Role Transitions in Families Due to Health Issues: Married Couples' Viewpoints

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Key Words :
family roles
role transition
married couples
family development

ABSTRACT

The present study involving the families of patients who developed health problems aimed to examine their approaches to changing their family roles and adapting themselves, from the viewpoint of a couple. The subjects were five patients with sequelae associated with cerebrovascular disorders or undergoing hemodialysis and five spouses. Semi-structured interviews with them were conducted during hospitalization and following discharge. The familial roles were grouped into the following six categories: housework, earning an income, nursing care/child-raising, liaison, and enshrining ancestors, and examined changes in these roles over time. The results were as follows: 1) When patients with preschoolers or school-aged children were hospitalized, the roles of housework and child-raising were shared by their parents. When patients with adult offspring or in the young-elderly group were hospitalized, the roles of housework and home nursing care were shared by the offspring of the patients. After patients were discharged, these roles were played by a spouse or one family member alone in all cases. 2) When a family member had a health problem, it became difficult for the family to continue to earn an income. 3) When it became necessary for a family member to provide nursing care, the new role increased or decreased his/her role in providing other family members with emotional support. 4) When patients with adult offspring or in the young-elderly group developed health problems, they shifted their roles and authority to their offspring.

I. Introduction

If a person has developed a health problem, this person and their family will be required to change their daily activities, and the family environment and relationships will easily change. As these changes are considered to cause further problems, it is necessary to support patients and their families in this period.

In order for health care professionals to provide the families of patients with support or to identify the nature of necessary support activities, they are required to adopt a viewpoint that allows them to understand the family of a patient as a whole.[1)] However, since nursing care provided in clinical settings usually focuses on individual patients, health care professionals have difficulty providing the families of patients with support despite their recognition of its importance. In the field of research on adult and elderly nursing care, many more studies have focused on patients and primary care providers than those emphasizing patients and their families,[2-10)] and these studies viewed family members as background factors behind patients, considering family structures and relationships as related factors.

In the field of family sociology, a variety of approaches for understanding the families of patients have been studied and developed.[11)] Family development approaches, which integrate many different concepts, including theories of interactions and family life cycles,[11-13)] can be used to comprehend internal processes that occur in families, changes in their structures, and differences between generations. The approach focusing on "roles" in particular helps researchers view "patients and their families" as a unit, examine their changes in integrated and multidimensional manners,[14)] and develop more appropriate family intervention methods.

Within the framework of theories of family roles, changes in relationships related to family roles, expectations, and skills are regarded as role transitions.[15, 16)] Research on shifts in familial roles started to be conducted in the mid-1980s, utilizing the framework of familial stress theories established by Hill and McCubbin.[17)] During a period of transition of familial life stages or when the structure of a family has changed, role transition occurs as coping behaviors performed by family members.[17)] In the field of family sociology, studies of role transition between husbands and wives have primarily been conducted to identify factors contributing to husbands' participation in housework and to discuss changes in their lifestyles, such as retirement.[18-21)] Regarding parent-child relationships, there have been studies of generational changes associated with role and authority transitions as viewed by elderly parents.[22, 23)] In the field of nursing science, studies of changes in role awareness and coordination were conducted, with an emphasis on the relationship between patients and care providers.[24, 25)] When people develop a chronic disorder, their families will be required to play a new role as nursing care providers. No studies have been conducted to examine the influences of these factors on family members from the viewpoint of role transition.

When people have developed health problems, they will often be admitted to hospital for treatment and then discharged home. The present study examined how the families of patients changed their roles and adapted themselves during this process, with a focus on couples - the center of families. The obtained results should be useful for clinical research on care and support approaches, taking into consideration patients and all other family members and their post-discharge lives.

II. Study Methods

A qualitative and descriptive research method including semi-structured interviews was adopted.

1. Conceptual framework

The present study aimed to examine changes in the lives of families of people who have developed health problems and their family roles, from the viewpoint of patients and their spouses as a subsystem. In this study, the theory of roles based on developmental theory was adopted as a conceptual framework (Figure 1). Figure 1 suggests that health problems affect role expectation and recognition: components of a role,

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This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.

