

Sick role theory, based on the early work of Parsons (1972)[2] offers another perspective for studying the effects of disability on the family. Within this framework, the family's reactions are dealt with in terms of their role expectations for the disabled member. Role change, complementarity of roles, and role conflicts are of primary concern within this framework. Sick role theory has been used in this study as a framework for studying the expectations of family members concerning appropriate behavior toward the disabled father.

A third perspective which has received relatively little application to studying the effects of disability on the family, is the family crisis perspective. Within this framework, disability of the father would be conceived of as a potential crisis-inducing stimulus. The crisis is conceived of as a family problem, requiring the participation of all family members for its resolution. Family resources, family problem solving strategies, and family interaction are of primary concern when studying family crisis.

A major deficiency in much of the rehabilitation research is that the length of time following disability has not been controlled. This weakness fails to account for the process of adjustment which has been well documented in the literature. To report a variety of effects and relate them causally to the event of disability, without recognizing that, in many cases the changes may represent interim steps in an ongoing process, reduces the generalizability of the results to a very low level. This is most likely in studies in which the subjects include those from disability onset to say, two years post-disability.

---

[2] Parsons, T. The social system. New York: Free Press, 1951. (Original publication.)

It is for this reason that two models which deal with process were selected. Montgomery's (1978) conceptual model provides one of the most comprehensive descriptions of family crisis available. It describes the process by which the family recognizes their problem, how they define it, develop problem-solving strategies and apply them to their situation. According to Montgomery, the occurrence of stroke in the working father may initiate the crisis process. The second process model used in this study is that provided by Wright (1960).

To avoid the pitfalls of rehabilitation research which were mentioned earlier, the case study approach was selected. This approach is better suited to eliciting process information than is a single sampling technique. Furthermore, since the area has received relatively little research attention, it is more appropriate to use an exploratory approach with the goal of identifying a variety of factors which may affect the problem in question.

The objectives for this study of family reaction to stroke in the working father are listed below. They are derived from the work of Wright (1960), Parsons (1972), and Montgomery (1978). It is the intention of this research:

1. To determine whether the occurrence of a stroke in a working father precipitates a family crisis.
2. To identify the kinds of problems which families encounter during the early post-stroke period.
3. To describe the ways in which the family deals with the problems which they encounter.
4. To determine the effect of the father's incapacity on the family's problem solving approaches and on their acceptance of his condition.

CHAPTER II

THEORY AND RELATED RESEARCH

This study takes as its base concepts from three bodies of literature. It is concerned with the relationship between disability acceptance, the sick role, and family crisis. In this chapter relevant concepts from each of these areas will be reviewed in turn. Research questions arising from the literature review will be presented at the conclusion of the chapter.

Disability and Loss

Neff and Weiss (1965) state that "... the central core of the psychological aspects of disability has to do with the psychodynamics of loss" (p.789). Adjustment to physical disability is commonly seen as the process of reconciling a loss (Janis & Levanthal, 1965; Parkes, 1972; Vargo, 1978; Wright, 1960). When acceptance of disability is seen as a process through which the individual comes to cope with a significant loss, Lindemann's (1944) classic work on grief and Kubler-Ross's (1969) renowned work with dying people are useful sources for increasing our understanding of adjustment to disability. Their descriptions are strikingly similar to that offered by Wright (1960) who focuses on the process of adjustment to disability. The work of Wright (1960) builds on the earlier work of Dembo, Leviton, and Wright (1975) which, since its publication in 1956, has come to be recognized as a classic in the field of rehabilitation. The description of the process of disability which follows is based on the framework provided by Wright (1960).

The Process of Adjustment to Disability

Wright (1960) describes three sequential stages which persons adjusting to disability move through. They are: denial, mourning and acceptance. The stages are not mutually exclusive: fluctuation back and forth between stages is common. Acceptance of disability is conceived of as a social psychological process shared by the disabled person and his close associates as they deal with the impact of disability on their relationships.

Although most accounts of adjustment to disability which are reported in the literature focus on the disabled person, family reactions have been studied by a small number of researchers. Their findings will be incorporated into the following description of the process of adjustment to disability.

Denial. Some authors describe an initial shock reaction which occurs almost immediately following the first awareness of loss and acts as an emergency defense (Fink, 1976; Lindemann, 1944; Neff & Weiss, 1965; Shands, 1955; Weller & Miller, 1977a). The individual, overwhelmed by stress, manifests disorganized and unproductive behavior such as weeping, panic, hysteria, or total passivity. He may experience intense anxiety, confusion, helplessness, or depersonalization. This reaction is usually brief since the individual cannot long endure the intense stress and begins to employ the self protective measures of denial. Even while showing the highly chaotic behavior of shock, the individual frequently makes remarks such as: "This is not me", and "This has not happened" (Kerr, 1977; Shands, 1955), which suggest that he is denying his situation. The individual's rapid shift from shock to denial combined with research reports based on retroactive studies may account for the combination of these stages by authors such as Wright (1960) and White and Gathman (1974).

Denial is a protective mechanism used by the individual to control the intense anxiety associated with the reality of his situation (Vargo, 1978; Weller & Miller, 1977a). It provides a temporary solution to his crisis (Siller, 1977) in that the intense emotion associated with his situation is repressed until he can muster the psychological strength to face the dreaded reality. Denial may be manifest by a lack of concern about one's condition, active denial of the severity of the condition, or denial of the implications of the injury (Weller & Miller, 1977a; Wright, 1960).

Denial may be used selectively by individuals well beyond the initial stages of adjustment. Wright (1960) refers to this as "as if" behavior (p.20). In this instance the individual acts "as if" he were normal or nondisabled by concealing his disability in interpersonal relationships. Wright contends that this behavior is frequently used as a defense against the experience of devaluation and that it often restricts social interaction rather than promoting it.

> The price of trying above all to hide and forget is high. It is high because the effort is futile. A person cannot forget when reality requires him to take his disability into account time and again. The vigilance required for covering up leads to strain, not only physically but also in interpersonal relations, for one must maintain a certain distance in order to fend off the frightening topic of the disability. (Wright, 1960, p.24)

Family members also manifest signs of intense anxiety and denial (Bray, 1977; Weller & Miller, 1977b). Initially they often fear that their disabled member will die. As this fear subsides they frequently become obsessed with the care of their loved one and question the competence of hospital staff. Occasionally family members will avoid any contact with the disabled. As the patient's denial begins to control his initial shock, family members generally support it by maintaining an optimistic view of recovery and avoiding expression of their own emotional pain, focussing on the routine aspects of care, and actively protecting the patient from receiving any distressing information.

At this stage families are usually very threatened by counselling since their coping is tenuous, based on denial of a reality (Weller & Miller, 1977b) which they are not yet prepared to deal with. However, the prolonged use of "as if" behavior can be damaging to their relationships.

> If the formal surface behavior which is appropriate to stranger relationships persists, they [the family] will begin to feel like strangers to each other. Closeness, which is built upon easy communication, sharing of feelings, the warmth of sympathetic interactions, gives way to estrangement. Basic understanding between the persons cannot be reached. (Dembo, Ladieu & Wright, 1953, p.85)

Initiated by any experience which closely resembles "normal living" such as a weekend pass home from the hospital, the disabled member's denial begins to give way to mourning (Kerr, 1977). This may be seen as a turn for the worse by the family whose security depends upon acting "as if" nothing were troubling them. The task of mourning involves gradually coming to terms with the painful experience of loss, the very thing which their denial was employed to avoid.

Mourning. Mourning represents the phase in which the loss (of a body part or function) is gradually worked through. For Siller (1977) and Weller and Miller (1977a) mourning is crucial in response to any kind of severe disability. It involves bringing into the present the myriad of memories and dreams associated with that which has been lost and gradually severing the ties with the valued state that was (Freud, 1917/1960; Lindemann, 1944; Parkes, 1972; Wright, 1960). Freud (1917/1960) referred to this as "the work of mourning".

Others (Barker & Wright, 1953; Geis, 1972; Vash, 1975) consider the experience of devaluation to be central to the mourning process. Absorbed by what is different about himself and about himself in relation to others, the individual readily perceives himself as less equal than his associates. This contributes to feelings of worthlessness as a person. It is likely that deinvesting in memories of one's past non-disabled state and overcoming devaluation effects are interrelated aspects of mourning.

Fink (1976) suggests that mourning occurs about the time that physical recovery reaches a plateau. During mourning the individual's energy and attention are directed to his changed situation. He experiences his loss in terms of the personal and social satisfactions which are now denied him (Wright, 1960). He may show both anger and depression as he gradually comes to terms with the implications of his disablement. Some authors (Kubler-Ross, 1969; Weller & Miller, 1977a) describe these reactions as separate stages. However, Wright (1960) concludes that they are but different aspects of the same process.

The mourning phase has been described by Fink (1976), Kerr (1977), Lindemann (1944), Parkes (1972), and Weller and Miller (1977a). Their descriptions include feelings of vulnerability, helplessness, emptiness, worthlessness, frustration, guilt and resentment. These feelings may be manifest through overt hostility, irritability, withdrawal, extreme dependency, hopelessness, or a lack of motivation.

Lindemann (1944) and Weller and Miller (1977a) contend that early and acute depression following the loss is usually associated with a shorter period of mourning and a more successful adjustment to the changed situation. They consider grief not only appropriate but essential for a satisfactory outcome. However, grief work cannot be hurried (Siller, 1977); it can be accomplished only at the rate with which the individual can handle his increasing awareness of his condition. Neither is mourning a task which can be done and cleared away as a fait accompli. "It is experienced intermittently after the deepest pangs are mitigated" (Wright, 1960, p.115).

For the family, mourning is usually the most difficult phase to cope with. In part, this is because they too become depressed (Weller & Miller, 1977b). Energy to deal with their own feelings and those of their disabled member reaches a very low level. Faced with the grim reality, they may experience feelings of hopelessness, revulsion, guilt, frustration, exaggerated responsibility, and helplessness. In an attempt to cope with their own feelings, they may avoid contact with the disabled or they may promote extreme dependency. Grieving openly with their disabled member usually requires the support and encouragement of staff members (Weller & Miller, 1977b).

Acceptance of the disability and the resumption of ordinary life activities cannot occur until grief has been adequately expressed. A discussion of the adaptations involved in the transition from mourning to acceptance will follow.

<u>Acceptance</u>. Acceptance of disability does not mean succumbing to one's unfortunate state but rather adapting to the situation so as to

continue one's life by minimizing the disruptive disability-related effects. In order for this to be achieved, changes in one's value system are necessary (Dembo, Ladieu & Wright, 1953).

Vash (1975) provides a personal account of the value changes associated with her disability.

> When I did [accept my disability], it wasn't at all like the staff and the literature had envisioned. It wasn't even defusing the disappointment that I would never again hear whistles when I walked, or dance, or ride in a horse show, or walk alone in the rain, or go to the bathroom by myself. It sure as hell wasn't the much touted process of discovering substitute gratifications for the ones I had lost.
>
> It was more like those things not only didn't matter any more, they wouldn't have mattered even if I could still have done them. I didn't need to be able to do them, or mourn their loss - in order to maintain some image of myself. I felt I understood the relinquishments that come with age. Joys of an earlier era are continuously "put away". Substitutions needn't be sought; new joys simply emerge, appropriate to the new era. I found myself no longer afraid of aging. Acceptance of disability was simply acceptance of myself; and there were parts of me that were harder to accept than my disability by far. I didn't have the language then, but from personal studies I've done since, acceptance of disability was exactly the process the Western interpreters of Eastern mystics speak of as "centering", "ridding oneself of Ego", and "casting off attachments so they become, at most, preferences". The fact that a few of these attachments were ego-images and activities interfered

> with by disability was just one happenstance of a much larger process. (pp.152-153)

In the acceptance stage, which Fink (1976) suggests begins once physical functioning has reached its optimum, disability is no longer seen as a barrier. The individual reorganizes his perception of his resources and abilities and gradually resumes his more usual activities (Fink, 1976; Kerr, 1977). The family, in turn, develops accommodative patterns which include the disabled as an active participant rather than the focus of family life. Previously hidden feelings of anger and guilt are frequently expressed by family members. As they are resolved the family unit resumes its usual way of life (Bray, 1977). The value changes which they must make in the process are described below.

Dembo et al (1975; 1953) and Wright (1960) identify four interrelated changes which must be made within the person's value system in order that mourning can be overcome and acceptance of loss can be achieved. They are (a) enlarging the scope of values, (b) containing disability effects, (c) subordinating physique, and (d) transforming comparative values into asset values. Each of these changes will be described briefly.

The grieving individual, preoccupied with his loss, attends to that which has changed and pays little attention to that which remains unchanged. His energies are concentrated on the loss aspects of his disability. Consequently, he is aware primarily, of only those values which have been affected by his disablement. Values not affected by his injury do not concern him.

The scope of values can be enlarged through a variety of adaptations. The individual may come to see, in a new way, a value which he had presumed lost. For example, he may come to appreciate that he valued walking as a means of locomotion and that a wheelchair enables him to maintain that value. Comparison of one's state with that of others frequently enables the individual to recognize values which he holds but which he had not been cognizant of. Dormant values may be aroused, as for example, religious or social service inclinations. And involvement in the necessities of daily living may illuminate capabilities and values which the individual had not previously acknowledged.

Due to the effects of, what Wright refers to as spread (1960; 1977), a disturbance in physique leads to assumptions about defects in other non-affected parts of the person. Spread would account for the overprotection of a disabled child and for the tendency to raise one's voice when speaking to a blind person. The effects of spread would also explain the view that achievements of the disabled are compensatory rather than demonstrations of abilities not related to the disability. While it is evident that public attitudes contribute to the devaluative effects of spread, the disabled individual, through his daily experiences, can come to appreciate that that aspect of physique which has changed is associated with but a small number of the experiences available to him. In essence, by containing disability effects, he will be able to view himself not as a disabled person, but as a person with a disability.

In our society physical beauty and physical competence are highly valued. The disabled person commonly views himself in relation to these standards and feels devalued because he does not measure up. Subordinating physique requires that other standards such as personality be given priority in assessing one's value as a person.

Use of comparative values involves evaluation against a standard, whereas use of asset values involves evaluation based on qualities inherent in the object of judgement itself. "... if the non-injured remains the wished for ideal, no matter how often he does as well or better than the non-injured, he will still devaluate himself as an imperfect non-injured person" (Dembo, Ladieu & Wright, 1953, p.82). To move from a comparative frame of reference for self evaluation requires that the individual come to accept himself as the person that he is; that he come to recognize that his disability represents but one aspect of his being. This awareness would be characteristic of acceptance.

This section of the review of literature has related the process of disability acceptance to reconciliation of a loss. It has described the stages of acceptance namely; denial, mourning, and acceptance in both the disabled and the family. The following section provides a review of family crisis theory and research into the effects of disability on the family.

Family Crisis

Although the emphasis is different, common ideas are contained in the varied definitions of family crisis. Families who are forced by a problem situation to change their usual way of doing things would be said to be in crisis (Farber, 1964; Hill, 1958; Montgomery, 1978; Parad & Caplan, 1965). They characteristically experience a threat to their continued existence in the face of their need to change. Their previous sense of equilibrium is eroded by the effects of the crisis-precipitating event, leaving them to develop new patterns of functioning as a family in their changed situation. Resolution of the crisis, together with an accompanying reduction in the stress which they are experiencing is dependent upon their ability to develop new and appropriate approaches for dealing with the demands of the problem.

Family crisis is not an isolated experience of a small number of unfortunate families who are ill-equipped to deal with their social obligations, but rather an experience common to all families at one time or another (Waller & Hill, 1951). What varies from family to family is the way in which they confront the task of modifying their patterns for handling their affairs (Hill, 1958).

