The Influence of the Beliefs of Nurses: A Clinical Example of a Post-Myocardial-Infarction Couple

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The beliefs held by nurses have the potential to influence the beliefs of the individuals and families for whom they care. This clinical example presents the experience of a couple who presented with marital conflict at the Family Nursing Unit, University of Calgary, about 8 months following the husband's second myocardial infarction. As the story of this couple's recovery experience unfolded, the constraining influence of the hospital nurses' beliefs on the wife's behavior throughout her husband's recovery became evident. The iatrogenically induced beliefs constrained the wife from voicing her concerns directly to her husband because she believed she could increase her husband's stress and make him ill. A clinical model of family systems nursing that focuses on beliefs guided the assessment and intervention offered to the couple. Ironically, this clinical case example describes how one group of nurses assisted the family by challenging the beliefs of another group of nurses. The importance and influence of beliefs, particularly the beliefs of nurses, are highlighted.

INTRODUCTION

Cardiovascular nurses have an impressive track record of commitment to patient and family education. Throughout acute care and cardiac rehabilitation, nurses deal with psychosocial responses of both patients and their family members. The following clinical example illustrates the powerful influence of the information and advice that nurses offer. Nurses provide information and advice that are based on beliefs about what is best for the patient and family. However, when instructive advice is offered, the information and the process of offering the information may have both intended and unexpected effects.

This article will describe briefly the family nursing clinic that the couple attended and a clinical practice model for advanced family nursing practice, namely Systemic Belief Therapy (Wright, Watson, & Bell, 1994). One important aspect of this model includes assessment of family members' beliefs about illness and about their ability to influence the illness.

CONTEXT OF PRACTICE: THE FAMILY NURSING UNIT

The Family Nursing Unit (FNU) is a nursing clinic that was established in 1982 for the interactional study and treatment of families with health problems (Wright, Watson, & Bell, 1990). Families who are experiencing difficulties with chronic illness, life-shortening illness, and/or psychosocial problems across the life cycle are offered four therapeutic sessions. A nurse (either a faculty member or graduate nursing student) conducts the family session while a clinical team observes and phones in suggestions from behind a one-way mirror. The FNU provides opportunities for masters and doctoral nursing students to develop advanced practice skills in family systems nursing (Wright & Leahey, 1990,1994b; Wright, Watson, & Bell, 1990). This advanced family nursing practice focuses on the interaction and reciprocity between illness, families, and nurses. Knowledge and advanced clinical practice skills encompass the ability to deal with multiple systems levels simultaneously (illness, individual, families, and larger systems).

CLINICAL PRACTICE MODEL: SYSTEMIC BELIEF THERAPY

Systemic Belief Therapy (SBT) (Wright, Watson, & Bell, 1994) is the clinical model that has coevolved from the clinical work of Dr. Lorraine Wright and Dr. Wendy Watson. This clinical practice model focuses on assessment of and intervention in family members' beliefs about the illness. In this approach, a belief is defined as a conviction of the truth of a subjective reality that influences biological functioning. A fundamental premise of this approach is that individuals or families hold beliefs about their problems that are constraining or facilitative. Constraining beliefs perpetuate problems and restrict options for alternate solutions to problems. Facilitative beliefs increase options for alternate solutions to problems. Both constraining and facilitative beliefs arise from interactional, social, and cultural contexts. Therefore, beliefs arise out of the life one is living (Adams, 1985). They are the blueprint from which we construct our lives.

This clinical approach has been documented as useful with families experiencing illnesses such as hypertension (Duhamel, Watson, & Wright, 1994), family violence (Robinson, Wright, & Watson,

1994), osteophytes and chronic pain (Watson, Bell, & Wright, 1992), cancer (Wright & Nagy, 1993), epilepsy (Wright & Simpson, 1991), angina (Wright & Watson, 1988), cardiac illness (Wright, Bell, & Rock, 1989), and suicide (Watson & Lee, 1993).