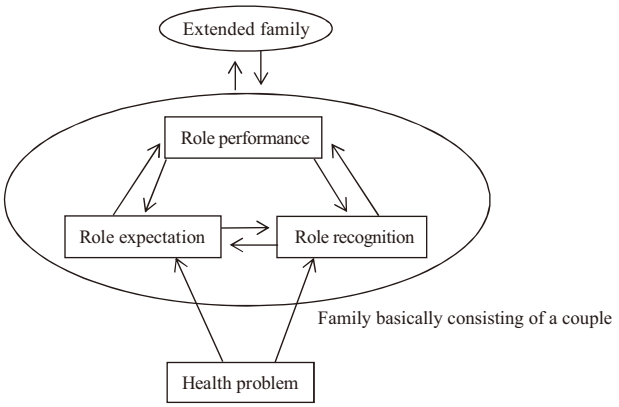


Figure 1. Role transition when a family member has developed a health problem

and their changes influence role performance. In the process, the influenced role expectation affects role expectation and recognition, which also interact with each other. Such a process occurs between couples in particular, and also among family members including elderly parents and their offspring (extended families).

2. Operational definitions of terms

The present study adopted the following operational definitions of terms:

[Family]: A family consisting of a patient and his/her spouse is defined as a conjugal family (husband and wife), and a family consisting of a couple, their children, and their (elderly) parents is defined as an extended family.

[Family development]

Changes in the structure of a family, or a group of people who function in specific cultural and social systems, and their relationships over time. The present study adopted the theory that the development of a family can be classified into seven stages according to the number of family members and the level of development of the oldest child.[26, 27]

[Role transition]

This study examined changes in family development from the viewpoint of the roles of family members, and interpreted them as changes in the relationships among the roles within a family, role expectations of other family members, and abilities to play their roles.[26]

[Role performance]

Behaviors actually performed while taking into consideration social norms, recognitions based on circumstances, and expectations from other people

[Role expectation]

Expectation of the behaviors of other people according to recognition based on social norms and circumstances

[Role recognition]

Understanding of behaviors expected of oneself by other people, based on recognition of social norms and circumstances

[Family roles]

Shared roles to be played by each member of a family to maintain the group. The framework of the classification was developed by reference to the following: Items from Koyama's[28] Japanese version of the classification revised based on the methods developed by P. G. Herbst and R. Blood, the structure of group roles suggested by Morioka and Mochizuki,[13] items from the married-couple subsystem suggested by Nye and Gecas,[29] and the classification by Kamiko;[30] six role categories were extracted (Table 1).

Table 1. Classification categories of family roles

1. Role of doing housework
2. Role of earning an income
3. Roles of providing the elderly and patients with nursing care and parenting
4. Roles of the alleviation of tension and emotional integration
5. Role, as a representative liaison, of helping family members interact with their relatives, neighbors, and various organizations in the community
6. Role of enshrining ancestors

Housework-related roles in the present study refer to activities such as cooking, laundry, simple carpentry, and locking up the house. The role of the acquisition of income refers to the activity of earning income. The role of the provision of nursing care for infants, elderly people, and patients refers to daily-life support, including meals, toilet, and bathing, to help the young, the elderly, and the infirm live a normal life. Activities of taking consideration of the health conditions of other people were also included. Child-raising in this study refers to parenting of high school-aged or younger children. The roles of relaxation of tensions and emotional integration (emotional roles) refer to behaviors of caring, understanding, discussing, cherishing, and opening up to and going out with others. The role of liaison represented by helping family members interact with their relatives, neighbors, and various organizations in the community refers to interactions among relatives and PTA activities. Visiting ancestors' graves is defined as the role of enshrining their souls.

