SOCIOLOGICALLY ORIENTED THERAPY FOR THE HEART ATTACK VICTIM

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THERAPEUTIC INTERVENTION

This is an account of sociologically oriented therapeutic intervention with an individual who had suffered a heart attack, and with his family. It describes assessment, intervention, and outcome of the treatment process, and touches on the issue of the establishment of clinical sociology.

Coronary heart disease is the number one chronic illness in the United States. Myocardial infarction, or "heart attack" is a frequent outcome of coronary heart disease. For the accelerating number of patients who survive a heart attack, hospital care is usually quite adequate. However, the illness necessitates a long recovery period at home, as well. During this period professional assistance tends to be minimal.

During the convalescence period, social and emotional problems frequently arise for both the ex-patient and for other family members (Adsett, Bruhn 1968; Bilodeau, Hackett 1971) Although families usually deal with these problems without professional intervention, they can have serious implications. For example, a significant number of heart attack patients never return to full time employment, although they are judged by physicians to be physically capable of returning to work (Wishnie, Hackett, Cassem 1971).

INTERVENTION PROCESS

In this case the individual has suffered a heart attack in late March, and entered into sociological therapy in October of the same year. The initial session was with both husband and wife. Some later sessions also included three of their children who lived at home. Two children had matured, and were living independently.

ASSESSMENT

The presenting problems centered around the husband-patient. He was depressed, anxious, and concerned about the future. He had recently returned to his job as a high school teacher, and was trying to decide whether to continue, or to seek permanent disability. Further probing revealed his fear of involvement with significant others, lest he should become overstressed, leading to another heart attack. He desired to alter what were perceived as injurious patterns of interaction and anxiety, and to resolve doubt about how to make these changes. As the session progressed, the wife expressed feelings of being overextended, anxious, angry, and guilty. The three children, two daughters aged 12 and 15, and a son aged 19 attended later sessions, and also acknowledged feelings of anxiety, anger, and guilt.

INTERVENTION TARGETS

Intervention was targeted on three levels: 1) the individual; 2) dyad relations; and 3) the family. While major focus was on the heart attack victim. individual intervention was not exclusively limited to him. Similarly, the major dyad focus was on the marital pair, but not exclusively so. For heuristic purposes there three levels are presented here as if they were treated as discrete categories. In practice, the three were intermingled considerably.

INDIVIDUALS

The heart attack patient's behavior fit the classical *Type A* pattern (Friedman, Rosenman 1974). He tended to have a sense of time urgency about his activities, desiring to do more and more, in less and less time, and displayed frustration when not able to work at a suitably fast pace.

His strongest asset was judged to be a newly acquired, rather general understanding of the relation between his day-to day behavior and his heart attack, and his desire to change that behavior. This motivation was capitalized in three ways:

1) I tried to help him sharpen his insights into the linkages between specific behaviors and the heart attack. 2) A combined form of cognitive therapy and symbolic interaction was used to enable him to alter cognitive, and ultimately, affective states (Meddin 1982). 3) New coping strategies were devised with participation of his family, which enabled him to modify both family and work roles.

In the case of his wife, emphasis was placed on gaining insight and modifying cognition. Feelings of anxiety, anger, guilt, and

overextension were labeled as normal reactions. According to the literature, they are typical. Her specific situation was thereby placed in a larger context. Efforts wre made to help her explore the objective bases for her feelings, and to modify those that were judged dysfunctional.

DYADS

On the dyad level, emphasis was placed on communication patterns, both in terms of content and frequency. Frequency of husband-wife interaction was increased, and style was altered. For example, the husband/father habitually imparted both information and anger in the form of put-downs in the same communication constellation. When made aware of his behavior, he modified it in relation to his wife and to his son.

The father-son dyad required particular attention. The father was angry at the son because he was still living at home, but was not attending school, and was not working. There was a history of conflict between the two, and the father was avoiding direct confrontation because of his health problems. However the atmosphere between the two was considerably strained. A "safe" area for them to discuss their differences was set up by using a therapy session just for that purpose. The father and son were then able to discuss their differences in a relatively productive manner.

THE FAMILY

Sessions that involved all five family members focused primarily on: 1) expression of feelings of each person; 2) improvement of communication patterns; and 3) articulation and redefinition of roles of family members. Of particular interest was the feeling expressed by the wife and the children of "walking on egg shells" around the husband/father. This sense of strain was discussed and dealt with. Other issues were also dealt with, such as the husband/father's tendency to withdraw from family interaction, and from problems involving sibling relations that had been overshadowed by the father's illness.

