

**Chapter 3**  
**FAMILY CONCEPTS**

Chapter 3 Content Outline

DEFINING FAMILY

FAMILY DIVERSITY

FAMILIES WITHIN THE COMMUNITY CONTEXT

FAMILY CARE FROM GLOBAL PERSPECTIVES

FAMILY SYSTEMS

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FAMILY NURSING

## **CHAPTER OBJECTIVES**

At the end of this chapter, readers should be able to:

- Identify the different ways family may be defined.
- Describe ways family diversity affects nursing practice.
- Identify a variety of ways to describe family health.
- Explain relationships between family health and ecological models.

## DEFINING FAMILY

*Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has.*

Margaret Mead

*Confusion about concepts closely associated with family, family nursing and family health make discussions difficult. Much of nursing's body of knowledge about family is in formative stages and great opportunities to clarify meanings, operationalize concepts, and formulate care models still exist. Comprehensive and coherent models to guide family practice continue to be illusive. Stronger evidence about what defines family-focused care is still needed. Some attempts to describe family health have focused on dimensions such as functionality, psychosocial aspects, or ability of members to successfully complete tasks. According to Anderson and Tomlinson (1992), family health is complex, lacks consensus, includes too many borrowed constructs, and is deficient in theoretical constructs that tie its multiple interacting systemic factors together. "The lack of specific paradigmatic emphasis that recognizes the family system, and the confusion of differing definitions of family health leaves the direction of nursing practice and nursing research unclear" (Anderson & Tomlinson, p. 57). Families are viewed as systems with the whole being greater than the sum of the parts. Use of the term 'family' seems to imply that others have similar assumptions and meanings, but failure to make*

meanings explicit too often the family will be interpreted as white, middle class, heterosexual, two parents, and Euro-American ancestry. Many myths about families come from white middle-class projecting their experiences as national trends or uncontested facts (Contz, 1992). Dominant cultures have ways of swaying what characterizes a traditional family, universally desirable, and standard. Failure to define family explicitly means that unintended ideas become standards for judgments, comparisons, and biases and powerful groups distinguish others as ‘they’ or ‘them.’ Newman (1997), speaking about the nursing discipline and its paradigm stated “we are moving from attention on the other as object to attention to the we in relationship, from fixing things to attending to the meaning of the whole, from hierarchical one-way intervention to mutual process partnering” (p. 37). In single published works, speeches or conversations, authors, policy makers, educators, and health care providers often slide from one definition to another without noting differences. What does it mean when religious activists speak of family values? When legislators speak about family health? When physicians speak of family practice? When nurses talk about family care? Ideas are too often oblique and unclear!

Coontz (1992), has concluded that “there is no one family form that has ever protected people from poverty or social disruption, and no traditional arrangement that provides a workable model for how we might organize family relations in the modern world” (p. 5). The Western family

seems to be in flux and it is common to encounter reconstituted, blended, single parent, homosexual, foster, interracial, immigrant, and homeless families. MSN Encarta, the on-line encyclopedia, defines family as a basic social group united through bonds of kinship or marriage that provides its members with protection, companionship, security, and socialization. Legal definitions of family prior to the 1960s mostly described the nuclear family. Some laws have been contested, but most state laws and local ordinances continue to support this view even though society presents contrary evidence. In the United States, federal guidelines provide one way to understand family. The U.S. Census Bureau defines family as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered members of one family. A household may be composed of one such group, more than one, or none at all. A family household is a household maintained by a householder and includes any unrelated people who may be residing there.

A useful definition of family is “a group of people, connected emotionally and/or by blood, who have lived together long enough to have developed patterns of interaction and stories that justify and explain these patterns of interaction” (Minuchin, Lee, & Simon, 1996, p. 29). A definition of family used in studying alcoholic families is “a set of interconnected individuals acting together to produce a unique social unit that changes in a predictable fashion over time” (Steinglass et al., 1987, p.

13). A family “is characterized by two or more persons related by birth, marriage, adoption, or choice,” and possess “socio-emotional ties and enduring responsibilities, particularly in terms of one or more member’s dependence on others for support and nurturance” (Allen, Fine, & Demo, 2000, p. 1). Stuart (1991) suggested critical family attributes are:

- Family is a system or a unit
- Members may or may not be related or live together
- Family may or may not have children
- Members have commitments and attachments to one another that imply present and future obligation.
- Family functions to protect, nourish, and socialize its members.

