

Chapter 4:
HEALTH AND FAMILY HEALTH CONCEPTS

Chapter 4 Content Outline

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CHAPTER OBJECTIVES:

At the conclusion of this chapter, the reader will be able to:

- Differentiate between the concepts of health and family health.
- Identify several different ways the family health term is defined.

No one can whistle a symphony; it takes an orchestra to play it!
Anonymous

Health is a concept that has wide recognition and many associated meanings. Family health is a term widely used by health care practitioners, including nurses, but the concept is seldom defined or operationalized. Although the phrase is broadly used in literature, authors often use the concept loosely within single works and fail to provide precise or clear definitions. The purpose of this chapter is to provide readers with a discussion about variables and factors related to health and family health concepts. Findings from the author's research about health and family health are provided.

BEING UNHEALTHY

In the author's research about family health, composite definitions of unhealthy, health, and family health were derived. Being unhealthy was viewed as more than the presence of disease, illness or disability (Table 4.1). Unhealthy was described as a condition experienced when pain, biophysical and/or emotional symptoms prevented the self-efficacy needed to perform usual tasks, the inability to fulfill normative roles and social obligations, and a sense of powerless in accomplishing previously desired activities. Subjects saw themselves as unhealthy when pain, biophysical symptoms or emotional conditions interfered with the

ability to fulfill desired activities. A key indicator of unhealthy was the inability to perform the usual expected family roles and fulfill obligations related to duties and responsibilities. In other words, as long as persons continued to perform some semblance of what members viewed as normative, they were considered healthy. This meant that members' chronic illnesses, disabilities and even terminal illnesses were not necessarily interpreted as impediments to daily health activities and the suffering individuals were not always viewed as unhealthy. Self-care limitations were frequently described as unhealthy especially when the limitations interfered with desired tasks and activities. Self-efficacy appeared to be an important measure for circumscribing the bounds of who was healthy or unhealthy.

<<<<<<<INSERT Table 4-1 HERE>>>>>>>

DEFINING HEALTH

Health, in the author's dissertation research, was associated with not being sick, but extended beyond disease and illness.

Participants described health as the absence of illness or disease and an ability to actively engage in daily life activities (Denham, 1997). Family members in the dissertation study described health in four ways:

- The absence of illness or disease
- The ability to actively engage in life
- A balance among multiple family life dimensions

- A holistic phenomenon with physical, emotional, social, spiritual and ecological dimensions.

Health was also viewed as a balance of multiple life dimensions such as members' needs, developmental characteristics, gender differences, and factors related to chronic conditions. Participants described physical, emotional, social, spiritual and ecological relationships to health.

Participants in the study of family health during bereavement provided similar ideas about health, but added some additional factors (Denham, 1999b). For this subject group, health meant not being so sick that one could not work or be physically active. One participant said good health was being "fit enough to do what you want to do" and bad health "means you can't." As the subjects described what it meant to be healthy individuals, they described things like an ability to perform usual daily activities, fulfill family roles, and be their own person. Other things identified by most participants were the ability to maintain control over their lives, mental well-being, and faith or feelings of spiritual connectedness. Members with a terminal illness were viewed as healthy as long as they could maintain some independence, complete some self-care needs, and participate in some activities of daily living.

In the third research study where the participants were viewed as more vulnerable families, health was described as not

being physically sick, the ability to take care of basic needs, and feeling good about yourself and others (Denham, 1999c). These family members discussed biophysical, emotional, psychosocial, environmental, and spiritual spheres of health. Many participants also described health in terms of routine patterns related to 'healthy living'. For instance, they viewed eating right, exercise, self-care, doing meaningful things, and having support systems as important factors for being healthy.

Findings from the research collaborate much of what is found in the literature and support a view that health as more than the absence of illness and disease. Participants described holistic aspects of health that included, but extended beyond biophysical indicators. Health, in all three studies extended beyond disease and illness and was often associated with:

- Able to work and/or be physically active
- Not being sick
- Able to take care of basic needs
- Active participation in family roles
- Able to have some control
- Complete usual daily activities
- Emotional well-being
- Spiritual connectedness
- Personal individuation.

