Resilience in Families of Husbands with Prostate Cancer

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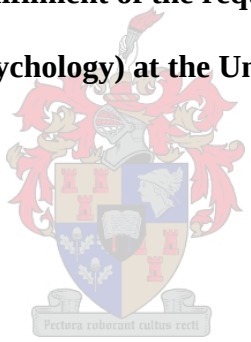
Assignment presented in partial fulfilment of the requirements for the degree of Master of Arts (Counselling Psychology) at the University of Stellenbosch



Supervisor: A P Greeff PhD

December 2005

STATEMENT

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any other university for a degree.

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Signature Date

SUMMARY

Family resilience is an increasingly visible concept in the field of family psychology. The aim of the present study was to identify family resilience qualities associated with the successful adaptation of families with a husband diagnosed with prostate cancer. The Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & Thompson, 1991) served as the theoretical framework in the design and the execution of the research. Both qualitative and quantitative measures were used in this cross-sectional survey research design. Twenty-one husbands and their spouses independently completed seven questionnaires, a biographical questionnaire and answered an open-ended question. Qualitative findings revealed the importance of intrafamilial support, spiritual/religious beliefs and professional support and knowledge in families coping with prostate cancer. Quantitative results indicated that family adaptation to prostate cancer was fostered by family hardiness (the family's internal strengths and durability), affirmative communication and social support.

OPSOMMING

Gesinsveerkragtigheid is 'n toenemend sigbare konsep op die gebied van gesinsielkunde. Die doel van hierdie studie was om gesinsveerkragtige eienskappe te identifiseer wat geassosieer word met die suksesvolle aanpassing van gesinne waar prostaatkanker by die eggenoot gediagnoseer is. Die *Resiliency Model of Family Stress, Adjustment and Adaptation* (McCubbib & Thompson, 1991) het as die teoretiese raamwerk by die opstel en uitvoering van die navorsing gedien. Sowel kwalitatiewe as kwantitatiewe middele is aangewend in die deursnee-opname navorsingsontwerp. Een-en-twintig mans en hul gades het onafhanklik sewe vraelyste en 'n biografiese vraelys voltooi, asook 'n ope vraag beantwoord. Kwalitatiewe bevindinge het die belangrikheid van intragesinsondersteuning, geestelike/godsdienstige geloof en professionele ondersteuning en kennis by gesinne blootgelê wat met prostaatkanker worstel. Kwantitatiewe resultate het aangedui dat gesinsaanpassing in die teenwoordigheid van prostaatkanker aangemoedig word deur gesinsgehardheid (die gesin se interne sterktes en bestendigheid), bevestigende kommunikasie en sosiale ondersteuning.

Pectora roborant cultus recti

ACKNOWLEDGEMENTS

Many people have been supportive throughout this study. In particular, I would like to thank the following:

Annina Sloane, a counsellor, for her enthusiasm and putting me in touch with the relevant people.

GVI Oncology for granting me permission to do this study.

Dr. André Dreyer for his valuable input regarding medical and emotional aspects of prostate cancer.

For the husbands and wives who participated in this study.

My supervisor, Prof. A.P. Greeff, for his wisdom and continuous support and encouragement throughout the process.

Leanne van der Westhuizen for her insight and emotional support.

The Cancer Association of South Africa for information regarding incidence of prostate cancer in South Africa.

Abrie Greeff for capturing the data collected.

Dr. Martin Kidd for his assistance with the statistical analysis.

My husband, Rainer, for his patience, ongoing support and belief in my abilities.

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Introduction

Prostate cancer rates in South African men rank among the highest in the world (Mqoqi, Kellett, Sitas & Jula, 1998 – 1999). It is the most common cancer in men and has a serious impact on the quality of patients' lives (Boehmer & Clark, 2001). In 1999 the Cancer Association of South Africa reported that one in 24 men were at risk of developing prostate cancer (Mqoqi et al., 1998 - 1999).

Research on family survivorship following a diagnosis of cancer is virtually non-existent (Mellon & Northouse, 2001). Considering the high incidence of prostate cancer in South Africa, and the implications for the patient and other family members, research is necessary to establish how many families are coping with the effects of prostate cancer, and what makes certain families cope better than others. There are clear advantages to knowing how families who show resilience work together to navigate their way through stressful times. If key processes utilised by resilient families are identified, the efficacy of support structures could be improved on. These support structures could include the provision of much needed information about the illness, individual and family therapy, as well as support groups in which relevant issues are addressed and worked through. Families are a rich source of information regarding their own efforts for recovery and growth and this information can benefit other families who may not possess, or be aware of their own capabilities. Past research has focused on the negative effects of a disease to such an extent that the resilience shown by families has not been adequately recognised (Midence, 1994). This research project focuses on factors or characteristics that are present in resilient families and findings should ideally be utilised by hospitals that treat prostate cancer patients in planning and presenting social support structures for patients and their families. It is further hoped that the findings could be an inspiration for families who feel isolated and without support in seeking out, or building on those aspects that have been shown to be present in resilient families.

Prostate cancer is an uncontrolled growth of abnormal cells, beginning in the prostate, a small gland below the bladder. In most cases, prostate cancer grows slowly, but as the cancer develops, it may spread beyond the prostate to nearby organs or other parts of the body (Reese et al., 2003). Although the disease is rare in men under the age of 50, the incidence thereafter rises steeply with each subsequent decade (Balderson & Towell, 2003). It is most often diagnosed when men are in their 60s (Litwin, sited in Curtis & Juhnke, 2003). At this critical time in mens' lives, they may face many concurrent stressors like an existing illness, declining physical abilities, loss of significant others and reduced income. In addition, men also face the prospect of retirement and mortality (Blum, cited in Curtis & Juhnke, 2003). For many people a diagnosis of cancer still means death, and as recently as 20 years ago most people believed that cancer was incurable. Research, technology and advances in diagnosis and treatment, have helped cure many cancer patients (Danielson, Hamel-Bissell & Winstead-Fry, 1993).

Screening procedures for prostate cancer include the Digital Rectal Examination (DRE), the Prostate Specific Antigen Test (PSA), the Prostate Biopsy, Transrectal Ultrasound (TRUS), and Imaging Tests (Reese et al., 2003). The DRE involves the insertion of the doctor’s gloved, lubricated finger into the patient’s rectum to identify any abnormalities in the shape and consistency of the gland. Alternatively, the Prostate Antigen Test measures the levels of Prostate Specific Antigen (PSA) in the bloodstream. PSA is a small protein molecule produced by the gland and when detected at elevated levels, men are advised to have a biopsy to establish whether cancer is present. The Prostate Biopsy involves the removal of a small amount of tissue at six to eight locations in the prostate. This is done with a biopsy gun under the guidance of a Transrectal Ultrasound (TRUS), which is an ultrasound probe that is placed in the rectum creating sound waves and producing an image of the prostate. Risks and complications of a biopsy include infection and/or blood in the urine, stool or semen. Imaging tests are used to determine the spread of cancer cells. These tests include Bone Scans, which

detect whether cancer has spread to bones, Computer Tomography (CT) and Magnetic Resonance Imaging (MRI), which are able to detect tumours in bones or soft tissues (Reese et al., 2003).

Cells removed during biopsy are viewed under a microscope in order to learn more about the cancer cells. The cancer is then graded with the Gleason System, which gives an indication of the aggressiveness of the cancer. Scores of 2 to 4 are generally considered low, 5 to 6 are lower than average, 7 is intermediate and scores ranging between 8 and 10 are deemed high (Reese et al., 2003).

