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# Family resilience: Towards a new model of chronic pain management

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**Summary** This paper presents a critical appraisal of the potential of family resilience as a new model of care for chronic pain. For nurses, this model offers new strategies for working with families where a member experiences chronic pain.

Chronic pain is characterised by one or more of the following: pain that lasts more than six months, from a non-life-threatening cause; and/or which is not responsive to available treatment. Chronic pain has the potential to be longstanding and difficult to treat and may result in negative outcomes for individuals and their families. However, a family resilience model of care moves the nurse from a traditional deficit base or problem-focused model of care to one which addresses the individual's and family's strengths. Strengths based models of care such as family resilience offer a fresh approach within Australia's developing agenda of primary health care.

A family resilience or strengths based model of chronic pain has the potential to facilitate transformation and growth within families that will enable them to be more resourceful when facing immediate and long term challenges. Further research into the effectiveness of this approach to nursing care is required to develop specific implementation strategies for working with families experiencing chronic health conditions such as chronic pain.
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## Introduction

Advances in technology, medicine and society have resulted in many more people living longer, often with some form of chronic illness or debilitating disease. As a chronic condition, chronic pain is of major concern worldwide; with statistics showing that one in five people now suffer from this

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condition (Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006; Breivik, Hattori, Moulin, & Dwight, 2005). Areas of people's lives that can be negatively impacted by chronic pain include: physical, psychological, social, emotional, spiritual and financial dimensions. Individuals and their families often face serious challenges as a result of such impacts (Walsh, 2003).

Pain, including chronic pain, is multimodal and as such includes sensory, affective and cognitive experiences for the person in pain and those around them, creating a negative effect on health and wellbeing (Sturgeon & Zautra, 2010). To date few studies have explored the health and pain beliefs of significant others and how these impact on an individual's adjustment to living with chronic pain (Cano, Miller, & Loree, 2009). For these reasons, the application of a strengths based model of chronic pain management is considered important for individuals and family members living with a chronic pain condition.

The outcomes of previous studies on strengthening resilience in individuals with chronic conditions or major life impacts such as breast cancer, mental disorder, pain, chronic illness and renal failure, have been encouraging (Edward, Welch, & Chater, 2008; Kralik, van Loon, & Visentin, 2006; Preece & Sandberg, 2005; Radina & Armer, 2004; Saunders, 2003; White, Richter, Koeckeritz, Munch, & Walter, 2004), as have the resilience studies with children, families and communities (Bonanno, Rennicke, & Dekel, 2005; Howard, Dryden, & Johnson, 1999; Lee et al., 2004; Paton, Millar, & Johnston, 2001). In these earlier studies, a strengths based approach to care was used to move away from a deficit based approach to one which supports families to utilise their inherit strengths. This resulted in the family being viewed in a more positive light by healthcare professionals (Walsh, 2003).

Little work on the usefulness of a resilience based approach to health care has been attempted so far in the area of pain (Karoly & Ruehlman, 2006). The adoption of a family resilience based model of chronic pain management is thus proposed. This approach offers nurses and other health care providers, especially those working alongside families in the community, the potential to develop and implement strategies that will assist families to deal more effectively with the challenges arising from chronic pain.

This paper presents a critical appraisal of the potential that a family resilience model of care offers to nurses and others working with people who experience chronic pain. We contend this model offers a new and more effective way of understanding and supporting families as they attempt to meet the challenges posed by chronic health conditions such as pain.

## Chronic pain and chronic illness

Described as the oldest medical problem and singularly universal physical affliction of humankind (Meldrum, 2003), pain is one of the most difficult complaints to treat and possibly the least understood (Rey, Wallace, Cadden, & Cadden, 1998). When pain becomes chronic, an extra layer of complexity is added to health care management. For any health condition, chronicity is marked by a long duration, frequent recurrence over a long period, and is associated with slow progression of severity of the condition (Pease, 2005). Kralik (2002) defines a chronic illness as persisting over time with no easily definable beginning, middle or end. Even though the symptoms may be treatable and to some extent alleviated, there is usually no cure for the illness. Chronic pain is defined by the International Association for the Study of Pain (International Association for the Study of Pain [IASP] Taskforce on Taxonomy, 1994) as a persistent pain not usually amenable to treatment or to the commonly used methods of pain control. Importantly, chronic pain is defined as lasting longer than six months and being the result of non-life-threatening causes such as malignancy (Wall & Melzack, 1999). The experience of chronic pain is therefore consistent with the definition of a chronic illness (Tollefson, Piggot, & FitzGerald, 2008; Wall & Melzack, 1999).