Burgess (cited in Waller & Hill, 1951) and Hill (cited in Waller & Hill, 1951) contend that the type of crisis-provoking event will strongly influence the family response. On the other hand, Angell (cited in Waller & Hill, 1951) and Cavan and Ranck (cited in Waller & Hill, 1951) emphasize internal family characteristics such as integration and adaptability in predicting the outcome of family crisis. Farber's concern (1964) is with the interaction process through which the family deals with the crisis. Consideration of each of these factors in isolation permits only a limited understanding of family crisis; an integration of knowledge from these viewpoints is likely to prove more useful. Montgomery's model (1978) offers such an approach. A review of his conceptualization of family crisis follows.

Montgomery's Conceptual Model of Family Crisis

The underlying premise of Montgomery's model (1978) is that change, although necessary for all families, is not easily achieved (p.7). His conceptualization of the family, as a dynamic organization, in which the mere passage of time presents a series of predictable demands, provides the basis for the requirements of change. He draws here from the developmental model for family study (pp.9-11). It is from the systems model of the family that he derives the second aspect of family crisis, namely, resistance to change (pp.11-19). This framework accounts for the forces which act to maintain the status quo. It maintains that change in one part of the family system can only occur if the entire family changes, and that, in order to prevent such a disruption, homeostatic manoeuvers tend to be employed, thereby minimizing the effect of change on the family system. Montgomery's concern is with the ways in which the family deals with their own resistance to change.

Definition. Family crisis is defined by Montgomery as "a process which begins with an inappropriate pattern and ends with the family's reorganization as either intact or modified" (p.21). Patterns, he explains, are the customary ways of functioning as a family which are developed over time and which provide stability in the system (pp.27-28). An inappropriate pattern is one which no longer accomplishes the end for which it was established or, which does so at the expense of other parts of the system (p.21). An example would be a pattern in which one member of the family makes all decisions concerning the management of finances. In the event of sudden illness or disability of the decision maker, the family would be lacking a necessary requisite for their continued stable functioning.

Montgomery differentiates four components of the crisis process. The first is a period of incipience, during which the appropriate pattern exists but is not revised. This is followed by a stressor which brings to the family's attention the need to make a change in their usual way of handling their affairs. The period of time during which they attempt to develop a more workable pattern is referred to as the secondary adjustment period. Once having corrected their inappropriate pattern, the family moves into reorganization, during which, other adjustments are made within the system so that the new pattern is compatible with the other parts of the system. Figure 1. provides a graphic representation of this process. A more detailed examination of each of the four components of family crisis follows.

The period of incipience. This period is characterized by the existence of an inappropriate pattern which the family fails to modify. In the models of Hill (1958) and Parad and Caplan (1965) this component of crisis is identified merely as an inadequacy of family resources. This inadequacy, according to Montgomery, may or may not be known to the family. In any event, the pre-crisis family does not rectify their inappropriateness. Rather, they elect to continue in their established ways in lieu of dealing with the uncertainty and stress which accompanies the testing out of new solutions.

Montgomery classifies patterns in two ways; according to their fit with the needs of the family system and, according to their purpose. Appropriate patterns, he says, "enable the family to meet the expectations of society, to satisfy the needs of individual family members, and to satisfy family structural requirements " (pp.36-37). Although they use different frameworks, Glasser and Glasser (1970) and Olsen (1970) include comparable criteria in their delineations of the adequately functioning family. They would tend to agree with Montgomery that appropriate patterns frequently become inappropriate and therefore must be revised in order to maintain an adequate level of family functioning.

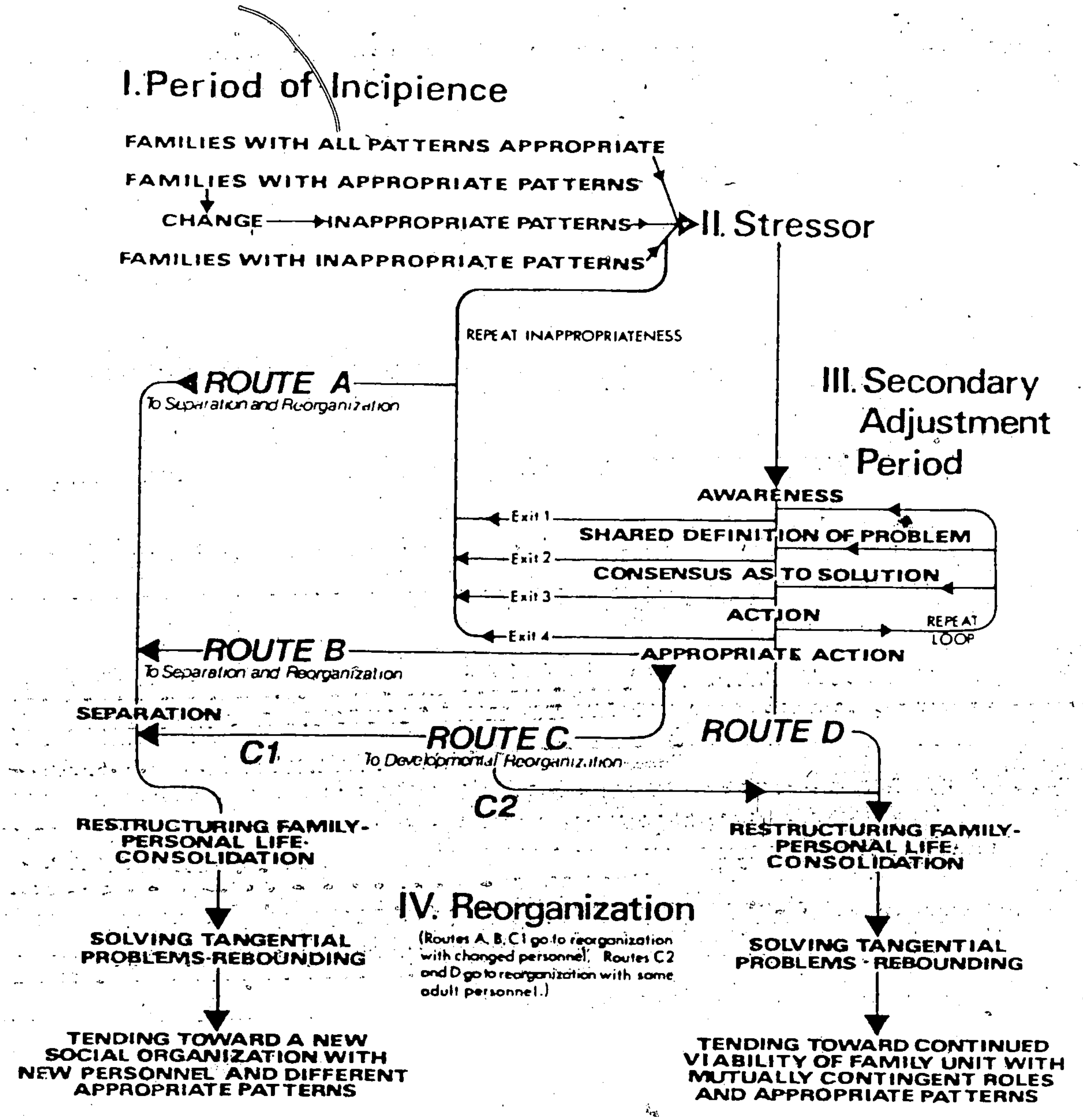

Figure 1. Graphic model of family crisis (Montgomery, 1978, p.23).

Inappropriate patterns are patterns which fail to meet the requirements cited above. They do not simultaneously meet individual and family needs; consequently one is achieved at the expense of the other, and the family is weakened by the use of that pattern.

Execution patterns are patterns designed to get specific things done. They may relate to internal family needs or to the needs of the family relevant to their functioning within society. Examples would include preparation of the family meals and meeting of the family's expenses.

Correction patterns, on the other hand, are more general in that their purpose is to correct inappropriate execution patterns. They are concerned with the internal family process through which the family makes a correction, and therefore, can be applied repeatedly to inappropriate execution problems.

Montgomery indicates that the course of family process during incipience will be influenced both by the kind of stressor and the family's capabilities. He describes family capabilities in terms of the appropriateness or inappropriateness of both execution and correction patterns and the stressor, as either anticipatable or unanticipatable. The interaction of stressor type and family capabilities as they relate to the period of incipience is presented diagramatically in Figure 2. As indicated, families with both appropriate execution and correction patterns will be better equipped to deal with crises than families lacking appropriate correction patterns and families lacking both appropriate correction patterns and execution patterns.

This leads to consideration of the stressor, which represents the second component in Montgomery's model of family crisis. A more

Appropriate Family Patterns	Methods of Handling Change	Stressor Type (which will lead to crisis)
Execution and Correction	Continual revision of execution and correction patterns. No major upheaval.	Unanticipatable
Execution only	No problems as long as revision is not needed. Social and family change not met by pattern revision.	Unanticipatable Anticipatable
Correction only	Inappropriate execution patterns are corrected sufficiently without continued hassles or insufficiently with repeated internal conflict.	Unanticipatable
None	No remedy	Unanticipatable Anticipatable

Figure 2. Family process as a function of stressor type and appropriate family patterns (Montgomery, 1978, p.48).

detailed description of the stressor follows.

The stressor. According to Montgomery, the stressor "marks a point at which there is the awareness on the part of at least one family member that family life must change from what it was" (p.55). His usage of the term includes both the objective occurrence of an event which leads to crisis and the subjective experience which it invokes. Since "stressor" usually means "crisis precipitating event", when the meaning "experience of distress" is intended, the reader may fail to select the second meaning and be temporarily confused. This is particularly true in reference to discussions of repeat inappropriateness which moves the family again to the stressor (See Figure 1., p.18).

Stressors (stress-inducing events) may have their source within the family or outside of the family. They may be widespread, affecting many families as in the case of a flood, or they may be specific, affecting only an isolated family, as for example the accidental death of a family member. They may be anticipatable such as is retirement or they may be unanticipatable as in the case of diagnosis of a fatal illness in a family member. Furthermore, at the occurrence of the stressor, families may foresee what lies ahead for them or they may fail to anticipate the consequences of the situation. Each of these characteristics of the stress-inducing situation will affect the family's response. Montgomery maintains that consideration of whether the stressor is anticipated or not and whether the family can foresee the consequences or not, are of primary importance.

Anticipatable stressors afford the family opportunities for careful analysis, discussion, and agreement concerning correction of their inappropriate pattern during incipience. The family may not, however, take advantage of this awareness prior to the occurrence of the event, and opportunities for rational problem solving will be reduced due to the intensity of the stress accompanying the many ramifications of the event. Stressors which are unanticipatable, on the other hand, do not allow for correction of inappropriate patterns in advance of the event. Consequently, the pressure for relief is greater and the process is likely to be characterized by immediate stop-gap types of solutions which fail to take into account the basic pattern which is no longer appropriate for that family.

Whether a family sees in advance that it is headed for a stressor, and whether it acts to either minimize or avoid the stressful effects, may be an indication of what Hill (1958) refers to as the family's crisis-meeting resources. Kaplan, Smith, Grobstein, and Fischman (1973) emphasize the significance of the family's ability to foresee the consequences of their situation.

> Successfully resolving any crisis depends largely on each individual's ability to experience with minimum delay the immediately painful consequences of a stress-producing event and to comprehend and anticipate, even though dimly, the later consequences - that is the pain, sorrow, and sacrifice that the trauma will cause. (p.62)

Montgomery suggests that adequately functioning families foresee anticipatable stressors and minimize their impact by acting prior to their occurrence, whereas, families whose functioning is inadequate fail to do so. In the case of unanticipatable stressors, he further suggests that adequately functioning families reorganize after the event, but that, families whose functioning is inadequate fail to achieve reorganization.

It is to the process of pattern change and eventual reorganization which the stressor moves the family. Pattern change comprises the third component of Montgomery's model of crisis. We move now to a discussion of the secondary adjustment period.

Secondary adjustment period. During this period the family's task is to correct their inappropriate patterns. The adequacy of their existing correction patterns or those which they develop in the process will determine their ultimate success (p.69). The more quickly the family identifies the source of their difficulty and acts to correct it, the greater will be their chances of success (p.77). This is because the crisis-producing event causes disruption throughout the family organization, creating a variety of problems which quickly reduce energy levels to the point where there is little left for careful analysis, thoughtful discussion, and planned action. Closely related to this, is the effect of repeated failure on the morale of the group. Montgomery contends that as long as one of the responsible family members adopts a "why bother?" attitude, the family will not be able to make the necessary pattern revision (p.95).

This points to the need for the family to balance instrumental and integrative functions while it is engaged in pattern revision. Instrumental tasks are concerned with meeting the functional demands of the family, whereas, integrative tasks are concerned with meeting the psychological needs of its members. The former would be directed toward such things as division of labor and decision-making, and the latter would be directed toward fostering the good feelings of the membership. If either one is served at the expense of the other, successful crisis resolution is unlikely (p.71).

So too, is it necessary for the family to balance flexibility and consistency during secondary adjustment. Flexibility is demanded in order to implement change, but so too is consistency, for the shared sense of group which the members maintain will influence the possibility of consensus. It readily becomes apparent that pattern revision is most likely to occur when the entire family moves through each step as a group.

The process of pattern revision involves a series of steps. The family must first share an awareness of the problem. This should lead to a definition of the problem or identification of the inappropriate pattern. Consensus concerning the appropriate remedial action, and finally corrective action complete the revision process. As shown in Figure 1., the family may not move systematically through each of these steps directly to the appropriate solution, but may instead return to an earlier step via either the continued use of an inappropriate pattern or through recognition of their previous misinterpretation of the situation. This can be related to family interaction patterns or to an actual misfit of the group effort and the problem that they are dealing with. This will become clearer in the discussion of the steps comprising secondary adjustment which follows.

Awareness, on the part of one person, that a problem exists, must be shared with the rest of the family in order that family change can be implemented. If the member who is aware keeps this information to himself and attempts to solve the problem by changing his own behavior, homeostatic mechanisms will be employed by other members of the family, and the effects of his efforts will be neutralized. The family's openness to receive such information and the individual's willingness to disclose it, will determine how quickly they achieve a shared awareness. Failing to achieve shared awareness, they will continue to use the inappropriate pattern and to experience the accompanying stresses.

It does not follow that, once awareness has been shared, the family will understand or agree on what the problem is. "Frequently, the stressor does not clearly specify the problem and it must be interpreted before the inappropriate pattern can be correctly identified" (Montgomery, 1978, p.88). Confusion of the problem with its symptoms will lead to inappropriate solutions and continued experiencing of distress. The family's readiness to explore the meaning of the symptoms will be influenced by a number of factors: their ability to communicate clearly, the degree of trust and support which characterizes their interaction, each individual's commitment to the family goals, previous experiences in handling family problems, and the available time and energy of each member. A deficiency in any one of these will weaken the family's resources and inhibit their ability to achieve consensus concerning the nature of the problem. Without consensus, movement to the next step, that of developing a solution, will not be possible. Continued use of the inappropriate pattern by some family members will perpetuate its existence and family change will be blocked.

Once having reached agreement about what the problem is, the family's next step is to develop a solution. Once again, reaching consensus is crucial. Levels of commitment and trust are particularly important since the task requires that the family be prepared to take risks by deinvesting in a pattern which was previously comfortable for them. They must be open to considering and creating new ways for relating as a family: readiness to do so is rarely equal among family members. Montgomery suggests that the appointment or emergence of a leader usually facilitates the process since the leader is likely to ensure that they remain on task (pp.91-92).

