Interactive Family Learning Following a Cancer Diagnosis

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Purpose/Objectives: To describe the experience of families when a member is diagnosed with cancer.

Design: Descriptive, qualitative study.

Setting: Patients’ homes.

Sample: Eight adults, two to five months postdiagnosis, who were receiving radiotherapy or chemotherapy for stage I or II solid tumors and family members, including seven children between the ages of 13–18. Thirty people interviewed total.

Methods: Patients recruited from an oncology outpatient clinic and gynecologic inpatient unit of a teaching hospital interviewed on one occasion with at least two immediate family members in patients’ homes. Semistructured interviews were tape-recorded and analyzed for themes and categories using the techniques of constant comparison.

Main Research Variables: transitions from health to illness.

Findings: Families described a learning process in which information was gathered, interpreted, and shared. Families learned together by reviewing the past, gathering and sharing information, and sharing their experiences of living with someone undergoing treatment for cancer. By revealing their own personal perspectives, patients taught their families about their illness experiences and what constituted effective support.

Conclusions: Interactive family learning is a mode of learning and a form of support in which the whole family may participate early in the process of learning to live with cancer.

Implications for Nursing: Nurses can facilitate patient and family learning by considering the interactive manner in which families acquire information. By acknowledging how past experiences with cancer inform the present, nurses can help families identify beliefs influencing the illness experience. By including families in teaching sessions; facilitating communication between patients, families, physicians, and nurses; and providing take-home learning materials, nurses can facilitate shared information gathering. Nurses should acknowledge the value of learning about illness by experience, accept patients and families as experts, and encourage revelation of patients’ and families’ perspectives of the illness to enhance feedback on support and coping.

Key Points . . .

➤ Families learn together by reviewing the past, sharing the work of gathering and interpreting information, and sharing experiences.

➤ Patients teach their family members through personal revelations about their experiences with cancer and about helpful support.

➤ Nurses can use information gathered by patients and families to facilitate effective relationships with healthcare providers and explore illness beliefs.

When a family member is diagnosed with cancer, the family’s experience is more complex than healthcare professionals may observe in the clinic or hospital. Often, healthcare professionals relate to patients and one family member only (Jassak, 1992); therefore, reports of adjustments and changes that are part of the family’s reactions to a new illness are filtered through this member. Curiosity about the nature of the transition families experience in the first months after diagnosis became the springboard for this study. Other studies have examined transitions from health to illness in oncology (Davies, Reimer, Brown, & Martens, 1995; Jassak; Lewis, 1986, 1993), but the current study’s authors found no research that examined family transitions through whole family interviews when a member initially was diagnosed with cancer. The authors convened whole families to explore this transition more fully.

Literature Review

According to family systems nursing (Friedman, 1997; Wright & Leahey, 2000), when one family member experiences a major change, such as the diagnosis of cancer, the whole family is influenced. The responses of family members, in turn, influence patients and the overall family experience. Lewis (1986) reviewed the oncology literature from 1977–1985 and concluded that, despite methodologic limitations, the studies illustrated multiple family stressors and needs. Kristjanson and Ashcroft (1994) cited more than 200 clinical articles and studies that examined the impact of a family member’s diagnosis of cancer. Most of the research has been cross-sectional, and data were collected from one individual in the family (most frequently, a spouse). Recent family research in oncology has
focused predominantly on spouses or primary caregivers (Au-
coin-Gallant, 1999; Hilton, Crawford, & Tarko, 2000; Philips
et al., 2000; Rees & Bath, 2000). Variations exist in the de-
mands and responses families report, but overwhelming evi-
dence states that families are heavily involved throughout the
process of adjustment to living with cancer.