Staging the cancer determines the spread of cancer, and how widespread it is. Lower-stage cancers are confined to the prostate. Higher-stage cancers have spread from the prostate to nearby organs, bone, or other body tissues. Knowing the cancer's grade and stage helps with establishing a treatment plan. Treatment plans may be based on watchful waiting, treatment to cure or treatment to control. Watchful waiting depends on the grade and stage of the cancer, age and overall health of the patient. In this case, PSA is monitored and frequent follow-up exams are indicated to watch for changes. Low or mid-stage cancer may often be cured with surgery or radiation. There is often no cure for high-grade or high-stage cancer, but it may be controlled using the method of surgery, radiation, hormone therapy or chemotherapy (Reese et al., 2003). Radiation therapy can target cells from outside the body (External-beam radiation), or from the inside of the body (Interstitial brachytherapy). Risks and complications associated with these treatments include bowel, urinary and sexual dysfunction (Balderson & Towell, 2003). As one would expect, these side-effects could result in anxiety, depression and irritability. Possible side-effects include mild to moderate diarrhoea, incontinence, frequent urination possibly with a burning feeling, erectile dysfunction, urinary obstruction, some loss of pubic hair, fatigue, bloating or gas pains,

bleeding or scarring of the bladder or rectum, urinary retention or irritation or inflammation of the rectum (Reese et al., 2003).

Hormone therapy may slow the growth and spread of cancer and includes Luteinizing hormone-releasing hormone (LHRH) agonists, Antiandrogens and Orchiectomy. LHRH are medications that reduce the amount of testosterone produced by the testicles. Antiandrogens block the body's ability to use testosterone, and Orchiectomy involves the removal of the testicles, the main source of testosterone. The risks and complications of hormone therapy may include sexual dysfunction, diarrhoea, loss of energy, osteoporosis, hot flashes and breast enlargement or tenderness. Chemotherapy is used to destroy cancer cells in the body. It may slow the growth of the cancer and may even relieve pain and other symptoms (Reese et al., 2003).

Prostate cancer, as with any chronic illness, is a source of stress demanding major adjustment for the patient as well as family members. In addition to the physical consequences there are psychological and social repercussions, which affect the patient and family (Cohen, 1982). From a family systems perspective, what happens to one family member always affects other family members, and how the family confronts and manages a stressor like prostate cancer, would determine the survival and the well-being of the entire family (Walsh, 1998). Each man may respond differently to the diagnosis and treatment of prostate cancer. There are lasting effects on quality of life, which include: changes in sexual function, ongoing concern about health years after treatment has ended, psychological distress and ongoing challenges for the entire family in coping with these effects (Mellon & Northouse, 2001).

Cancer has been consistently implicated in the coping literature as necessitating a wide range of coping options to deal with shifting functional abilities, medical implications, treatment modalities and psychosocial reactions (Livneh, 2000). It is common for health care

providers to focus on the patient and overlook family members' distress (Strong, 1988). Spouses of chronically ill patients very often experience as much distress as the patient does (Klein, Dean & Bogdanoff, 1968). The family is a major source of emotional and social support, and the family provide the context of adjustment in which the patient responds to the disease (Lewis, 1990). Research on family adaptation to chronic illness has shown that strengths of families should be considered in understanding how families adjust to their stressful situation over time (Horwitz & Kazak, 1990).

Although some families do not show resilience under these stressful conditions, some emerge stronger and more resourceful (Walsh, 1996). Experience shows that two families faced with the same illness stressor may respond very differently. One family may rally its members and mobilise itself to deal with the demands of chronic illness constructively, while another family may become immobilised and unravel as the demands of the chronic illness become overwhelming (Danielson et al., 1993). Families may respond in positive and adaptive ways and this potentially buffers or protects family members from negative psychosocial sequelae (Patterson, Holm & Gurney, 2004). Crises and stresses can, however, derail family functioning and affect relationships between family members (Walsh, 2002).

McCubbin and McCubbin (1988) define family resilience as "characteristics, dimensions, and properties of families that help families be resistant to disruption in the face of crisis situations" (p. 247). Alternatively, resiliency refers to a dynamic process encompassing positive adaptations within the context of significant hardship (Luther et al., sited in Lazarus, 2004). When describing family resilience Walsh (1996) describes the family resilience perspective as affirming the family's capacity for self-repair. Viewing families from a resilience perspective alters the idea of a family under immense stress as beyond repair. Instead, from the resilience perspective, families are viewed as challenged by adversity. It

recognises the family's potential for transformation and growth during and after very stressful events, in this case, a diagnosis of prostate cancer (Walsh, 2002).

Having drawn on previous research on family resilience, Walsh (2003) developed a family resilience framework. Walsh (2003) identified three domains of family functioning that influence family resilience, namely communication patterns, belief systems and organisation patterns. Walsh (1998) describes communication processes that facilitate family functioning as including clarity, open emotional expression and collaborative problem solving. Family communication has been found to be a source of strength for some cancer victims (Danielson et al., 1993). In times of crisis it is beneficial to clarify a stressful situation as much as possible in order to enhance a shared understanding among family members (Walsh, 1998). Communication helps bring clarity to the family's situation in that it facilitates the process of making meaning of the experience of illness, both for the patient and the rest of the family (Walsh, 2003). Meaning refers to the degree to which the family may use the event to learn more about themselves and others (Curtis & Juhnke, 2003). When communication is vague, the result could well be confusion and misunderstanding (Walsh, 1998). Expressing emotions is important in dealing with a prolonged ordeal like prostate cancer because by expressing emotions, for example fear, feelings are not bottled up and do not end up blocking the communication process (Walsh, 1998). Communication also enhances problem solving by way of open disagreement and problem solving skills. Avoiding problems could lead to unresolved issues becoming more disruptive in the long term (Walsh, 1998).

Family belief systems influence family resilience by helping the family make meaning of adversity. How families view their problems and their options could have a huge impact on whether they cope or become dysfunctional (Walsh, 1998). Belief systems facilitate a positive outlook and offer spiritual guidance or support (Walsh, 2003). A family faced with a pile-up of demands needs to make meaning of their situation in order to come to terms with it and

select adequate and appropriate coping behaviours. According to McCubbin and McCubbin (1996) this is facilitated by the family's existing family schema. Family schema contains the shared values, beliefs and expectations of the family, which help the family, make meaning of the situation (McCubbin & McCubbin, 1996). The family's schema level of appraisal (blueprint of functioning) is considered as a force that can facilitate family coping and adaptation (Danielson et al., 1993). Shared faith is able to give the family a framework for finding meaning and perspective (Weaver & Flannelly, 2004). Research results suggest that a relationship with God may function in a complex manner as a resource in coping with prostate cancer (Gall, 2004). Religiosity and spirituality contribute to psychosocial adjustment to cancer and its treatment. Religion offers hope to those suffering with cancer, and it has been found to have positive effects on the quality of life of cancer patients and their families. In addition, religion and spirituality provide effective coping mechanisms for patients and family members (Weaver & Flannelly, 2004).

The final domain of functioning affecting family resilience is family organisation, which include flexibility, connectedness and social and economic resources (Walsh, 2002). In times of stress, families need to mobilise their resources, buffer stress and reorganise in order to fit the changing conditions that are brought about by a crisis situation (Walsh, 1998). Families who are flexible are able to adapt to changing demands, yet are equally able to maintain orderly patterns in their functioning. Connectedness among family members allows for mutual support and collaboration, while separateness and autonomy are also present. Such connectedness allows family members to rally together, while being able to respect differences among each other (Walsh, 1998). Fellow family members and social networks may provide practical assistance, as well as a community connection in times when families are experiencing a crisis. Families who show resilience have been found to reach out to others

in their time of crisis, while isolated families tend to find it more difficult dealing with a crisis (Walsh, 1998).