Focusing on member ages and family life stage (e.g., engagement, marriage, parenthood, families with various aged children, retirement), subgroups (e.g., single parents, adolescent parents, families with chronically ill children, step-families), context (e.g., cultural, social, political, historical, and temporal settings), and diversity (e.g., race, ethnicity, homosexual, inter-racial) are important issues when considering family definitions. If family is examined, as a collective unit comprised of individuals, then four properties might be considered:

- Absolute qualities that describe the individual.
- Relational qualities that explain member interactions.
- Comparative qualities that describe members’ similarities and differences.
- Contextual qualities that describe features relevant to the whole. (Lazarsfeld & Menzel, 1969)

A crucial aspect for describing family rests in knowing how individual’s vary their conceptions across stages of family development and how and when family of origin is transformed to family of procreation

(Brennan & Wamboldt, 1990). It appears that interpersonal communication and social transactions are germane to development of family conception. Some agreement about family definitions might rest in seeing them as basic social groups, spousal units, cohabitational units, or parent-child units (Trost, 1988). While some families stress consanguinity, conjugality or sharing a domicile, others have few restrictions and accept a wide variety of social groupings as family (Trost, 1990). Perhaps an appropriate definition is “the family is who they say they are,” a description that “is based on the family’s beliefs about their conception of family rather than who lives in the household” (Wright & Leahey, 2000, p.70).

Family definitions emphasize biological ties or structural relationships, functional and emotional relationship aspects (Amato, 2000) and members with long-term committed relationships (Tomm, 1994). Friedeman (1998), in her family textbook, defines family as “two or more persons who are joined together by bonds of sharing and emotional closeness and who identify themselves as being part of the family” (p. 9). Hanson (2001) in her family text defines family as “two or more individuals who depend on one another for emotional, physical, and economic support. The members of a family are self-defined” (p. 6). Family is a group of individuals bound by strong emotional ties, a sense of belonging, and fervor for involvement in the lives of one another (Wright, Watson, & Bell, 1996). Friedemann (1995) says family is a structured

organized unit, composed of subsystems defined by emotional bonds and responsibilities that interact with its environment. Individuals comprising the family unit have relationships with the members, family, and environment. Ganong (1995) said families have an ethic of privacy, are value laden, influenced by the sociocultural context, and multigenerationally continue over time. The term ‘family paradigm’ refers to “the family’s shared view of its environment [a view that] may be partly a product-directly or indirectly-of the perceptual and cognitive response dispositions of its members and the influence of these dispositions on one another” (Reiss & Elstein, 1971, p. 121).

**Unnumbered Box 3-1**  
**Critical Thinking**

Ask students to use three pieces of paper for this assignment. On the first sheet of paper they should write two different definitions of family, one from the perspective of what they know about families in the U.S. and one that captures a world or global perspective of family. When finished, students should pass their definitions to a classmate who can suggest ways to modify or expand the definitions. Student should then consider the classmate’s suggestions and then rewrite their definition on the second sheet of paper reflecting how they choose to incorporate or reject the suggestions. Next, students should share their new definitions to a different student than the one who first read the definition. Again students should respond to what is written and make comments about ways to modify or expand the definitions. Each student should then rewrite the definitions on the third sheet of paper.

After students have rewritten the definition for the third time and ask them to compare their definitions and identify which one they prefer. When finished, have a class discussion about the process of defining families from different perspectives. Ask them to share ideas they learned from the critique of others? Discuss whether continued work on the definitions made them better products? Ask some to read their first and last definitions. Identify if there are differences between definitions of families from U.S. perspectives and more global perspectives. Discuss what the implications for nursing practice and research might be?

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## **FAMILY DIVERSITY**

Tensions between those who view families from various perspectives lead to questions about whether an ideal family form exists or if a particular process has an inherent rightness that supercedes others. Debate about the superiority and rightness of a particular family type often persists as if members had some innate ability to independently choose among parents, ancestral heritage, and contextual background. The plurality in the modern world family differs greatly from past views of the ideal family and myths about the 'normal' family must be examined. Educators, practitioners, and researchers must grapple with ideas that 'alternative' family forms are less 'normal.' McAdoo (1993) suggested that emphasis placed upon family strengths and positive modes of adaptation provide positive approaches for addressing family diversity.