The overarching concept of SBT is that the belief about the problem is the problem. Families have taught us that when they experience illness it is their beliefs about the illness that invites difficulties and *not* the illness itself. One concept underpinning SBT is the fundamental systemic notion that the individual is best understood in a relational context. This concept invites nurses to inquire about the significant context of the individual and his or her problem:

- Who is also influenced by the illness or problem?
- Who is influencing the illness or problem?
- What influence has the problem had on the marital and family relationships?
- What influence have the marital and family relationships had on the problem?

The systemically prudent nurse will also inquire about the influence of the health care provider system on the illness, individuals, and relationships (Imber-Black, 1988).

Foundational models of family assessment and intervention, namely the Calgary Family Assessment Model (CFAM) (Wright & Leahey, 1994b) and the Calgary Family Intervention Model (CFIM) (Wright & Leahey, 1994a, 1994b), also are used in conjunction with SBT. Throughout the family assessment conducted at the FNU, the nurse asks questions that explore family members' core beliefs about the cause of the illness, beliefs about treatment, beliefs about the prognosis or outcome, beliefs about the role of family members, beliefs about the role of health care professionals, and beliefs about the role of spirituality/ religion. Constraining and facilitative beliefs are explored through therapeutic conversations. Constraining beliefs are challenged as the nurse invites family members to entertain alternate views of the family and the presenting problem. The nurse also actively draws forth, coevolves, and offers facilitative beliefs to embellish and increase awareness of family strengths and resourcefulness.

THE CLINICAL EXAMPLE OF A POST-MYOCARDIAL-INFARCTION COUPLE

The couple described in this clinical example presented at the FNU at the University of Calgary 8 months following the husband's experience of two myocardial infarctions and angioplasty within a 2-month period. The wife contacted the FNU on the advice of a research nurse who had coordinated a drug trial related to the husband's illness. The wife described the presenting problem as her husband's refusal to participate in family responsibilities following his two recent heart attacks. She also mentioned her own health problems (hypertension and arthritis) and her 7-year-old daughter's recent diagnosis of attention deficit disorder. The senior author of this article was the faculty member and nurse who conducted the interviews with the couple. A clinical team of faculty and graduate students participated in the sessions from behind the one-way mirror.

Brief Family Description

Gwen (age 39) and Alex (age 45) had two children, a son (Greg, age 12) and an adopted daughter (Rachel, age 7). They were a traditional nuclear family. Alex was the breadwinner and had a stressful job in the oil and gas industry. Gwen was responsible for the household maintenance, family finances, and management of the behavior difficulties of Rachel, who was being tested and treated for attention deficit disorder.

Highlights of the Clinical Sessions

During the first family session, the structural assessment of CFAM was completed through the use of the genogram and ecomap tools (Wright & Leahey, 1994b). Health histories of both the husband and the wife were explored, as were their beliefs about the influence of the cardiac disease on their family. Both Alex and Gwen were pleased to recount the lifestyle changes Alex had made following cardiac rehabilitation. He had evolved from "Mr. Couch Potato" to "Mr. Jock." However, the cardiac disease had invited protectiveness in the wife toward her husband that created a focus for escalating marital conflict.

The following verbatim transcript from the first session reveals the senior author's (LMW's) exploration of the influence of the ischemic heart disease on the couple's relationship and of the reciprocal influence of family members on the cardiac illness. The transcript of the therapeutic conversation shows the uncovering of the wife's constraining belief that influenced her behavior toward her husband.

Therapeutic Conversation From Session One

Alex: She tends to shelter me, I think.
Gwen: Yes, I do.
LMW: What's your worry if you didn't shelter him?
Gwen: [upset] The stress seems to be a major factor in his having chest

pain, I don't know that it is now but I know a few months....
Alex: I don't think I get angina, but if I'm under a lot of stress I do experience some chest pains.
Gwen: If we would fight, I would create a stressful situation, he would get stress pain, and then I would feel guilty as all get-out.
LMW: Because you would somehow think that you triggered a heart attack then, would you?
Gwen: Well, I might.
LMW: So you think that you could do that?
Gwen: I don't know that I wouldn't. And I know when he was in hospital, the second time, that they would phone me when he wanted to see me. One time when things were really bad, and he was suffering severe angina, and they were hoping that he wasn't going to have another heart attack, they would say that he would like me to come in and sit with him, but if I could not keep my composure they didn't want me to come through the door.
LMW: Wow, that puts a lot of pressure on you. Did it feel like pressure?
Gwen: Oh, at that particular time I broke down and cried three times before I got in to see him, but when I did get in to see him, I was fine.
LMW: So is that where you got this idea that you could actually trigger a heart attack?
Alex: I don't think she ... can trigger a heart attack as much as ...
Gwen: I think I can trigger the stress.
LMW: You can trigger the stress and stress can trigger the heart attack?
Gwen: I have to sort of monitor the stress and not dump it on him.