At this point it is important to consider the level at which the family proposes to change. Montgomery contends that second order, rather than first order change is required to achieve crisis resolution (p.140). By this he means that change which merely maintains homeostasis in the now dysfunctional system will not resolve the crisis. Rather, the change must, of necessity, further disrupt the family system. This disruption is due to the effect of change on other parts of the system which have until now, been coordinated with the dysfunctional pattern, and will require realignment with the alternate pattern.

Montgomery says that second order change, which is associated with system revision, as opposed to system maintenance, involves "a change in the structure, or personnel, or basic values" (p.114). A change in structure would involve the development of a new system of organization, not merely the reshuffling of roles and responsibilities. A personnel change would occur if a new member were added to the family or if a family member left the family unit. And value changes would be said to occur if the family developed new goals or priorities to replace those previously held.

It remains for the family, after having arrived at a solution, to act in accordance with their plan. Once again, if this step is to be successful, all family members must change. Furthermore change in the same direction and at the same time will support the integration of their new pattern. Resistance on the part of one family member will inhibit the process.

Action directed toward solving their family problem, whether appropriate or not, serves an important function. Further attempts are more likely because their action will have shattered previous images, thereby increasing their preparedness to construct for themselves a new family image.

Resolution of their difficulties will have been achieved once the family employs an appropriate pattern. Repeated attempts are usually required in order for this to be accomplished. Resolution of the problem is generally characterized by either restructuring of the family with a changed membership or the continuation of the family as an intact unit.

In either event, if their solution is the product of sound problem solving approaches, their resolution will be associated with the advancement of both individual and family goals. Once they have made the necessary pattern change, the family is ready to move on to reorganization.

Reorganization. At this point in the crisis process, major change has occurred within the family system. It remains for the family to make the necessary adjustments within the system to incorporate the newly developed pattern and to return to "a new dynamic equilibrium". The first task, Montgomery refers to as consolidation; the second, rebounding. In the first instance the focus is on achieving pattern consistency within the system. Behaviors which support the new pattern must be developed to replace the now-outdated behaviors. In the second instance, the focus is on the needs of the family, which were poorly served during the period of time that their energies were directed toward working out a solution. The family needs to have fun and to enjoy being together again. Once these tasks have been achieved, the family would be considered to have resolved their crisis.

This concludes the review of Montgomery's model of family crisis. It provides an account of how families deal with their need to change and their own resistance to do so. It outlines the process through which families move into a crisis and cope with it, emerging either as an intact unit which has been strengthened by the experience, a modified unit which has grown through the experience, a separated unit which has disintegrated because they were unable to correct their own dysfunction, or a family which continues to struggle without remedying their difficulties.

The application of Montgomery's model to real-life families with real-life troubles remains to be tested. The effect of disablement of a family member on the family is one instance where its relevance might be demonstrated. We turn now to a review of the research dealing with the effects of illness and disability on the family.

Research into the Effects of Illness and Disability on the Family

There is but a small body of literature which deals with the effects of illness or disability on the family. Most research in this area has taken what Farber (1964) refers to as a "stimulus-response" approach to crisis. By this he refers to studies in which the end results are described and related back to a causal event. Reports of investigations into family process following the event of disablement are, except for the case of the effects of a retarded child on the family, simply not available. The research findings which follow deal with a wide variety of disabling events, rather than one specific type of disability, since no one disability has been studied extensively. Commonalities among the effects of a wide variety of disabilities on the family are yet to be discovered. Thus far, the area has not received sufficient research interest for this to be possible.

That illness or disability is a family matter, not just an individual affair, is supported by researchers and practitioners in the fields of rehabilitation (Bray, 1977; Dembo, Ladieu & Wright, 1953; Weller & Miller, 1977b), family crisis (Anthony, 1969; Parad & Caplan, 1965), medical sociology (Parsons & Fox, 1968), and mental health MacVicar & Archbold, 1976; Kaplan, Smith, Grobstein & Fischman, 1973; Klein & Lindemann, 1961; Olsen, 1970). Research into the effects of illness or disability on the family has focussed on three main areas: the family system, the marital relationship, and the social situation of the family. Findings from each of these areas are presented in turn.

Effects of disability on the family system. Kaplan, Grobstein, and Smith (1976), in a study of forty families in which a child had recently been diagnosed as leukemic, reported that families commonly experienced problems in four areas. These were: marital problems, sibling problems, health problems, and functional problems (the meeting of role responsibilities). They also found that families who made an adaptive response to the crisis had virtually no marital or sibling problems as compared to families who made a maladaptive response and who experienced a large number of marital and sibling problems. There was no significant difference in the occurrence of health or functional problems between the groups. Kaplan et al suggest that the degree of supportiveness between spouses and family members, the openness of their expression of feeling, the honesty of their communications, and their ability to accept the nature of the diagnosis distinguished the two groups. In Montgomery's model, these would be integrative tasks. These findings suggest that maintenance of family integration may be crucial to the outcome of family adjustment to the diagnosis of a fatal illness in one of their members.

Malone (1977), in a study involving 25 family members of 20 aphasic patients, reported the types of problems which families identified in terms of their perceived severity. The three most distressing related to the interpersonal area. They included feelings of fear, possessiveness, and dehumanization surrounding the role changes which occurred, feelings of irritability in general, and guilt feelings relative to their relationship with their aphasic member and in relation to the actual event which led to the aphasia. Less distressing was the problem of an alteration in their social life. Financial problems, job-related problems, and health problems were all seen as less distressing than those relating to the interpersonal domain.

Duff and Hollingshead (cited in MacVicar & Archbold, 1976) found that families defined their problems following disablement of a family member in accordance with the role of the disabled member. In families where the disabled person had been the breadwinner, their problems were defined as financial, whereas if the wife-mother role was disrupted, families identified problems in the area of domestic and child care tasks. The methodology is not known in this instance, so one cannot conclude that integration problems were not experienced by these families.

Marra and Novis (1959) state: "Disablement of the husband...outmodes existing patterns of family adjustment...thereby making new systems of adjustment and interaction necessary....[T]hese adjustments...often place the stability of the total family unit in jeopardy before its former equilibrium is established" (p.40). They found that from the husband's point of view his disability affected economic stability, marital and family relationships, and attitudes toward himself and others. The major effects on the family unit included a shift of responsibility to the wife for home management, increased responsibilities for the children, constriction of social activity, financial distress and altered plans for size of the family.

The findings reported above suggest that families experience personal, interpersonal, and transactional (extra-family) difficulties following the disablement of a family member. Findings specific to the effects of disability on the marital relationship follow.

Effects of disability on the marital relationship. It has been suggested that the cultural and family role of the father is particularly significant relative to the kinds of adjustments which families make (Deutsch & Goldston, 1960; Ludwig & Colette, 1969; Thomas & Britton, 1973). Thomas et al (1973) found that dependency on the family was less acceptable to males than to females. Similarly, Deutsch et al (1960) report that in families where the dependent disabled member was female or had an instrumental role, return to the home rather than institutionalization was more frequent.

In families where the dependent disabled member was the husband, Ludwig et al (1969) found greater role flexibility between spouses and the wives assumed greater responsibility for decision making in the areas of financial and home management. Carpenter (1974) reports that the disabled husband whose wife is employed assumes more responsibility for household tasks than does the disabled husband whose wife is not employed. The severity of the husband's disability was also found to be a significant factor in the extent to which he assumed household responsibilities. According to these studies, dependency of the disabled spouse is a significant variable in the role adjustments which the couple makes.

In a comparative study of husbands' and wives' level of satisfaction, in families where the wife's physical mobility was restricted, Skipper, Fink, and Hallenbeck (1968) found that companionship satisfaction for the woman did not correlate with her physical mobility although there was a direct positive relationship between the husband's level of satisfaction and the wife's physical mobility. This is explained in terms of the number of outside social activities which husbands discontinued in order to spend more time with their disabled wives.

The strain of disability on the marital unit has been documented by Nagi and Clark (1964) and Franklin (1977). Nagi et al (1964) report higher rates of separation and divorce among couples under 30 following the disablement of a spouse. They also indicate that most separations and divorces occurred within five years of the disability. Couples who remained married following disablement of a spouse tended to have greater educational, occupational, and financial resources than did those who separated or divorced. Franklin (1977) also reports that the incidence of separation and divorce is higher among the disabled than the non-disabled. She reports that the potential time available for the disabled to pursue work, social, and personal activity is less than that for the non-disabled. This she suggests forces disabled couples "into a stronger reliance on their own interpersonal resources and thereby places greater demands on the marriage relationship" (p.18).

The research findings reported above indicate that disability of a spouse leads either to changes within the relationship or actual dissolution of the marriage. This would suggest that disability of a spouse can be a particularly stressful experience for the married couple. We move now to consider how disability of a family member affects the family's relationship with the community.

Disability, the family, and the community. Following an extensive survey of families in which there was a disabled adult, Franklin (1977) concluded that: "Contraction, rather than compensation,...is the major impact of disability on the family structure" (p.18). The disabled population was found to have fewer educational and economic resources and to receive no significant assistance from their extended families. Consequently, "[d]ecreased participation...highlighted the patterns of the disabled in their family setting. Chronic poor health impoverished not only those it afflicted, but those living with them" (p.18). Franklin's findings support the position of Hilbourne (1973), who claims that

> in so far as they [the family] have to take on additional burdens, tasks, and responsibilities, in addition to those they would normally be expected to assume, this limits the flexibility they have in playing other roles and may mean forgoing activities and roles which would otherwise be available to them. (p.502)

Farber (1964) suggests that withdrawal from social relationships in families with severely handicapped children is a protective mechanism used to avoid the hostile reactions of those who do not accept their changed styles of family life (p.424). It is likely that both the stigmatizing effects and the restrictions on time and energy contribute to the contraction of which Franklin speaks.

This concludes the review of research into the effects of disability on the family. The next section concerns itself with the sick role, its conceptualization, its applicability to disability, and its effect on rehabilitation progress.

The Sick Role

The sick role concept, as first described by Parsons in 1951 has been widely used by sociologists, psychologists, and anthropologists. Disability and handicap have also been studied using his conceptualization (Ludwig & Adams, 1977; Starkey, 1977; Wawzonek, 1974). Since the degree to which the roles of the sick person, the disabled person, and the handicapped person are conceptually interchangeable is questionable, the terms will be differentiated.

Illness, Disability, and Handicap

Illness, according to Parsons (1972) is

> a socially institutionalized role-type: It is generally characterized by some imputed generalized disturbance of the capacity of the individual for normally expected task or role-performance, which is not specific to his commitments to any particular task, role, collectivity, norm, or value. (p.117)

The attribution of illness to an individual then, requires an interference in his capacity for behaviors considered important to his social position as well as a social recognition of this dysfunction. The definition of illness is highly dependent upon social judgements relative to the adequacy of one's performance in that society.

Disability, on the other hand, is defined by Hamilton (cited in Vargo, 1978), as "a medically diagnosable impairment of some physical function(s)" (p.31). The relationship of the impairment to the fulfulment of role responsibilities is not included in this definition, so one would conclude that disability need not interfere with role performance. Furthermore it is possible that the ill person might overcome a chronic or continuing impairment and resume his previous role responsibilities, thereby moving from the role of sick person to that of disabled person.

Handicap, according to Vargo (1978) refers particularly to the psychosocial concommitants associated with a perceived deficiency. This conceptualization is very broad; it can encompass such basic features as one's age, sex, and color as well as his physical ability to function within his social role. A handicap, then, is a barrier, largely psychosocial, to one's complete functioning within his physical and/or social environment.

The loss of a limb would be considered a disability for the individual who, with the use of a prosthesis, continues to meet previous responsibilities and who does not significantly alter his life style. On the other hand, loss of a limb would be a handicap for the person who refuses to use a prosthesis, limits his social involvement, and fails to meet his previous responsibilities. Illness or disability could become a handicap, depending upon the individual's personal reaction to the experience and the response of others around him toward his impairment.

Parsons (1972) suggests that illness and the enforced dependency upon medical staff may be desirable from the individual's perspective. That sick behavior could be employed to meet psychological needs, would suggest a tendency toward a handicapping condition. The development of a handicap however, requires that those in association with the individual support that behavior.

While the distinctions between the terms illness, disability, and handicap are fine, they are at the same time, highly significant in examining the way in which a family reacts to a stroke in the father. This point will become more apparent in the analysis of data. For the meantime we will examine Parsons' formulation of the sick role more closely.

Parsons' Theoretical Formulation of the Sick Role

Parsons' original formulation of the sick role, which has remained unchanged by subsequent research, describes four specific aspects of the role (Parsons, 1972). They are: (a) that the individual's incapacity is seen to be beyond his own powers to overcome; consequently he is not considered responsible for his state, (b) that his incapacity provides a legitimate basis for exemption from his normal role obligations, (c) that, since illness is seen as an undesirable state, the individual is expected to want to get well, and (d) that the individual and/or his family will seek competent help and work cooperatively with the care givers toward his recovery.

The sick role, by definition, requires that the person accept help from others, usually medical staff. This enforced dependency creates problems for the individual (Parsons, 1972) and for the family (Parsons & Fox, 1968). In the first case, social values concerning mastery over one's environment and achievement within one's social position strongly oppose dependency. This, Parsons and Fox (1968) consider to be a valuable therapeutic force especially in as much as the staff support these values by making the dependent relationship conditional to the patient's striving for mastery and achievement. In the second instance, Parsons and Fox maintain that the family has great difficulty maintaining a balance between the permissive-supportive (dependency-related) aspects of treatment and the disciplinary (mastery and achievement-related) aspects of treatment. Thus, willingness to assume the sick role may be a function of a number of factors. We move now to consider some of them.

Tendency to adopt the sick role. Wilson (cited in Gray, Reinhardt, & Ward, 1977), points out some of the factors associated with a person's readiness to accept medical care, a central expectation of the sick role. He says:

> No one is "born" as a patient...The decisive element in assuming the role of patient is probably not the sheer fact of

> sickness or accident, but the recognition by the affected individual and/or certain other people of a particular need for help in coping with the condition...The decision to become a patient, whether it is autonomous or imposed, is conditioned by many factors including the urgency of symptoms, degree of experience with the sick role, and availability of help. (p.369)

His position concerning the individual's tendency to assume the sick role includes personal factors, social factors, and general reality factors.

Among the personal factors influencing sick role tendency is the perceived urgency of one's condition. It has been found to correlate significantly with frequency of illness (Hinkle, Christenson, Kane, Ostfeld, Thetford & Wolff, 1958; Thurlow, 1971). In these studies individuals whose definition of their situation as difficult or demanding were found to have a higher incidence of illness than individuals who defined their situation as interesting and satisfying. It is suggested that the individual's perception of this situation may be more significant than the actual situation. Shontz (1977) supports this. He says, "what has been universally regarded as crucial [in determining the individual's response] is the personal meaning of his disability to each individual client" (p.334).

Phillips (1965) and Blackwell (1967) found that individuals judged to be more self reliant were less likely to show a willingness to seek medical help. This would suggest that individuals who were more committed to the social values of mastery and achievement, were more resistive to adopting the sick role. Mechanic and Volkart (1960) indicate that illnesses which are common, predictable, and non-threatening are commonly associated with the tendency to seek medical help. The social acceptability of a particular illness then, may influence the individual's readiness to assume the sick role.

These studies have focussed only on the readiness to seek competent medical help. This is but one aspect of the four features of Parsons' model of the sick role. Whether the subjects in these studies were prepared to endorse the remaining three aspects of the role is not known. We move now to consider the empirical validity of his model.

Applicability of the sick role. Berkanovic (1972) in an attempt to determine the dimensions of the sick role, found that expectations concerning the sick role did not encompass a single role description. Rather, sick role expectations appeared to be dependent upon individual characteristics and symptomatology. Kassebaum and Bauman (1965) report similar findings in their study of the applicability of Parsons' four dimensions of the sick role to the chronically ill. They indicate that, in the case of chronic illness, the expectation that one should attempt to overcome the illness and return to his earlier level of functioning, is inappropriate. So too, is the right to complete exemption from one's social role obligations.