Psychosocial transition is described in the stress and crisis
literature as a process across and beyond a turning point in life
that comprises change from one relatively steady state to an-
other (Parkes, 1971). Transitions of interest to nurses include
normative changes (e.g., the transition from couple to parents)
and situational changes (e.g., the transition from health to ill-
ness, the transition from hospital to homecare patient). Chick
and Meleis (1986) further defined psychosocial transition by
suggesting several characteristics of transitions: process, dis-
connectedness, perception, awareness, and patterns of re-
sponse. Schumacher and Meleis (1994) developed a model of
transition as a central concept in nursing and identified com-
mon transitions, universal properties of transitions, and indi-
cators of healthy outcomes. One study of supportive care
when family members were terminally ill revealed a phase of
transition the researchers called “fading away”—the transition
from living with cancer to dying with cancer (Davies et al.,
1995). The transition experienced by families involves ending
one period of life, living through a period of uncertainty or
chaos, and moving to a new beginning of terminal illness
(Bridges, 1980). Bridges’ study became a model for the cur-
rent study, which examined an earlier stage in the disease tra-
jectory. The current study’s authors used the models of trans-
ition (Schumacher & Meleis) and family systems nursing
(Wright & Leahey, 2000) to develop the following research
questions: What is the family experience in the transition from
being healthy to having a diagnosis of cancer? What is the
impact of the illness on the family? How does the family’s re-
response influence the experience?

Methods

Given the descriptive and explorative nature of the research
questions, the authors chose a qualitative research method.
Qualitative methods provide an opportunity to examine fami-
lies’ experiences of the process of transition, from their points
of view, through interviews and comparative analysis. Data
collected from several family members concurrently were ex-
pected to allow for mutual prompting of memory and discus-
sion of the process of transition.

A convenience sample was accrued through the ambulatory
oncology clinic and inpatient gynecology-oncology unit of a
teaching hospital. Consistent with the family systems nursing
framework, families were interviewed as a group. Adults with
stage I or II solid tumors who were diagnosed two to five
months before the interviews and receiving chemotherapy or
radiotherapy became eligible participants. At least two consent-
ing family members, age 13 or older, participated in the fam-
ily interviews. Participants spoke French or English. The au-
thors defined “family” as “a group of two or more individuals
usually living in close geographic proximity, having close emo-
tional bonds, and meeting affectional, socioeconomic, sexual,
and socialization needs of the family group or the wider social
systems” (Gilliss, Roberts, Highley, & Martinson, 1989, p. 72).
For clarity, family members diagnosed with cancer will be re-
ferred to as “patients.”

After the hospital ethical review board approved the project,
a staff nurse approached potentially eligible patients and ob-
tained verbal consent for a researcher to discuss the project with
the patients and families. The bilingual (French and English)
clinical researchers were not providing care to the patients and
families. A researcher approached 13 patients for participation;
5 refused to participate or needed to delay participation beyond
six months. Time boundaries were based on clinical experience;
the authors wanted to allow some time for adjustment to the di-
agnosis and treatment so that patients and families would be able
to reflect on their experiences. All family members provided
written consent at the time of the interview. A single, semi-
structured interview using open-ended questions, lasting one to
two hours, was conducted in French or English in the patients’
homes. The authors created an interview guide for the popula-
tion studied based on the Davies et al. (1995) study of family
transitions in palliative care (see Figure 1).

Interviews were tape-recorded, transcribed verbatim, and
analyzed for themes and categories using the techniques of
constant comparison (Glaser & Strauss, 1967; Strauss &
Corbin, 1990). Working separately at first, the two clinician
researchers and the nursing research consultant read the inter-
views thoroughly. Initially, the researchers coded the interviews
open-endedly, phrase by phrase, and examined excerpts of data
in detail in relation to emerging themes. Analysis involved
handwritten notes directly on the transcripts and frequent
memos. The clinician researchers and consultant reached con-
sensus regarding themes and coding and clarified the coding
rules. In this manner, the coding process was checked for reli-
ability. As often as possible, subjects’ own words were used to
develop emerging themes.