McCubbin and Patterson (1983) proposed a model of resiliency, which explains how variables, such as those outlined by Walsh (2003), influence family adjustment and adaptation under stressful conditions. The Resiliency Model of Family Stress, Adjustment and Adaptation is based on the work of Reuben Hill, who conducted research on war-induced separation and reunion (McKenry & Price, 1994). According to Hill's ABCX Model of Family Crisis, the ability of the family to cope with potential stress or a crisis (X) is dependent on the interaction between three factors: A (the stressor), B (the family's resources or strengths), and C (the family's interpretation of the stressor) (McKenry & Price, 1994).

McCubbin and Patterson (1983) reformulated Hill's ABCX Model by adding post-crisis/post-stress factors. They proposed the Double ABCX Model of Family Adjustment and Adaptation Response (FAAR). McCubbin and McCubbin (1989) developed a Typology Model of Family Adjustment and Adaptation. This model describes the family's response to life changes in terms of two phases; the adjustment phase and the adaptation phase. The above-mentioned models focused on the stressor, the family's use of resources, their appraisal of the situation and patterns of coping, and abilities to solve problems while dealing with a stressor (Danielson et al., 1993).

The most recent, expanded version of this model, The Resiliency Model of Stress, Adjustment and Adaptation (McCubbin & Thompson, 1991), emphasises family adaptation (Danielson et al., 1993). The Resiliency Model provides a framework that assists in determining whether or not a stressor may cause a family crisis (Danielson et al., 1993). It explains why some families recover and are deemed resilient, while others remain vulnerable when experiencing the same stressor (McCubbin & McCubbin, 1996). In addition, this model may be used to explain how the variables outlined by Walsh (2003) influence family

adjustment and adaptation. It attempts to guide health professionals in determining what family types, capabilities, and strengths are needed and available, or even created, to manage illness in the family (Danielson et al., 1993).

The family faced with an illness stressor is required to adjust in order to incorporate the impact of such a stressor (see Figure 1). The entire family is affected and reacts to illness (Danielson et al., 1993). The extent to which the family would adjust to an illness stressor is determined by the severity of the stressor, the vulnerability of the family, the family's established patterns of functioning, their appraisal of the stressor and the family's existing problem-solving skills (McCubbin & McCubbin, 1996).

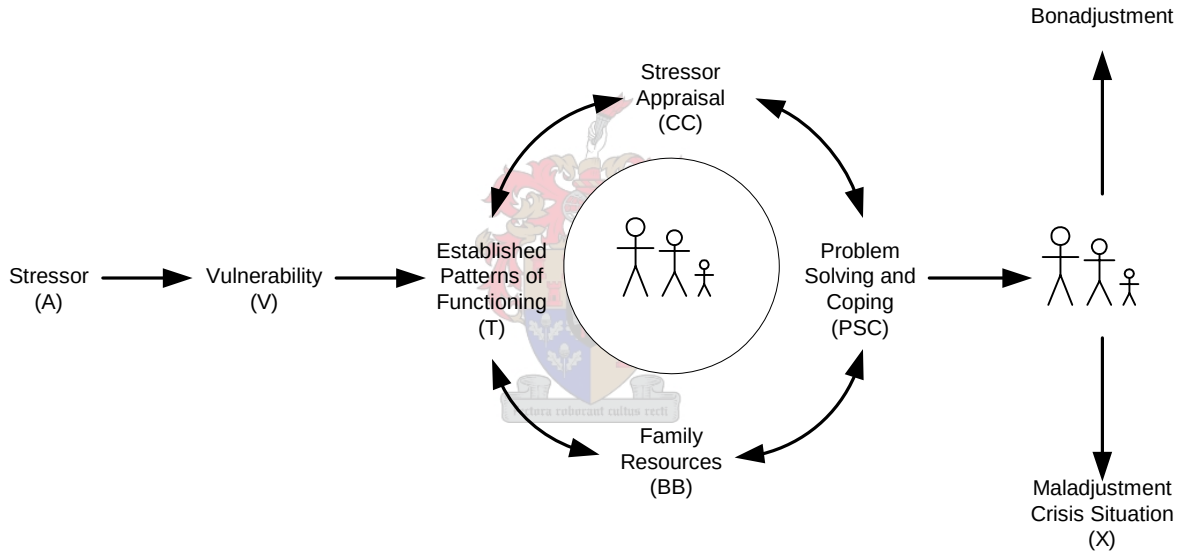

Figure 1. The Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin, Thompson & McCubbin, 1996), the adjustment phase.

Some stressors could be dealt with and do not create major hardships for the family system. Outcomes of the family's efforts to adjust may vary along a continuum from positive bonadjustment to the other extreme, maladjustment (McCubbin & McCubbin, 1996). Bonadjustment occurs when the family moves through the situation with relative ease, and this results in a positive outcome. However, when a stressor is severe – for example, a chronic illness like prostate cancer – hardships are numerous and demand substantial changes. When

established patterns of functioning are disrupted, the family may experience maladjustment and a resulting state of crisis (Danielson et al., 1993).

Family crisis may be conceptualised as a condition of disruptiveness, disorganisation, or incapacitation in the family social system (Burr, sited in Danielson et al., 1993). The crisis demands a change in patterns of functioning to restore the integrity of the family, and this movement to initiate change marks the beginning of adaptation (see Figure 2). Entry into the adaptation phase requires the family to use internal and external resources to maintain the family's integrity and to protect the family (McCubbin & McCubbin, 1988).