Even when suffering from an illness or coping with a terminal illness, others tended to view members as mostly healthy when able to maintain independence, complete at least some self-care needs, and participate in some activities of daily living. Health

included the ability to have some control over self-care, participate in usual roles and daily life activities, and achieve meaningful accomplishments. Mental and spiritual aspects were repeatedly described.

DEFINING FAMILY HEALTH

Definitions should provide clear representations of ideas. Family health is much discussed, but few attempts have been made to describe broad over-arching definitions. While the literature reflects wide use of the term, it remains ambiguous and lacks conceptual clarity. References to family health often reflect the opinions, knowledge, and experiences of professionals, but family health research often lacks operationally defined concepts. Many nurses, as well as others, frequently refer to family health by describing functional, psychological, and biological aspects of individuals and families. Family health is often described as a goal of nursing, but clear decipherable outcomes related to that goal are usually non-existent. The current literature is even less consistent in providing clear definitions of family health than the health concept. Although families are often described as potential support systems for health, few family-focused investigations about family health have been completed (Backett, 1992; Duffy, 1988; Gilliss, 1991; Ransom, 1986; Thomas, 1990).

Table 4.2 describes the findings from the three family health studies about the things the participants reported as family health influences. In the dissertation study, family health was described as a dynamic and complex concept more greatly influenced by multi-dimensional household variables, member interactions and the cultural context than by individual member's occasional medical encounters (Denham, 1997). It appeared that the participants viewed family health as the dynamic ways members holistically cared for one another using communication, cooperation, and caregiving to develop and sustain health routines within the contextually embedded household. Subjects mostly viewed their families as healthy, but reported that less healthy or unhealthy times were occasionally experienced. Individual members often identified themselves as 'healthy families' even when a member was experiencing illnesses; living with a chronic condition or disability; caring for a dying member; or grieving their loss. The term 'healthy family' was mostly used to explain a family state where functional and relational aspects of life were viewed as manageable. For instance, one family with three children described rather serious health concerns for two of them and extensive disabilities for the third, but the family members still viewed themselves as a 'healthy family' because they were able to

influenced by member interactions, household resources, personal and family routines, neighborhood threats and supports, conflicting values of the larger society, and institutional policies.

Family context, member relationships, and health routines were identified as important family health influences. In the Family Health Model, family health is viewed as a process of multiple member interactions and health related behaviors that evolve over time that members use to attain, maintain, sustain, or regain health of individual members and the family as a whole. Complex contextual factors that may or may not be under the family's control shape family health differently for diverse families. For instance, the Appalachian families in the studies viewed extended family, kin, and friends as more important family health determinants than specific health care services or access to medical professionals. Although traditional medicine and health care providers were viewed as important contributors to over-all health, participants viewed household contexts, processes, and behaviors as more important family health indicators. It is surmised that other families with different cultural contexts will have some different ideas and meanings associated with family health. All families have functional processes and routine behaviors that affect individual health practices and the family's

definition of family health. These processes and behaviors are inextricably linked to the family context.

FAMILY HEALTH

Family health is a dialectic challenged by the family health literature and research to integrate the interacting family development, family functioning, and health systems (Anderson & Tomlinson, 1992; Neuman, 1996). A dialectic can be defined as a discourse or conversation where methods of reasoning and intellectual investigation are used to engage beliefs, elicit truths, wrestle with opposing ideas, and examine the tensions among interacting forces. Unfortunately, the nursing discipline has mostly targeted care and services toward individuals and not wrestled as fervently as needed with the implications of the complex family systems. This neglect has resulted in continual slippage among ideas such as family as a system, family health systems, family nursing practice, health and illness cycles, family health, and family health promotion. Discussion of these concepts often results in double entendre with levels of meaning neither clearly differentiated or easily discerned.

Family health is more than the sum of the health of individuals and not clearly discernible through individual assessments (Loveland-Cherry, 1996). Friedemann (1995) describes family health as congruence, a dynamic process that

occurs as a result of balancing stability, growth, control, and spirituality in response to a changing family environment. “Family health” is a concept that is often referred to in the literature and is identified as a goal of nursing intervention; however, it is seldom defined” (Loveland-Cherry, 1996, p. 23). Mauksch (1974) emphasizes that a “family health estate” includes the interdependent relationships of health of the individual and that of the family and its exploration should be in terms of individual and family health related roles, tasks, knowledge, attitudes, values, and beliefs. Tomlinson and Anderson (1996) have argued that “family health should link family structure, function, and health variables; incorporate the biopsychosocial and contextual system aspects of nursing; specify the paradigm view; and address the levels of family interaction with the nurse” (p.137). Five realms of system level phenomena related to the family’s experience of family health have been described in terms of processes in the areas of interaction, integrity, coping, development, and health (Anderson & Tomlinson, 1992). Family health care can also be described as the process of providing families with health care services within the scope of nursing practice.