Results

Eight families (30 people), including 23 adults and 7 children
between the ages of 13–18, were interviewed two to five
months after the patients’ diagnoses. This convenience sample
consisted of a variety of family types, developmental stages,
ethnic groups, and cancer diagnoses (see Table 1); only one of
the patients was male. In the initial stages of analysis, six
themes of family experience were described as points along a
continuum (see Figure 2). These themes described patient and
family reactions to illness, treatment, and the healthcare system.
Curiosity about “transitions” motivated this research. How-
ever, during the ongoing analysis, the authors’ attention was

1. Can you tell me more about your illness?
2. Can you tell me about some of the changes that have hap-
pened in your family over the past weeks or months?
3. How are things at home? What is the most difficult part?
What is going well?
4. What services have you used in adjusting to this situation?
5. What has it been like for all of you to have someone with a
new illness?
6. In your opinion, who is most affected by this situation?
7. How have you coped with difficult situations in the past?
8. What advice would you offer to others who are experienc-
ing a similar situation?

Figure 1. Interview Guide
Note. Based on information from Davies et al., 1995.
drawn to the concept of families learning together as an interactive process. By definition, learning is gaining knowledge of something or acquiring skill in some art or practice by experience or example; to learn is to know or to become informed (Collins New English Dictionary, 2000). Interactive learning involves family members bringing pieces of the puzzle together to form an integrated picture or mosaic about how to live with cancer. Emerging themes describing this learning process included reviewing the past, sharing the work and effort of gathering and interpreting information, learning through experience, and learning through patients’ revelations of their own perspectives.

**Reviewing the Past**

One of the learning resources most accessible to families was past experience. Families pooled memories of past experiences with cancer or other major illnesses. In two families, beliefs clearly were influenced by a sense of fatalism: “Everyone we know who had cancer, died of it.” “In my home country, when you get cancer, you die.” Adult siblings in Family H reported past experience with their mother’s death from cancer as not important because “we were young and we didn’t stop to talk about it.” The impact of cancer was much greater now that they, the children, were facing illness. Two women spoke of separating themselves from the experiences of immediate family members’ past deaths.

Other families focused on the way information had been withheld in the family; reactions to these experiences were strong and became the basis for contrasting beliefs.

*Patient’s husband:* When I was [the children’s] age, my mother died of breast cancer, too. Back then, we were sort of kept in the dark about everything, and one of the things [patient and husband] said was that “we’re going to keep the children informed of everything.” (Family D)

*Daughter:* I remember when my aunt was dying last year, Grandma was always saying my aunt was “fine, fine.” Grandma was very positive.

*Patient:* That’s blindness! That’s not being positive. (Family A)

Positive comparison was part of reviewing the past. Families compared their current experiences to people in worse situations. Role models also were elicited by remembering how others had conducted themselves when they were sick. The patient in Family E made a negative comparison of his diagnosis of cancer to his experience with a heart attack several years earlier. He had recovered more quickly, whereas his current intensive chemotherapy left him quite weak and dependent on others.

Thus, as families reviewed the past together, both negative and positive memories were evoked. Learning occurred through reflection as families discussed past experiences. Responses to this reflection ranged from being fatalistic to being determined to react differently in the face of illness.

**Sharing Information Gathering**

Families shared information gathering as they sought information on behalf of other family members, explored medical opinions, and learned from the experiences of outside acquaintances. As information was being shared within the family, an informed trust was building in relation to the healthcare system.

Working as a learning team, families actively sought out information on behalf of other family members and “wanted to know.” Family members, rather than patients, generally were propelling this activity. Several people had consulted medical textbooks or dictionaries. They also referred to information booklets issued at the hospital; all the children in Family A had read a booklet prepared for children whose parents had been diagnosed with cancer. The families all wanted information.

*Patient’s boyfriend:* We tried to help [the patient] discuss it as well as we could with the knowledge we had—and you don’t know anything about this kind of stuff until it occurs—and then you try to become more knowledgeable. We all pitch in and find out what we can do about it. (Family C)

*Patient’s adult son:* I did not even know what a lymph node was—we went through the education process, finding things out. (Family B)

Families spoke of a variety of information resources within the healthcare system: nurses, doctors, research protocol data