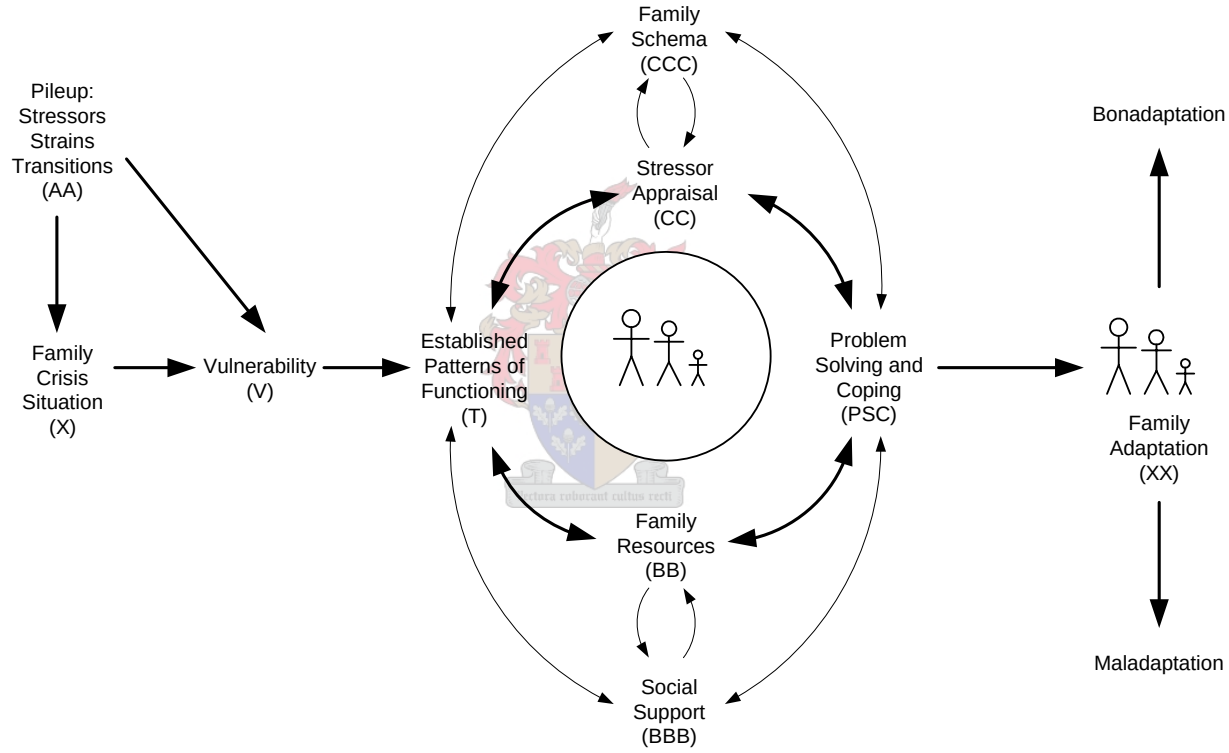

Figure 2. The Adaptation phase (McCubbin, Thompson & McCubbin, 1996)

The X factor in the Resiliency Model accounts for the crisis, which results from maladjustment to stress. The AA factor accounts for the pile-up of demands. Crises within a family are usually resolved over time and at the time of the illness stressor; the family may well be dealing with other crises or stressors (Danielson et al., 1993). This pile-up of demands

contributes to the vulnerability (V) of the family. The demands may undermine the family's ability to adapt to the illness (McCubbin et al., 1996). Different family types (T) may respond differently to stressors. Family type represents the family's established patterns of functioning (McCubbin et al., 1996). The BB factor in the Resiliency Model represents the resources called upon to be utilised in an effort to facilitate adaptation. These resources may include psychological, social or family resources (McCubbin et al., 1996). Resources may include the family's own strengths and capabilities, and they represent the potential for meeting demands. The BBB factor includes community resources and support, which could be called on to achieve adaptation (McCubbin et al., 1996).

The CC factor refers to the family's situational appraisal of the family's capability. When demands are experienced the family evaluates and interprets the experience on an ongoing basis. Tension and stress are produced when coping and resources are perceived as inadequate to deal with the demands (Danielson et al., 1993). The CCC factor represents family schema and meaning. When faced with an illness stressor, the family appraises its past and future in order to give meaning to the illness and the changes that result from it. The family schema includes shared values or beliefs, priorities, goals, rules and expectations. The family schema can change in response to stressful experiences (Danielson et al., 1993).

The problem-solving and coping factor (PSC) includes any covert or overt efforts to manage a demand on the family system. These coping efforts may occur on an individual or at a family system level. Coping and problem-solving may be directed at reducing or eliminating stress, the acquisition of resources, the ongoing management of family system tension and shaping the appraisal of the stressor (Danielson et al., 1993).

Family adaptation (XX) is used to describe the family's effort to achieve some balance in response to a crisis. It includes the initial crisis (X), and the subsequent adjustment and adaptation (maladaptation or bonadaptation) (Danielson et al., 1993). The success of

adaptation (bonadaptation) is determined by the interaction of the family's pattern of functioning, internal resources, support networks, the family's appraisal of the situation and the stressor, and finally, the family's problem-solving and coping skills. The family's ability to confront and manage disruption, buffer stress and effectively reorganise itself would influence adaptation for each family member and ultimately, the well-being of the family unit (Walsh, 1998). Families may, however, not achieve these new family patterns, and the result is maladaptation. Maladaptation results in the family returning to a crisis situation and new ways of adapting need to be sought (Danielson et al., 1993).

Research on family resilience in South Africa is limited, particularly research focusing on resiliency factors playing a role in families faced with an illness stressor, such as prostate cancer. The factors identified by Walsh (2003) have been found to promote resilience in families. Many studies have, however, focused on single variables in their research. The aim of this study is to identify which factors outlined in the family resilience framework are associated with the successful adaptation of families with a husband with prostate cancer. It is hypothesised that there is a positive correlation between factors outlined by Walsh (2003) and family adaptation.

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Method

A cross-sectional survey research design was used to collect data by means of questionnaires and an open-ended question answered by two members (husband and wife) of participating families. Factors (resources, qualities or characteristics) associated with family adaptation (the dependent variable in this study) were identified as resiliency factors (see Figure 1).

Participants

A counsellor at a healthcare facility in the Western Cape was approached to propose this study and recruit families from the hospital's prostate cancer support group. A meeting was also arranged with an oncologist at the healthcare facility, to propose the study and discuss

issues related to prostate cancer that could impact on the inclusion criteria of families participating in this study. The type of treatment and stage of cancer was not used as exclusionary criteria. The oncologist was asked whether certain stages of prostate cancer and different types of treatment were more traumatic for patients and their families. He reported that in his years of experience he has found that the impact depended on many variables, but added that often treatment in the early stages of prostate cancer could be particularly traumatic because of high anxiety and the need to keep the condition private (A. Dreyer, personal communication, 22 April 2005).

A research proposal was delivered to the head of psychosocial services at the healthcare facility's oncology unit, who responded positively within one week of receiving the proposal. Once consent had been granted, the researcher obtained a list of telephone numbers of members who were attending the support group organised by the healthcare facility. All 63 men on the list were contacted telephonically. The researcher also attended one of the support groups in order to meet as many members as possible, and to explain the purpose of the study to them. Of the 63 men contacted, four had been given a clean bill of health, eight were unreachable by telephone, one member had passed away, three members had attended the support group on behalf of a family member diagnosed with prostate cancer, one member was a nutritionist visiting the group, and four were no longer married. The details of postal addresses of the remaining 42 men who agreed to participate in this study were acquired during the telephone interview.

The families thus identified met the following criteria. The diagnosis of prostate cancer was made at least six months prior to participating in this research. The minimum time of six months was identified in order to allow for a time period in which families would have had some time to adapt to the diagnosis. Secondly, the husband diagnosed with prostate cancer had to be between the ages of 55 and 80. Initially it was hoped to have an age category

between 50 and 65, but because a large percentage of the men in the group were over the age of 65, they were included by virtue of group membership, which was an important criterion. The decision to approach participants who had attended at least one support group was made in order to reduce the chances of contacting families who would be resistant to talking about themselves. It was assumed that the choice not to attend the support group could be an indication of the importance of privacy to that particular family. Support group members would have had the opportunity to engage with other prostate cancer sufferers. An additional criterion was that the couple participating had to be married.

By the end of data collection 21 men and their wives (46.7%), accurately completed and returned all the questionnaires. The mean age of male participants was 68 years (SD=8.1), while the mean age for female participants was 64 years (SD=7.5). All the couples were married and the mean length of marriage was 40 years (SD=10.9). Only one couple has been married for four years, while the rest have been married for 30 years and more. All the couples have children, but only six of the couples still have one dependent living at home. English speaking couples made up 62% (n=13) of the sample, while 38% (n=8) were Afrikaans speaking.