Teaching nurses and students about responsible interactions with families from diverse backgrounds must be undergirded with strong commitment to fuller understandings about notions of cultural care, family diversity, and faithful allegiance to assuring that culturally appropriate health care is provided (American Academy of Nursing Expert Panel on Culturally Competent Health Care, 1992). A general consensus exists within nursing that culturally competent and sensitive care is necessary for meeting diverse client needs, but ways to assure effective modes to teach and fully learn principles are still conundrums. According to Friedman (1997), areas of family diversity that nurses need to include are:

- Race, ethnicity, and religion
- The immigration experience
- Generational differences
- Language
- Class and poverty
- Residence and/or regional differences
- Family forms

Content about culture and family diversity need to be integrated as conceptual threads throughout curricula at the undergraduate, graduate, and doctoral level.

Classroom lectures provide information and theoretical basis for practice, but experiential opportunities are needed to fully understand caring responses to human diversity. Knowledge alone does not impart competence or proficiency. Encounters with differences in ethnicity, race, gender, class, and sexual orientation through clinical experiences, practicum, and internships are needed where bias, prejudice, and feelings can be personally engaged. Learning strategies that can be used to address family diversity include:

- Creating emotional climates that foster open contexts, respect for difference, and nonjudgmental attitudes.
- Using assignments that expose divergent viewpoints and contradictory ideas.
- Encouraging active student dialogue and engagement.
- Utilizing small groups to involve opinion-sharing conversations about multiple realities in diverse families.
- Including reflexivity or self-reflection as a teaching strategy to critically examine knowledge, experiences, and perspectives.
- Discussing the realities of diverse families.
- Selecting clinical sites that promote opportunities for learning experiences about diversity and culturally competent care.
- Writing assignments that include both interviews and library reviews.

(Friedman, 1997)

Respect for differences, tolerance for ambiguity, and discussions about diversity can be part of classroom and clinical experiences, but nurses must personalize them in terms of their bias and prejudices. Oppression and discrimination are rooted in stereotyping, ethnocentrism, homophobia, and other ‘isms.’ Cultural competence means employing opportunities to face the discriminatory actions and attitudes one often sees in others, but ignores in oneself.

Allen, Fine, and Demo (2000) suggest some questions to consider and answer for embracing the diversity in U.S. and the world’s families:

- Should we focus on similarities or differences?
- What is the best way to characterize family diversity?
- Can and should families be compared against a benchmark?
- Can research on white, middle-class, heterosexual families be generalized to other families?
- Can outsiders understand insiders?
- Are existing family theories relevant for inquiries about family diversity?
- What criteria should we use to evaluate families?
- Should oppression and privilege be described subjectively or objectively?
- Why do different methodological approaches often generate different findings?
- Should we make our values about family diversity explicit?

Diversity is a critical issue that must be anticipated and addressed if nursing is going to attend to the schisms between the therapeutics needed to address health.

### **Unnumbered Box 3-2**

#### **REFLECTIVE THINKING EXERCISE\*\*\*\*\***

What is your personal cultural background? Although many Americans have great knowledge about their race, many have far less knowledge about their family ethnicity and any associated cultural traditions. If you do not know your cultural background, then you may want to gather some of this information from close and extended family members. Once you

have identified your cultural background, then list 8-10 things from your family experience that seem pertinent to family health. How many of these items are culturally influenced? A class discussion of students findings and conclusions can provide a way to compare and contrast lived cultural experiences affecting family health.

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## **FAMILIES WITHIN THE COMMUNITY CONTEXT**

The preponderance of the evidence about family is compounded when families are viewed from household or contextual perspectives. Interactions with friends, neighbors, peers, co-workers, professionals, and others and relationships encountered at school, work, and play environments all have potential to affect health. For example, a low-income single mother lives in a small apartment with two elementary school age children. The playground in the apartment complex is a thoroughfare for unemployed persons who have been known to misuse alcohol and abuse drugs. These young children want to go outside and play! Their mother thinks the fresh air and activity would be good, but keeps them inside because she has housework that needs attending to and is afraid to leave them unsupervised. Does this neighborhood environment affect family health? If you were the nurse seeing this mother on her clinic visit, what information would you still need in order to suggest interventions to promote family health? What kinds of questions would you need to ask?