Segal (1976), after a critical review of the last two decades of research based on Parsons' formulation, concluded that the "dimensions of the sick role vary extensively and do not necessarily always occur together" (p.167). He suggests that the nature of the illness, that is, whether it is acute or chronic, and the individual's willingness to assume the sick role, significantly influence the extent to which the dimensions of the sick role are fulfilled in any one situation.

Gordon (1966), in an extensive study designed to test the empirical validity of Parsons' model, concluded that, "despite the fact that many researchers consider Parsons' concept of the sick role definitive, it has not been validated or effectively delineated" (p.97). His findings suggest that there are at least two different sets of role expectations for illness states. These he refers to as the "sick role" and the "impaired role". The "sick role", he found, was associated with a serious or uncertain prognosis and closely adhered to Parsons' formulation. The "impaired role", on the other hand, was associated with a known and non-serious prognosis and tended to support normal behavior. This description might also be considered as the "disabled role".

He further comments on the significance of his findings:

> It is my belief that the appropriateness or inappropriateness of the role response to the ill person can delay, prevent, or promote recovery - misappropriate responses can keep a person an invalid, delay seeking of care, or lead the ill person to function normally before he is able. (p.100)

Thus, it becomes important to evaluate the appropriateness of role expectations throughout the recovery period, for the ill person may become either a disabled person or a handicapped person, depending upon the expectations which influence his behavior.

Thomas (1970) concluded that Parsons' sick role concept did not adequately describe the disabled, in as much as the role behavior of disabled persons shows extreme variations and cannot be encompassed by a unitary concept. He identifies five roles of the disabled to describe the wide variations of behavior. The roles which he describes are: (a) disabled patient, (b) handicapped performer, (c) helped person, (d) disability co-manager, and (e) public relations man.

The disabled patient role most closely resembles Parsons' sick role model, however, the elements of the sick role are extended for the duration of the impairment. The short term temporary aspect of the sick role is waived. The handicapped performer role applies to the behavior of the disabled person who, having lost the capacity for certain behaviors, continues to perform social obligations through the use of self-employed compensatory approaches. The helped person role applies to the disabled person who requires the assistance of another person for any aspect of his normal functioning. The helped person's dependency is a significant aspect of this role. The disability co-manager assumes an active part in the decisions and management of his own care and the public relations man acts to explain and interpret his disability to the non-disabled with whom he interacts.

Thomas suggests that the disabled individual usually engages in different roles at different times and under varying circumstances. This conceptualization provides for increased variability in role expectations, however, its usefulness has not been demonstrated. References to his disability role types are noticeably absent from the rehabilitation literature. Parson's model continues to be the primary reference in the field. Inasmuch as Parsons' model adequately describes the role expectations for the acutely ill, it remains a useful concept for examining role expectations relative to the convalescing stroke victim. In this regard, we turn to a review of the literature dealing with the relationships between sick role behavior, family behavior, and rehabilitation success.

Rehabilitation, the Sick Role, and the Family

While there is some evidence that the family plays a significant part in the rehabilitation of a disabled member (Litman, 1972; Wawzonek, 1974) the relationship is not clear. Siller (1963) suggests that the role of the family becomes significant only after the acute treatment phase since, until that time, the family must relinquish all responsibility for care to the treatment team.

Robertson and Suinn (1968) indicate that the degree to which the patient and family members can predict the attitudes of one another relative to the disability correlates with rehabilitation success. In this instance shared role expectations would be more likely. New, Ruscio, Priest, Petrioli, and George (1968) in an attempt to determine the extent to which patients and their families agreed upon the patient's ability to manage basic aspects of self care, found a high correspondence with their spouses and a low correspondence with their children. In the same study they found that friends and professionals tended to see the patient as more independent than he actually was. The findings are explained in terms of the extent to which each group was involved with the patient in providing for his basic needs. They suggest that the role expectations of each group varies as a function of the nature of their involvement with the patient. This would fit with Thomas' (1970) conception of the varied roles of the disabled. It would also account for the role problems which he describes as the individual moves from one social context to another.

Dependency, which is one of the central expectations of the sick role, has been shown to correlate both with successful completion of rehabilitation programs (Ludwig & Adams, 1977) and with failure to return to work although judged fit for employment (Starkey, 1977). In these studies it was the patients judged to be less dependent and subservient who terminated their programs prematurely and who returned to work. The role of the family in these studies is not known. Although there is relatively little research into the effects of the family's role expectations for the disabled person on his rehabilitation progress, one cannot discount its possible significance.

This concludes the review of theory and related research which provides the conceptual basis for the investigation of family reactions to stroke in the working father. The specific research questions formulated from this review are presented below.

Research Questions Arising from the Literature Review

The following research questions, derived from the review of literature, comprise the focus of this research project. They are designed to permit integration of concepts from three bodies of literature: disability acceptance, family crisis, and the sick role.

1. Does the occurrence of a stroke in an employed father with dependent children initiate a process in which family patterns are modified?
2. In families where the employed father has recently suffered a stroke, what specific problems are encountered?
    a) in fulfilling functional roles,
    b) in maintaining the health of the members,
    c) in relating to one another, and
    d) in other areas of family functioning.
3. How does the family, in which the employed father has recently suffered a stroke, deal with the problems which they encounter? How do they:
    a) arrive at a definition of the problem(s),
    b) decide on (an) appropriate solution(s), and
    c) determine who will be responsible for carrying out their proposed solution(s)?
4. What is the role of the stroke victim during the family's initial adjustment to his incapacity?

CHAPTER III

METHOD

This study was conducted in cooperation with the psychology department of the Glenrose Hospital in Edmonton, Alberta. The Glenrose Hospital is a 349 bed provincial hospital which provides a comprehensive program of care for physically disabled and convalescent adults as well as emotionally disturbed and physically disabled school-age children. Out patient services are provided for approximately 200 children and 700 adults per month. As a member of the stroke team, the psychology department provides assessment and counselling services to stroke patients and their families.

In this chapter the methodolody for the study will be presented. The sample will be specified and the research design will be explained. The instruments used for data collection and data analysis will be described.

Sample

Two families were studied. In each family the father had, within the previous year, suffered a stroke leading to left hemiplegia and completed a rehabilitation program at the Glenrose Hospital. Fathers were between the ages of 40 and 60 with at least one dependent child. They had been employed at the time of their stroke.

Patients who met the above criteria were contacted by a staff psychologist to obtain permission for release of their names to the investigator. The staff psychologist also obtained the verbal consent of the patient's physician for his inclusion in the project. A letter, which outlined the study and invited their reactions, was subsequently mailed to the doctors (See Appendix D).

An appointment was arranged with each patient and his family to discuss the research plan and obtain their consent to participate (see Appendix C). The signed consent of all family members over 15 years of age was obtained. Confidentiality and anonymity were assured. Each patient's signed consent for release of information contained in the medical record was obtained by the psychology department.

Design

In order to study the process through which the family was moving, and in order to obtain a depth of understanding of each family, the case study approach was selected. A series of semi-structured interviews were conducted with each family. Interviewing was done in the families' homes and followed the Data Collection Guide (see Appendix A) which was developed by the investigator. The interview guide was developed to elicit information concerning family resources, family perception of the precipitating event, specific problems encountered by the family following the father's stroke, and problem solving strategies which the families had employed. Observational data and medical information from the patient's record was also incorporated.

The Data Collection Guide was developed from the work of several authors. Section B, which deals with family resources, derives from the work of Hansen and Hill (1964). Section C, which deals with family perception of the precipitating event, derives from the work of Hill (1958). Section D, which deals with the specific problems which the family has encountered, is based on the work of Kaplan, Grobstein, and

Fischman (1976). And Section E, which deals with family problem solving strategies is based on Montgomery's model (1978).

The interviews were recorded on audiotape for the subsequent analysis of data. Brief process notes were made for each interview.

Analysis of Data

The data were analyzed using the Guide for Analysis of Data (see Appendix B) which had been developed in conjunction with the Data Collection Guide. The Guide for Analysis of Data consisted of specific questions derived from disability acceptance literature, Parsons' sick role theory, and Montgomery's family crisis model.

The findings were written up as two case studies describing the process which each family went through following the father's stroke. Four research questions (see Chapter II, p.42) were addressed using the data contained in each case study.

CHAPTER IV

RESULTS

In this chapter the findings elicited through the use of the Data Collection Guide (see Appendix A) will be presented. Each family description will include: (a) medical information related to the father's stroke, (b) family data, including family composition and crisis meeting resources, (c) family perception of the crisis precipitating event, (d) problems encountered following the father's stroke, and (e) problem solving strategies which were employed. Following presentation of the case studies, the four research questions (p.42) will be addressed. We turn now to the family case studies.

Family A

A total of 8 hours was spent with this family during the months of July and August, 1979. Following is a description of the process which they related in response to the investigation of their reactions to the father's stroke.

Medical data. Early on the morning of August 1, 1978, Mr. A. awoke with stomach pains and vomitting. Later that same morning, after he had fallen out of his bed, his wife discovered that he was unconscious and that his left side had become paralyzed. He was moved by his wife and 23 year old son, F., to their local hospital and later that morning was transferred to one of the larger city hospitals.

Mr. A. had suffered a right cerebral vascular accident (CVA or stroke) which left him paralyzed on the left side (hemiplegic). His left arm was extremely weak and spastic. His left leg was less severely affected although he could neither walk nor maintain his balance in the sitting position. He had partial blindness in his left eye and showed a lack of awareness of the existence of his dysfunction.

By August 18, at which time he was transferred to the Glenrose Hospital, Mr. A. had become relatively self sufficient in his daily care. He walked without aids or assistance, although his left side continued to show marked weakness in comparison to his right. His vision had gradually returned and he no longer denied that there was anything wrong with him.

Mr. A. was involved as an inpatient in the stroke rehabilitation program at the Glenrose Hospital from August 18 to October 6, 1978. During this time he was seen by medical, nursing, social work, speech and audiology, physiotherapy and occupational therapy, and psychology staff. His progress over this time was slow.

Family and financial problems surfaced. He showed occasional tearfulness, impulsiveness, and confusion. Memory loss and impaired judgement were questioned. He had difficulty concentrating on his exercise program and complained of being distracted by other patients. He was discharged to the outpatient service at his own request on October 6, following an extended pass at home.

It was felt at that time that he had made a good functional recovery. He continued to show neglect of his left arm as well as poor coordination in bilateral hand activities. Visual-motor perceptual problems continued, although he had been able to compensate for his impairment and obtain his driver's license. It was, however, the judgement of the stroke team, that he would not be able to return to his previous employment as a truckdriver. Vocational assessment and counselling were planned for a later time.

Mr. A. attended the outpatient exercise program for a week, after which time he was followed by the psychology department. He has maintained this contact to the present time.

Family data. Mr. A. is a 54 year old laborer who has, for the last 7 years, worked as a self employed truckdriver. His wife, Mrs. A., is 49. They have been married for 31 years and have 8 children ranging in age from 8 to 30. A 9 year old daughter, A., and a 16 year old son, B., are living at home. Since the time of Mr. A.'s stroke, their 20 year old daughter, C., has been married. Although he wasn't living at home at the time of his dad's stroke, the 23 year old son, D., was working for his father. Consequently he spent a great deal of time at home. The family interviews included the parents and these four youngest children.

Both Mr. and Mrs. A. have completed Grade 9. Each of their children has achieved either grade 11 or 12 as well as some additional training either on the job or through a technical program. At present, one son works as a tinsmith, two sons work as truckdrivers, and C. works as a secretary. The remaining children are not employed. B. is in grade 9 and A. is in grade 4.

All of their children live in the Edmonton area. Mr. A. also has a mother, a brother, and a sister living in the city. Mrs. A.'s parents live in another city in Alberta. The A.'s frequently visit Mrs. A.'s parents as well as their own children; however their contacts with Mr. A.'s family are less frequent. The A.'s pride themselves in having been financially self sufficient throughout their marriage. Although they have frequently been in debt, they have not received any financial assistance from their families.

At the time of Mr. A.'s stroke, they had no savings. Mr. A. had, in spite of his wife's objections, just purchased a new truck which had put them badly into debt. They were also paying off their house mortgage.

The A.'s are regular church goers and Mrs. A., in particular, identifies the church as a source of strength in relation to her needs following her husband's stroke. Mr. A. identifies medical personnel as his source of support, and B. and A. identify a counsellor associated with the church as their source of support.

Except for a 6 month hospitalization with war injuries, Mr. A. has had no previous experience with illness. Prior to his stroke he worked from 12 to 14 hours a day and never missed a day's work in his forty years of working. Mrs. A. has, over the last 25 years, had a series of surgical procedures performed. She recovered quickly and disruption in the home was minimal. Their children have had no significant health problems.

Their youngest son, B., was born with cerebral palsy which has left him with a mild degree of right sided weakness. He has only limited use of his right hand and arm due to spasticity and muscle contractures. Mrs. A. says of her husband, "I don't think he accepted that there was something wrong with the child for quite awhile. I kind of had to take the bull by the horns and go it on my own [seeking medical diagnosis and treatment] ...because he was working." She reports that Mr. A. tended to overprotect B. and that only in the last year has he been allowed to have a bike or mow the lawn. Before this his dad had said that he "might kill himself...or cut his foot off." In each case, it was

B. who broke the pattern by riding a friend's bike and cutting the lawn when there was no one around. Initially this provoked his dad's anger, although, since his stroke, Mr. A. has not objected to B. using the lawn mower or riding a bike. B. says of this change in his dad, "He knew what I had to put up with all my life [once he had the use of only one arm]."

During the interviews most of their comments were directed to the interviewer rather than the family as a group. Mrs. A. and the older son did most of the talking. They took a forceful authoritative stance, frequently speaking for other family members or talking over them. Mr. A. offered his spontaneous comments only occasionally in a soft expressionless tone of voice. When C. was present his participation was more frequent. C. contributed spontaneously but was frequently ignored by her mother and D. The two younger children were rarely heard by the family unless the interviewer directed the conversation to them.

In short, the A. family had few crisis meeting resources prior to Mr. A.'s stroke. They were financially insecure, they had had little experience with illness and prolonged hospitalization, they had not resolved an earlier crisis experience, and they did not consider the family unit as a source of support for them in their time of need.

<u>Perception of the precipitating event</u>. The A. family does not share a common understanding of Mr. A.'s diagnosis. Each family member felt it was very serious, but described it in terms of his own needs. For example, B. defined his dad's condition in terms of his difficulty "getting along" with the family. The severity of his condition was

related to the possibility that it could lead to the break-up of the family: "Mom might walk out...or Dad might walk out...maybe I might run away." For A., her dad's condition was "real serious" and meant that "Mom and Dad have more fights." She said that it was "real scary."

Mrs. A. described her husband's condition as due to brain damage and then spoke at length about how helpless she felt in the face of the situation, a pattern which she reverted to frequently throughout the data collection period. "I find that at times I can't cope...just feel so helpless...I just wonder how much more I can take without going into a nervous breakdown or something." Mr. A. felt that his condition was "real severe." He said, "It's hard to accept that I can't do anything on my own anymore...go anywhere by myself...work and try to help the family."

Their sources of information about Mr. A.'s condition were varied. Mr. and Mrs. A. had obtained their information from the medical staff, whereas B. said, "I found out on my own." When the children had questions they usually raised them with the family counsellor from the church. Mrs. A. said that she had explained her husband's condition to the children and that she thought that B. would understand since "he's got brain damage." However, B. says that that hadn't really helped him to understand his father's condition.

