

## **Chapter 5**

### **FAMILY CONTEXT:**

#### **A DIMENSION OF FAMILY HEALTH**

### **Chapter Outline**

#### **FAMILY HEALTH FROM CONTEXTUAL PERSPECTIVES**

##### **Cartesian Thinking**

##### **Unraveling the “Messiness” of Family Health**

##### **Objective Versus Subjective Perspectives**

##### **The Naturalistic Paradigm**

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#### **FAMILY AS CONTEXT**

##### **Family's Multiple Contexts**

##### **Family as the Unit of Care Versus Context of Care**

##### **Assumptions about Family Context**

### **CHAPTER OBJECTIVES:**

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

- Differentiate views and consequences associated with holistic and reductionist thinking.
- Identify phenomenology as a perspective to understand the ‘messiness’ of family health.
- Compare and contrast family as context of care with family as unit of care.
- Discuss implications of contextualism.

## **FAMILY HEALTH FROM CONTEXTUAL PERSPECTIVES**

*In the middle of difficulty lies opportunity.*

*The important thing is to not stop questioning.*

*Imagination is more important than knowledge.*

*--Albert Einstein*

*Nurses often discuss environment as an important aspect of individual and family care, but ideas associated with environment often remain vague and not clearly delineated. Most family models place greater importance on the innate qualities of individuals and the personal interactions between them than on the effects of the contextual environment where they live, work and play. This chapter provides a foundation for deliberating about contextual care and emphasizing the importance of family context to family health. It is important that nurses understand where knowledge derives from and how it impacts practice. Family context affects family roles, member interactions, functional capacities, individual health behaviors, and family health. Nurses must gain greater familiarity with contextual aspects if they are going to understand the tremendous influence imparted by the embedded environment on family households and daily lives*

It is often suggested that family health should be considered from contextual perspectives, but full discussions about what this means related to practice is generally absent. Most discussions about environment have been about mechanisms relevant to individuals' health rather than family health. A literature review completed to identify the ways nurses focused on the environment indicated that the greatest focus was on the immediate or institutional environment from the patient's or nurse's perspective (n=53 studies), while only four studies

focused on the local community, and a single study addressed social, economic, and political contexts of the environment (Kleffel, 1991). Kleffel concluded, "there is a paucity of nursing literature dealing with contemporary environmental issues" (p.44) and that nursing research seldom addresses the ecological causes of the prevalence, severity, and duration of illnesses. Descriptions of what characterizes family care and ecological perspective are often vague or missing.

Urie Bronfenbrenner, Professor Emeritus of Human Development and Family Studies and Psychology at Cornell University, has influenced persons from many disciplines through his work as a developmental psychologist, teacher, scholar, and contributor to social policy development. When Bronfenbrenner (1979) formulated his ecological theories of human development, he said the present state of developmental psychology was "the science of the strange behavior of children in strange situations with strange adults for the briefest periods of time" (p. 19). One might question whether nursing is largely a science about ill and diseased individual care, practiced in ill and disease care situations, with ill and disease care providers for the briefest periods of time? Most nurses do not focus on health promotion, disease prevention, or risk reduction, but on individual care for those seeking medical management for episodic illnesses or disease management in agency or institutional settings. Nurses are mostly acquainted with individual care and possess little knowledge and few skills about family-focused care.

**Unnumbered Box 5-1****Reflective Thinking**

Nurses generally learn about family in their early nursing education and believe that because they occasionally talk with or encounter families in some ways that they are providing family

care. Take some time and earnestly think about your personal experiences with patients and their families.

How much thought have you given to including the family in the care needs of the patient? How often do you seek to discover the diverse needs of patients and families as they live in their households? What things do you assess about family? What interventions do you use that include family members in meeting client needs? When are you most likely to include families in your plans? When are you least likely to include families in your assessment, interventions, and evaluations?

After you carefully consider your own experience, talk to a nurse colleague and brainstorm about things that you might do to increase your skill of including family in your clinical practice. A class discussion about these ideas may help students identify variations in the ways nurses address family in practice.