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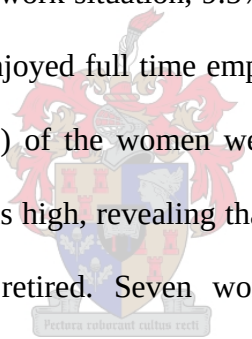
When answering the question regarding the highest level of education attained, eight (38.1%) of male participants indicated having received a university education, while one (4.8%) female participant attended university. Of the male participants, six (28.6%) were trained at post-matric level, which excluded university training, while three female participants (14.3%) reported to have been trained at post-matric level. Male participants with a highest education level of matric made up 9.5% (n=2) of the sample, and 52.4% (n=11) of women reported a highest education level of matric. There were three men (14.3%) who did an apprenticeship after school, while two (9.5%) of the men and six (28.6%) of the women reported having a highest level of education of Grade 10.

Classifying participants' occupations according to skills, category or qualifications required to carry out their particular job, revealed the following: 14.3% (n=3) of the males compared to 4.8% (n=1) of the females classified themselves as highly qualified, 38.09% (n=8) of the males and 24% (n=5) of the females as professional, 4.8% (n=1) of males as commercially independent, 14.3% (n=3) of males responded to the category of skilled worker or artisan with trade qualifications, 4.8% (n=1) of males and 19.5% (n=4) of females chose the category of routine clerical and administrative worker, service and sales worker, 14.3% (n=3) of the men and 14.3% (n=3) of the women classified themselves as economically inactive, and the category of other was chosen by one male (4.8%) and four (19.05%) females.

When asked about their current work situation, 9.5% (n=2) of males were employed full time, while 24% (n=5) of females enjoyed full time employment. Of the men, 19.05% (n=4) were self-employed, and 9.5% (n=2) of the women were self-employed. Given the age of participants, the retirement figure was high, revealing that 71.4% (n=15) of the husbands and 33.3% (n=7) of the wives were retired. Seven women (33.3%) in the sample were homemakers.



Families reported annual income as follows: 19.05% (n=4) of families earned an annual income of between R10 000 and R40 000, 14.3% (n=3) between R40 001 and R80 000, 19.05% (n=4) between R80 000 and R110 000, 9.5% (n=2) between R110 001 and R170 000, 9.5% (n=2) between and annual income of R170 001 and R240 000, and the remaining 28.6% (n=6) reported an annual income of above R240 000.

Nineteen (90.5%) of the twenty-one couples indicated that they were involved in religious activities.

Measuring Instruments

A biographical questionnaire was compiled and administered in order to determine the composition of the family, number of children living at home, marital status, socio-economic status of the family, education levels of the husband and wife, age and gender of respondents, and religious affiliation. An open-ended question was posed to participants aiming to elicit from them which factors they believed helped their family the most through their stressful time. In addition, this question was aimed at providing a deeper, more personal understanding of why and how families coped, and were still coping.

Quantitative data was gathered by means of six questionnaires, each measuring different aspects of family functioning. McCubbin, Thompson and Elver developed **The Family Attachment and Changeability Index (FAC18)** to measure family adaptation and functioning. The FACI8 consists of 16 items with two subscales (eight items each), namely attachment (bonding) and changeability (flexibility). Attachment refers to the degree to which family members are emotionally bonded. Families who are bonded together emotionally in a meaningful way are usually open to discussion, feel close to one another, are involved in doing things together and want to stay connected to each other (McCubbin et al., 1996). When families are characterised as flexible, they are able to change the rules within the family. In addition, these families are able to change their boundaries and roles in order to accommodate the rest of the family in times of crisis (McCubbin et al., 1996). Participants are asked to identify how often certain things are happening currently in their family, as well as how often they would like things to happen in their family. Responses range through 1= never, 2=sometimes, 3=half the time, 4=more than half, and 5=always. Sample statements from this scale include, "*In our family it is easy for everyone to express his/her opinion,"* and "*In our family, everyone shares responsibilities."* The attachment subscale has an internal reliability of .73 and the changeability subscale an internal reliability of .80. In this study an internal

reliability coefficient (Cronbach Alpha) of .51 was obtained for the total score. However, when calculating the reliability coefficient for the two subscales individually, the internal reliability for the attachment subscale was .74 and for the changeability subscale 0.77, which are both relatively high. This questionnaire represents the dependent measure against which the other measures had been correlated to determine whether they could be identified as resilience factors.

The Family Hardiness Index (FHI) was developed by McCubbin, McCubbin and Thompson and measures characteristics, such as internal strengths and durability of the family unit. The FHI has three subscales, namely commitment, challenge and control. The control subscale aims to measure the family's sense of being in control of family life rather than being controlled or conditioned by external forces or circumstances (Bower, Chant & Chatwin, 2004). The challenge subscale measures the family's resourcefulness and ability to embrace and integrate new ideas into their existing schema (Bower et al., 2004). The family's sense of internal strength, dependability and ability to work together as a unit is measured by the commitment subscale (Bower et al., 2004). The FHI is presented as a 20 statement questionnaire requiring families to respond on a 4-point Likert scale, ranging through 0=false, 1=mostly false, 2=mostly true, 3=true. The internal reliability of this questionnaire is .82 and it has a validity coefficient of between .20 and .23 with family satisfaction, time and routine and adaptation (McCubbin et al., 1996). In this particular study an internal reliability coefficient (Cronbach Alpha) of .50 was obtained for the total score. On calculating the internal reliability coefficient of the subscales separately, the following alpha values were found: For the challenge subscale the reliability coefficient was .79, for the control subscale it was .44, and for the commitment subscale it was .61.

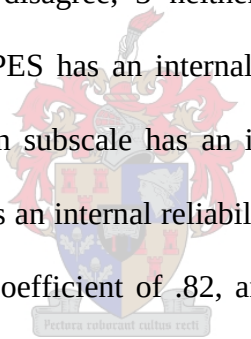
Developed by McCubbin, Patterson and Glynn, **The Social Support Index (SSI)** measures the extent to which families find the desired support in their community, including

family and friends. The items measure community integration, the family's utilisation of community resources, esteem support and network support. This instrument consists of 17 items that are rated on a five-point Likert scale. The Likert scale ranges from strongly disagree to strongly agree, with higher scores indicating more social support (Mellon & Northouse, 2001). Sample statements from this scale include, *"If I had an emergency, even people I do not know in this community would be willing to help", "There are times when family members do things that make other members unhappy",* and *"I feel secure that I am as important to my friends as they are to me."* Community based social support is regarded as a very important dimension in family resilience (McCubbin et al., 1996). It has an internal reliability of .82 and a validity coefficient of .40 (McCubbin et al., 1996). In this study the SSI has an internal reliability coefficient of .77.

The Relative and Friend Support Index (RFS) was developed by McCubbin, Larsen and Olson and assesses the degree to which families make use of friends and relatives for support. It is presented as an eight statement questionnaire and consists of a 5-point Likert type scale, ranging through 0=strongly disagree, 1=disagree, 3=neutral, 4=agree, 5=strongly agree. Sample statements from this scale include: *"Seeking advice from relatives"*, and *"Sharing problems with neighbours."* It has an internal reliability of .82 and a validity coefficient of .99 (correlation with the original Family Crisis-Oriented Personal Evaluation Scale) (McCubbin et al., 1996). In this particular study an internal reliability coefficient of .87 was obtained.