3. Subjects

The subjects were patients admitted to two hospitals in a prefecture who satisfied all of the following conditions and their spouses, namely, five couples:

- Patients with cerebrovascular diseases whose physical function was impaired or condition worsened so that they required dialysis treatment due to the most recent hospitalization
- Middle-aged to elderly males and females
- Married people (regardless of the duration of marriage)
- People scheduled to be discharged home
- People who were unlikely to be readmitted to hospital for three to four months

4. Period of the survey

The survey was undertaken between April and October 1999. Interviews were conducted twice: during hospitalization and two to three months after discharge, to examine changes over time. The appointed time and place for the interview were decided by taking into consideration the physical conditions

This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.

and lives of patients and their families and prioritizing their intentions. Interviews with husbands and wives were conducted separately to encourage them to speak about their spouses honestly.

To give due consideration to research ethics, we provided patients and their spouses with oral and verbal explanations when we asked them to participate in the survey. Before they consented to the study, it was explained to them that they could withdraw from the interview at any time and that what they said would be kept secret from their spouse.

5. Structure of the questionnaire (question items)

The question items were developed based on the category structure of the Calgary Family Assessment Model,[31] with the goal of understanding families, and the Questionnaire Survey for the Understanding of the Structure of Family Roles,[22, 28] with the goal of understanding "married-couple/parent-child subsystems" (Table 2).

Table 2. Question items

a) Attributes of the families of the subjects
(1) Type of family
(2) Age
(3) Relationship to the patient
(4) Employment status
(5) Health condition (medical history/chronic disorders)
(6) Living together with or separately from the patients
(7) Driver's license
b) Married couple subsystem (patients and their spouses)
(1) Academic background
(2) Form of the marriage
(3) Most reliable person
(4) Behaviors of the day (status of performed family roles)
(5) Role recognition
(6) Roles expected of the spouse
(7) Stress experienced or not experienced
c) Parent-child system (Generations of patients' children and senior parents)
(1) Status of performed family roles
(2) Role expectation and recognition
(3) Stress experienced or not experienced
d) Social network
Relationships with relatives, neighbors, friends, and patients' associations

6. Data analysis method

Data were coded and classified into "role performance", "role expectation", and "role recognition". "Role performance" was classified for each of the six family role categories. Data obtained from three different periods: "prior to the onset of the disease (until the day before hospitalization)", "during hospitalization", and "following discharge", were classified to examine changes over time and extract common items.

III. Results of the Study

1. Summaries of case examples

Table 3 shows summaries of case examples of subjects and their families. The subjects were classified into the following family developmental stages: one couple in the child-raising period, one couple with children at school, two couples with adult offspring, and one young-elderly couple. There were two male (husbands) and three female (wives) patients. The ages of the patients ranged between 39 and 61 years old; husbands were aged 39 to 63 years old and wives 29 to 61 years old. Regarding health problems, there were three patients undergoing artificial hemodialysis due to renal diseases and two patients with impaired physical functions due to cerebrovascular disorders.

2. Changes in family roles in each of the developmental stages

In this section, common items extracted from the data and representative remarks of the subjects are presented.

1) Examples of patients with preschoolers (in the child-raising period) and school-aged children

a. When the wife was in good health, the husband helped her with housework and parenting.

The husband took out the garbage, took the children out and brought them home, played with the children, cleaned the bathtub and rooms, took care of the garden and trees, and managed their land.

I often played with our children on holidays. Since my wife (patient) was busy in the morning, I cleaned the bathroom every day. I sometimes cleaned the rooms as well (husband with school-aged children).

b. When husbands or wives were hospitalized, their spouses did the housework and parenting, and provided nursing care.

When husbands or wives were admitted to hospital, their spouses did housework and provided child and nursing care, in addition to earning an income. Specifically, the roles of nursing care performed by them included preparation for hospitalization, hospital visitation, the collection of information on the health problem, listening to explanations provided by physicians, and conveying them to the patient.

I am in charge of almost all of the housework. I listen to explanations provided by the physician and convey them to my wife the following day. I always drop by the hospital on my way home from work (husband with school-aged children).

c. When husbands or wives were hospitalized, their mothers helped with housework and child-raising.

When the spouses of patients left home for work or hospital visitation, their mothers prepared meals, took their children to and from kindergarten, and took care of them.