Each member of the family "hoped" that Dad's condition would improve. However there was little agreement between Mr. A.'s goals and those which the family held for him. Neither was there any indication of readiness on the part of family members to become involved in helping him to deal with specific problems of recovery.

B. wanted to see a change in "his attitude...his grabbing other people...almost in all ways...be a nice person instead of being mean... be happy once in awhile." A. hoped that her father's condition would improve, however she did not say in what ways. Mrs. A. said that she expected that her husband would improve "as time goes along and things heal...have to accept things and calm down...first is accepting, then normal processes come along...now I think he's resigned, with the doctors' help, to accept it." She expressed some doubt about his continuing to live at home: "If there was any back sliding - I don't know how much I can take" as well as the possibility of his returning to work: "The doctors say 'no'...maybe something light...practically doing nothing." D. said, "I'd like it [Dad's complete recovery], but I'm not going to get my hopes up."

Relative to possible improvement, Mr. A. said that he hoped to improve and that he was trying "to keep control" of himself. He said that he didn't feel that he could face it by himself, to which his wife responded, "I know you couldn't. He's leaned on me all through the years, more than he realizes." Then she went on to explain what she thought his problems were, speaking about him rather than to him. This pattern was also evidenced by the older son, D., and was repeated frequently throughout the interviews.

There was no recognition of Mr. A.'s remaining function. Rather, each person related to a specific area of dysfunction which was particularly threatening to him or her. Neither was there any suggestion as to how Mr. A. might achieve the goals which they held for him or any recognition that they might facilitate his recovery. It was as though the problem was his and he would have to handle it on his own; similarly each family member would have to deal with his own problems. Clearly, no one in the family had come to accept Mr. A.'s disability.

Each person's responses reflected his or her depression. Their anger, fear, and hopelessness became even more apparent as the interviews progressed. This will become clearer in the following sections.

Problems encountered. The A. family has had many problems since Mr. A.'s stroke. The parents identify financial problems as their greatest problem while the two younger children see fighting as the biggest concern. Both Mrs. A. and A. have had chronic health problems for the last six months. Each of these problem areas will be described in turn.

Mrs. A. says that finances were a problem even before her husband's stroke in that they were already in debt for a truck which had been bought to replace another one which was not yet paid for. When Mr. A. first started trucking, he turned over to his wife complete responsibility for managing the household expenses. She received a set amount of money each month for this purpose. Mr. A. assumed responsibility for managing the finances relative to his business. Each person handled their affairs independently so that neither one knew of the other's role. Consequently, when Mr. A. became ill, Mrs. A. was not prepared for the financial responsibilities related to his business.

Soon after Mr. A. had his stroke, while his wife was attempting to manage the home and visit him in hospital each day, her doctor placed her on an antidepressant. However she discontinued its use, since she said that she didn't like taking "anything like that." There were no significant illnesses in the family until early March, when A. developed a bowel infection and eczema and Mrs. A. developed a throat infection. They were both on medications for nearly six months. The family did not associate these health problems in any way with Mr. A.'s stroke.

The fighting, of which A. and B. spoke, related to their own spats as well as to the arguments which they witnessed between their parents. Mr. A. described having become much closer to the older daughter, C. since his stroke. Apparently she visited him several times a day while he was in hospital. Although they did not share feelings about his condition, they both describe their relationship as "special." It was noted when she was present for the family interviews that she took a supportive role with her father, and that he spoke more frequently and more forcefully. Mrs. A. and the older son, D., also described a similar liason. Since D. had been driving his dad's truck and, since he had a good knowledge of the financial situation relative to it, he readily advised his mother on money matters in that area. She states that he "was a big help...real moral support."

With the two parents having formed alliances with the older children, and with a family pattern of not discussing their concerns within the family, the two younger children had virtually no emotional support until the family was directed to the family counsellor with the church in February. Integrative needs were being neglected. It was during this period that A. and B. saw their fighting as a real problem. B. described A. as "always bugging" him and A. felt that B. was always telling her what to do.

The problems between Mr. and Mrs. A. have been by far more continuous and complex. Although much of the information which supports this position was given by Mrs. A. as her perceptions of the problems related to her husband's recovery, marital discord of many years' standing was exposed by the stress associated with Mr. A.'s stroke.

Mrs. A. says "it's not really fighting, it's just that all of a sudden he explodes...and I find it so hard to cope with." Mr. A. describes their difficulties as "too much togetherness." Apparently this has been pointed out to them by several therapists, and while they both identify it as a problem, they have done almost nothing to change it. It is likely that togetherness creates stresses which are released through fighting and which are related to more basic issues.

Mrs. A. is most verbal about her distress with her husband's continual presence at home. She says, "He's like a shadow since this happened. I can't go anywhere or do anything and he's right there. When he first came out of the hospital I couldn't get a phone call and he'd be on the other phone monitoring.... It was just like all of a sudden I had no privacy whatever.... Lots of times I couldn't take him with me because it just wasn't feasible.... He'd get very angry if I'd say 'well you're not going'." When questioned about why she thought her husband behaved in this way, Mrs. A. said that she knew he had fears. However, she frequently repeated the same type of complaint and said that she couldn't understand why he did it. It is apparent that the integrative component was one with which she was not prepared to deal.

Mr. A. on the other hand said that he was "probably scared" when she left him home alone. His biggest fear, he said, was that she might leave him, and as far as he was concerned, "Life just wouldn't be worthwhile without her."

Mrs. A. accuses her husband of having been "overprotective and jealous" of her for their entire marriage. She says, "I feel that he just doesn't trust me and never has." She relates an instance where, against his wishes, she had applied for a receptionist job in a local hotel and he became angry with her and asked her if she was looking for another man.

While Mrs. A. feels that her husband doesn't trust her, she also questions the validity of his behavior: "I think he's been using his illness as a crutch. 'I'm a sick man, now you just do as I want you to do or else I'll just have another stroke.' I think he's just used it as a blackmail for a whole year." "I keep wondering. He says he doesn't know he's doing it [becoming suddenly very angry] until it's over. But I'm beginning to wonder if he's not playing that up too." Apparently this loss of emotional control was not evidenced in hospital and it only occurs in relation to his wife and the two youngest children. Mr. A. says that he can't understand why all of a sudden, "I'm not myself. I'm just somebody else...threatening to jump out of the car and stuff like that." Mrs. A. readily admits her fears in relation to his explosiveness and her need to protect the younger children. D. says that when he is around, his father "watches his temper.... He knows I won't go for it" but that he loses control with other family members because "they're scared of him." This may be one of the few ways in which he can exercise control, a very important aspect of his pre-illness behavior. Again, the family's difficulty dealing with interactional issues is apparent.

Mrs. A. describes her husband as "the Lord and master" in their home. "His control was through power...if they didn't do as he said it was the belt." Relative to decisions regarding money management she says, "I used to feel that I didn't know anything because he wouldn't listen to me. He'd do it in spite of me." And in relation to her periodic suggestions that she look for work outside of the home, "He used to say, 'You go to work - well pack your bags and leave'." "'If you go to work it's divorce because I'm not going to have a working wife'." Mr. A. explains that it hurt his pride to think of her working and furthermore, he didn't feel that she should have to work and manage the home and children.

It is clear that Mrs. A. resents her husband for having controlled her in this way and is reluctant when the older children challenge her to accept responsibility for having allowed it. She says, "Well I was afraid of his temper.... I used to keep thinking, 'You've got to keep peace in the family'.... I had the idea that if I did that sort of thing [what I wanted] and tried to get my own way, he'd say, 'Well you spoilt brat, you've got to have your own way or nothing goes right! He's said that before." She admitted to feeling like a child and spoke of going against his wishes as though she were disobeying.

Moreover, she says, "If there was no love, I could have left him long ago." "You put 31 years of marriage down the drain as if it never happened, that's not easy to do. Furthermore the thing that gets me about these marriage breakdowns is the fact that there's a wedding, there's a funeral - no matter what it is, you've got to come together with that person.... It could come to that [a split] if stress continued and I found I couldn't take it anymore, but it wouldn't be without a great deal of trying very hard to prevent it...there's so many questions left unanswered if you just pack up and go." In this discourse, which was repeated several times, she justifies having put up with an unsatisfactory relationship. To what extent religious convictions, social censure, and her own emotional needs have influenced her to stay, it is not clear. It is possible that she hasn't been aware of her discontent until recently and now seeks to justify not having done something earlier to change it.

Since Mr. A. had his stroke, the power balance has reversed. Mrs. A. has taken the dominant role in the home. She now does all the driving, makes the money decisions, and decides how the family will spend its time. These were all matters about which she previously had little to say. Mr. A. says that he believes that one reason they have had so many fights since he came home from the hospital is that, "she had full control of everything and I had none." His wife reports that, "Just recently he was telling me it felt like he'd lost everything and I'd taken everything away from him, and I said,'whatever I took away to take it back. I don't need it and I don't want it.' But he hasn't taken it back yet." Mr. A. admits that he's scared to take back the responsibility for handling the money and speaks of "trying to prove to himself that he can do it." Apparently when Mr. A. first came home from the hospital, without consulting the family, he automatically took over writing cheques to cover the truck expenses, as he had done prior to the stroke. This led to a great deal of conflict in that there was no money to cover the expenses and D. and his mother, who had continued to deal with the money, didn't know what their financial state was because they had not been informed of the cheques which Mr. A. had written.

At the same time Mrs. A. and D., who have shared the dominant role, are very critical of his performance in other areas. His son says about his tilling the garden, "It's not that he can't do it, he can do it but it's just...it wouldn't be a very good job. So one of us would have to come along and do it again." "I knew he couldn't do the job that I could do, so I just told him to forget it and I just kept on doing it." D. also speaks about how hard it is to tolerate his father asking the same questions more than once or telling him to do things in a way that seems not to make sense. Mrs. A. admits that, although her husband wasn't able to do the garden as well now as he had before, that he had been able to keep the weeds down. She was particularly distressed, however, by his continued need for reassurance concerning how well he had done the job. "Now he needs such reassurance...everything that he does, he's got to be reassured that it looks alright. He'll ask you a hundred times, 'Does it look alright?'...before, he knew himself that it looked alright." She accounts for this in the following way: "He's so unsure of everything. I think he's unsure of us too", to which he replied, "I think maybe it's that I'm putting everybody to a test as well as myself." This was one of the very few instances when they showed even a slight congruence in their awareness of Mr. A.'s emotional needs. However, a willingness and capacity to deal with this task were not evidenced. Rather, the response to his needs was one of anger. "He's felt sorry for himself from the day it happened","...continually worrying about himself", "He wanted sympathy", "He's only looking at it from his point of view...we've had to change our lives just as much as he's had to change his, and that isn't easy.... It's been just as hard for us", "I just wish he could stop and count his blessings and be thankful he's as good as he is."

Much of their anger has been directed toward the inadequacy of the treatment program: "The thing I can't understand is why in God's name do they send somebody home and let them stay at home without treatment, without watching exactly...should be somewhere, like not exactly a hospital...where they could be sent and you know all this could be taken care of." "Where do you send him and how do you make him do what he's supposed to do?... Why isn't there someplace that they could be taken care of that this wouldn't occur so much in the home?" "I'm sure if you got them into an exercise program and got their muscles and brain moving...", "...they're sent home and the family's supposed to do it [treat the patient], and the family hasn't got a clue." This was a constant theme, expressed repeatedly by D. and Mrs. A. Mr. A. did not agree completely with their remarks, inasmuch as he felt that it was important to spend some time at home in order to be "ready to learn" and benefit from additional programs. At the same time he recognized that his being at home continuously was creating tension between him and his wife. The older daughter C., on the other hand, came closest to recognizing a family problem when she said, "...should be someone coming into the home...working with the family...teaching them how to cope, because that's where the problem is." While she and her father have some awareness of the problems being within the family system, they occupy submissive roles and consequently little consideration is given to their viewpoint.

This is particularly apparent in the amount of talking for and talking about Mr. A. which D. and his mother do. Many of their remarks were preceded by, "His biggest problem is...", "what he needs is...", what he thinks is...", and "He feels...". Very often Mr. A. disagreed with them when questioned, although he rarely did so spontaneously. In fact, in some ways he accepted the submissive role: "...if it would make everybody happy, I think I'd be satisfied." Remarks like this from time to time suggest that Mr. A. has begun to take the submissive role previously held by his wife, and that he may be disregarding his own needs in order "to keep peace" in the family.

It is not likely that Mrs. A. will resume her previous submissive role in the marriage, and it may be that they will resist establishing a more equitable role distribution. She says, "In all our years of married life, I've never felt the self worth that I feel now. I always felt I was just at home looking after the kids - a little underdog, I guess you could put it - because he was the authority on everything. All of a sudden the roles have switched because I'm kind of the authority... I think he thought I couldn't do it, now I'm showing him I could do it." Neither is D. ready to allow his father some of the control which was previously his. He talks of having to draw the line on his father's explosive behavior: "He never used to put up with us. I figure there's no reason I should have to put up with it.... If there was no one around to draw the line somewhere, who knows where he'd be, what he'd be doing?" He also spoke of the risks involved in his father tilling the garden and mowing the lawn: "He could break his arm...and if he fell or something...". Although he denied that he was protecting his father and denying him opportunities to feel good about himself, he continued to take this stance. Later in the interview he inquired as to when the real estate agent was coming since he wanted to be present so that he "doesn't take advantage." Upon questioning, the family readily agreed that a year ago, it would have been Mr. A. who took such a stance.

The examples provided above indicate that the A. family is experiencing relationship problems which affect a large part of their family experience. Possibly the most significant of these has to do with their inability to respond appropriately to the emotional needs of their members. This is evidenced by the establishment of two coalitions within the family which have excluded the two youngest children. It is also apparent in the way the family prevents Mr. A. from "proving" to himself that he can still do many of the things which he did prior to his stroke. Although they can frequently explain the basis for some of Mr. A.'s behavior which disturbs them, there is virtually no attempt to empathize with him or to provide any kind of support for him. Compliments are rare, usually solicited. There were no direct expressions of concern for one another or encouragement to share feelings within the family during the interview series.

In fact their pattern for handling feelings has been to deal with them privately. Mrs. A. learned early in their marriage to say nothing and "keep the peace". She says that she almost never cries. B. also said that he never cried, rather he would "try to think nice thoughts." Although A. frequently cried in response to her parents' fights she said that she didn't really have anyone to share it with until they saw the family counsellor. Even though C. and her father claimed to have a very close relationship, they did not talk about how they were feeling and never cried together. Mr. A. said, when questioned about this, "We never got that serious."

Their inability to empathize with one another has contributed to communication problems and a series of misunderstandings. Remarks such as, "How can I take your pride away?" were noted to limit the sharing of concerns. Patterns of speaking over other members were apparent as well as speaking for them. In several instances incorrect assumptions were exposed.

Role conflict has added to the family's relationship problems. Their previous pattern of roles was quite rigidly defined: "I knew what she was supposed to do and she knew what I was doing." There was no evidence of role flexibility which led to difficulties for Mrs. A. when she first took over responsibilities which had been her husband's. Although their execution pattern of rigid role distribution relative to the division of labor had been functional, they lacked the appropriate correction pattern to maintain its appropriateness. Mr. A., in particular, is caught between trying to assume his previous role as the dominant protector and provider and being thwarted in his attempts to do so. The expectations of at least those family members who now hold the power, are that he should be the submissive, cooperative, nonfunctional family member. In part, their expectations support the sick role behavior appropriate for the acutely ill. However, in spite of their dominant position, they abhor sick or impaired behavior.