FAMILY HEALTH AND ILLNESS

The family health and illness cycle was originally developed by William Doherty for a special issue of Family

Relations as an attempt to organize the health and illness literature and provide a way to sequence family experiences (Doherty & McCubbin, 1985). The cycle is best viewed as categories of family responses to illness and health as members interact with health care systems through the phases of health promotion and risk reduction, vulnerability and disease onset or relapse, illness appraisal, acute response, and adaptation to illness and recovery. Viewing the family patterns might be helpful to family nurses as they provide care at specific time points and provide assistance when exploring previous illness related experiences. However, “this framework does not capture the complex dynamics involved in multiple illnesses in family members” and the model does not “show all the important interactions between the family and other social groups” (Doherty & Campbell, 1988, p. 27). Also, the model makes the events appear as if they are separate occurrences rather than simultaneous ones.

Most attempts at health promotion have been viewed from individual perspectives with less attention aimed at how to include and empower the family. Health promotion refers to activities aimed at maintaining or enhancing clients’ well-being through the appropriate use of resources (Pender, Barkauskas, Hayman, Rice & Anderson, 1992). Pender (1996) differentiated between health promotion (i.e., strategies related to potentiating individual

lifestyle and personal choices in a social context) and health protection (i.e., strategies with environmental or regulatory measures that safeguard populations and thwart health insults).

When family health is discussed, most would probably agree that health promotion and protection are also included.

FAMILY HEALTH IN THE UNITED STATES

Who are the gatekeepers for family health in the United States? In actuality, one might argue that no gatekeepers exist; however, it has been the social role of government to protect the public's health. Goals of public health hinge on the need to protect the community against risks associated with interpersonal contact and communal life (Institute of Medicine, 1988). Public health aims at protecting, promoting, and restoring health by using science, skills, and beliefs to develop and enact social behaviors that change with technology and values. In the United States, many different federal agencies exist to oversee and direct health-related activities. The Department of Health and Human Services houses the Health Care Financing Administration (Medicare and Medicaid), the Public Health Services, the Department of Agriculture, the Department of Defense, and the Environmental Protection Agency. Each department has many agencies and often multiple agencies operate within similar areas of concern. Each state has a public health system and is responsible for the health of

residents within state boundaries. The business of public health is largely handled at the local level by county health departments. Among the principle responsibilities, county agencies carry out the national and state mandates and manage a broad spectrum of health services. Agencies vary in their abilities to collect and analyze health data, respond to crises, plan for and evaluate health services, disseminate health information, and influence health policies locally.

The American Association for World Health is the only private national organization in the U.S. dedicated to funneling a broad spectrum of critical national and international health information to Americans at the grassroots level. The organization's mission is to reach all rural and urban communities and aid local leaders to influence positive health practices by implementing programs that promote wellness and prevent disease. Since 1979, Healthy People has been a national health promotion and disease prevention initiative that brings together national, state, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve the health of all Americans, eliminate health disparities, and improve years and quality of healthy life (US Department of Health, Education, & Welfare, 1979). Goals of Healthy People 2000 were to (a) increase the years of healthy life

for all Americans, (b) decrease health disparities for all Americans, and (c) increase the access to preventive health care services for all Americans through targeting 22 priority areas related to health promotion, health protection, and preventative services (US Department of Health and Human Services, 1990). These national health objectives have widely impacted the missions, goals, and planning objectives of state and local health departments throughout the nation. Healthy People 2010 identifies 28 leading health indicators representing ideas and expertise of a diverse range of individuals and organizations concerned about the Nation's health (US Department of Health and Human Services, 2000). National health objectives provide a road map to identify the most significant preventable health threats, establish national goals, and identify interventions that reduce these threats. The major premise is, "the health of the individual is almost inseparable from the health of the larger community and that the health of every community in every State and territory determines the overall health status of the Nation" (US Department of Health and Human Services, 2000, p. 3).