Gwen's experience during the onset of the illness was that she was encouraged by the nurses to conceal her own stress for the sake of her husband's recovery. The nurses' instructions reflected a belief that expression of emotion by a wife was unsafe, even life-threatening, for her husband. This belief of the nurses had a great impact on Gwen and perpetuated an additional belief that Gwen could indirectly trigger another heart attack in her husband. Perhaps Gwen incorporated this belief because it fit with her belief that the nurses were more knowledgeable about her husband's condition than she was. In their description of the evolving relationship between health care providers and recipients, Thorne and Robinson (1988, 1989) have called this the "stage of naive trust."

The tendency for family members to avoid conflict to shield or protect the ill family member when there has been a heart attack or bypass surgery has been reported in the nursing research literature (Hilgenberg, Liddy, Standerfer, & Schraeder, 1992; McRae, 1991; Nyamathi, 1987; Rankin, 1992; Riegel & Dracup, 1992; Tapp, 1993). However, the belief that family visiting is detrimental to the patient is not supported amid increasing evaluation of the effects of unrestricted versus restricted family visitation in the Clinical Care Unit (Tee & Struthers, 1994).

This family's experience invites a more focused consideration of the origin and perpetuation of some nurses' unsubstantiated belief that family members' expression of emotion could be life-threatening if displayed in the presence of their family member suffering a myocardial infarction. These types of constraining beliefs can be challenged by offering families alternate views. For example, nurses can convey what has been learned from other families' experiences. The ultimate goal is to invite the family to reflect, that is, to think about their thinking. In the following therapeutic conversation, Gwen's iatrogenically induced constraining belief that she needed to protect her husband from her own feelings was challenged by the nurse.

Therapeutic Conversation From Session One

LMW: Let me tell you something else that's really fascinating. So the nurses had this belief that if you couldn't keep your composure and you cry and you upset him, that maybe the stress could trigger..., but let me tell you something else that you may already know. A common belief in the literature that I've read a lot about, and families have told me, is that if you keep all your stress to yourself, that *that* could trigger a coronary. So you see, I wonder if you ever worry about that for yourself? That keeping things, trying to protect him from stress....
Gwen: Yes, my dad died of a coronary. I sat at my mother's bedside. She's had two heart attacks. She had one in our home, and my brother had a heart attack this summer, so I believe in it a lot.
LMW: Well, I'm sure you must. I'm sure you must because, if you're trying to help your husband to not be stressed, and to help him by keeping your stress, keeping things to yourself more, then I wonder if you believe you could trigger a coronary for you?
Gwen: Yes, you're right about it. I worry, that's why, I worry about the stress, period, because as I see it, I see that my health is being affected by it.

In this interaction, the nurse offered an alternate belief about the connection between the non-expression of emotions and stress, and she drew forth the wife's beliefs about triggering a coronary in *herself.* An alternate view of protecting her husband at all costs was coevolved: Gwen's life-saving behavior for Alex could become life-threatening behavior for herself. Gwen was tearful as

this concern for her own health was disclosed in the presence of Alex. When Alex was asked directly if he thought his wife would have a heart attack, he stated, "No." He perceived that Gwen had a "pretty good life," and he proceeded to minimize her stresses.

By the end of the first session, a significant interactional pattern was identified. Specifically, it was as follows. When Alex came home from work, he would unwind by "dumping" his stress of the day through his conversations with Gwen. Gwen absorbed his stress because she was concerned about the impact of stress on his health. She had her own concerns and stress about the children and household issues, but she believed that she could not share her stressors because of her fear of triggering stress angina in Alex. She also believed that Alex did not want to hear about her stress. This interaction between Alex and Gwen exemplifies how behavior is intricately connected to beliefs; every action of Gwen evolved from her beliefs.