This suggests that the sick role is not as significant as is the dependent, submissive aspect which previously defined Mrs. A.'s role. Mrs. A., having assumed responsibility while he was ill, is not prepared to return to Mr. A. responsibilities which he may still be capable of handling. This has contributed to Mr. A.'s depression. He says very clearly, "I think the most important thing is for me to feel better about myself." On the other hand, it reflects her anger about having been dominated for so many years by her husband.

The members of this family are depressed. Their focus has become one of protecting their own interests. They have little energy to invest in the concerns of other family members and they do not see a way out of their struggling. Their relationship problems now represent an aggravation of a previously existing dysfunctional execution pattern and the lack of an appropriate corrective strategy. We turn now to examine their problem solving strategies.

Problem solving strategies. The A. family's approach to family problems is primarily autocratic, the decisions being made by the person in authority. In this instance it is Mrs. A. and D. who have taken over for the family. About involving other family members in making decisions which affect the whole family, he says, "Just me and Mom...get too many people involved it's impossible." Mr. A. says, "I was informed...but not involved." The other children indicate that they were not involved in discussions about money, health or relationship problems, all of which the family experienced. The approaches which the A.'s used in dealing with each type of problem will be described.

The health problems experienced by Mrs. A. and A. were dealt with simply by obtaining medications for them. No specific changes in their living patterns were made.

Financial problems were dealt with in part by deliberate effort, and in part through good fortune. Mrs. A. was the one who, after discussion with D., took deliberate action to deal with some of the money matters. One of these measures was to arrange with their bank manager that they be carried indefinitely on an overdraft for the payment of utilities and house and truck payments. This approach is still in operation. She also explored the possibility of obtaining social assistance but was informed that they did not qualify. Similarly she initiated action for commencing Mr. A.'s veteran's pension and federal pension prior to the usual retirement age. Arrangements were also made for D. to buy his father's truck and for the A.'s to sell their home and move to rental accommodations. This apparently had been a plan which they had made for retirement rather than a plan which took its roots in the financial problems related to Mr. A.'s stroke. In both instances these plans were arrived at by Mrs. A. and D. Mr. A. offered little resistance to their implementation. As for the money matters that were dealt with by good fortune, the church and other local organizations presented them with large amounts of money and food hampers periodically for the first five months.

Their relationship problems have been approached in terms of providing symptomatic relief rather than considering the underlying dysfunctional pattern. Without discussing their fighting, A. and B. independently decided how they could best deal with the other. B. decided not to say anything when A. was annoying him and she decided to do some of the things he told her to. While this solution has reduced the incidence of their fighting, it has perpetuated the family pattern of no discussion and "keeping the peace".

Mr. and Mrs. A. have also avoided discussing their fighting. She says, "There are times we have [talked about it] .... It's such an instant thing though...you're not even forewarned...only way I can get over it and ignore the whole thing is just not open my mouth and keep quiet. But that doesn't always fix things up." As to the outcome of their discussions, she says, "He always says he knows that he's doing wrong and he's going to try and be different and we talk about it that way." Mr. A. agrees with this description of their discussions.

It is apparent that the A.'s define the problem as Mr. A.'s stroke and that they do not consider it to be a problem requiring family action: "He's under the one [jail term] that he's got to get well and we're under the one that we've got to cope." In fact their explanations of "too much togetherness" focussed on Mr. A.'s being at home, not going out to work and not having outside interests as opposed to Mrs. A.'s being continually in association with him or to ways of working out a more balanced program for their time together. Soon after Mr. A. was discharged from the Glenrose Hospital, Mrs. A. began to complain about how unfit he was to be discharged and about how difficult it was for her to cope with his behavior. She pleaded with the psychology department that they should arrange some type of ongoing therapy for him. Arrangements were made for him to enroll in a Life Skills program commencing in January. This all day group program provided some separation for them and apparently acted to decrease the tension in the home somewhat. Yet, although she continued to complain bitterly about the importance of continued rehabilitation and getting her husband out of home, she did not encourage him to drive to the daily program offered by the newly formed stroke association. Neither did she arrange for other transportation or drive him to it herself. In effect then, although they might have reduced their togetherness, they chose not to.

Further evidence of the family's perception of the problem as Mr. A.'s stroke is provided by their emphasis on making plans for him. Their discussions of plans for work, training, and rehabilitation were conducted without consulting him even though he was present. Although, when questioned, he did not always agree with their assessments or their plans, they continued to define his needs for him.

Mr. A.'s spontaneous contributions to discussions of problems related to him focussed on the ways in which he expected new medications or new doctors to help him and on how much better he expected it to be once they sold their house and moved. He could not, however, explain what changes he expected to occur which would reduce the stress on the family.

In summary, the A.'s have not, in the year since Mr. A.'s stroke, developed an awareness of the dysfunctional patterns which perpetuate their struggling. They have dealt adequately with transactional matters in that school performance and community responsibilities have been maintained. Similarly, they have dealt with the instrumental needs of the family: maintenance of the house and car and provision of adequate finances, food, clothing, and medical care. Their difficulties in the interpersonal domain have, however, not been dealt with. This is in part due to the definition of the problem in terms of the father's stroke. Probably more important, though, is the lack of adequate correction patterns through which the family as a unit could come to a workable way of relating to their changed father, while at the same time allowing for the personal growth of each of its members. Their unwillingness to share and invite the contribution of other members, their resistance to considering changing themselves, and their tendency to discredit their father suggest that they are likely to continue struggling without remedying their difficulties or that they may disintegrate because they can no longer endure the tension associated with their own dysfunction.

We now move to the presentation of the second case study: another family in which the father who while employed, suffered a right CVA leading to left hemiplegia.

Family B

A total of 5 hours was spent with this family during the months of July and August, 1979. Following is their account of the effects which the father's stroke has had on their lives.

Medical data. Late on the afternoon of May 2, 1979, while finishing work, Mr. B. experienced a headache together with numbness and heaviness in his left arm. He could not complete putting his tools away. He was taken to the hospital where he was diagnosed as having had a right cerebral vascular accident resulting in left hemiparesis.

On admission to hospital he was reported to be restless and drowsy. His speech was slurred and the left side of his face drooped noticeably. He had marked paralysis in his left arm and movements of his left leg were weak and uncoordinated. He had no sense of position in his hand and arm, and only limited sensation on his entire left side. Reflexes on the left side were also weak.

Mr. B. was transferred to the Glenrose Hospital on May 28, 1979, having made a good recovery. He walked without aids or assistance and managed most aspects of his personal care. He still had some slurring of his speech as well as weakness and lack of sensation in his left arm and hand.

A month later, prompted by the arrival of relatives from Europe, he was transferred to the outpatient program at his own request. It was the judgement of the stroke team that his left finger movement had improved although he would still require teaching in order to be able to return to his previous employment as a carpenter. He was at that time, independent in all aspects of his self care and his speech was slow.

Mr. B. attended the outpatient program for a week before taking a three week holiday with his relatives. He returned to the program for another week following a brief admission to hospital at the conclusion of his holiday. He had complaints of nausea, vomitting, headache, and dizziness. Apparently a small stroke was suspected.

Family data. Mr. B. is a 54 year old self employed carpenter. He and his 56 year old wife have been married 28 years. They have three children aged 26, 22, and 16. Their youngest, M., a son, is the only child living at home. The elder son lives in another province and the daughter lives and works in Edmonton.

The B.'s emigrated from Europe in 1957. Both Mr. and Mrs. B. had 8 years of education in Europe. Their two older children have obtained their Grade 12 as well as a technical school training. The youngest son, M., is going into Grade 11.

Mrs. B.'s sister and her husband own and live in the upper storey of the B. house. They maintain a close relationship in terms of helping one another with house and garden work as well as sharing personal concerns. Mrs. B.'s brother and his wife also live in Edmonton. They maintain close contact through visits and phone calls. The B.'s own a lakeside cottage not far from the city. They frequently spend a week at a time at the lake since they enjoy the company of many of the other cottage dwellers there who come from their home country. They have formed a social club which meets regularly throughout the winter and periodically during the summer. The B.'s derive great pleasure from this association, which is their only community involvement.

Mr. B. has had several previous encounters with illness and hospitalization. He was treated for tuberculosis of the kidneys a number of years ago. Three years ago he suffered a heart attack. He was off work for a year at that time and recalls that time as a very difficult one for a number of reasons. He is still on medication for his heart condition and he periodically experiences shortness of breath and palpitations. Mrs. B. has arthritis for which she has been taking medication for the last five years. She says that it affects her entire body and that she is always in pain. Their children have been healthy and have required almost no medical attention.

The B.'s had enough money in savings to live for the year that Mr. B. was off work following his heart attack. However, they have not been able to build their savings up to any substantial amount since this time. Apparently they recently sold a small piece of property in order to finance a trip to their home country and the small amount of money which was not used for their trip was placed in savings. The B.'s own their own home, however they have not paid their taxes for this year.

During the interview Mr. B. did most of the talking although M. and his mother made spontaneous contributions. Family members spoke to one another and checked out their perceptions with one another. They frequently asked for clarification of a comment made by another member and disagreed openly among themselves. They showed a sense of humor and frequently laughed together. The interview process was relaxed and supportive.

In summary, the B. family evidenced several valuable resources for meeting and dealing with a potential family crisis precipitated by Mr. B.'s stroke. They had recently dealt with a similar experience when Mr. B. had his heart attack. They maintained a very close relationship with Mrs. B.'s siblings and they showed a style of communicating which encouraged the participation of their members in the discussion. Their financial reserves had been somewhat depleted by Mr. B.'s last illness so that their security in this area was reduced.

Perception of the precipitating event. The B.'s share a common understanding of Mr. B.'s diagnosis in as much as each family member offers similar descriptions of how he has changed and what the implications of his condition are. M. speaks of his father being "more relaxed" since the stroke. Similarly Mrs. B. says that he has recently "slowed down." Mr. B. himself admits that he isn't nearly as "edgy" as he was before his stroke and that "there's just not enough energy left."

At different points in the interview series each family member mentioned Mr. B.'s difficulty using his left hand as well as the fact that he was a little slower in performing many of his previous activities. However, they all indicated that they expected that Mr. B. would recover the use of his hand enough to be able to return to carpentry. Mr. B. described it thus: "It is a different feeling altogether in this hand. I have to get used to it...how to do it differently than before. That feeling...is missing now so I have to find another way.... It may be a slower one, but I have to go out and I have to experience it and I have to try." "It's maybe not far enough to say.... doctor still has hope." M. was quite definite that he expected his dad's hand to improve. "Just look how fast that hand recovered already", as was his mother who spoke of "practicing day by day."

Each family member was very aware of Mr. B.'s frustration with his impairment. Mrs. B. said, "He has more temper than before.' A little bit -

and he's screaming", and M. commented, "Maybe because I know that he was sick I try to make it more comfortable for him. That way he doesn't have to yell at me so much. And then I don't have to get mad." Mr. B. described this as his biggest problem: "My problem is that I can't do things the way I want, and that's all. Whatever I do I have it in my mind different. I know what it's supposed to look like and I can't get it.... I used to be quite handy and it just doesn't seem to go anymore... You can't do this anymore and that doesn't turn out. And even if you've done something it doesn't turn out and you're not satisfied with it. You know what you could do, what you were able to do.... You might do some other things alright, you know, but still not everything comes out."

So too, they shared common concerns about Mr. B.'s condition and its implications for them. About returning to work, Mr. B. said, "I don't want to - I have to. It doesn't rain dollars." "She [Mrs. B.] worries I might die." "You can't just sit around and wait and say, 'As long as I'm sitting nothing can happen.' It still can happen." Mrs. B. said, "Every time he goes out I worry about it. It was too often in a row for me." "He won't listen to stop working. I say okay, that's enough now.... Actually it's not my right to tell him.... I'm scared that something will happen again and I don't want that.... He doesn't realize it himself, so sometimes I think I must tell him." "We can't live without money. When unemployment is gone, what then?" M.'s comments were quite similar: "I think if he'd take it easy, he'd be okay.... Just relax.... You don't have to be working all the time. You could sit down.... I don't think it would be good [for Dad to go back to work]. He might have another stroke...might die."

So too, they expressed concern about Mr. B.'s continual worrying.

Mrs. B. said, "From my side, he should stop worrying about other people... I guess everybody would worry a bit. He always worries....can't help it.... before he was able to go to work and he worked and everything [money] went around.....not so much to worry about because you are healthy." And M. says, "Like you just said, 'I've got to go to work, I've got to support my family.' You're worrying." Mr. B. is well aware of his worrying: "I haven't changed. It was there before; it's now there; and I guess that it will be as long as my eyes are open." "It's my fault. I made them my dependents.... It's my responsibility [to provide for them]."

Mr. B.'s source of information concerning his condition has been primarily medical. Mrs. B's primary source has been her sister-in-law who is "a therapist" who has worked with disabled children and adults. M. says that he has learned about his dad's condition mostly through his mother who kept him informed daily of Mr. B's progress in hospital. He also indicated that whenever he had questions about his father's condition, he consulted his mother.

There is a high level of congruity in the perceptions which the members of the B. family have of the nature of Mr. B.'s condition. They recognize similar changes in him since his stroke and they express similar concerns about his recovery and continued employment. They clearly identify Mr. B.'s stroke as a family problem, yet they have not allowed it to become the focus of their entire family experience. Neither do they see it as a threat to their continued existence as a family unit. This is evidenced by their perceptions of the problems which they experienced subsequent to Mr. B.'s stroke. We move now to consider the problems which they encountered.

Problems encountered. When asked about the problems which they experienced following Mr. B.'s stroke, Mr. B. tended to see some of their difficulties as more problematic than did Mrs. B. For example, Mr. B. felt that the problems related to home responsibilities were very significant, whereas, Mrs. B. remarked, "Sure it was a problem, but we managed." Apparently, just prior to his stroke, they were midway through decorating their living room, a project for which Mr. B. usually assumed the major responsibility. Mrs. B. was left with shopping for materials, painting, and plastering. The difference in their perceptions of the problem is probably related to his concern about helping to "fill in and take the burden off everyone a little bit."

Other aspects of home management did not present problems for the B. family even though Mrs. B. spent the largest part of each day with her husband in the hospital. "My sister came in and cooked the meals for M...same for me when I came home, so that I wouldn't have to cook. Everything went smoothly...was not really a problem because we were living together [with my sister].... She drove me to the hospital because I don't drive." Similarly M. worked the garden, mowed the lawn, and drove his mother to the hospital. "Well Mom had to go to the hospital so I had to drive her. She asked me and I said I would."

Another problem which Mrs. B. dealt with readily was that of writing the cheques to cover their regular expenses. Prior to her husband's stroke she had never written a cheque. This too was something her husband had always done. Financial concerns were not initially a problem since Mr. B. was eligible for unemployment insurance for the first three months that he was away from work.

No significant health problems were experienced by any of the family members. M. did not miss school or have any difficulty maintaining his school achievement. Mrs. B. does not recall her arthritis becoming more bothersome. She said, "I was twice as busy as before... you forget about yourself. I had to go to the hospital and I had to see him. Then you forget your own problem." However, she did admit, "I got more nervous and had high blood." Apparently she was given a mild tranquilizer by their family doctor which she took for only a month because it made her "a little bit too much relaxed." Her sister-in-law then gave her "some herb pills...[which she takes] any time - as soon as tears are coming. Then they are gone and I can talk again." Mrs. B. says that she has always cried easily and that once, several years after they came to Canada, she was hospitalized for her crying "because I was homesick."

The B.'s have not experienced problems in their interactions, in fact they feel that in some ways they may get along better now than they did prior to Mr. B.'s stroke. Mr. B. said of the change between himself and M., "His behavior has changed. It seems that when you talk to him at least it registered and he's doing many things that you are talking about. Before you could tell him a hundred and fifty times.... It seems like it's going smoother now. I don't have to get angry because he's become better." M. agreed that their relationship was more comfortable and said, "I don't know, maybe I've changed [but it feels] just natural." Mrs. B. and M. felt that their relationship had not changed. Mrs. B. also felt that her relationship with her husband was improved. This she relates to his having "slowed down" following his stroke. She could not explain how this affected their relationship although it may be that she reminded him less to relax and consequently he was less irritable.