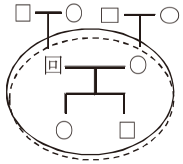
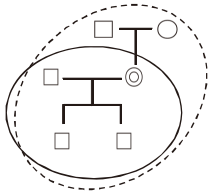
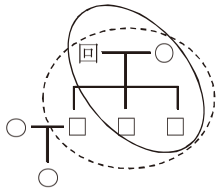
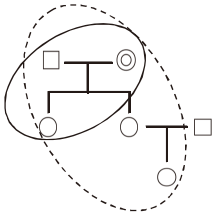
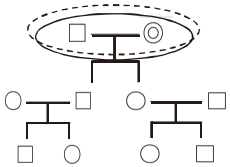
When my husband was ill, our children were taken care of by my mother-in-law three days a week and by my mother once a week. My mother-in-law took care of our children at her home on weekends (wife in the child-raising period).

d. When husbands or wives had become ill, their spouses recognized that they would have to earn an income instead and did so.

When husbands or wives had become ill, their spouses felt anxious over their future, considering that they would have to compensate for a decrease in the family income, and became determined to work harder or do extra work.

This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.

Table 3. Summary of case examples

	An example of a couple in the child-raising period		An example of a couple with school-aged children		Case A (a couple with adult offspring)		Case B (a couple with adult offspring)		Example of a couple in the young-elderly period	
	Husband (patient)	Wife	Husband	Wife (patient)	Husband (patient)	Wife	Husband	Wife (patient)	Husband	Wife (patient)
Age	39	29	51	46	52	52	55	53	63	61
Health condition	Cerebellar infarction Right cerebellar ataxia	In good health	In good health	Dialysis due to chronic renal failure	Dialysis due to chronic renal disorders	In good health	High blood pressure	Dialysis due to diabetic nephropathy	Asthma from 10 years ago	Occlusion of the left middle cerebral artery Left hemiplegia
Job (prior to hospitalization)	Attendant	Full-time housewife	Company employee	Clerk in a hospital	Self-employed	Self-employed	Company employee	Company employee	Company employee	Full-time housewife
(following hospitalization)	Clerk	Sideline business at home	Company employee	Full-time housewife	Retired	Self-employed	Company employee	Full-time housewife	Househusband	Management of important documents
Academic background	High school	Dropout of a two-year college	Dropout of a college	Dropout of a two-year college	High school	High school	High school	High school	High school	High school
Reliable family members	Wife	Husband	Wife	Husband/Parents	Wife	Eldest son	None	Husband	Wife	Husband
Structure of the family -------- Family members of the husband and wife from the couple's perspective										
Persons living with the patient	The eldest daughter (5) and son (3).		The eldest (16) and second (11) sons: During their mother's hospitalization, they took care of themselves.		The second (26) and third (24) sons: Company employees. During their father's hospitalization, they sometimes helped their father attend hospital and did housework.		The eldest daughter (28): Nurse. The patient did not expect her to do housework and provide nursing care.			
Living separately	The parents of the couple living about 90 minutes away by car from their house.		The parents of the patient living in the neighborhood.		The eldest son (28) living 20 minutes away by car from the couple's house:		The second daughter (26) living in the neighborhood.		The eldest son (37) living on the same premises: He and his parents agreed that they would not interfere with each other.	
	The parents of the patient: They stayed overnight at the patient's home once a month.		They did housework when the patient was not at home.		While his father was hospitalized, he was in charge of the family business.		The patient expected her to do housework and provide nursing care.		The eldest daughter (35): Full-time housewife living about 30 minutes away by car from the couple's house.	

This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.

After my husband became ill, I worried about our future every day. I started doing extra work because my husband might lose his job (wife in the child-raising period).

e. After husbands were discharged, they became more involved in housework.

A husband (patient) washed the dishes after meals to alleviate the physical fatigue of his wife and prevent her condition from worsening. He felt sorry for his wife, and started doing what he could to help her: taking in the laundry and cleaning the bath and other rooms, which were also rehabilitation exercises for him.