Views of family from systems perspectives permeate much of the thinking in nursing and certainly help understandings about some health interactions. However, system thinking does not consistently include holistic or contextual perspectives that affect family care needs. Clear articulation of what is meant by holistic care and carefully identifying implications could be a mammoth task. Although nurses give lip service to beliefs about holistic care and environmental impact, reviews of nursing assessments, care plans, interventions, and patient outcomes generally fails to produce evidence that supports these beliefs. Comprehensive models that address the holistic and environmental contexts believed important are mostly non-existent.

Although medical approaches increasingly discuss needs for more holistic perspectives, most practice models continue to emphasize family as a unit without fully understanding the meanings and affects of the members' family experiences in day-to-day lives (Hartwick & Lindsey, 1995). Nurses seldom reflect on the impact of member interactions or the interactions with the environments as part of health. Challenges to develop knowledge that includes astute awareness of fundamental postulates, abilities to envision alternative viewpoints that perturb the current paradigms, and openness to ideas marginal to current ones continue (Hartwick, 1995; Maturana & Varela, 1987; Old, 1992). In other words, nurses need to become discontent with the *status quo* experienced in practice settings and ask troubling questions! Development of innovative care models to address broad family needs will occur when nurses allow themselves to think outside present practices prescribed by the systems where they are employed. Development of knowledge is an evolutionary process that questions previous conjectures and allows ideas to be reformulated when they result in practices that fail to achieve optimal outcomes, meet specified needs, or have meaning. Today's nurses stand on the edge of a practice frontier of family nursing and family-focused care yet to be fully engaged.

### **Cartesian Thinking**

Rene Descartes (1565-1650), a mathematician, resolved that the world was dualistic and things could be solved in mechanistic ways. He asserted that the mind and body existed independently of one another, but each could be acted upon by science. From a Cartesian perspective, one often arrives at the mistaken view that since mind and body are separate then a single objective truth is possible, attainable, and desirable. Cartesian thinking has allowed us to dissect persons into distinct parts that detach them from the whole. Cartesian thinking allows us to view persons as objective reality that can be explained and known within their distinct parts.

Cartesian thinking permits us to think that minds and bodies are unconnected or at least not fully dependent upon one another. This form of thinking means that when problems occur solutions are sought to "fix the problem."

At the beginning of the 20th century when the major causes of disease and illness were related to infectious and communicable diseases, Cartesian thinking allowed us to solve many dilemmas. Naming the problem, identifying the cause, and devising a cure resolved the solutions to many past scientific enigmas. However, results of Cartesian thinking often disallow potential confounding factors outside the dimension of interest and neatly resolve the 'messiness' associated with problems. Cartesian thinking permits one to parcel health problems into parts or compartments. However, research supplies evidence about multiple causation of health risk and illness concern. For instance, psychoneuroimmunology provides evidence about the interconnections among emotions, the immune system, health, illness, and disease. Findings about abuse and violence provide evidence about the interplay of individual, family, environmental, and societal causes. Today's family health concerns focus on complex issues such as living with chronic diseases and disabilities and responding to new knowledge about genetics and diseases. Focus on single health determinants and solitary cures in one realm seem too simple of a solution for complex family health problems. If one aims to use the foundation of knowledge as a way to structure new models for future needs, then holding too tightly to traditions useful in the past may become stumbling blocks. Insightful questions relevant to family health and current societal needs are needed to prepare for future health care trends.

### **Unraveling the "Messiness" of Family Health**

Current technologies and practices are challenged by the 'messiness' found in the complicated needs of today's families. Some needs inherent to family care are: (a) the diverse

needs of multiple members, (b) difficulties with understanding the complex variables that potentiate and negate health, (c) interrelated causation of problems, (d) time-related effects of causes and treatments, (e) developmental variations of multiple persons sharing a common household, and (f) longitudinal patterns across multiple generations. In order to fully understand the family health concept, it seems that greater attention is needed to the complex interactions over the life course of members' developmental processes within households that are embedded in evolving social contexts. Merely attending to individual medical needs seems shortsighted! Attention to short-term outcomes and costs and narrow consideration of long-term ones could ignore important evidence and preclude the critical thinking necessary to ascertain more beneficial family health outcomes.