In summary, the B.'s experienced the problems related to Mr. B.'s stroke as minor and short lived. We turn now to a description of their problem solving strategies which will shed light on some of the reasons why their problems were seen as minimal.

Problem solving strategies. Of those problems which they faced following Mr. B.'s stroke, the B.'s considered finances to be the biggest one. Mrs. B., who although she disliked doing it, made the necessary arrangements for the commencement of Mr. B.'s unemployment insurance payments. This she did with the assistance of her sister. Aside from the help which her sister provided in managing the household tasks, Mrs. B. also relied on her assistance with cheque writing and purchasing materials for the completion of the decorating of their living room. Her sister-in-law went with her to the doctor so that she could help to ask questions about Mr. B.'s condition, and her sister-in-law also gave her the "herb pills" which helped her to control her crying. Her close relationship with both her sister and her sister-in-law provided Mrs. B. with moral support as well as extra manpower for getting things done. This correction pattern, which was initiated in part by her request for help with things she had not previously done, and in part by her relatives' responsiveness to the situation, enabled the B.'s to modify their execution patterns with little disruption.

Further evidence of the strength of their corrective patterns is provided by the way in which family decisions were made during the time that Mr. B. was in hospital. Mrs. B. said that, just as she had done prior to his stroke, she continued to consult with her husband about how she should handle certain things. "I discussed it first with him...should I buy it or should I not buy it." I took everything [cheques to be written, unemployment insurance forms] to the hospital. I talked to him about it and he signed it. Then I mailed it." "When the first cheque came I told him this is how much you got and then I paid the bills with it." Mr. B. says about this way of handling their affairs, "Even if I was in the hospital I still knew what was at home... It was very good to know what's going on, how things are going and it gives more relaxation too." This pattern for handling their affairs also suggests that the B.'s did not reinforce the dependent submissive behavior commonly associated with the sick role. Rather they emphasized Mr. B.'s ability to continue fulfilling his usual roles in the family by modifying their behavior to allow for it.

This is not to suggest that they denied his illness or avoided relating to it. Mrs. A. was particularly aware of his changing status from day to day. She said, "I guess then he worried more than I did. I worried too - but I tried to talk it out of him." Her supportive role was also evidenced in relation to their son, M.: "Well I told him what happened and he asked 'How's Dad?' I told him 'better' or 'not so good today' or something like that you know." M. indicated that he found this to be helpful for him since he didn't like to go to the hospital. That Mrs. B. met many of the integrative needs of her family, is evident, however it was not at the expense of instrumental needs since their difficulties in other areas were not considered to be problems.

About his wife's integrative role, Mr. B. readily admitted that she was the one in their family who worried about the others and who helped them to feel better. "She's the one. She's the mother. I guess it comes more or less naturally. She grew into this.... You know she's managing and you don't have to put effort into it - she already has. She still is the one who actually transmits things to the kids.... She can say way softer 'I'm sorry about...' than I can do it."

Mr. B. readily credits his wife with having coped very well with the demands imposed upon them by his stroke. He says, "Not only since the stroke - all the way along.... She's a very good manager.... It would have been a way different burden if I would have known she couldn't do it you know. She can do it, so why should I worry? [I knew] she could do it when I married her." Yet Mrs. B. was not accustomed to handling many of the matters which required attention at that time. Her husband says, "Many things she didn't have to do - and when you haven't got to do it you can't do it, eh? Well, now she had to." Mrs. B. admitted that she didn't like doing many of the things which her husband usually handled but that "I can do it if he's not around." Mr. B. had described doing things "commonly" early in their marriage and then later, when the children arrived, establishing a division of labor which gave each of them certain responsibilities. To what extent their early sharing facilitated Mrs. B.'s assuming some of her husband's role responsibilies, it is not known. It may be that, following his heart attack three years earlier, she had become somewhat familiarized with the responsibilities of his role. Also, she was able to ask for her husband's guidance in performing certain aspects of his role responsibilities which he could not meet. In that they were able to share information of this type, they demonstrated a flexibility in their roles. Role conflict was also minimized by allowing Mr. B. to retain responsibility for decisions which he usually made.

Interactional matters were not a problem for the B.'s. Neither were transactional matters in that Mrs. B. promptly took care of them. Although they continue to be concerned about financial matters they have developed a plan to see them through at least the next year. This provides evidence of their developing an appropriate execution pattern in order to prevent a crisis at some later time. When Mr. B.'s unemployment insurance benefits have expired, if Mr. B. is not ready to return to work, they will apply for Social Assistance. This is a plan which he resisted strongly following his heart attack. However, at this point he says, "What else can you do?" In the time that it takes for the application to be processed, they will rely on their savings. Should it become apparent that Mr. B. will not be able to return to work during the following year they will apply to the Canadian government and to the government of his home country for his early retirement. If it becomes necessary they will sell their lakeside property, an alternative which Mrs. B. was initially opposed to. It was noted that, over the period of time from the first interview to the last, the B.'s became progressively more accepting of several alternatives which they had initially resisted. At the same time, Mr. B. expressed less and less urgency to return to work. Whether this is reflective of their problem solving strategies or of his general improvement, it is not known.

In summary, the B.'s evidenced strong correction patterns characterized by continued discussion, role flexibility, and empathic support. Both individual and group concerns were attended to. Problems were readily identified and dealt with so that while they were distressed by their father's stroke, their family life had not been threatened.

Mr. B. expressed depression concerning his loss of function: "I don't feel like it [whistling and singing]. It got lost somewhere on the way. It has all to do with when things don't go smooth, it somehow affects you.... The burden is there. You can't smile and sing if you get whipped. These things don't go together." At the same time he showed that he was beginning to accept it: "I need someplace first before my regular work...to get certain knowledge, to see how you're still feeling, how you can handle this without the feeling that you haven't got."

As he described it, his family also shows an acceptance of his loss of function: "They supported me. They are realizing...each one realizes that there is a change in my way of being you know - that I can't do as much anymore, that fast anymore - things like that. These are all facts which are there and they realize that it is due to the stroke. There was no tiredness before or anything. I could go and do things and fast and efficient. These things don't go anymore. They realize that...they understand that. They accept it the way it is." This is perhaps reflective of the attitude which Mrs. B. expressed concerning her husband's desire to return to work, a matter which causes her considerable concern: "That's up to him - what he feels - what to do or not. I guess another person can say 'go do this or that' and he doesn't like it. It would be a burden for him, you know. It wouldn't work out." These remarks suggest that the values which the B.'s held prior to Mr. B.'s stroke were not challenged by the changes which occurred in Mr. B. as a result of his stroke and that, as a result, their acceptance of his incapacity was achieved without a major revision of their value system with its accompanying tension and confusion.

Within the three months since Mr. B.'s stroke the family has coped well with the related demands. They have also come to accept the limitations of his condition. Furthermore, their family life has not been significantly disrupted.

This concludes the presentation of the case studies of the two families, both of which were faced with the problems surrounding a stroke in the father. We move now to respond to the research questions around which this study was designed.

Research Question 1

Does the occurrence of a stroke in an employed father with dependent children initiate a process in which family patterns are modified?

The intent of this question is to determine whether stroke in the father precipitates a crisis for the family. It takes as its source Montgomery's conceptualization of family crisis as a process which begins with pattern inappropriateness and ends with the family's reorganization either as an intact unit or as a modified family unit. It will be dealt with by considering: (a) evidence of pattern inappropriateness, (b) evidence of pattern change, (c) problem solving steps, (d) levels of change, and (e) awareness of family change.

In both families, pattern inappropriateness became apparent following the father's incapacitation. For the A.'s, pattern inappropriateness was related to their management of finances, their role distribution, and their interaction patterns. Since Mr. A. owned his own business, he was not eligible for unemployment benefits. Their practice of living from paycheck to paycheck without establishing a cash reserve constituted an inappropriate execution pattern. The pattern of role distribution which the A.'s had arrived at prior to Mr. A.'s stroke was one in which Mrs. A.'s personal growth had been sacrificed in order "to keep the peace". Once having experienced a sense of accomplishment in taking over family responsibilities previously her husband's, she was no longer prepared to resume her previous role. The earlier execution pattern had become dysfunctional.

In the interactional realm, the A.'s failed to share ideas and feelings. This contributed to feelings of anger, depression, and isolation in the family members. Furthermore, it prevented them from arriving at consensus as to the nature of their problems and how they might be dealt with. Their autocratic approach to problem solving acted to intensify feelings and further reduce their chances of success. In their inability to come together as a group and work as a unit, recognizing and supporting one another, the A.'s lacked an appropriate correction pattern for dealing with their distress. The A. family, then, showed both inappropriate execution patterns and correction patterns in the face of the father's stroke. This left them vulnerable to both anticipatable and unanticipatable stressors. It had been their good fortune to this point to have escaped a series of crises with which they could not cope.

The B.'s, on the other hand, evidenced inappropriateness only in their execution patterns. At the time of Mr. B.'s stroke there was a substantial reduction in his income so that earlier patterns of saving and spending required modification. Similarly, their earlier division of labor, such that Mr. B. took primary responsibility in obtaining materials for and actually completing the renovations of their home, required readjustment.

A second aspect of crisis is that of pattern change. If the family is to emerge with a new organization, they must in the process, modify their way of dealing with certain family matters. The A.'s had a year long history of having attempted to change their way of dealing with their distress. They had not, however, been able to accurately define their problem. Consequently, their problem solving approaches were directed toward the symptoms of their pain, rather than its cause. For this reason, their solutions were essentially stop-gap solutions which provided for them only temporary relief.

The B.'s readily identified their problems and made the necessary modifications in the financial and role distribution areas such that they were able to continue meeting transactional and interactional responsibilities. This they did, through continual discussion and joint decision making, as had been their customary practice prior to Mr. B.'s stroke. Their application of this appropriate correction pattern enabled them to make the necessary pattern changes with only minor disruptions in their family life.

The problem solving process employed by the A.'s had not, in the year since Mr. A.'s stroke, moved beyond the awareness level. Each family member is aware that a problem exists, however they have not been able to reach consensus about what it is or how it should be handled. Consequently their attempts to deal with it have been ineffective. They have continued to repeat their inappropriateness and to experience the associated stress.

The B.'s have, on the other hand, moved through the complete crisis process. Awareness of a need for pattern change was readily recognized by Mrs. B. who consulted with her husband, son, and sister. Definition of their problems was prompt, as was consensus concerning the solution and the acting appropriately on that decision. The B.'s have, in the three months since Mr. B.'s stroke, moved through the crisis process as an intact unit with mutually contingent roles and appropriate patterns.

The level at which the A.'s have attempted to deal with their distress has been inappropriate. They have used first order change strategies which act to maintain the system. In that the role distribution has changed and their values related to "keeping the peace" have been challenged, second order change is required. Only if they can achieve a new structure and new values will they be able to resolve their dilemma.

For the B.'s, first order change was adequate for dealing with the problems which they encountered. A major system revision was not required. Although Montgomery suggests that second order change is necessary for crisis resolution, it is apparent that the strength of the B.'s correction patterns enabled them to make the minor adjustments required to deal with their difficulties without altering the homeostasis of their system.

Awareness of change might also be considered in determining whether a family has moved through a crisis, since Montgomery emphasizes the cognitive processes of problem definition and rational problem solving. Both families were hard pressed to identify ways in which they, as a family, were different since the father's stroke. The A.'s spoke of an increased awareness of the feelings of others, which since they admitted they did not know how to deal with them, probably reflects the high degree of tension which they are experiencing. The B.'s could not identify any ways in which their family had changed either. In their case this would relate to the level at which they made the necessary changes. Since second order change was not necessary for them, they have maintained their family system at its previous level of homeostasis.

Returning to the question as to whether a stroke in the father precipitates a family crisis, the findings indicate that the answer is yes. Pattern inappropriateness and pattern change were common to both families. In one case their changes allowed the family to move through the crisis process; in the other family their first order changes were inappropriate and they continue to struggle. That a family could move through the process, though, without making second order change, is an interesting finding. It will be discussed in the final chapter.

Research Question 2

In families where the employed father has recently suffered a stroke, what specific problems are encountered: (a) in fulfilling functional roles, (b) in maintaining the health of the members, (c) in relating to one another, and (d) in other areas of family functioning?

In both families first order change occurred in the reassignment of role responsibilities in order to meet those role expectations previously met by the father, and in order to allow the wife to spend long periods with her husband each day during his hospitalization. The families did not consider this reorganization to be problematic. In neither family were school problems, on the part of the children, reported.

No health problems were reported in the B. family, whereas, in the A. family both Mrs. A. and the youngest daughter developed chronic infections some six months after Mr. A.'s stroke. In each case they had not previously experienced health problems of that kind.

The problems which the A.'s had in their relationships were described in terms of the behaviors which most threatened a family norm relative to "keeping the peace", namely, fighting between the two younger children and fighting between the parents. As they described their problem it became evident that their emotional needs for support and acceptance were not being met within the family. This, however, they failed to realize. In the B. family no relationship problems were experienced.

Both families identified money problems as one of their biggest concerns. In each instance it was the breadwinner who suffered a stroke so it is not surprising that their financial security was threatened. Even in the B. family, where there were alternate sources of income, due to Mr. B.'s uncertain prognosis, they considered finances to be a major problem.

Research Question 3

How does the family, in which the employed father has recently suffered a stroke, deal with the problems which they encounter? How do they arrive at a definition of the problem(s), (b) decide on (an) appropriate solution(s), and (c) determine who will be responsible for carrying out their proposed solution(s)?

In the B. family, problem solving was done in a democratic way. Mrs. B. tended to be most aware of family problems which she promptly shared with her husband, her son, and her sister. As had been their pattern prior to the stroke, the B.'s continued to make their family decisions jointly. There was little energy wasted on deciding who would do certain things, rather, family members offered their services as soon as they learned of what needed to be done.

In the A. family, problem solving was approached in an autocratic style. Mrs. A., in association with the older son, D., took the leadership role in attempting to deal with their family problems. Each family member showed an awareness of family problems although there was no attempt to arrive at a common definition or to work as a unit in developing a plan for dealing with the problems. Their solutions were primarily aimed at providing symptomatic relief. In regard to responsibility for carrying out the varied solutions which they arrived at, the greatest load was seen to be Mr. B.'s - since he was, in many ways, considered to be the problem.

Research Question 4.

What is the role of the stroke victim during the family's initial adjustment to his incapacity?

This question was intended to determine whether the family reinforced the sick role expectations outlined by Parsons. In particular, it is concerned with the extent to which the family expects the stroke victim to be exempt from his previous role obligations. The two families studied showed quite different expectations of their sick member despite the relative similarity of his incapacity.

In the A. family, Mr. A. was denied the opportunity to resume financial responsibilities which had earlier been his. Even in the area of decision making concerning their finances, he was informed of the plans which Mrs. A. and the older son D., had developed. So too, was he prevented from doing many of the chores around the home such as tilling the garden and mowing the lawn. His family also protested in response to his wishes to drive the family car, even though he had passed a handicapped driver's test. Although their expectations of him were that he be dependent, submissive, and cooperative relative to their plans for him, there is little evidence to suggest that these expectations were illness based. Rather, they appear to relate more directly to family dysfunction. In that the wife has abdicated her previous role which was defined by similar behavioral expectations, the simplest way for the family to restore homeostasis is to cast the disabled father in that role.