I clean the windows of our house because I was told that it would be a good rehabilitation exercise for my hands. Since I rely too much on my wife, I apologize to her for this by doing that. I may be trying to find what I can do (husband in the child-raising period).

f. Patients recognized that they could not continue to earn as much of an income and withdrew from or reduced their work following discharge.

Since my husband was replaced by another person at work due to his long-term hospitalization and impaired physical functions, he changed his job to perform simpler tasks.

Although a wife (patient) wanted to continue her job and the physician approved of this, she withdrew from work, taking into consideration the burden of work, time constraint due to treatment, and the wishes of her family.

A colleague who replaced me during my hospitalization continues to work in that position. I could not resume my previous work due to my impaired right hand and ear, and I changed my job to perform simpler tasks (husband in the child-raising period).

g. After husbands or wives were discharged, their spouses provided nursing care.

While patients were receiving care at home, their spouses provided them with the following nursing care: health management for them, efforts to improve meals, encouragement to perform self-care, psychological support, and ensuring their safety.

I told my husband (patient) that he should also pay attention to his condition because I cannot stay home all day to take care of him, although I can cook when I am at home (wife with school-aged children).

h. After a patient had been discharged, his wife wished that her children would provide nursing care in the future.

The wife hopes that her children would become health care professionals so that the patient (her husband) and she would be able to receive care from them in the future.

I hope that my children will become health care professionals. Although I do not want to ask my children to help me with housework right now, I am expecting them to take me to hospital when I am older (wife with school-aged children).

2) Examples of patients with adult offspring (a) (b) and in the young-elderly period

a. When the patient was in good health, her husband only performed the role of earning an income.

The wife used to do all of the housework. The husband was committed to his work and enjoyed his hobbies all day long on days off and holidays.

I played with his friends after work and did not care about my wife (patient) at all (husband in the young-elderly period).

b. While patients were in hospital, their spouses did housework and provided nursing care.

When their spouses were admitted to hospital, the husbands and wives performed the roles of earning an income, doing housework, and providing nursing care. Specifically, the role of providing nursing care included preparation for hospitalization, hospital visitation, the collection of information on the health problem, listening to explanations provided by physicians, and conveying them to the patient.

I received explanations from the physician, and I conveyed them to my wife (patient) several times. I visited the hospital in the morning and evening (twice a day), and also performed housework (husband in the young-elderly period).

c. When patients had developed health problems, they expected their children to perform housework, earn an income, and provide nursing care.

Patients and their spouses expected their sons to earn an income and conduct household management, and their daughters to perform housework and provide nursing care: the roles that had been performed by patients prior to hospitalization.

I can feel at ease because my second daughter, who is married, comes to our house every evening to do housework for my husband and eldest daughter while I am in hospital (wife with adult offspring (b)).

d. When patients had developed health problems, their children did the following tasks: housework, earning an income, nursing care, liaison, and enshrining ancestors.

While a patient was hospitalized, her son was in charge of the family business, interacted with relatives, and paid respects to their ancestors' grave. Her daughter did housework and provided nursing care.

Since I had to stay with my wife (patient), my son participated in a Buddhist memorial service and paid respects to our ancestors' grave during the Bon Festival period (husband in the young-elderly period).

e. When patients developed health problems, they recognized that they had to give up or reduce their role of earning an income, and retired from or reduced their work.

Patients retired or reduced their work for the following reasons: long-term hospitalization, time constraint, impaired

This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.

physical functions, self-awareness of decreases in physical and psychological strengths as well as abilities, to prevent recurrence, and the wishes of family members. The spouses of patients retired or coordinated their work schedule.

As my husband has to attend hospital frequently, he works at his company once a week, and does simple work at home on other days (wife with adult offspring (a)).

I had to retire in order to provide nursing care and do all housework because I live alone with my wife (husband in the young-elderly period).

f. After patients were discharged, their spouses or only one family member primarily performed housework and nursing care.

The spouse of a patient or one family member performed the following tasks as nursing care: housework/health management of patients, efforts to improve meals, encouraging self-care, psychological support, helping the patient attend hospital, and ensuring the safety of the patient.

Since my husband was discharged, I have been checking his water intake, measuring his blood pressure, and preparing sodium-restricted meals (wife with adult offspring (a)).