The third session was a key turning point in the therapeutic work with this couple. Through the nurse's sensitivity to, and persistent uncovering of, Gwen's frustration, more information about the couple's relationship unfolded. Gwen expressed her concern that the nurse and clinical team did not yet understand the depth of her concerns for the couple's relationship. She elaborated on the story of their escalating arguments, despite her fears for Alex's health, and disclosed that there had been two occasions when Alex had come very dose to being physically violent with her. Gwen described her deep hurt and humiliation the time Alex had been angry and had tried to throw her out of the house. She was deeply offended by this incident and most upset that the children had observed the entire episode. Alex was visibly angry as Gwen related these experiences. Gwen revealed in this session that she was not sure whether their marriage was going to survive.

As anger and arguing began to rule this relationship, another interactional pattern emerged. On occasions when Gwen was feeling exhausted and underappreciated in their marriage, she directly expressed her anger and frustration toward Alex. Alex would respond defensively, and their "bitter and ugly" verbal arguments would escalate. Gwen would tease Alex about his anger, and Alex would tell Gwen to "get out of the house" if she was unhappy. Gwen's exhaustion and sense of underappreciation arose, we believe, from her iatrogenically induced beliefs about suppressing her emotions.

Due to the intense symmetrical nature of the marital relationship, the nurse met with each partner individually at the end of this intense and climactic session. To interrupt the vicious marital interaction and ease the conflict each spouse was experiencing, the nurse invited each spouse to experiment with a change in his or her own behavior. Therapeutic engagement, language, and timing were key to creating a context in which such an experiment would be experienced as palatable by each spouse. Based on what the nurse now understood about the influence of the illness on this couple and the interactional patterns occurring in the relationship, the nurse invited Alex to look for opportunities to show Gwen his appreciation of and caring for her, and to apologize to Gwen for the two incidents of physical violence. Gwen was invited to be more expressive in her appreciation and love for Alex. The nurse explored Gwen's belief that she was depressed, and offered an alternate hypothesis that perhaps Gwen was actually exhausted. Possible ways for Gwen to recoup her energy were explored within the frame of this hypothetical and alternative diagnosis about her energy. It is important to note that the ideas and advice offered each spouse were proposed in an invitational, not expectational, manner. To follow or to not follow the advice was clearly an option for each partner.

When the couple returned for the fourth session, Gwen and Alex reported significant improvement in their marital relationship. Gwen noticed that Alex had been catching himself when he was short-tempered about work-related issues. Alex had expressed appreciation for his wife's ability to deal with their daughter's behavior. Gwen reported that she had been going to bed earlier, had not been working so hard at housework, and had been taking time out for herself. Alex reported that he was enjoying Gwen more when she was rested, and their fighting had significantly decreased.

During this fourth session, the influence of the beliefs of nurses during the acute and early rehabilitation phase re-emerged. In the following transcript, the influence of the nurses' beliefs are ever present as the impact of the illness and of the subsequent lifestyle changes on the spouse are discussed.

Therapeutic Conversation From Session Four

Gwen: The whole time Alex was sick, it was mostly the nurses who would talk to me and people in the hospital, and they would say that I should be very careful not to let Alex depend on me. And they would say that I should not, like he's got to go home and pursue his own diet and his own lifestyle and exercise and all of that. That is not my concern. That's not my problem that Alex has to do that and that if I start pushing him in any of those directions, he's just going to get angry. I mean I was told that by everyone, that I should back off and let him pursue the changes he had to make.

LMW: Right [not with the tone of "That is correct" but rather "Go on"].

Gwen: And if s really hard when I see what's happening to him at work or even the eating. That's another thing I tend to bug him about, for me to do that. And I think if s sort of because, he doesn't just have the heart attack, you know, if he has another heart attack, it doesn't, it's not his personal heart attack, it’s me....

LMW: It's not just saying it’s his responsibility, it yes....