While annual costs of national health expenditures have steadily risen over the last two decades, the monies spent for public health remain only a small proportion of the total budget. In 1998, a total of \$1,149.1 billion was spent on health care, but only 3.2%

of these dollars were spent to address public health activities (National Center for Health Statistics, 2000). In 1998, 75.4 million persons made outpatient visits for medical care; this is an overall rate of 28 visits per 100 persons (Slusarcick, & McCaig, 2000). Black persons had higher rates of visits than whites and women visited more frequently than men. A total of 829.3 million visits seeking medical care in physician's offices or 3.1 visits per person were made in 1998 (Woodwell, 2000). While females (60.3%) made more visits than males (39.7%) to seek medical care from physicians, persons 75 years or older each made an average of 6.6 annual visits. About 89.8 million of the total visits were injury related with 70% of these identified as unintentional injuries. Blood pressure checks and upper respiratory infections were the most common reasons for seeking medical care. In 1996, there were 13,500 home health and hospice agencies that provided services to 2.4 million home health patients and 59,000 hospice patients (National Home and Hospice Care Survey, 2000). While more than twice as many females received home health services than males, far less gender differences were noted when it came to those receiving hospice care. Most all of these health care episodes and costs related to needs of single individuals with little if any attention aimed at family needs.

NURSING ORGANIZATIONS AND FAMILY HEALTH

The International Council of Nurses (ICN) is a federation of national nursing associations representing nurses in more than 120 countries. Founded in 1899, ICN is the world's first and widest reaching international organization for health professionals that strives to ensure quality nursing care for all, sound global health policies, the advancement of nursing knowledge, worldwide respect for the nursing profession, and a competent and satisfied nursing workforce. The ICN says that individuals given opportunities, knowledge, and access to services and resources have the capacity to produce their own health and the health of their families. The organization focuses on globalization, identifying how health care and nursing practice need to respond and evolve. Health determinants and health promotion are viewed more broadly than by the traditional health sector. Health is viewed as related to many factors including shelter, food, education, social security, health care, social services, income, respect for human rights, and employment. These determinants shape values, lifestyles choices, coping skills, and health behaviours. The ICN serves as a leader for thinking about nursing and health of the world's families from international perspectives.

Sigma Theta Tau International, founded in 1922, includes approximately 120,000 nurses residing in over 90 countries and territories, with 406 chapters located at 503 college and university campuses in the U.S. and other nations. This professional nursing organization aims to create a global community of nurses who lead in using scholarship, knowledge, and technology to improve the health of the world's people by increasing the scientific base of practice. The society seeks to aid the development of more inclusive perspectives of professional practice that extend beyond the U.S. and North America.

HEALTH IN THE LITERATURE

Concerns about health research include the need to better understand the contextual aspects and differentiate between consumer and provider viewpoints. Colantonio (1988) found laypersons were more concerned about functional messages and positive terminology when discussing health, but professionals were mostly focused on illness. Consumers define health broadly and suggest that practitioners and researchers use multidimensional health models (Kenney, 1992). It is important to view persons contextually when considering health and include “the social, political, and environmental factors affecting the health of differing populations” (Pender, Walker, Sechrist, & Frank-

Stromborg, 1990, p. 122). High risk, ethnic diversity, biophysical characteristics, developmental levels, and cultural backgrounds are all contributory health factors (Pender, Barkauskas, Hayman, Rice & Anderson, 1992). The literature has clearly shown that health is affected by poverty, culture, socioeconomic factors, and environment (Evans, 1994; Kagawa-Singer, 1993; McLeod & Shanahan, 1993; Nelson, 1994; Weinart & Long, 1987). While health research includes many variables, factors related to the embedded context, developmental perspectives, and complex multi-member interactions are largely ignored. Implications of health attributes, resiliency factors, or confounding antecedents are seldom fully considered. Fragmented and reductionist approaches to the study of health result in inconclusive evidence about strengths of the competing relationships among the myriad of possible variables. Programmatic studies of health that include well-defined or operationalized family groups, longitudinal designs, interdisciplinary perspectives, and ecological frameworks are often missing when one reviews the body of literature that touts itself as family-related. Practice and research that centers on isolated variables and ignores the complex dynamic health relationships continues to impede knowledge development pertinent to family-focused care.