3. Influences of role transition on emotional aspects

1) Positive effects

a. Following discharge, couples provided each other with emotional support more often.

After patients were discharged, they talked, cared, encouraged, and discussed with their spouses more often because there was more time for them to spend together: the role of earning an income was assumed by other family members and patients were assisted by their spouses when they attended hospital.

I did not care about my wife when she was in good health or prior to her hospitalization. Now, I spend more time with her, providing nursing care, doing housework, and talking with her (husband in the young-elderly period).

2) Negative effects

a. Spouses and family members of patients felt stressed.

The spouses of patients felt burdened because they had to coordinate relationships between patients, who had been deprived of their roles, and their children, who had become in charge of them, and assume a new role involving the health management of patients. Since only one family member provided nursing care and did housework in most cases, they became stressed.

As my husband had not felt that his company needed him following his discharge, I consulted with him about his job to inspire him while being careful to keep him from feeling pressured. Our eldest son had to replace my husband on very short notice, and had difficulty adapting to work. As a mediator between my husband (patient) and son, I always have to be careful. I also feel stressed conducting the health management of my husband (wife with adult offspring (a)).

b. Following discharge, patients could not adapt to the workplace and felt helpless.

I was replaced by someone while I was in hospital, and I do not think that the workplace needs me. I became frustrated because I was not assigned to the tasks that I used to perform prior to hospitalization. I also felt anxious about being fired and helpless, thinking that there is nothing I can do.

Will I ever be able to work in the same manner as I used to? Will the company continue to employ me under such conditions? I may have to change my job (husband in the child-raising period).

c. Following discharge, my husband could not receive nursing care support from our children.

My husband was expecting to receive rehabilitation support from our daughter-in-law. However, he could not receive any support at all and became frustrated with our son and daughter-in-law.

I was expecting my daughter and wife to help me with rehabilitation at home. However, my son, who lives next door, has been busy at work since I was discharged, and our grandson stays for only a short period of time. I wish that my daughter-in-law could pay more careful attention to me (husband in the young-elderly period).

d. Following discharge, patients could not talk with their spouses and became frustrated.

Following discharge, patients wished to hold conversations with their spouses. However, the spouses had no time for these because they were tired from working, doing housework, and child-raising, and patients became frustrated with their reactions.

My husband leaves for work early in the morning. When he comes home from work, he washes the dishes after dinner, takes a bath, and falls asleep immediately. He is often reluctant to hold a conversation with me even when I talk to him. I wish to talk to him about our children and future (wife with school-aged children).

IV. Discussion

Family roles in each family developmental stage were discussed.

1. Division and transition of family roles

Murata[32] suggests that, to overcome the health problems of a family member, namely, a family crisis, it is important for people to adapt flexibly to changes in their family roles and lifestyles, and become able to receive external resources and support in appropriate manners, separately from the circumstances. In five cases presented in the present study, family roles were shared by husbands and wives when a family member had developed a health problem,[26] and the roles previously played by patients and their spouses were assumed by extended family members. Family roles such as doing housework, child-raising, and nursing care could be shared by two or more family members, and the role of earning an income was often assumed by no-one or one family member. The traditional idea regarding gender roles

This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.

that "Husbands work outside and wives do housework" is considered to be deep-rooted in Japan.[33] To address the health problems of a family member, it is essential for the family to be able to share their roles and perform them regardless of their gender.

Impaired physical functions may reduce the scope of daily life activities and influence the division of roles. It is advised to simplify the roles to be performed, and encourage family members to share roles by utilizing social resources and family networks. However, patients in the child-raising period, whose ADL levels had been maintained to some extent, were able to recognize housework as part of rehabilitation in their daily lives and perform it. In the above-mentioned cases, role performance was facilitated based on the purpose of treatment and the roles of the spouses of patients, or heavy burdens on them, were reduced. It is necessary to apply these cases to clinical nursing settings.