Gwen: Like that's fine to say that....
LMW: It's fine to say it's his responsibility but....
Gwen: But when he gets sick....
LMW: The impact of it, yes....
Gwen: There are repercussions that affect me tenfold because I'm in charge of picking up the pieces.
LMW: So do you think that your, I guess I'm trying to understand, your belief around this... Is your belief that, that, nagging him is your way of showing you're caring, or do you think it's taking responsibility?
Gwen: It's taking responsibility.
LMW: All those nurses say, don't take responsibility....
Gwen: Don't get me wrong, it's not *my* belief, I don't have a belief in this. It's what I was told by professional people, so I don't think there's room for my belief cause they know more about it than I do....
LMW: What do *you* believe, though? I'm real curious about *your* beliefs. You told me what the nurses believe. What do *you* believe, if you were just left to follow your instincts?
Gwen: Well I am a responsible person. So, that's where I come into a little conflict here because I sort of feel it's, like he sometimes calls me his conscience [laughs]. It's my responsibility to sort of... not let him go astray, I guess. I don't know. I'm in a little conflict because I would rather that he would just do everything right all by himself and I didn't have to remind him because I do think that's nagging, but the other part of me sort of thinks that I would be irresponsible if I just let him do that.
LMW: So, if you were to follow your instincts, you know, set all the nurses aside, and all those different things, and you just followed Gwen's instincts, what would you do?
Gwen: I would probably nag a lot, more than I am [laughter]. I would. I would be probably cooking a lot more stringently than I am now and I would be....
Alex: Her nagging is love for me.
LMW: Yes, that's what I'm saying, I was trying to understand, does she see her nagging as her love and caring....
Alex: I look at it as that. That she cares for me and she worries about me so she tells me not to do things and she tries to, to push me further to the direction that I should be going that I can't do myself.
Gwen: No, but you get mad at me for nagging.
Alex: Well sure I get mad at ya, [both are smiling and laughing] but I still....
Gwen: And you don't laugh like that when you're mad at me either.

The conversation between the nurse and Alex offers the perspective that nagging and responsibility for nagging are enacted by Gwen as gestures of her love and caring for Alex. Gwen counters with her experience of nagging; whether it is enacted out of love or responsibility, nagging contributes to Alex's anger and her own frustration.

Once again, the wife described the powerful influence of the beliefs of nurses during the early recovery period and the resulting conflict about her own sense of responsibility. The impact of the hospital nurses' beliefs raises various questions:

- How did Gwen invite these comments from the nurses?
- What did the nurses see in Alex, in Gwen, that invited them to think that their advice would be useful?
- Was the advice based on their assessment of this couple, on their work with other families, or on information from current nursing literature?
- What was it about this particular advice that stood out so clearly for Gwen?
- Did it strike her as important at the time, or upon later reflection?
- How did it link with preexisting marital patterns of interactions?

The impact of adjustment to lifestyle changes and health-monitoring behaviors by spouses following acute cardiac events is frequently reported as a stressor and a source of conflict within the marital dyad (Artinian, 1991; Gilliss, 1984; Hilgenberg et al., 1992; McRae, 1991; Stanley & Frantz, 1988). Unfortunately, there is a paucity of nursing research on interventions that could assist nurses to provide useful advice to spouses to cope with this stressor. For this couple, the nurse (LMW) suggested an experiment. The couple was invited to engage in a weekly 20-minute consultation with each other. During the consultation, Gwen was to offer Alex advice about further refinement of his lifestyle changes. She was also to offer Alex a commendation about those things he was doing well. The consultation was reciprocally balanced with an invitation for Alex to offer advice to Gwen about her tiredness and exhaustion. The distinction between offering a consultation and insisting that advice be followed was discussed. A consultant offers advice without expecting or insisting that it will be followed. The role of the consultee is to listen, to reflect on the consultation, and to choose what he or she wants to do. The couple decided to try the experiment and to return several weeks later for a final follow-up session.