Like many chronic illnesses, the impact of chronic pain cannot be measured in purely individual or monetary terms (Australian Bureau of Statistics, 2006; European Federation of IASP Chapters International Association for the Study of Pain [EFIC], 2007; Kemler & Furnee, 2002). The available literature outlines the impact of chronic illness on families as affecting family roles, emotional adjustment, friendships, occupation and leisure; which is just as costly and destructive as a direct monetary impact (Harris, Morley, & Barton, 2003). Similarly, the experience of adversity related to chronic illness can create a range of issues for families, who may struggle to manage the impact. However, many families also cope well with the challenges of chronic illness, which can be a sign of resilience.

## Chronic pain and families

The effect of chronic pain on a person's lifestyle often increases gradually and many people who live with mild chronic pain see it as no more than a nuisance or inconvenience (Silver, 2004). However when pain curtails a person's lifestyle the consequences are not confined solely to the person in pain, they are also familial (Silver, 2004). Increased medical bills coupled with a decrease in income often means that entire families are unable to maintain a standard of living they have been accustomed to (Roy, 2006; Silver, 2004). Further, a once active parent may now be a sedentary bystander in family activities and couples may experience role reversals, communication breakdowns, and sexual and emotional dysfunction (Silver, 2004). This situation results in shifts in responsibilities and duties around the home with tasks such as cooking, cleaning, mowing and shopping now falling to children, extended family members or partners. Long-held dreams and plans for the future may no longer be realistic which, despite the concern for the loved one in pain, can lead to resentment and frustration within families (Harris et al., 2003; Newton-John & Williams, 2006; Romano et al., 1995; Roy, 2006; Silver, 2004). The impact of this can clearly be evidenced when the Holmes—Rahe Social Readjustment Scale (1967, p. 214) is applied. The scale is designed to estimate total stress, in reponse to life events, experienced by individuals over a one year period. As stress is cumulative, so too is the scale. Through assigning 'life change units' to life stressors and events, there is clear evidence to validate the link between increased stress and illness and changes in health status and stress (Rahe &