Laws, policies, social institutions, culture, traditions, and the media also affect families. Do these aspects have potential to impact family health? If so, in what ways does this occur? Lets return to thinking about

our low-income mother. She has just learned that the state laws governing her family income have changed. The new law states that she can no longer stay home with her children and receive welfare support. The law now demands that she go to school, work or receive some form of training in order to retain her eligibility. While she is willing to obey the law and appreciates the opportunity to improve her economic situation, she has concerns about the safety and care of her two elementary children. Who is going to get them off to school, see that they are on the school bus, and provide after-school care until she arrives home in the evenings? The law provides financial coverage for transportation for her, but not enough for the multiple places she needs to go to assure her children's care and safety until she returns home. While the law provides some financial assistance, the places where the care is available entail leaving her children with strangers. While this mother is concerned about the well-being of her children, she does not think taking her children to a strangers home via public transportation in all kinds of weather increases their health. How does social policy and national law potentially affect family health? How does a nurse providing family-focused care respond to the larger systems that impact family health? What kinds of knowledge do family nurses need about health policy and advocacy?

While family health is characterized by the complex ways household members interact within their context to obtain, sustain, and regain maximum health for all, this definition excludes the complex

interactions with larger systems and nurse roles. Merely agreeing that family-focused care is needed to promote family health provides little direction for addressing complex care needs or evaluating outcomes. If family health is to be viewed as an achievable outcome related to family-focused care, then it seems logical that relevant family models and theories are needed. According to Gilliss (1991), in order to develop a science of family nursing, it is vital that “we are more attentive to the development of paradigms and theories that adequately address the nurse and family together” (p. 21).

**Unnumbered Box 3-3**

**Critical Thinking\*\*\*\*\***

Ms. Jones has called the health department for assistance and you happen to be the nurse answering the phone call. She is quite distressed and is having some difficulty talking to you. It seems that she may be having flight of ideas and not thinking logically. She tells you that one of her children, a two-year-old boy, is ill. He has been running a fever for several days and has vomited throughout the night. She also tells you that she has a 4-month-old infant and she has run out of formula. She explains to you that she is a single parent, has no transportation of her own, and has no insurance benefits.

What are you going to do to assist her? Prioritize the needs you have identified. What are the outcomes you want to achieve? List all the possible alternatives for helping her that you can identify. Which interventions will you select? What kinds of follow-up care do you think might be needed? How will you evaluate the outcomes? What does family health look like in this situation?

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**FAMILY CARE FROM GLOBAL PERSPECTIVES**

Few models are inclusive enough to take broad ecological perspectives into thinking about the many variables associated with family health. Compelling evidence to substantiate that health is inextricably

linked to the places where we live and the health of others now exists. Increased worldwide travel, growing rates of immigration, and internationally linked economies provide proof that events occurring on one side of the globe quickly disperse. Infectious diseases and epidemics can swiftly spread with profound impact on families and communities throughout many continents (i.e., HIV, AIDS, Mad Cow Disease).

The World Health Organizations (WHO) objective is the attainment by all peoples of the highest possible level of health. Health, as defined by the WHO is “a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity” (WHO, 1944, p.29). This ideal health state was later redefined as “the ability to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities” (WHO, 1986, p. 426). Health is characterized as a holistic phenomena and an ecological relationship of persons in relationship to their environment. In 1977, the World Health Assembly decided that the WHO’s major social goal should be that all people attained a level of health that permits them to lead socially and economically productive lives. It is not an end to disease and disability, but assurance that medical services are available for everyone’s needs and targets to verify that health resources are evenly distributed and essential health care is accessible to everyone. The WHO goal is to see

that families are free from avoidable burden of disease so that they can shape their lives.

The WHO in Europe originated the idea of Healthy Cities about 1985 and envisioned health as the result of more than medical care. The Healthy Cities movement spread to Canada and the United States and now includes projects in well over 1000 cities world wide with more starting all the time. People are viewed as healthy when they live in nurturing environments and are involved in community life. The Healthy Cities concept took into consideration the important influences of context or the places, surroundings, relationships and opportunities related to individuals. The projects highlighted the interconnections among diverse elements and societal problems and suggested the solutions to both community and quality of life problems were interwoven. Community strengthening and empowering are approaches used to solve problems, provide support, and increase health.