2. Role transition

When patients with high school-aged or younger children were hospitalized, their spouses primarily provided nursing care, and the mothers of patients (grandmothers) helped them with housework and child-raising. During hospitalization, patients and their spouses received support from extended family members, as viewed by them, who were living with or separately from them. However, in all cases, the spouse of the patient or one family member performed the roles, and some of them felt stressed. As the functions of a family continue to weaken, it has in recent years become increasingly difficult for a network consisting of only family members to address the above-mentioned problems due to the proliferation of nuclear families, aging of the population, and decrease in the birth rate. Since family members overburdened with various roles often feel stressed after patients are discharged, it is necessary to provide support while taking into consideration the post-discharge lives of family members as nursing care providers to alleviate their stress.[34]

Family roles are closely associated with the authority of family members.[13] Previous studies suggested that, as children start to assume some of the roles played by their parents at an age of approximately 71 years or older, the authority of the parents also shifts to their children.[22] When parents with adult offspring and those in the young-elderly period developed health problems, some roles important to families, including the acquisition of income, liaison, and enshrining ancestors, were assumed by their children (role transition). When individuals who financially support their families, which empowers them, suddenly become unable to perform their roles due to illness, with these roles being assumed by their children, parent-child relationships tend to worsen until parents accept this new situation. A sense of loss regarding a person's roles often influences their perceived significance of their existence and health awareness. It is necessary to: encourage the families of patients to assume new roles so that they can understand the significance of their existence and reason for living, give consideration to them by reducing their roles using a step-by-step approach, and implement intervention to inspire them to change their values and view role transition as a positive change rather than a negative one.

3. Influences of role transition on emotional aspects

Japanese couples with preschoolers or younger children tend to have fewer opportunities for communication.[35, 36] According to the results of the present study, after patients with high school-aged or younger children were discharged from hospital, they expected their spouses to communicate with them more often or to perform emotional roles. This family developmental stage is an important period for couples to review their future direction, and they are faced with a number of problems. To help patients and their families address the occurrence of unexpected health problems, it is necessary to encourage them to communicate with each other more often. In the case of "couples with adult offspring" and those in the young-elderly period whose spouses stopped earning an income or worked less, they communicated with each other more often following discharge than during or even prior to the hospitalization period. Satisfaction with spouses experienced by people in the elderly period significantly correlated with the time couples spent on conversation and other activities.[37] In some cases, a new role in the provision of nursing care performed by husbands or wives due to the health problems of their partners improved their marital relationship.

Since people in the young-elderly period had lived with the belief that they and their married children should not interfere with each other, the roles of providing nursing care were not shared at all. The occurrence of health problems highlighted their poor relationships. The study results suggest that it is important for people to establish close relationships with their children (including those in law) and emotional bonds with them, rather than interfering with them.

V. Conclusion

The present study involving the families of patients who had developed health problems aimed to examine their approaches to change their family roles and adapt themselves, from the viewpoint of a couple, which is the core of a family, as a subsystem. However, the number of subjects was small: one couple in the child-raising period, one couple with school-aged children, two couples with adult offspring, and one young-elderly couple. The results were as follows:

1. When patients with preschoolers or school-aged children were hospitalized, the roles regarding housework and child-raising were shared by their parents. When patients had adult offspring or were in the young-elderly group, these roles were shared by their children. After patients were discharged, these roles were played by their spouses or one family member.
2. When a family member had developed a health problem, it became difficult for the family to continue to earn an income.
3. When it became necessary for a family member to provide nursing care, this new role increased or decreased this person's role of providing other family members with emotional support.
4. When patients with adult offspring or in the young-elderly group had developed health problems, they shifted their roles and authority to their children.

The results of the present study do not necessarily apply to all disorders because all subjects were patients undergoing dialysis treatment and with impaired physical functions, and the number of subjects and their attributes were limited. It

This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.

is necessary to conduct further studies involving a larger number of subjects in order to generalize the results.

Acknowledgement

I would like to express my appreciation to the families of the patients for participating in the interview survey, and the staff members of the hospital for providing introductions to the subjects, despite their busy health care activities.

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This paper was published at "the Japan Society of Nursing Research" Vol.25 No.5 in 2002.