**Table 1** Holmes—Rahe social readjustment rating questionnaire.

| | Event | Value |
|---|---|---|
| 1 | Marriage | 100 |
| 2 | Troubles with the boss | 73 |
| 3 | Detention in jail or other institution | 65 |
| 4 | Death of spouse | 63 |
| 5 | Major change in sleeping habits (a lot more or a lot less sleep, or change in part of day when asleep) | 63 |
| 6 | Death of a close family member | 53 |
| 7 | Major change in eating habits (a lot more or a lot less food intake, or very different meal hours or surroundings) | 50 |
| 8 | Foreclosure on a mortgage or loan | 47 |
| 9 | Revision of personal habits (dress, manners, associations, etc.) | 45 |
| 10 | Death of a close friend | 45 |
| 11 | Minor violations of the law (e.g. traffic tickets, jay walking, disturbing the peace, etc.) | 44 |
| 12 | Outstanding personal achievement | 40 |
| 13 | Pregnancy | 39 |
| 14 | Major change in the health or behavior of a family member | 39 |
| 15 | Sexual difficulties | 39 |
| 16 | In-law troubles | 38 |
| 17 | Major change in number of family get-togethers (e.g. a lot more or a lot less than usual) | 37 |
| 18 | Major change in financial state (e.g. a lot worse off or a lot better off than usual) | 36 |
| 19 | Gaining a new family member (e.g. through birth, adoption, oldster moving in, etc.) | 35 |
| 20 | Change in residence | 31 |
| 21 | Son or daughter leaving home (e.g. marriage, attending college, etc.) | 30 |
| 22 | Marital separation from mate | 29 |
| 23 | Major change in church activities (e.g. a lot more or a lot less than usual) | 29 |
| 24 | Marital reconciliation with mate | 29 |
| 25 | Being fired from work | 28 |
| 26 | Divorce | 26 |
| 27 | Changing to a different line of work | 26 |
| 28 | Major change in the number of arguments with spouse (e.g. either a lot more or a lot less than usual regarding childrearing, personal habits, etc.) | 25 |
| 29 | Major change in responsibilities at work (e.g. promotion, demotion, lateral transfer) | 24 |
| 30 | Wife beginning or ceasing work outside the home | 23 |
| 31 | Major change in working hours or conditions | 20 |
| 32 | Major change in usual type and/or amount of recreation | 20 |
| 33 | Taking on a mortgage greater than $10,000 (e.g. purchasing a home, business, etc.) | 20 |
| 34 | Taking on a mortgage or loan less than $10,000 (e.g. purchasing a car, TV, freezer, etc.) | 19 |
| 35 | Major personal injury or illness | 19 |
| 36 | Major business readjustment (e.g. merger, reorganization, bankruptcy, etc.) | 18 |
| 37 | Major change in social activities (e.g. clubs, dancing, movies, visiting, etc.) | 17 |
| 38 | Major change in living conditions (e.g. building a new home, remodeling, deterioration of home or neighborhood) | 16 |
| 39 | Retirement from work | 15 |
| 40 | Vacation | 15 |
| 41 | Christmas | 13 |
| 42 | Changing to a new school | 12 |
| 43 | Beginning or ceasing formal schooling | 11 |

Holmes & Rahe, 1967, p. 214.

Arthur, 1978). Of the forty-three considerable life stressors identified in the Holmes—Rahe scale, 34 can be linked to families with chronic pain (Silver, 2004). See Table 1 for an overview of these stressors.

The solitary experience of chronic pain has been found to diminish an individual's role within the family — physically, emotionally, and psychologically — often resulting in a diminished sense of self worth (Finer, 2006). Individuals can become focused on their physical state, experiencing multiple vague symptoms and decreased activity. In addition, decreased expectations and concerns about care provision and an increased sense of failure, frustration and dissatisfaction can develop (Weisberg & Clavel, 1999). The intractable nature of chronic pain as well as its potential to impact on the entire family forms the basis of our argument for the utility of a family resilience model for chronic pain.

## Why a strengths based model of chronic pain management instead of the current deficit model?

The current treatment of chronic pain relies on symptomatic treatment using a deficit approach where treatment is focused at an individual level. However, such an approach has been criticised for its focus on what is wrong, missing or abnormal, which can lead to people feeling labeled and stigmatised. Further, this approach gives little credit to the individual for being able to cope with their pain or solve the problems associated with a chronic condition (Feeley & Gottlieb, 2000). Chronic pain is known to be notoriously difficult to treat and can lead to a long and frustrating relationship between a health care practitioner and patient, especially when people living with chronic pain demonstrate little or no noticeable impairment (Sturgeon & Zautra, 2010; Tollefson et al., 2008).

For nursing, a family resilience model of care recognises families for their strengths rather than their deficits (Darbyshire & Jackson, 2004). Importantly though, this model does not ignore an individual's problems; instead it focuses on how people cope with them. We argue that the adoption of a family resilience approach to people with chronic pain has the potential to shift the clinician's focus from one of individual centered care to a family approach. As many individuals with chronic pain often live within a family context, we propose that further research is needed to help uncover how some families remain resilient in the face of chronic pain, while others do not. By revealing how some families survive the experience of chronic pain, nurses and other healthcare professionals may be able to adopt new ways of working with less resilient families.