FAMILY HEALTH IN THE LITERATURE

Family health definitions mostly have been from the professional or expert position rather than family perspectives and semantic slippage is often prevalent within single investigative works. Definitions often reflect functional perspectives, less often include contextual points of view, and rarely include biophysical aspects. Family functioning and adaptation have been widely used to conceptualize family health (Barnhill, 1979; Bigbee, 1992; Fisher & Ransom, 1990; Friedmann, 1991; Grey, 1993; McCubbin, 1989). Others have explained family health from developmental perspectives (Blecke, 1990; Duvall & Miller, 1985; Lasky & Eichelberger, 1985; Lau et al., 1990). Family health has also been described as the household production of health with the home identified as the developmental niche (Berman, Kendall, & Bhattacharyya, 1994; Harkness & Super, 1994; Schuman & Mosley, 1994). Family health has been investigated in relationship to societal concerns (Franks, Campbell, & Shields, 1992; McLeod & Shanahan, 1993; Wise & Low, 1992; Zlotnick & Cassanego, 1992), in relationship to patterned family behaviors (Bennett, Wolin, & Reiss, 1988; Boyce et al., 1977; Campbell, 1991; Fiese, 1993; Keltner, 1990, 1992; Rogers & Holloway, 1991; Steinglass, Bennett, Wolin, & Reiss, 1987, Thomas, 1990); and as a socially constructed phenomena (Backett, 1992; Cox & Davis, 1993).

Despite all that has been written, models for understanding the depth, breadth, and scope of family health are lacking.

Anderson and Tomlinson (1992) noted that family health studies are thwarted by conceptual ambiguity, confusion in defining the unit of care, and a failure to include health as the central construct. A prolific body of literature that fails to provide a definitive description of the health phenomena increases the obscurity of the family health construct (Friedman, 1992). The terms family health (i.e., more than the absence of disease or dysfunction) and family health promotion (i.e., behaviors that increase well-being) are often used interchangeably, but a need to describe these ideas as distinct terms or concepts continues (Bomar & McNelly, 1996). Failure to clearly define the family health construct and the lack of consistency in its operationalization impede the usefulness of the family health concept.

Unnumbered Box 4-1

COOPERATIVE LEARNING EXERCISE

It is amazing how easily things are glossed over when we read and careful consideration of the text is ignored! Divide students into small groups and ask each group to identify a specific family or health textbook to identify whether definitions are clearly provided for the terms “health” and “family health.” Groups should identify whether these definitions are consistently used throughout the text. If the terms are used differently, list these meanings and describe how they agree or conflict with the original definitions provided. Share the findings as an in-class discussion and discuss potential implications.

TEST YOUR KNOWLEDGE

1. Describe what is meant by the term health.
2. Explain how the term health is different from family health.

3. Identify ways nurses' perceptions of health and family health influence their practice.
4. Do you consider family health and healthy family as different concepts? Why or why not?
5. Discuss your definition of health promotion and describe how this affects your current nursing practice.
6. Identify three ways national agendas or organizations perceive health and could influence family health practices.
7. Describe the work of a nursing organization that impacts family health.

Table 4.1
Factors viewed as unhealthy

- Presence of pain, bio-physical or mental health symptoms
- Usual roles were disrupted
- Obligations were unfulfilled
- Self-care was limited
- Disparity between desired and actual behaviors.

Table 4.2
Family Health Influences

Study #1

- Family context (e.g., family membership, extended family, spaces within the home, neighborhood location, peer and social relationships, biological heritage, cultural traditions, community resources, the larger environment, social policies, state laws, access to medical care).
- Family relationships (e.g., communication, coordination, caregiving).
- Participation in health related routines.

Study #2

- Family context (e.g., member resources; household factors; member assets and/or deficits).
- Family relationships (e.g., family togetherness, closeness, and fun; shared values among members; mutual respect, support, and care; shared sense of humor).
- Individual and family health behaviors.

Study #3

- Family context (e.g., household resources and/or deficits, social capital, household and neighborhood factors, public policy, the political milieu.)
- Family relationships (e.g., processes of communication, cooperation, and caregiving influenced over time, family development, unique member needs and values, and household boundaries).
- Member and family health routines (e.g., self-care, dietary, mental health, family care, preventive care, illness care).