The Family Crisis-Oriented Personal Evaluation Scales (F-COPES) was developed by McCubbin, Larsen and Olson. It is designed to identify the problem-solving and behaviour strategies of the family. The F-COPES consists of five scales covering two dimensions, namely internal and external coping strategies. Internal coping strategies include reframing and passive appraisal, while the external coping strategies include looking for social support,

spiritual support, and mobilisation to seek and accept help. Reframing refers to the family's capability to redefine stressful events in order to make them more manageable, whereas passive appraisal refers to the family's ability to accept problematic issues and minimising reactivity. The items measuring social support identifies the family's ability to actively engage in acquiring support from relatives, friends, neighbours and extended family. The ability to acquire spiritual support is also measured as a problem-solving strategy in families. Finally, the F-COPES measures the ability of the family to mobilise its members to acquire and accept help from others. The F-COPES is presented as a 30 statement questionnaire requiring respondents to record their answers on a 5-point Likert-type scale regarding how often they utilise a particular coping behaviour to deal with problems. Responses range through 1=strongly disagree, 2=moderately disagree, 3=neither agree nor disagree, 4=moderately agree, 5=strongly agree. The F-COPES has an internal reliability of .77 (McCubbin et al., 1996). In this study the mobilisation subscale has an internal reliability coefficient of .70, where the social support subscale has an internal reliability coefficient of .90. The spirituality subscale has an internal reliability coefficient of .82, and the passive appraisal subscale an internal reliability coefficient of .67. Finally, the reframing subscale has an internal reliability coefficient of .56.



Finally, **The Problem-Solving Communication Scale (FPSC)** was developed by McCubbin, McCubbin and Thompson to evaluate positive and negative communication patterns within the family related to coping. It has an internal reliability of .89. All families communicate in both positive and negative ways and the 10-item FPSC measures both positive and negative communication patterns within the family related to coping (McCubbin et al., 1996). Families are required to respond on a 4-point Likert type scale, ranging through 0=false, 1=mostly false, 3=mostly true, 4=true. Sample statements from this scale include, *"We talk things through till we reach a resolution," "We yell and scream at each other,"* and

"We walk away from conflicts without much satisfaction." The scale produces an overall score, as well as two subscale scores 1) incendiary communication: the pattern of communication that is inflammatory and tends to exacerbate a stressful situation and 2) affirming communication: the pattern of communication that conveys support, care and exerts a calming influence. In this study the positive and negative subscales have an internal reliability coefficient of .87 and .73 respectively. For the total scale an internal reliability coefficient of .82 was obtained.

Procedure

All 63 men on the list of support group members, received from the healthcare facility's oncology unit, were contacted telephonically. Of the men contacted, 45 agreed to complete the questionnaires. Each telephone call was used as an opportunity to motivate the aim of the research, ensure confidentiality of participants, clarify time since diagnosis, age, marital status, preferred language and postal address. Furthermore, it was emphasised that results of the study would be reported in an anonymous way, and informed consent was obtained from the men who were willing to complete the questionnaires.

Once all the men were contacted, and the 45 men were identified as possible participants, two sets of questionnaires were mailed to them, one for the husband to complete and one for the wife to complete independently. Confidentiality and the anonymous use of information was assured. Participants were asked to complete the questionnaires and mail them back to the researcher. Stamped envelopes with return addresses were included in the packages mailed to participants. The packages included the six discussed questionnaires, a biographical questionnaire, the open-ended question, instructions for completion of the questionnaires, and a letter of consent for each participant to sign.

After two weeks of mailing the questionnaires, outstanding participants were contacted. Some of them were away on holiday, others said that the questionnaires were too long to

complete and that they did not have the time, and some said they had changed their minds about completing the questionnaires. It took approximately two months to receive the last one of 21 sets of accurately completed questionnaires. The data from the questionnaires was entered into a spreadsheet in preparation for statistical analysis. The answers to the open-ended question were analysed according to themes. Themes were extracted from participants' answers and were not pre-determined. Themes that emerged included intrafamilial support, open and honest communication, individual characteristics, social support, religion and spirituality, and professional support and knowledge.

Results

Results obtained from the open-ended question and the questionnaires completed by participants indicate that there is a significant correlation between family adaptation, as measured by the Family Attachment and Changeability Index (FAC18), and various other factors, which are indicators of family resilience. Results also indicate that there are both similarities and differences in the responses of men and women.

All 42 participants responded to the open-ended question in which they were asked to report on what they believed were the most important factors that helped their family after the diagnosis of prostate cancer. Responses were organised according the most important factors identified by participants, and according to internal and external resources. Internal resources include those which reside within the individual and family, whereas external resources include those resources utilised outside the immediate family. Both internal and external categories were made up of common themes identified in participants' responses. The frequency of responses for men and women appear in Table 1.

Table 1

Resiliency Resources as reported by Husbands and Wives (N=42)

Resources	MALES (n=21)	FEMALES (n=21)
Internal		
Intrafamilial support (practical and emotional support amongst family members)	6 (28.6%)	8 (38.1%)
Open and honest communication		5 (23.8%)
Individual characteristics (self support, personality and acceptance of the situation)	6 (28.6%)	4 (19.1%)
External		
Social support (extended family and friends)		2 (9.5%)
Religion and spirituality (activities and beliefs)	5 (23.8%)	1 (4.8%)
Professional support and knowledge (psychologists, doctors etc.)	4 (19.05%)	1 (4.8%)

Responses to the open-ended question indicated that men and women found intrafamilial support to be the most important coping resource during the stressful experience of prostate cancer. Within the boundaries of the family, emotional support and understanding appeared to be most valuable to both men and women. The role of the family was emphasised as being crucial to their survival as a family unit. Responses categorised as part of external resources

revealed that women depended mostly on their spirituality, whereas men found professional support and knowledge of their condition most comforting.

Spearman correlations were calculated in order to establish any significant relationships between family adaptation and potential resiliency variables. Correlation coefficients appear in Table 2.

Table 2

Spearman Correlations between Family Adaptation (FAC18) and Potential Resiliency Variables

Variables	**Males (n=21)**		**Females (n=21)**	
	r	**p**	**r**	**p**
Social Support Index (SSI) (the degree to which families utilise emotional, esteem and network support in their communities)	0.46	0.04*	0.49	0.02*
Relative and Friend Support (RFS) (the degree to which families make use of friends and relatives for support)	-0.05	0.82	0.23	0.31
Family Hardiness Index (FHI) Total score	0.46	0.04*	0.44	0.04*
Commitment (family's sense of internal strength, dependability, and ability to work together)	0.00	0.99	0.58	0.01*
Challenge (family's efforts to be innovative, active, to experience new things and to learn)	0.36	0.11	0.50	0.02*
Control (family's sense of being in control of family life rather than being shaped by outside events and circumstances)	0.40	0.07	0.17	0.45

(table continues)

Table 2 (continued)

Variables	Males (n=21)		Females (n=21)	
	r	**p**	**r**	**p**
Family Crisis Oriented Personal Evaluation Scales (F-COPES)				
Social Support (family's ability to actively engage in acquiring support from relatives, friends, neighbours and extended family)	-0.19	0.40	0.02	0.92
Reframing (family's capability to redefine stressful events in order to make them more manageable)	0.39	0.08	0.63	0.00*
Spiritual and Religious Support (family's ability to acquire spiritual/religious support)	0.24	0.30	0.21	0.39
Mobilisation (family's ability to acquire community resources and accept help from others)	0.11	0.63	0.13	0.57
Passive appraisal (family's ability to accept problematic issues minimising reactivity)	0.27	0.23	0.24	0.30
Family Problem Solving Communication (FPSC) Total score	0.50	0.02*	0.77	0.00*
Incendiary Communication (the pattern of family communication that is inflammatory in nature, and tends to exacerbate a stressful situation)	-0.51	0.02*	-0.80	0.00*
Affirming Communication (the pattern of family communication which conveys support and caring and exerts a calming influence)	0.47	0.03*	0.70	0.00*