Therapeutic Conversation From Session Five

LMW: How do you feel things are going for you in your marriage? How are you getting on?
Gwen: Well, there's not the conflict.
LMW: There's not the conflict.
Gwen: I was always backing off conflict.
LMW: Ah, yes.
Gwen: You know, like I was angry, and I was afraid to be angry because I knew if I got angry it was just going to get worse. I'm not backing off any more so I guess in that respect, it's more relaxed. And, I don't know, things are better.
LMW: And what gives you sort of the strength to not back off?
Gwen: The strength to not back off.... Well, [laughter] we don't have the outbursts like we used to. I was, I was afraid of the outbursts. They were ugly. And he doesn't do that. Plus, you know, he's better behaved so I don't have to get mad very often [laughter]. Things are just better. Well, I have a little more faith in his health too, I think he's doing....
LMW: Ah, cause that's what I was curious about, were you more courageous about not backing off from conflict because you weren't worried it would trigger a coronary....
Gwen: Well, I think, you know, just the distance in time from the heart attack and working your way through, and realizing that, you know, like so, you've had a heart attack, you know, I think you're fine [laughter]. You can take it.

The couple provided significant evidence of change during this final session. Gwen explicitly described the shift in her belief that she needed to avoid conflict to protect Alex. She now sees Alex as stronger. She also has noticed a change in his behavior toward her ("he's better behaved"). Perhaps the couple also has learned different ways to express concerns and to show caring. The couple's behavior in the session was much lighter, connected, and punctuated by notably different expressions of affirmation, particularly by the husband. Alex described himself as being "shocked out of a rut," and stated, "I'm happy, I'm comfortable, I'm in love, I'm in admiration!"

The family continued to report these changes at a 6-month follow-up outcome study interview.

IMPLICATIONS FOR CLINICAL PRACTICE

This clinical example illustrates one family's experience of marital conflict following myocardial infarction complicated by the influence of hospital nurses' beliefs on the wife. The couple was very complimentary about the expert nursing care received during hospitalization and cardiac rehabilitation. However, as the story of their experience unfolded, it appeared that the family's interpretation of nursing advice that they had received during the early recovery was connected to constraining beliefs that were problematic later in the recovery period. The interventions of validating the couple's own beliefs and challenging the problematic beliefs by offering alternate advice and information based on an understanding of the couple's beliefs about the illness and about their influence over the illness proved to be a useful approach. Health professionals' beliefs were no longer privileged over this couple's beliefs. We believe that this approach of uncovering, exploring, and validating this couple's beliefs enabled them to open space to new ideas and opinions about how to best manage their illness concerns and their marital conflict. The therapeutic conversations also provided a means to air concerns, to express feelings, and to exhibit caring.

This clinical example raises questions upon which nurses may need to reflect:

1. Are we aware of the influence of our beliefs on patients and families, and how these beliefs, once expressed in words, may sustain or constrain?
2. Do we need to be more cognizant of the influence of our own beliefs on the advice we offer to patients and families?
3. How do we determine whether we understand the contextual relationships (i.e., preexisting patterns of interaction) that influence how people use the information we offer?

It is impossible to anticipate all of the possible ways that patients and families reflect on the ideas and suggestions that are offered. Ideas, advice, and opinions of nurses take hold when there is a "fit" between the intervention (i.e., opinion or advice) offered by the nurse and the unique structure of family members (Wright & Leahey, 1994a; Wright & Levac, 1992). Families often place great trust in the advice offered by persons whom they perceive to be experts and often privilege these ideas over their own. Because nurses are in the privileged position of offering ideas and advice to families suffering with illness, we need to assess the impact and influence of our beliefs on the families we are sanctioned to assist. More important, we need to be aware that families possess ideas about their health problems that are both facilitative and constraining.

CONCLUSION

Systemic Belief Therapy, which draws forth and coevolves families' facilitative beliefs and intervenes in constraining beliefs about their illness problems, offers promise as a clinical approach. However, it also must be emphasized that this approach is only complete when the beliefs of the clinician also are acknowledged. It is the fit between these two belief systems—those of the family members and of the nurse—that enables healing to occur. The clinical work with this post-myocardial-infarction couple illustrates the effectiveness of nursing interventions when there is acknowledgment of the importance of beliefs.

NOTE

1. The names of the family members have been changed to protect their identity. The family has provided written consent to have its clinical experience described in publication.

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