### Table 1. Family Participants

<table>
<thead>
<tr>
<th>Family</th>
<th>Patient</th>
<th>Cancer Diagnosis</th>
<th>Family Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Woman, age 40</td>
<td>Cervix, stage II</td>
<td>Daughter (age 16) and son (age 13) (9-year-old daughter present)</td>
</tr>
<tr>
<td>B</td>
<td>Woman, age 66</td>
<td>Breast, stage II</td>
<td>Husband and three adult sons</td>
</tr>
<tr>
<td>C</td>
<td>Woman, age 28</td>
<td>Cervix, stage II</td>
<td>Mother, sister, and boyfriend</td>
</tr>
<tr>
<td>D</td>
<td>Woman, age 43</td>
<td>Breast, stage II</td>
<td>Husband and sons (ages 13 and 15)</td>
</tr>
<tr>
<td>E</td>
<td>Man, age 48</td>
<td>Colon, Duke’s B</td>
<td>Wife, son (age 18), and wife’s mother</td>
</tr>
<tr>
<td>F</td>
<td>Woman, age 41</td>
<td>Cervix, stage I</td>
<td>Husband, daughter (age 16), and son (age 14)</td>
</tr>
<tr>
<td>G</td>
<td>Woman, age 35</td>
<td>Cervix, stage I</td>
<td>Husband and daughter (age 14) (10-year-old son present)</td>
</tr>
<tr>
<td>H</td>
<td>Woman, age 52</td>
<td>Ovarian, stage II</td>
<td>Two brothers, one adult son, and one sister-in-law</td>
</tr>
</tbody>
</table>
managers, and pharmacists. Family members attended doctors’ appointments to help gather details of diagnosis and treatment. Frequently, family members sought informal second opinions to clarify information.

**Patient:** I was scared to find out, but [boyfriend] has a doctor friend and he took the time to find out. Which I wouldn’t [do]. (Family C)

In Family B, three adult sons who completely directed the information seeking for their 66-year-old mother pursued a second and then a third medical opinion. When they received conflicting advice, they “didn’t know who to turn to” to determine if treatment was going to be worthwhile for their mother. Access to several medical opinions did not always clarify treatment decisions.

Other patients’ experiences provided a further learning resource. Some patients and family members polled acquaintances and fellow patients with cancer.

**Patient’s son:** I know three women that have gone through that, and two of them have had their breast removed. So I started talking with them, finding out more about it. That helps a lot . . . They can tell you what to expect; describe to you, not from a doctor’s point of view, but [from] somebody that lived it—the experience. (Family B)

One patient stated that she would have preferred to be informed by staff. The patient in Family D avoided conversation with other patients in the hospital waiting room. She had attended a patient support group and was frightened by thoughts of disease progression. She was “saving her feelings” so she could focus on her own recovery.

Thus, the families showed variation in the method and tempo of information gathering. Written information was important for some; the experience of other patients was not always a welcome resource. The tempo varied in that some family members and patients wanted information at different rates.

Learning from others’ experiences helped families to interpret their own. More specifically, the development of “informed trust” was relevant with respect to information from healthcare professionals. The notion of informed trust arose as part of families’ interactive learning processes and was grounded in the need for information. People were willing to trust and wanted to trust—after they had gathered sufficient information. This informed trust reflected a guarded trust and wanted to trust—after they had gathered sufficient information. This informed trust reflected a guarded confidence built on families’ own information gathering. Informed trust was moderated by factors such as previous experiences with cancer, suspicions about the healthcare system or healthcare professionals, consumerism, research skills, and a need to know what is going on in one’s body. As families spoke of lengthy diagnostic periods, differing medical opinions, and uncertain prognoses, they appeared to wrestle with the need for information and the need to trust.

**Patient’s son:** You’re wondering all kinds of things, when you don’t know. And I think it helps to go to different doctors and talk. It wasn’t a question that you doubt the doctors, or that you doubt their diagnosis. You’re just trying to learn more. The more you learn about it—sure, it raises other questions—and then when the doctors . . . when you go to the doctors that start the treatment . . . and they’re not doing some of the things that you thought they were going to do, it kind of puts doubt in your mind. But I think learning about what’s happening helps tremendously. (Family B)

Several patients and families achieved a comfortable level of confidence in their physicians; they appeared to have developed an informed trust. After a protracted diagnostic period, the patient in Family C was transferred to another hospital. At the second hospital, she found she had more confidence in the doctors—they were “more direct . . . and gave me more definite answers.” For others, confidence appeared to be elusive; a lingering uncertainty existed. In Family G, the doctor had not clarified terms such as “high risk,” neither English nor French was the family’s language, and a lack of understanding about pertinent physiology existed. In Family B, an adult son spoke about “disbelief” with regard to the efficacy of treatment.