### Resilience and family resilience

Resilience can be defined as individuals not only successfully coping with adversity or crisis, but emerging from that adversity stronger and better equipped to deal with future adverse events or crises (McCubbin & McCubbin, 1988; McCubbin, McCubbin, Thompson, Han, & Allen, 1997; Walsh, 1996). The concept of human potential in the face of adversity has been explored under numerous guises since the mid 1970s, yet why some individuals respond positively and live well when faced with hardships or catastrophes and others in similar circumstances do not is not fully understood (McCubbin & McCubbin, 1988; Walsh, 2002). Originating from studies of 'at risk' children in the 1960s (Benard, 1991; Howard et al., 1999; Rutter, 1987; Silva & Stanton, 1996; Werner & Smith, 1989), there has been substantial development in understanding the construct of resilience and its application in a variety of fields including health, medicine, education, psychology, social welfare and business (Benard, 1991; Black & Lobo, 2008; Bonanno et al., 2005; Bonanno, 2005; Garmezy, 1991; Kralik et al., 2006). However, there is limited research into family resilience and its application to health and healthcare.

The successful ability of a family to not just cope with, but weather crises together and emerge stronger and more resourceful is the basis of family resilience (McCubbin & McCubbin, 1988; McCubbin et al., 1997; Walsh, 2006). Yet family resilience is not simply about managing stressful situations, surviving an ordeal or 'bouncing back' (Walsh, 2002). 'Survivors' are not necessarily or always resilient (Wolin & Wolin, 1993). A family resilience approach concentrates on the critical influence of positive relationships between family members (Patterson, 2002) and acknowledges that these relational and interactional bonds can assist families. This approach moves beyond the mere recognition of isolated protective characteristics of individuals, to a position where the collaborative efforts of family members and how these are effective in addressing prolonged adversity are acknowledged.

Resilient families are strengthened by factors described by McCubbin and McCubbin (1993) as being either protective or recovery focused. Protective factors facilitate adjustment, while recovery factors promote adaptation. For example, McCubbin and McCubbin (1993) identify hardiness, routines and traditions, as some of the protective factors families employ when living with a chronic illness such as chronic pain. The recovery focused factors refer to changes in a family's schema post crisis, which result in new patterns of functioning. This progressively develops over time through changing family interactions and relationships. The use of problem solving, and buoyant attitudes, therefore allows families to love and support each other through normal times and to draw on their collaborative strength in times of crisis (Black & Lobo, 2008).

The key feature of the McCubbin family resilience model (1988; 1997; 1993) is the suggestion that multiple influences interact to predict a family's level of adaptation to a crisis. These influences include: vulnerability, family type, resources, appraisal of the stressful situation, problem solving and coping skills (Hawley, 2000). This suggests that environmental factors and a family's outlook can impact on resilience. The consequence of this is that cohesive families with a strong sense of being and a view that things will eventually work out, are thought to have a tendency to weather the storm of adversity and crisis positively and possibly even thrive under adverse conditions (Hawley, 2000).

From another perspective, Walsh (1996), another prominent researcher in family resilience, introduces the concept of relational family resilience. Central to her approach is the notion of the family as a functional unit. As such, she claims that it is the way families work together to acquire

information and skills, and then process that information, which is important. Walsh (1996) also describes a developmental process that families negotiate when dealing with a crisis or stress. She suggests that the particular pathway taken by a resilient family is a unique journey for that family, and clearly negates the possibility of a blueprint for any singular model of 'the resilient family' (Walsh, 1996, p. 269). Underpinning Walsh's family resilience model is a strengths and systems based theory. This acknowledges that families consist of individuals, who are important, with each having resilient qualities, but where the sum of the family is more than the individuals. In fact, it is the relationships between the individuals, that Walsh (1996) claims is most important.

Research indicates that all families have strengths and by building on those strengths the adverse effects of stress can be reduced (Anthony & Cohler, 1987; Bigbee, 1992; Coontz, 1992; DeHaan, Hawley, & Deal, 1996; Garmezy, 1985; Hawley & DeHaan, 1996; Kobasa, Maddi, & Khan, 1982; McCubbin et al., 1997; Walsh, 2006). While there is no singularly defined set of qualities of resilient families, literature shows that there are recurrent themes and attributes that resilient families display. These include a system of belief by which a positive meaning is obtained from adversity, a positive outlook, a sense of spirituality, a feeling of connectedness, flexibility, social and economic resources, and effective communication processes (Walsh, 1998). More recently, Black and Lobo (2008) reviewed the work in the area of family resilience and consolidated the views of many theorists into a list of common factors and traits found in resilient families. These attributes are outlined in Table 2.