Evolving family health paradigms need to be innovative, identify key priorities, and focus on comprehensive measures and interventions to meet complex needs of today and tomorrow. Science concentrates on the objective, things that can be seen, heard, tasted, felt or validated in measurable way. While the need to accumulate empirical data in scientific ways continues, they must be expanded. Bronfenbrenner (1979) said, "it seems to me that American researchers are constantly seeking to explain how the child came to be what he is; we in the USSR are trying to discover not how the child came to be what he is, but how he can become what he not yet is" (p. 40). Greater understanding about the impact of embedded contexts and social changes on present and future development and processes is needed.

The affects of context on functional processes are deeply entangled relationships that are not easily separated. Disentangling this 'messiness' requires increased understandings about member-to-member, member-to-context, and family-to-context relationships. Member-to-member relationships occur within the household niche, but are influenced by things such as

relationships, friendships, and acquaintances outside of the family. For instance, peer relationships influence thinking and actions of pre-adolescent teens and employers affect attitudes of parents. *Member-to-context* relationships are those that occur between an individual or family sub-system and settings beyond the boundaries of the household niche. Thus, church attendance and a youth's participation on the high school football team may both affect the family, but the impact on members may be different. *Family-to-context* refers to relationships that occur between a family and embedded contextual settings beyond the boundaries of the household niche. For example, neighborhoods can influence the family's sense of security or risk, job adequacy, educational effectiveness, and accessibility to health services. Other contextual factors associated with family health are historical periods, economic conditions, political positions, and social milieu.

**Unnumbered Box 5 –2****Critical Thinking Activity**

Find three or four students to work together to complete this exercise. Consider Bronfenbrenner's (1979) statement, "it seems to me that American researchers are constantly seeking to explain how the child came to be what he is; we in the USSR are trying to discover not how the child came to be what he is, but how he can become what he not yet is." Each person should first identify what it means to take the perspective of "explain how the child came to be what he is" and then the perspective of "discover not how the child came to be what he is, but how he can become what he not yet is."

After students have worked separately, then the group should share their ideas, identify where they agree or disagree, and consider if the group brings new ideas to individual perspectives.

## Objective Versus Subjective Perspectives

In the past, subjective data was viewed as less verifiable and often discounted by academics and scientists. Inductive reasoning is the process of coming to conclusions based on evidence, while deductive reasoning is viewed as an argument based upon logical principles rather than the assessment of evidence. Empirical evidence is compatible with the results of systematic observation and experiments and has served to support or falsify theories, thus either affirming or denying the existence of foundations of knowledge. Logical positivism is a term applied to the philosophy that underlies the scientific approach and assumes that there is a fixed orderly form of reality that can be observed and objectively studied. Positivism assumes that nature has a consistent order that is independent of scientific observation. Ian Hacking (1983) described ideas characteristically associated with a logical positivist approach to natural science:

- Emphasis is placed on the difficulties associated with absolutely falsifying or verifying theories.
- Sensory observation is the basis for all genuine knowledge.
- Discussions of causation are really no more than talk about concurrent confluence of certain types of events in a particular time and space.
- No physical necessity forces things to happen and so what remains are regularities between types of events and the ability to postulate wider ranges of possibilities.
- Hostility towards things unobservable.
- Opposition to metaphysics or the fundamental nature of reality and being; a study of things outside of objective experiences.

Popper (1959) says that science seeks theories that are logically consistent and can be falsified, but while scientific laws go beyond what can be actually experienced we are left in the

dubious position of never being able to absolutely prove truth, but instead we can provide evidence of fallacy. Popper concludes that a scientific theory must be provisionally accepted until it can be falsified, but even then the theories are not discarded based upon single refuted incidents. He held that one should accept the theory that is best corroborated by evidence, provides the greatest number of true statements, and is most testable. If it is not possible to ascertain absolute certainty, then one is faced with understanding available truth. Popper argues that science is not subjective, but neither is it fully objective. While the inductive process might be viewed as the hard evidence outside the scientist who observes it, most now agree that the act of observation itself influences what is observed. Popper rejects the view that induction is the pinnacle of scientific investigation and substitutes falsifiability in its place. Individuals encounter reality based upon perception, the things chosen to see, and the contributions one's mind makes as it interprets space, time, and causality. Popper's arguments allow us to conclude that while science implies seeking truth, knowledge is always limited in some ways by the ignorance of those pursuing it.