**Patient’s son:** When you’re going through all of these symptoms, you find it hard to believe. Maybe I shouldn’t have done [chemotherapy]. Maybe we are going through this suffering, and then it won’t have done any good. It’s the disbelief aspect of it. (Family B)

The authors saw the family working as a supportive learning team and gathering information from a variety of sources. The authors also considered the interplay between the need to learn and the need to trust and observed families at different stages in the evolution of informed trust with respect to healthcare professionals.

**Experiential Learning**

One prominent mode of learning was through patients’ and families’ own experiences as they lived through the illness and treatment. When asked open-ended questions about treatment, people talked about day-to-day life with cancer. Families described an experiential learning that was, by nature, interactive. Three domains of experience that had an impact on the family were treatment side effects, mood alterations, and family schedules and roles.

**Treatment side effects:** Patients and families had been given information about how to manage side effects of treatment. Once outside the security of the hospital, they had to use this information to recognize normal or usual reactions, treat problems with the medication provided or home remedies, and recognize when to call for professional help or return to the hospital. When faced with problems, families worked together to find solutions.

**Mood alterations:** Patients’ mood alterations presented particular challenges that all of the families were learning to live with. Sometimes, anxiety or irritability preceded chemotherapy treatment by several days. Some patients reported frustration with family members’ attempts to be supportive or helpful. Some family members struggled to accommodate this moodiness; the 18-year-old son in Family E spoke of having to walk away from arguments with his father during “chemo week.”

**Schedules and roles:** Family schedules and roles changed as families learned to adjust. The 16-year-old daughter in Family A found that having her mother at home full-time threw off her after-school routine. In Family G, the husband had two jobs and worked at least 16 hours a day and the patient had a newborn baby and no energy for the other four children, resulting in more work.
Interactive learning occurred as the sister and boyfriend of the 28-year-old patient in Family C spontaneously role-played her return to work. They rehearsed how to answer the prying questions of coworkers and primed the patient to face one man who was blaming her for the illness. Together, they were learning to deal with others who had different beliefs.

**Revelation**

Revelation was another mode of learning observed during interviews. Patients discussed their personal perspectives of the illness experience with family members. Certain aspects already had been shared with the family; others apparently were first-time disclosures. The encounter with illness had promoted self-reflection, “face-à-face avec moi-même” (face-to-face with myself) (Family A). Patients became more preoccupied with their own health. “Putting oneself first” was an egocentric strategy that allowed patients to face their illnesses. A dramatic revelation occurred in the interview with Family A. The divorced mother of three disclosed that she was thinking of changing jobs, changing priorities, and seeing her life in a new way: “I’m not only mother.”

While sharing their personal perspectives, patients gave their families feedback about supportive behaviors that were not helpful. Two women admitted that they were irritated by their families’ emphasis on positive thinking. Reminders to “be strong” or “keep fighting” were too frequent or did not make sense to patients.

**Patient:** Everybody tells you to fight. I was just so sick of hearing that word. Fight . . . I have many reasons to live. But I felt like, if it’s going to overtake me, it’s going to overtake me. What am I actually fighting, a cell? You know, me against the cell? (Family C)

Other patients reflected on what it was like to be in the “sick” role. They used “overprotecting,” “suffocating,” or “attitude mère poule” (mother hen attitude) to describe the actions of their extended family members.

The patient in Family A disclosed her belief that she was facing the possibility that death might be the outcome of her cancer. Another patient spoke of facing death.

**Patient:** After a while, you get tired of being sick, and you realize that you’ve changed. I worry more about my future. . . . I asked the doctor, “Now, is there a chance I could die?” He said a small, small chance. . . . If it happens, it happens, of course. If I have to die, I’ll die. (Family D)

In summary, the authors observed how these families learned together by reviewing the past, sharing information gathering, and understanding the everyday experiences of living with someone undergoing treatment for cancer. In a more direct, intimate manner, patients taught their families through revelations of their personal perspectives.