(table continues)

Table 2 (continued)

Variables	Males (n=21)		Females (n=21)	
	r	**p**	**r**	**p**
Age	0.11	0.64	0.26	0.26
Income	0.11	0.62	0.03	0.90
Years married	0.27	0.23	0.24	0.29
Number of children	0.08	0.75	0.03	0.88

*p<0.05

The results indicated that for men and women, family adaptation (FAC18) is fostered by social support, the degree to which the family utilises emotional, esteem and network support in their communities. A second resiliency variable that yielded a positive correlation with family adaptation is family hardiness, which includes commitment (the family's sense of internal strength, dependability, and ability to work together), challenge (the family's efforts to be innovative, active, to experience new things and to learn), and control (the family's sense of being in control of family life, rather than being shaped by outside events and circumstances). For men and women, there is a significant positive correlation between family adaptation and family problem solving communication. Results also revealed a negative correlation between incendiary communication and family adaptation. This means that there was a negative relationship between inflammatory communication patterns and family adaptation. Finally, a relationship was also found between family adaptation and reframing a stressful situation, in other words, the family's ability to redefine stressful events in order to make them more manageable.

Best sub-sets regression analyses were conducted for men and women, in order to determine which combination of variables (resources, qualities and characteristics) contributed to family adaptation (FAC18) in the face of a stressful experience like prostate cancer. A summary of the regression analyses is presented in Table 3.

Table 3

Regression Analysis Summary indicating which Combination of Variables Contribute to the Dependent Variable Family Adaptation (FAC18)

Variables	Males (n=21)		Females (n=21)	
	Beta	p	Beta	P
Social Support Index (SSI)	0.45	0.03*	excluded	Excluded
Family Problem Solving Communication (FPSC)	0.26	0.19	1.04	<0.01*
The Relative and Friend Support Index (RFS)	excluded	excluded	excluded	Excluded
Family Hardiness Index (FHI)\ Total Score	excluded	excluded	excluded	Excluded
F-Copes (Social Support Index)	-.39	0.08	-0.3	0.08
F-Copes (Reframing)	0.19	0.30	-1.15	0.31
F-Copes (Spirituality)	excluded	excluded	-0.12	0.3
F-Copes (Mobilisation)	0.18	0.35	0.15	0.35
F-Copes (Passive Appraisal)	excluded	excluded	excluded	Excluded

*p<0.05

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Two factors in total appear to be significant predictors of family adaptation (FAC18) for men and women. The factor for men is social support as measured by the Social Support Index (SSI). For women, family problem solving communication (FPSC) appears to be a significant predictor of family adaptation.

Discussion and conclusions

The present study aimed to identify factors which are associated with the successful adaptation of families with a husband diagnosed with prostate cancer. The Resiliency Model of Stress, Adjustment and Adaptation (McCubbin & Thompson, 1991) provided a framework that determined whether or not a stressor like prostate cancer may cause a family crisis

(Danielson et al., 1993). It was hypothesised that there is a positive correlation between factors outlined by Walsh (2003) and successful family adaptation.

The results of the open-ended question indicate that for husbands and wives combined, intrafamilial support (practical and emotional support amongst family members) is the most important internal coping resource identified (see Table 1). The importance of support within the boundaries of the family is not only confirmed by previous research (Balderson & Towell, 2003; Lea, Ever-Hadani, Goldzweig, Wygoda, & Peretz, 2003; Mellon & Northouse, 2001; Walsh 1998), but is supported by the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & Thompson, 1991). Silberberg (2001) described support within the family as assisting, encouraging, reassuring and looking out for one another, and found that support is strengthened when family members feel equally comfortable in offering and asking for support. Moreover, Antonovsky (cited in Curtis & Juhnke, 2003) found that the family can create an environment for cancer patients where they receive adequate information and feel supported. A positive relationship between family adaptation and family hardiness was observed (see Table 2), but the results were somewhat inconsistent. There was an overall significant correlation between family adaptation and family hardiness for both husbands and wives, yet on the individual subscales, significance was only observed for wives on the subscales commitment and challenge. For the men, there was a relationship between control (family's sense of being in control of family life rather than being shaped by outside events and circumstances) and family adaptation, albeit not a statistically significant one, but instead pointing toward a trend (see Table 2).

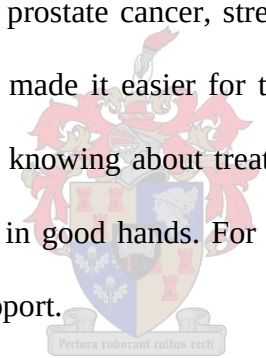
One possible explanation for these inconsistencies could be the relatively low internal reliability scores on all subscales of the Family Hardiness Index, with the exception of the commitment subscale. However, an overall positive correlation was found for both husbands and wives when measuring aspects of family hardiness, involving commitment, challenge and

control on the total scale. Affirmation that family hardiness mitigates the effects of stress is supported by previous research (Mellon & Northouse, 2001; Walsh, 1998; McCubbin et al., 1996), and the relationship is echoed in this research, by observing a correlation between family adaptation and family hardiness. Based on what the Family Hardiness Index measures, the results could imply that, overall, husbands and wives feel that their ability to adjust and adapt to prostate cancer is related to a sense of internal strength, dependability, and ability to work together. It further implies a belief that change is normal in life and brings growth opportunities. Moreover, the results may imply that husbands and wives feel they are in control of their family life and not easily shaken by outside events and circumstances.

In contrast to previous research (Albaugh, 2003; Danielson et al., 1993; Gall, 2004; Mellon & Northouse, 2001; Walsh, 1998), the present study does not appear to implicate spiritual and religious beliefs in family adjustment and adaptation to prostate cancer. On analysing responses to the open-ended question, however, spirituality and religious beliefs are identified by husbands and wives as the second and third most important internal coping resource respectively. Gall (2004) suggests that the relationship with God may function in a complex manner as a coping resource, and that longitudinal research is needed to clarify the role of religious/spiritual resources in coping with prostate cancer. It is also possible that these families respond differently to standardised questions that tap religious/spiritual resources versus an open-ended question that does not prompt a specific range of responses in any way.

For the husbands, the second most important coping resource is professional support and knowledge. This finding is supported by previous research (Balderson & Towell, 2003; Danielson et al., 1993; Lewis, 1990; Mellon & Northouse, 2001). It has been suggested by Danielson et al. (1993), that by replacing ignorance with information, it may be easier for families to come to grips with the reality of an illness crisis. According to Breau et al. (2003), men seek causal information and social support in an effort to accept their diagnosis.

Danielson et al. (1993) further suggests that the health-care team may be a good first source of answers to medical questions. According to Lewis (1990), both patients and family members need medically related information to manage the illness experience better. Balderson and Towell (2003) found satisfaction with medical care and information to be related to lower psychological distress. Furthermore, Mellon and Northouse (2001) found that survivors appreciated the support received from healthcare professionals, particularly physicians, while they were dealing with the cancer illness. Anxiety appears to be heightened by a family's lack of information or misunderstanding of cancer and, therefore, it is suggested by Danielson et al. (1993) that education plays a major role in reducing anxiety. The husbands in the present study, who said that professional support and knowledge were an important coping resource during their stressful experience of prostate cancer, stressed that knowing about the various treatment methods and side-effects made it easier for them to deal with their condition. In addition, they seemed to agree that knowing about treatments and survival rates made them feel more confident that they were in good hands. For these men, this coping resource was just as important as intrafamilial support.