**Table 2** Resilient family prominent protective and recovery factor characteristics.

| Resilience | Factor family characteristic |
|---|---|
| Positive outlook | Confidence and optimism; repertoire of approaches; sense of humor |
| Spirituality | Shared internal value system that gives meaning to stressors |
| Family member accord | Cohesion; nurturance; authoritative discipline; avoidance of hostile parental conflict |
| Flexibility | Stable family roles with situational and developmental adjustments |
| Family communication | Clarity, open emotional expression, and collaborative problem solving |
| Financial management | Sound money management, family warmth despite financial problems |
| Family time | Makes the most of togetherness with daily tasks |
| Shared recreation | Develops child social and cognitive skills; cohesion and adaptability |
| Routines and rituals | Embedded activities that promote close family relationships; maintenance even during family crisis |
| Support network | Individual, familial, and community networks to share resources; especially important for families in poverty |

Black & Lobo, 2008, p. 38.

## Family resilience—a new model of chronic pain management

Chronic pain impacts not only on the individual but the entire family. Most family resilience research to date has focused on families experiencing poverty, violence or some type of chronic illness (Geran, 2001; Lee et al., 2004; Nam & Kim, 2003; Sim, 2004; Tugade, 2001; Walsh, 2003), with none focusing on family resilience and chronic pain. We propose that a family resilience model of care for families in which a member experiences chronic pain offers nurses and other health professionals the opportunity to focus on the strengths of the family, rather than simply identifying their deficits. This move will change the way clinicians approach the family, including the person with the pain, shifting the focus from ''...how families have failed to how they can succeed'' (Walsh, 2003, p. 14). A family resilience model of chronic pain management does not suggest that families will always 'bounce back' untouched by their experiences (Walsh, 2006), rather it proposes that the use of a strengths based approach will assist clinicians to focus on what works for a family instead of just looking at their problem/s. Clinicians in other areas such as psychology and education have begun to utilise a strengths based approach when working with families experiencing adverse situations and have had successful results (Bonanno, 2004; Hawley, 2000; Masten, 2001; McCubbin & McCubbin, 1993; Walsh, 2006), supporting our call for the use of this new model of care in relation to chronic pain.

People who experience a chronic illness, such as chronic pain, often express a sense of hopelessness and abandonment by others, and live with the stigma of an ongoing condition for which there appears to be no cure. A family resilience model of care for chronic pain management embraces the whole person and offers the potential to help families look beyond disabilities and labels to encourage positive abilities, existing talents, and potential in their family member. In this way, the approach can prepare nurses and other health workers to encourage and nurture collaborative, supportive relationships within the family (Walsh, 2006).

Approaching the treatment of chronic pain using a family resilience approach has many potential benefits. For family

members, a resilience based model of care places a stronger focus on identifying strengths within the family so they, in turn, can confront the crisis of living with chronic pain from a positive position (Walsh, 2006; Weisberg & Clavel, 1999). This approach supports the re-establishment of communication between family members and improves understanding of the adverse conditions in which the family functions (Walsh, 2006). Placing an emphasis on family strengths helps to shift the emphasis off the current problem, issue or crisis and instead assists the family to focus on, identify, and build on their strengths. Resilience factors, in this way, offer not only an opportunity for family bonding but assist the family to emerge stronger, more resourceful, more loving and better equipped to face future challenges (Walsh, 2006, 2003).

### Implications for nursing

Having identified some meaningful connections between family resilience and chronic pain, where should we go from here? It has been argued that a resilience model of care identifies the capacity of families, work teams and communities to interact in the face of adversity; an extremely useful approach (Sturgeon & Zautra, 2010). However, Sturgeon and Zautra (2010) warn that relationships and social interactions and their impact on people with pain are much more complex than how they may first appear. Therefore, whilst we have proposed the benefits that could be achieved by using a family resilience approach when working with people with chronic pain, we must emphasise that this represents a new and emerging area of thought that should be treated accordingly. It is therefore essential that further research and clinical work be conducted (Luthar, Cicchetti, & Becker, 2000) to support the propositions in this paper and others, for example (Karoly & Ruehlman, 2006; McCubbin & McCubbin, 1993; Sturgeon & Zautra, 2010; Walsh, 2006; Zautra, Johnson, & Davis, 2005). Given this, we offer the following strategies that nurses may adopt within a family resilience model of care for managing chronic pain.