**Discussion**

Learning was the most striking element that arose when the authors asked patients and families general questions about their experiences. The families talked about how and what they were learning. For the authors, the concept of interactive family learning seemed to capture the process of the families’ adjustment to cancer. Exchange and reaction appeared to be intrinsic to the learning process. Individuals had an impact on each other as information and experiences were pooled within the families to facilitate adjustment.

The intended focus of this study was family transitions following a recent diagnosis of cancer. The authors may have missed the “beginning” and “ending” transition phases described by Bridges (1980) by not interviewing the families immediately postdiagnosis. Some researchers have contended that in these early months, families may be too focused on the struggle for patients’ survival to allow them to reflect on their experience (Breetvelt & Van Dam, 1991; Weisman & Worden, 1976). Other research has demonstrated that traumatic events can be remembered in vivid detail when recalled at a later date, when people are relaxed and comfortable (Christianson & Loftus, 1991). One alternative interpretation of the current results is that in this early transition phase, patients and families actually are learning.

The literature provides support for families’ need for information (Hilton, 1993; Kilpatrick, Kristjanson, Tataryn, & Fraser, 1998; Northhouse & Northhouse, 1987; Rees & Bath, 2000; Wright & Dyck, 1984). The current study revealed the interactive manner in which families acquire information: reviewing the past, sharing information gathering, and learning through experience. In addition, families shared information as patients made new revelations of their own personal perspectives of the cancer experience.

The concept of learning is central to the McGill Model of Nursing, which focuses on learning to be healthy, that is, to live healthily with or without illness (Gottlieb & Rowat, 1987). The McGill Model espouses that health is best learned through active participation and personal discovery (Kravitz & Frey, 1989). The current study supports this theoretic perspective in the families’ descriptions. One patient advised others to “read, read, read!” Families spoke of sharing the workload of gathering information; this further was identified as a technique for supporting patients. This study also supports the McGill Model and family systems theory in terms of the interactive manner by which knowledge was gained.

The current study demonstrated the manner in which beliefs about cancer affected the flow of information. Some people believed that “everybody dies of cancer,” whereas others were able to consider individualized prognoses. An open climate of discussion within families allowed for differing beliefs about cancer. Lack of consensus was uncomfortable, but alternative views and beliefs were aired. Healthcare professionals have become more cognizant of the influence of families’ beliefs on the illness experience (Duhamel, 1995; Richer & Ezer, 2000; Rolland, 1994; Wright, Watson, & Bell, 1996). Beliefs affect the information that families will accept and facilitate or constrain options in their responses to illness (Wright et al.).

The importance of information about patients’ personal perspectives was highlighted by the work of Wright et al. (1996). Patients are believed to be experts in their experiences of the illness; however, the family systems approach invites all family members to share their expertise. In the current study, patients’ revelations with the whole family present allowed for feedback regarding attempts to provide support. When giving voice to their personal perspectives, most patients affirmed that they were overprotected or that support attempts were ineffective. Duhamel (1995) contended that the phenomenon of overprotection and dependence is an important aspect of the influence of illness on family dynamics. Pistrang, Barker, and Rutter
(1997) explored how couples and dyads differentiated between effective and ineffective support attempts. Disclosure was an important factor in effective social support. In contrast, Lynam (1995) studied whole families in which young adults had cancer and reported that “being there for you” was a highly valued form of family support. The current study reflected a range of family supportive behavior and supported the concept that family interviews can facilitate the circulation of supportive information among family members (Wright et al.). Through these interviews, individuals’ revelations provided feedback that informed and influenced families’ perspectives. Furthermore, as family members interactively reviewed the past, shared information, and spoke of what they had learned through experience, they began to face reality and struggle together with the meaning of life, death, and hope.