For the wives involved in this study, the third most important resource in helping them through their stressful time was professional help and knowledge (see Table 1). Laverly and Clarke (1999) found that wives were inclined to seek information about prostate cancer in addition to that provided by doctors. Moreover, Laverly and Clarke found that increased knowledge helped both parties feel more involved in the decision-making process regarding treatment choices, which also enhanced their sense of control in an otherwise uncontrollable situation. The wives participating in this study valued professional knowledge and support for the same reasons as the men.

Social support was associated with family adaptation for both husbands and wives (see Table 2). This finding enjoys theoretical support when considering the Resiliency Model of

Family Stress, Adjustment and Adaptation (McCubbin & Thompson, 1991). Results from the regression analysis (see Table 3) revealed that for men social support, as measured by the Social Support Index, was a significant predictor of family adaptation. Previous research (Balderson & Towell, 2003; Breau et al, 2003; Danielson et al., 1993; DeFrain, 1999; Livneh, 2000; McCubbin et al., 1996; Mellon & Northouse, 2001; Walsh, 1998) also supports a relationship between seeking and accepting social support and successful adaptation to prostate cancer. DeFrain (1999) found that families who are more capable of dealing with hardship/crises sought help outside the boundaries of their immediate family. Mellon and Northouse (2001) found that the more the family's hardiness and social support, the more likely the family was to manage and cope with their illness stressor. In the current study, these findings appear to be echoed by the relationship between social support and family hardiness, and family adaptation to prostrate cancer.

Despite a significant positive relationship between social support (the degree to which families utilise emotional, esteem and network support in their communities), as measured by the Social Support Index and family adaptation, there was a negative relationship (close to significant) between social support (family's ability to actively engage in acquiring support from relatives, friends, neighbours and extended family) as measured by the F-COPES and family adaptation. This finding appears to be contradictory. The variables measured by the Social Support Subscale (F-COPES), include active coping styles or mechanisms, in other words, whether families try and cope on their own, or whether they venture out to seek and engage support. The negative relationship found may indicate that actively seeking and engaging support is related to family adaptation in combination with other variables (measured by the Social Support Index), in this instance, the extent to which the family actually finds the desired support from their communities. In this specific study, variables measured by the F-COPES (Social Support Index) in combination, and not in isolation, with

variables measured by the Social Support Index (SSI), are able to predict adaptation to prostate cancer. It is possible that for this particular sample, a specific combination of variables were associated with resilience in the face of an illness stressor, which points to the unique way in which families cope with prostate cancer.

A relationship was also observed between family adaptation and reframing (family's capability to redefine stressful events in order to make them more manageable). This correlation was positive for the women, and close to significant for the men, albeit not statistically significant (see Table 2).

Communication between family members has been implicated in family adaptation to chronic illness by many authors, as well as the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & Thompson, 1991). For the husbands and wives in this study, there was a positive relationship between affirming communication, in other words, a pattern of communication which conveys support and caring and exerts a calming influence, and family adaptation to prostate cancer. Results obtained from the regression analysis revealed that for the wives communication, as measured by the Family Problem Solving Communication Scale, was a significant predictor of family adaptation. Researchers (Boehmer & Clark, 2001; Danielson et al., 1993; Dunkel-Schetter, 1984; Gotcher, 1995; Gray, Fitch, Phillips, Labrecque & Klotz, 1999; Ka'opua, Gotay, Hannum & Bunghanoy, 2005) found that supportive, caring, encouraging and positive communication is positively correlated to patient and family adjustment to cancer. Danielson et al. (1993) found that it is easier if the family share their feelings versus hiding them, as this frees family members to offer each other support. In research conducted by Dunkel-Schetter (1984), clients with cancer described helpful communication as listening empathically and providing gentle encouragement. In the present study, incendiary communication (which is inflammatory in nature) appears to have a negative relationship with family adaptation. In other words, the

more family members engage in communication that tends to exacerbate the situation, the less likely the family will adapt to the cancer illness. In the present study, affirming communication, by conveying support and caring and exerting a calming influence, had the opposite effect to its negative communication counterpart. In support of this finding, Gotcher (1995) found that well-adjusted patients and maladjusted patients differed in the frequency of communication, the level of honesty in the communicative environment, the amount of encouragement received from family members, and the way unpleasant topics were handled.

In this particular study, age of participants, income, years married and number of children had no significant association with adjustment and adaptation to prostate cancer.

The qualitative and quantitative findings of this study yielded results that support the original hypothesis. There is indeed a significant relationship between variables outlined by Walsh (2003) and family adaptation to prostate cancer. These results indicated that for this sample of families, distinct familial qualities or characteristics were associated with family resilience. This means that these families have the potential to meet the demands of their illness stressor by making use of existing resources, or by having developed and strengthened additional resources by way of their coping behaviours (McCubbin & Thompson, 1991).

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Implications

Even though the sample in this study was relatively small, the results contribute to an understanding of resilience factors that help families cope with prostate cancer. On the basis of the findings, recommendations can be made to health care practitioners dealing with and caring for prostate cancer patients and their families.

When training health care professionals, it should be emphasised that the family is the most important context in which cancer patients adapt to their illness. This means that treating the patient in isolation excludes family members who are the most important resource and form of support for the patient. Including the entire family in the process is crucial because

effects of prostate cancer touch the entire family. Ongoing relationships should be developed with family members throughout the process, including diagnosis, treatment and palliative care. Hospitals should create the opportunity, context and the resources for family therapy, individual therapy, education, and support groups. In order for this to happen, counsellors or psychologists should be part of the broader health care plan of hospitals, as these members of staff would play a significant role in the lives of families coping with prostate cancer.

As indicated in this study, professional support and knowledge appear high on the list of perceived coping resources. This implies that families have the need for information, both medical and psychological. Prostate cancer support groups could be introduced as a platform for the dissemination of information, as well as an environment in which social support and validation of feelings could be experienced. Moreover, support groups offer an opportunity for skills training, for example learning how to seek out the necessary support in times of crisis, as well as developing communication skills. Family therapy would be a positive space in which to foster and enhance intrafamilial support and family hardiness. In addition family therapy creates an opportunity to build on families' existing coping skills. Prayer groups or gatherings could be an optional group or family activity, and could create a comforting environment in which people may share hope and make sense of their illness in a meaningful way.

All the aforementioned ideas flow from the results of the present study. Future research could focus on more detailed strategies and programs for the implementation of such ideas. This would require a thorough review of literature thusfar on family resilience. In order to keep programs consistent with the needs of families, families may be encouraged to participate in the planning of such interventions. Families are a rich source of coping strategies, and these ought to be harnessed in ways that would contribute to the education and support of other families coping with prostate cancer.

Limitations of this study

There are two limitations in this research that warrant discussion. The sample used in this study represents a small sector of the heterogeneous South African population. Even though the sample included both coloured and white families, cultural backgrounds and beliefs were not tapped for individual interpretations and experiences of prostate cancer. The second limitation involves comparison between spouses to establish any differences in responses that could have been gender-based. Furthermore, responses of wives and husbands were not compared to establish whether there was agreement or disagreement in their use of coping resources as a couple. Instead, responses of men and women were reported on independently. Future studies could consider these factors and incorporate such results into findings on family resilience.

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