## **FAMILY SYSTEMS**

The term family system is often used to describe medical and health-related professionals and resources that impact health and illness concerns of individuals who belong to families. The nature of family nursing has been argued from several perspectives over the years. Family as a system must be explained in terms of its complex interactions among the characteristics of its individuals and its unitary whole. Von Bertalanffy (1950) is usually credited as one of the first to describe general systems theory. Family as a system has been viewed as foundation for nursing practice and several have described this perspective (Friedemann, 1995; Friedman, 1998; Hanson & Boyd, 1996; Hanson & Mischke, 1996; Neuman, 1989; Wright & Leahey, 2000). Tomlinson and Anderson (1996) suggest a family health system model that builds on the Neuman Systems Model (1989) “where family health embraces more than the health of individuals as a part of a family and recognizes the family health system as a central phenomenon of nursing practice” (p. 137) would be helpful. Peter Steinglass, M.D. (1992), said systems theory provides a meaningful way to integrate biology and family dynamics and was the best framework currently available to tackle issues related to primary care practice, clinical course of illness, and organization of service delivery. Friedemann (1995) describes the systemic organization of family in terms of environment, person, family, health, and family health with dynamic targets of control, growth, stability, and spirituality used by the system to find congruence.

“The process dimensions of system maintenance, system change, coherence, and individuation encompass the concrete behaviors necessary to strive toward the abstract targets (Friedemann, p. 10). Friedman (1998) says that the three grand theories needed to assess families are systems theory, structural-functional theory, and developmental theory. However, Doherty (1992) points out that there is no central family theory, but a variety of theories in the family science field that focus on “how families create shared meanings, how families change over time, how families handle stress and resolve conflicts, and how families develop habitual patterns of interaction” (p 31).

### **FAMILY IN THE NURSING CURRICULA**

Most nursing education programs continue to primarily focus on individuals even though a greater emphasis on family as the unit of care exists. “There is a vast amount of literature on the family, but there is little on the family in nursing curricula until the past decade” (Hanson, 2001, p. 15). Green (1997) said that “a primary building block of providing nursing care that attends to the family’s illness experience is the ability to “think family”” (p. 231), which she identified as an appreciation for the interactive complexity of life from a systems perspective. While entry-level nursing programs “introduce the family as a significant context to the identified patient,” this appreciation “is not sufficient for developing expert intervention skills aimed directly at the family” (Gilliss, 1991c, p. 3). Students need to alter their experiential knowledge, attitudes, and ideas

embedded in a medical model that relies on linear thinking and cause and effect (de Montigny, Dumas, Bolduc, & Blais, 1997). According to Hanson, Heims, and Julian (1992), a review of the status of family health care nursing education five critical imperatives for theory building, practice, research, and family health care education:

- Define family health care and family as the unit-of-analysis.
  - Develop more definitive assessment approaches that can lead to identifiable intervention strategies.
  - Increase and improve interdisciplinary communication and collaboration within and between disciplines regarding theory building, practice, research, and education.
  - Implement and evaluate a revolutionary approach to teaching family health care in practice settings.
  - Support family-focused research strategies.
- (p.52)

Gilliss (1993) described levels of preparation for family nursing as family as context and component of society in the baccalaureate program, family as the unit of care in the masters program, and family research and theory development at the doctoral level. Hanson's (2001) summary of key findings about family nursing education in the U.S. and Canada (Hanson & Heims, 1992; Wright & Bell, 1989) found little variation across regions in the amount of family content included in the curriculum; they recommended:

- Greater inclusion and more explicit integration of family content across undergraduate and graduate curricula.
- Family assessment needs to be taught more systematically.
- Clinical experiences need greater inclusion of family.
- Case studies and progress recordings need to be supplemented with audio and videotapes and direct observation of the interactions.
- Faculty members teaching content areas need graduate work in family studies.
- Family intervention strategies need greater emphasis.

- Faculty members with expertise in family nursing need to be teaching the family content regardless of their specialty area.

In Australia, despite the continual interaction between nurses and client families, a hospital-based and medical model orientation has primarily focused care towards individuals and driven a nursing curriculum that has only recently started to emphasize family as the unit of care (St. John & Rolls, 1996). A survey of Australia's schools of nursing faculty members indicated that graduates were inadequately prepared for health educator roles for individual needs and nurses received even less preparation about needs of family as the unit of care (Higgins, 1991).

A nursing curriculum for the 21<sup>st</sup> century should utilize the full potential of the university to educate students in ways that develops the full range of human potential and incorporates a full range of approaches to human problems (Mohr & Naylor, 1998). Complex human care needs requires nurses equipped to use a wide range of heterogeneous treatment approaches and interventions that are not merely simple cause and effect relationships to address problems. Bell (1997) suggested that key topical areas related to family nursing that need to be incorporate into a 4-year undergraduate-nursing curriculum include structure, family systems, impact of health and illness on families, family development, and family functioning. Hanson (2001) identified several obstacles that prevent inclusion of greater family emphasis in nursing practice:

- Lack of undergraduate educational programs focusing on family or family care.