Learning directly affects patients’ and families’ interaction with members of the healthcare system. The concept of informed trust emerging from the data corresponds to discussions of trust between families and healthcare professionals in the literature (Engstrom, 1984; Lynn-McHale & Deatrick, 2000; Thorne & Robinson, 1989). Thorne and Robinson revealed a three-stage, evolving process of relationships between patients and families experiencing chronic illness and healthcare professionals: naive trust (i.e., trust is assumed), disenchantment (i.e., questioning), and guarded alliance (i.e., reciprocal trust rooted in patients’ and families’ “sophisticated working knowledge” of their own healthcare needs). The current study demonstrated the development of this working knowledge.

Learning through experience is one way that patients and families develop expertise (Wright et al., 1996). This experience-based expertise combines with expertise based on information gathering to give patients and families a sense of competence. In turn, these elements contribute to effective relationships between patients, family members, and healthcare providers (Lynn-McHale & Deatrick, 2000; Thorne & Robinson, 1989).

Limitations

Recurring themes were evident, but saturation of themes would have required further interviews. Furthermore, the literature emphasized the need for longitudinal studies (Lewis, 1986; Kristjanson & Ashcroft, 1994); however, the current study’s authors conducted only one interview with each family. Staff nurses initiated and conducted the study; thus, temporal and financial restrictions affected the size of the sample and the composition and number of interviews conducted.

Although not a limitation, the study raised questions regarding the distinction between the roles of researchers and clinicians. On one occasion, during the interview with Family A, the mother’s frank disclosure of her thoughts about death compelled the researcher to intervene as a nurse with the family and then complete the interview using the semi-structured guide. When a researcher intervenes with a family, the objectivity of the assessment and description of the family may be questioned. However, the systems perspective of families includes the belief that mutual interaction takes place between families and members of the healthcare system (Wright & Leahey, 2000). Therefore, the role dilemma experienced by the researchers may be related to the incongruity between approaching a family with a systems perspective and adhering to the traditional scientific belief that researchers must maintain objectivity (Feetham, 1991; Kristjanson, 1992).

Implications for Nursing Practice and Research

The results of this study suggest that nurses can facilitate patient and family learning in the early months after a cancer diagnosis by considering the interactive manner in which families acquire information.

Shared information gathering can be facilitated in many ways. Nurses should include families in teaching sessions and make use of family visits to share information, teach, and solicit understanding. Nurses should assess information needs and preferred modes of learning at several intervals and offer written or audiovisual take-home learning materials with the explicit suggestion that they be shared with other family members. Nurses also should encourage the use of the medical libraries and Web sites and recommend support groups that may provide useful forums for discussing health issues and sources of information.

Nurses can harness information gathered by patients and families to facilitate effective relationships between healthcare providers, patients, and families. Nurses should acknowledge the expertise that patients and families bring to the relationship and the working knowledge of illness gained through experience. Nurses must keep in mind that trust between clients and healthcare providers evolves over time.

Because family beliefs are likely to influence the flow and processing of information, nurses can draw forth these beliefs by exploring the impact of past experiences with cancer and how these inform the present. Through open-ended questions, nurses can explore differences between these beliefs and conventional care.

Family conversations and interviews can be used by nurses to circulate information and solicit feedback regarding support. Patients and family members can be encouraged to reveal and discuss their perspectives of the experience of living with cancer as a means to support each other more effectively.

The design of this study permitted observation of interaction within the family system. Such qualitative methods may be better suited to studies based on the systems perspective (Kristjanson, 1992). This suggestion also influences the question of researcher objectivity as previously discussed. Perhaps other methods, such as participant observation and fourth generation evaluation (Guba & Lincoln, 1989; Munhall & Boyd, 1994), could become part of family nurse researchers’ tool kits.

Summary

The insights offered by this study were, in part, gained by the fact that family members were interviewed as a group. However, many of these nursing actions can be used with individual patients with the implicit objective of inviting family involvement. Nurses can work with patients and families to review past experiences, share information gathering, develop expertise through experience with illness, and circulate information that provides feedback regarding support and coping and, thus, facilitate interactive family learning in the early months following a cancer diagnosis.

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References


For more information ...

➤ Journal of Interactive Learning Research
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