Nurses and health workers, as agents for change, can assist a family by providing information on the illness, explaining current treatment strategies and the importance of following prescribed regimes, assisting family members to learn new and more effective coping strategies, encouraging the use of problem solving and proffering advice on the expected psychosocial challenges the family may face in the future. Links to services that offer support in the community, such as community nursing services, home help, day care, and consumer groups, will also help the family to focus on problem solving for positive outcomes (Walsh, 2006). Highlighting strengths such as previously employed coping mechanisms and encouraging interventions such as relationship building, interpersonal skills, problem solving and communication are all known to help increase family resilience (Rutter, 1999). When an individual's personal goals are significantly disrupted and skills and resources compromised by the pain experience, the risk for untoward psychological consequences arises (Karoly & Ruehlman, 2006). Therefore nurses can play an important role by helping families recognise the early signs of disruption and to assist them in the use of self-regulatory resources (Karoly & Ruehlman, 2006). It has been claimed that individuals who learn to sustain positive social relationships and acquire social support demonstrate more effective adaptation to pain (Sturgeon & Zautra, 2010). These same interventions can be used by nurses and others to promote resilience when planning care with families who have a family member with chronic pain. This also includes families who appear to be coping well. Resilience is not a static state but a dynamic one that is subject to change. Supporting families when they are coping well is a preventive measure, which may also help them to develop protective factors that will be of use when future challenges and crises arise (Paton et al., 2001; Zautra et al., 2005).

It is important that family resilience be understood and addressed on an appropriate level for ''the whole is more than the sum of its parts, meaning that a collection of resilient individuals do not guarantee a resilient family. People in families, as in communities, are resilient together, not merely in similar ways'' (Bonomi, Boudreau, Fishman, Meenan, & Revicki, 2005; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008, p. 128). Therefore, strategies need to be designed with this in mind and developed to take account of the characteristics of a family as a whole. This may be achieved by helping families focus on making the most of togetherness when undertaking tasks and activities that promote close family ties and support. Promoting a positive outlook and open communication means nurses can enable people with chronic pain and their families to maintain and improve their wellbeing by fostering positive growth and building upon existing strengths (Foster, O'Brien, & McAllister, 2005/06; Usher, Jackson, & O'Brien, 2005). Finally, strategies such as motivational interviewing have been suggested as a way to promote an improvement in the health status of less resilient individuals (Karoly & Ruehlman, 2006). This strategy can be adopted by nurses to assist people to enhance resilient qualities that may be diminished or entirely absent. The success of the implementation of these strategies however, lies in the successful identification of resilient and non-resilient qualities of individuals and families; an area that requires further investigation.

## Conclusion

Currently, literature on the management of chronic pain from a family strengths or resilience perspective is very limited. In this paper we have argued that a family resilience model of care offers a means by which families who have a member with chronic pain can be supported by health professionals, particularly nurses, to view their worlds in different, more positive ways. The adoption of a strengths based approach offers an opportunity to enhance the current understanding of how people can successfully adapt to chronic pain and also provide helpful suggestions to guide future management programs. Recognising that families can be helped to become more resilient offers a potential platform from which nurses can begin to see families in new and more positive ways while also helping them to implement strategies to manage chronic pain in to the future. We recommend that further research which explores families with chronic pain, paying particular attention to the assessment

of resilience and family resilience related to chronic pain, be undertaken. Additional research to unpack the nature and usefulness of specific strategies that assist families to be more resilient is also required to develop this emerging area of nursing care. The current context of healthcare in Australia requires the development of new approaches to care that focus on strengths and other ways to improve the functioning of people with chronic conditions to ensure quality, cost effective solutions for the future.

## Conflict of interest

The authors declare no conflict of interest in relation to this manuscript.

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