- Lack of good family assessment models, instruments and strategies in nursing.
- Fallacy in believing that family nursing is common sense.
- Strong linkages between nursing and a medical model that focuses on individuals.
- Documentation, nursing diagnosis, and taxonomic systems emphasize the individual.
- Reimbursement systems require care be provided to individuals with a disease or diagnostic code.
- Care delivery systems encourage individuals to seek care unaccompanied by family members.

A true shift in nursing curriculum will require faculty to modify thinking and approaches; experience some disenchantment with past orientations, teaching philosophies, and traditional strategies. Nursing educators are encouraged to critically examine their own curricula programs in preparation for the 21st century and changing market conditions (Lewis, Brand, Duckett, & Fairbanks, 1997; MacLeod, & Farrell, 1994; Morris, 1997). Nurse educators teaching family content need expertise gained through formal coursework and practice. Educators must question previous assumptions, interrogate personal notions about traditional practices, and inquire about what constitutes knowledge and practice pertinent to families.

#### **Unnumbered Box 3-4**

\*\*\*\*\* **Reflective Thinking** \*\*\*\*\*

Each student should write a 1 to 2 page essay entitled “Me, Family, and Nursing.” This assignment should include consideration of personal values, beliefs, attitudes, and practices from past, present, and future perspectives. Essays should be shared with others in the class either by posting on an electronic web page, manually copied and distributed, or read aloud in class. Students should engage in discourse about the ideas presented in the essays. Where do students identify their strengths? Where are continued needs for knowledge and skills? In what ways do beliefs, values, and attitudes hinder changes in behaviors?

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## **FAMILY NURSING**

One definition of family nursing is, “the provision of care involving the nursing process, to families and family members in health and illness situations” (Friedman, 1998, p. 34). Friedman says family nursing is a specialty area that cuts across nursing specialties and depends upon how family is conceptualized (i.e., family as context, family as the sum of its members, family subsystem as client, family as client). Names used for family nurses (e.g., family health nurse, family nurse practitioner, family nurse clinical specialist) add to the confusion about practice roles (Bomar & McNeely, 1996). Roles seem to differ based upon practice settings, types of clients, beliefs and assumptions about families, and nurses’ education. Family nurses have long focused on the provision of services and problem resolution rather than what promotes “the discovery and enhancement of family capacity” or the ability to promote their own health and healing (Hartwick, 1997, p. 65).

A difference in the way nursing care is delivered has to do with whether family is described as client or as context (Tomlinson & Anderson, 1996). Approaches to family nursing might be from four different perspectives and include family as context, family as client, family as system, and family as component of society (Hanson). Friedemann (1995) differentiates between nursing of individual within a family and nursing of the family system. She explains that a focus on the member within a family implies a need to consider the individual’s

systemic interchange with the family and the environment and nursing actions need to be congruent with client's goals. Nursing of the family system is based upon the family's judgment of what constitutes normality or congruence and is aimed at process dimensions and system maintenance.

### **SUMMARY**

Understandings about family are slowly moving in new directions, but for the most part nurses mainly attend to care of individuals with few concerns about family health. Many definitions of family exist and nurses must make meanings explicit. Issues related to diversity are especially important when the focus is on family. Family health needs are closely aligned with household context, an area still needing to be more fully investigated. Nurses' need additional education about family and the forms of practice needed to optimize health for all members.

## TEST YOUR KNOWLEDGE

1. Define family and explain 3 ways care might be different than merely providing care for individuals.
2. Explain why it is appropriate for addressing family related to individual health care concerns and give an example of when it would be especially important.
3. Give three examples of family diversity and explain how these aspects may affect nursing care.
4. Provide a definition of family health and describe how your definition might influence the ways nursing is practiced.
5. Give an example of an individual health issue and explain how the nurse might target the family system to improve the outcome.
6. Give an example of an individual health issue and explain how the nurse might target a contextual system to improve the outcome.
7. Identify four things that nursing educators should be concerned about if they are going to teach student nurses about family care.
8. Describe what is meant by the idea of “think family.”
9. Discuss three things that are important for students to learn about family nursing.
10. Explain whether an ecological or systems model would be the better approach to meeting health needs.