OUTCOME

The outcome was considered positive by the therapist and by the family members. Noticeable changes took place in regard to individuals and relations. The heart attack victim reported increased feeling of well-being, as reflected in diminished depression and anxiety, and in enhanced self-esteem. Cognitive and behavioral changes were noticeable as were corresponding role redefinitions. Of special importance was the commitment on the father's part to continue his daily work roles so as to remain at work, and not to seek medical disability.

His spouse also reported a rise in self-esteem and in reduction in feeling angry and overextended. Communication was improved both between the marital pair and between father and son. In fact, the father and son resumed joint recreational activities such as fishing together.

Family members reported less sense of strain in interaction with each other, especially in relation to the husband/father. Communication was more open, and feelings were more directly expressed. Roles with corresponding duties and rights were better articulated within the family. In general, the family stress level was reduced.

SOCIOLOGICAL IMPLICATIONS

Although infrequently applied historically, by sociologists, the use of sociological concepts by counselors and psychotherapists from non-sociological backgrounds has a long history. Most forms of family therapy place heavy emphasis on *social system*, communication, and role concepts (Minuchin 1974; Satir 1967). Group therapy draws heavily on group dynamics, and practitioners working with individual clients draw on sociological concepts (Yalom 1975; Lazarus 1977).

The applications of sociological thinking in this case study are manifold, and start at the beginning of the assessment process. The need to go beyond the initial presenting problem, and to probe beneath the surface is a prerequisite for all good assessment. The sociological perspective enables one to do just that, and to analyze *reality* on more than a single level (Merton 1957).

Work with both the family and dyads was heavily integrated with social system and other interactional models. Concepts such as *social system, subsystem, equilibrium, communication exchange, role expectation*, and

performance provided the framework with which to perceive, interpret, and where appropriate, help change behavior, and eventually, thought and feeling. In working with dyads, *exchange theory* also offered a useful application.

On the individual and intrapsychic level, sociological contributions are less apparent. However, even here, sociology has a contribution to make. Sociologists do have a well established theory of the origin and maintenance of the social self and the dynamics of inner dialogue. And the theory of symbolic interactionism is highly compatible with cognitive therapy. It also has the virtue of linking cognition with interactional phenomena (Meddin 1982). A treatment strategy derived from both cognitive therapy and symbolic interactionism was applied with success in helping the husband/father change his cognitions, behavior, and ultimately, his feelings.

SOCIOLOGY: A LEGITIMATE CLINICAL DISCIPLINE

Sociology provides a powerful conceptual base for clinical intervention. In many ways, the sociological perspective is far more comprehensive than the intrapsychic perspectives so ubiquitous in the clinical professions today. The obvious shortcoming of sociology as an intervention medium is that until relatively recently, sociologists themselves have paid little attention to the clinical applications of their discipline.

If sociology is to be successful as a clinical enterprise, it must expand considerably in three areas: 1) development of sociologically informed and clinically relevant models of intrapsychic processes; 2) provision of clinical training for aspirant sociologically oriented practitioners; 3) provision of qualified clinical supervision. Obviously, concepts are not enough. Proper clinical intervention demands practical experience and supervision.

The clinical branches of other professions have long established themselves in terms of applied training. If sociologists can also provide this applied training, then the discipline can make clinical use of its own primary concepts — concepts that non-sociologists borrow and apply. This case history shows that sociology can be clinically applied in a powerful, broad and systematic fashion.

REFERENCES

Adsett C A, J Bruhn 1968 Short-term psychoatherapy for post-myocardial infarction patients and their wives. *Canadian Medical Assn J* 99 577-584

Bilodeau C, T Hackett 1971 Issues raised in a group setting by patients recovering from myocardial infarction. *Amer J Psychiatry* 128 73-78

Friedman M, R H Rosenman 1974 *Type of Behavior A and Your Heart.* New York. Knopf

Lazarus A A 1977 Toward an egoless state of being. 113-118 A Ellis, R Griegrer eds.*Handbook of Rational-Emotive Therapy.* New York. Springer

Meddin J 1982 Cognitive therapy and symbolic interactionism. Expanding clinical potential. *Cognitive Therapy & Research* 6 151-166

Merton R 1957 *Social Theory and Social Structure.* (Revised, enlarged ed) New York. Free Press

Minuchin kS 1974 *Families and Family Therapy.* Harvard U Press

Satir V 1967 *Conjoint Family Therapy.* (Revised) Palo Alto California. Science & Behavior Books

Wishnie H T, Hackett, N Cassum 1971 Psychological hazards of convalescence following myocartial infarction. *J Amer Medic Assn* 215 1292-1296

Yalom I 1975 *The Theory and Practice of Group Psychotherapy.* New York. Basic Books