In the B. family, Mr. B. was expected to assume his usual role responsibilities from a very early stage in his hospitalization. Although Mrs. B. acted on many of their decisions, Mr. B. was always involved in the decision making process. She brought any bills, correspondence, and cheques to him for his consideration and signing. On his passes home on weekends he drove the car and mowed the lawn without interference from his family. In effect, although they recognized his limitations, the B. family focussed on Mr. B.'s remaining function. They did not relate to him as a sick man.

This concludes the response to the research questions around which this investigation was designed. It remains only to account for the research findings and to evaluate the project. These are the concerns of the next and final chapter.

CHAPTER V

DISCUSSION

It is the purpose of this chapter to discuss the research findings reported in the previous chapter, to evaluate the research project, and to make suggestions for further research. We move now to the first of these, the discussion of the findings.

Discussion of the Research Findings

In coming to understand how families cope with the crisis of disability in a family member we must attempt to identify those factors which contribute to successful crisis resolution as opposed to those which are associated with failure. In the two families studied, their success or failure appears to have been related to previous similar experiences, correction strategies, and family integration.

The family which successfully dealt with their crisis did so through the use of first order change only. They were able to do this because the corrections required were minor, not involving a reorganization of the family system. They were able to make adjustments without challenging the established values around which their system was organized. First order change is easier than second order change and, because of the confusion, inefficiency, and tension associated with second order change, it is always preferred. Thus for this family, the crisis required less of them. Their organization was such that they could accommodate to the event without disrupting the homeostasis of their family system.

One reason why they may have been able to resolve their crisis through the use of first order change alone, is that three years earlier they had had a similar experience, when the father suffered a heart attack and was off work for a year. Several of the problems which the father's stroke precipitated were similar to those which they had dealt with in relation to his heart attack. They indicated that the earlier experience had been much more difficult for them, and that they had learned how to handle several of the problems which recurred with the father's stroke. It is likely too, that the earlier experience enabled them to anticipate some of their problems and so to act in advance in order to minimize the effects.

Another reason why this family has successfully resolved their crisis probably lies in their ability to meet the emotional needs of its members. Expressions of empathy, support, and affection were openly exchanged within this family as were their different ideas about issues which were discussed. In this milieu, energy was not wasted on protecting one's own sense of self and preserving individual goals so that, energy could be directed to the family task of identifying and solving their problems subsequent to the father's stroke. The high degree of integration manifest by this family was, no doubt, particularly relevant in the development of their strong correction patterns which enabled them to quickly and efficiently identify and correct their inappropriate execution patterns.

The family which has, thus far, not resolved their crisis, has also been using first order change strategies. However, in their situation, first order change is not appropriate. Second order change is required. This means that resolution of the crisis for them will be much more demanding. The patterns which are dysfunctional in their system affect both their values and their structure. Their first order interventions have acted to preserve the values and structure of their now dysfunctional system rather than to make the revisions required.

But second order change is very difficult for this family. They have lived most of their existence with the patterns which are now being challenged. An earlier crisis, that relating to the birth of their cerebral palsied son, has not been resolved. Their value of "keeping the peace" has prevented them from developing functional patterns for dealing with family problems. Because they lack the appropriate corrective skills it is likely that they will continue to struggle indefinitely or that they will declare a moratorium on their struggling by returning to their previous organizational pattern, but with the role distribution reversed. This would mean that the mother would retain the dominant role and the father would assume the submissive role. This organization would reduce the tension. However it would not be an adaptive response. As Rosenstock and Kutner (1967) point out, the father would in effect be alienated from the group and left to find personal satisfaction outside of the family. This would weaken the family and, in all likelihood, leave him a handicapped person rather than a man with a disability.

Without outside intervention, this family is unlikely to make the system revision which crisis resolution requires. They are very unlikely to develop corrective skills by chance. This is because they do not deal with family problems as a family. Neither do they attend to the emotional needs of their members. Until they develop these behaviors, appropriate corrective patterns cannot be realized and they will remain in crisis.

An additional factor related to their failure at resolution is their year long history of failure and the drain which it has had on the available energy for individuals to invest in a family solving process. It takes energy and courage, even when the skills are there, to bring about the necessary change for crisis resolution. This family is lacking in all three areas.

The evidence obtained from the study of the two families dealing with a crisis precipitated by the father's stroke supports the findings of Duff and Hollingshead (cited in MacVicar & Archbold, 1976). In each family it was the breadwinner who suddenly became disabled and financial problems were preceived to be of greatest significance. So too are the findings of Kaplan, Grobstein, and Smith (1976) supported in that the family with the smallest number of problems showed an adaptive response to the crisis, whereas the response of the family with the larger number of problems has been maladaptive. The absence of interactional problems in the family which showed an adaptive response also supports the findings of Kaplan et al (1976).

Very clearly the research findings indicate that the disability of a family member is a family affair, which from the time of its occurrence can be profoundly affected by the family's response. That response seems to be influenced more by the family's patterns for dealing with their business than by the actual event. In other words, the extent to which the family relates to the illness aspects of their disabled member's condition and the degree to which they move with him through the phases of denial, mourning, and acceptance are based in their own dynamics.

Montgomery (1978) suggests that successful resolution of crisis is directly related to the prompt initiation of appropriate solutions. Furthermore, other writers (Anthony, 1960; Olsen, 1970; Kaplan, Grobstein, & Smith, 1976) indicate that while the family is in a state of crisis they are more open to outside intervention. The case of the A. family clearly indicates a need for family counselling. It also points out the need for careful family assessment, since their difficulty is not one of disability acceptance, but rather dysfunctional interaction patterns which have developed in order "to keep the peace". Clinicians as well as families can confuse the symptoms with the problem and as a consequence provide little relief for their clients.

We, who work in the field of rehabilitation, must develop skills for differentiating between family problems which are based in a value system which emphasizes physical beauty and skill and which organizes their activity around that value, and between family problems which are based in family structure and values which are non-disability related. It may well be that the second instance is a far more common one for families dealing with disablement of a family member. Successful rehabilitation of the disabled person will depend upon our ability to determine whether disability non-acceptance is a problem or a symptom, as well as our ability to help the family deal with the problem once it is identified. To do this, rehabilitation must be conceived of as a family experience.

Evaluation of the Study

The objectives of the study have been realized in that the research questions have been answered and a greater understanding of family response to disability has been achieved. The case study approach was particularly useful in this regard since a great deal of information which was volunteered in the interview situation could not have been tapped through more structured approaches. The context of the comments which family members offered and the enactment of their relationships within their family were important factors in achieving a depth of understanding of the family's situation. Also, the ability of the interviewer to mov with the families as they described their process allowed them to pr it as they saw it rather than fitting it to a predesigned mold.

Montgomery's conceptual model was found to be a very useful to for identifying family process as well as [illegible] assessing family copin skills. Because of its very general na[illegible]t could not be imposed upon the families in the actual interview situation, yet it was found to correspond well to the accounts which the families offered when th analysis of family data was confronted.

The use of the disability acceptance model of Wright was found to add less to the understanding of family reactions to disability. This may, in part, be related to the relatively short period over whi the families were seen. Disability acceptance, according to most authors, is a lengthy process. Although correspondence was found between the stage at which the patient was and the stage at which the family was, it is not clear that they were moving in synchrony. Neith is it clear to what extent the process of acceptance related to the family process which was described. This matter is worthy of further study.

The use of the sick role concept added little to the understanding of family reactions to disablement of one of their members. The social prescribed role behaviors described by Parsons were of little significa to the families dealing with their disabled member. What was by far mo important in determining their expectations of the father, was the family's organization of roles and values. The fit between sick role expectations and role expectations derived from the family's organizati patterns was strictly coincidental.

The research tool which was designed for this study was found to be quite satisfactory. A correspondence between problems identified by the families and their own dysfunctional patterns was demonstrated, suggesting that this framework can be used to elicit information concerning pattern appropriateness. Since neither family demonstrated second order change, it is not clear to what extent the instrument would tap this information.

It was found, though, that the questions dealing with problem solving strategies were somewhat awkward to use in dealing with the first order change strategies which the families had employed. A modification of the instrument is suggested in order that first order and second order change strategies be dealt with in different ways. The inclusion of a section dealing with the families' awareness of significant change within their unit might also be included. As it stands, the tool could be used by clinicians for the assessment of families dealing with the disablement of one of their members. With the modifications suggested, it could be used for further research into the process of crisis resolution in response to the incapacitation of a family member.

Suggestions for Further Research

Although it would be desirable to study families in the earliest stages of crisis, this is not always possible. As Weller and Miller (1976b) have pointed out, and as was found in this study, some families are threatened by talking about how the disabled member's condition affects them. In this study the loss of emotional control due to the actual injury was also felt to influence patients and their families to decline participation in such a study. In effect then, during the early stages families may be more open to help than to being studied. In the first instance it is acceptable to be in difficulty; in the second, some sense of coping seems to be important. For this reason it is likely that the families who agreed to participate represent but a small sampling of the nature of family response to disability and that the combination of research and service objectives would be necessary in order to get a more complete picture.

The use of a longitudinal approach in which families could be studied for up to a year is desirable, particularly to determine the relationship between the processes of disability acceptance and crisis resolution. A much larger sample would also be necessary in order to come to any conclusions about the interaction of these processes.

A comparative study designed to examine the responses of families who are dealing with disability of the father for the first time and those who are dealing with a second disablement in the same person would be of interest in determining to what extent previous experience influences the family's coping ability. The finding from this study that a family can move through a crisis without making second order change might be better explained by further studies of this nature.

Finally, continued use of Montgomery's model, for studying families who are dealing with crises of various types, is recommended. Its potential value for understanding family process and for assessment of families has been demonstrated. Continued use of the model, together with the refinement which theory testing prompts, could contribute to the field of family counselling theory and practice.

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APPENDIX A

Data Collection Guide

A. Medical Data (obtained from the patient's record)

1. Medical Diagnosis
2. Extent of Injury
3. Date of Injury
4. Date(s) of data collection
5. Patient's prognosis
6. Rehabilitation potential

B. Family Data

1. Age and sex of family members
2. Number of years parents have been married
3. Education of parents and children
4. Occupation of father, mother, employed children
5. Previous experience with illness, injury or family crisis
6. Are there parents or relatives living in or near Edmonton?
7. Is the family involved in community or church groups?
8. What sources of help is the family making use of?

C. Family perception of the precipitating event?

1. What do you understand to be Dad's medical problem? (asked of each family member)
2. How serious do you believe it is?
3. What have been your sources of information in coming to this understanding?
4. Do you expect Dad's condition to improve? In what ways?
5. Do you expect that Dad will be able to: continue living at home? return to work?
6. Is there information about Dad's condition which you would like to know?

D. What are the specific problems which the family has experienced since Dad's stroke?

1. What problems have you experienced since Dad's stroke?
   - a) Has anyone had difficulty doing their usual tasks?
     - -school problems?
     - -homemaking?
     - -child care?
     - -problems on the job?
   - b) Have there been difficulties in taking over some of Dad's previous responsibilities?
     - -breadwinner role?
     - -other?
   - c) Has anyone had health problems?
     - -pre-existing condition?
     - -medical or psychiatric diagnosis?

d) Have you had problems getting along with each other?
-were these problems present before Dad's stroke or have they developed since?
-what do you think the problem is?

e) Are there other problems which we haven't yet discussed?

E. How have you dealt with these problems?

For each problem identified in D:

1. Who first described the problem?
2. What indications did you have prior to this, that there was a problem in this area?
3. How did you decide exactly what the problem was?
4. How did you decide what should be done about it?
5. Was someone assigned to do something about it?
6. Has anything been done to deal with it?
7. How effective has this solution been in dealing with the problem?

F. Observational Data

In the interview situation, how do family members relate to Dad?

-Do they speak to him? or for him?
-Do they look at him?
-Do they ask his opinions, acknowledge and react to his contributions during the interviews?

APPENDIX B

Guide for Analysis of Data (to be used in conjunction with the Data Collection Guide)

B. Family Data

In what developmental stage is the family?

What resources are available to this family for dealing with the problems which the father's stroke presents?

What resources are they using?

C. Family perception of the precipitating event

To what extent do family members share a common understanding of Dad's diagnosis?

Is there evidence of denial of the extent, or implications of his incapacity? (e.g. not asking for information, minimizing the effects of the injury?

Is there evidence of depression, anger, anxiety, fear in any of the family members?

Is information re: Dad's condition shared openly among family members? and significant non-family members?

Are family members encouraged to share their concerns about Dad's condition?

Does the family emphasize Dad's incapacity or his remaining function?

D. What are the specific problems which the family has experienced since Dad's stroke?

Is there evidence of concern primarily with instrumental or integrative functions?

Are their concerns primarily interactional or transactional?

Do family members identify personal concerns or do they focus on group concerns?

Are roles rigidly assigned or is there evidence of role flexibility?

Is there evidence of role conflict relative to taking on new roles?

Are relationship problems related to communication patterns, emotional neglect, role conflicts?

E. How have you dealt with these problems?

Does one person in the family tend to be most aware of family problems? individual problems?

Does one person emerge as the spokesperson and leader in relation to the problem-solving process?

Are problems readily identified or does the family tend to deny their existence until they are forced to deal with them?

Is there a difference in how the family deals with instrumental and integrative types of problems? interactional and transactional?

Do they modify execution and/or correction patterns?

What part does Dad play directly and indirectly in the problem solving process?

Does the family define their solutions as temporary or permanent? adequate or inadequate?

What kinds of outside help have been sought? and utilized?

Are family decisions arrived at through consensus? Is the process democratic? autocratic? laissez-faire?

APPENDIX C

Consent to Participate
in a research study dealing with family
reactions to stroke in the employed father

Having had the above study described to us by ____________________, we agree to be interviewed as a family and to provide information concerning the kinds of problems which we have met since Dad's stroke and to discuss the ways in which we have dealt with these problems.

We understand that the interviews (5-10 in total) will be recorded on audio tape and that the tapes will be erased following the completion of the study. We also understand that we will not be identified by name and that specific information which could be used for identification will not be included in the research report. It is also understood that confidentiality of information will be maintained beyond those people directly involved in the research study.

Signed: ____________________

____

____

Witnessed: ____________________

Date: ____________________

APPENDIX D

Letter to Physicians

June 22, 1979

Doctor ________________:

Thank you for giving your consent to Margaret Brackstone for the inclusion of your patient, Mr. ______________, in my research. The study has been designed to meet the thesis requirements for a Master's degree in Educational Psychology (Counselling). This research is being done under the supervision of Dr. Don Sawatzky, professor in the department of Educational Psychology. The administration of the Glenrose Hospital has approved the research proposal.

The specific questions which I propose to deal with are:

1. Does the occurrence of a stroke in an employed father with dependent children initiate a process in which family patterns are modified?
2. In families where the employed father has recently suffered a stroke, what specific problems are encountered:
   a) in fulfilling functional roles,
   b) in maintaining the health of the members,
   c) in relating to one another, and
   d) in other areas of family functioning?
3. How does the family, in which the employed father has recently suffered a stroke, deal with the problems which they encounter? How do they:
   a) arrive at a definition of the problem(s),
   b) decide on (an) appropriate solution(s), and
   c) determine who will be responsible for carrying out their proposed solution(s)?
4. What is the role of the stroke victim during the family's initial adjustment to his incapacity?

A series of taped interviews will be carried out with the entire family and the data will be analyzed using family crisis theory, sick role theory, and acceptance of disability theory. All patient information will be treated with confidentiality. The taped interviews will be destroyed following defense of the thesis. It is anticipated that each family will be seen between five and ten times in order to obtain the necessary data.

If you should wish to discuss the project further, please feel free to contact me at 462-2653. I will be happy to share my findings with you upon the completion of the study.

Yours truly,