Currently in practice, nurses consider the subjective reports about pain as valid. In 1999, the American Pain Association stated that pain should be assessed as the fifth vital sign. The subjective report is recognized as a clinical measure that should be assessed with the same degree of respect and regularity as other vital signs. The objectively measured vital signs are not viewed as indicators of pain, but the subjective self-report using a numerical scale is viewed as the gauge of pain intensity. Empirical evidence has shown that individuals' reports about their pain experiences are reliable indicators. The acceptance of a subjective indicator as an optimum pain measure resulted after a body of research provided evidence of its value.

What do we do with self-reports in other areas? In clinical practice, the patient's reported experience is a desired part of the assessment process. Medical diagnosis is at times elusive and difficult to confirm, yet individuals continue to report persistent symptoms (e.g., fibromyalgia, reflex sympathetic dystrophy, phantom limb pain) and abnormal clinical laboratory values are not always easily linked to diagnosed problems. Although evidence about relationships between stress and systemic conditions (e.g., cardiac conditions, gastritis) continues to grow, diagnosis is often difficult when tests fail to identify the problems. Assessment data includes symptoms, but less seldom inquires about causation related to contextual relationships or social conditions.

For example, a 23-year-old female with Type I diabetes is brought into the emergency department by a friend with a blood sugar of 626 and lethargic. The assessment results in prompt and appropriate medical attention, but often only the immediate circumstances leading to the emergency and presenting symptoms have been appraised. The medical response is appropriate, the patient's blood sugar is lowered, mental alertness returns, functional ability returns, and the patient is discharged home after several hours in the emergency room. While interventions are aimed at the immediate risks imposed by the emergency, far less is done to identify or intervene in the lifestyle behaviors, personal interactions, contextual factors, or the social structures that impact the individual's condition. After the emergency subsides, time is seldom taken to identify the family, peer, and social issues that support or threaten health. Interventions tend to be generic where a one size fits all response is provided. The 'messiness' surrounding complex family concerns often dissuades practitioners from providing more comprehensive approaches. Nursing has predominately aimed to meet the presenting needs without exploring alternative possibilities.

Nurse scientists intent upon rigor in design often exclude contextual factors and thus eliminate the possibility of findings that could provide more comprehensive understanding about

family health. For instance, a researcher might take many approaches in proposing a study seeking to answer the question: What causes differences in siblings' health seeking behaviors? While discrete individual holistic characteristics of siblings might be investigated and analyzed, important factors might not be included. Variations among sibling's health and health behaviors related to their unique genetic makeup, age, and gender might be considered and concepts like motivation and self-efficacy may be included in a study. However, it is less likely that family functional status at different developmental stages of each child, variations in life-course peer relationships, and non-shared environments would be explored. Affects of discrepant peer relationships and non-shared environments may be essential determinants for understanding variations in health conditions of multiple members. More inclusive models for conceptualizing the 'messiness' associated with holistic care and embedded context are needed.

### **Unnumbered Box 5-3**

#### **Cooperative Learning**

The following task has three components.

Identifying what the term *holistic* care implies to the student.

Identifying what things might be considered the 'messiness' of holistic care?

Analyzing how nurses can assess and intervene in the 'messiness' of holistic care?

Divide into groups. Each group should discuss individuals' descriptions of holistic care and come to some consensus about a definition. Next, each group should list all the things they perceive as the 'messiness' of holistic care. After the list has been completed, prioritize the list twice: first based upon the importance for nurse assessment and intervention; and, second based upon patient and family need.

Compare the two lists and identify where they differ. What implications do these differences have for nursing practice?

When all groups have completed the assignment, groups should share their definitions of holistic care and what they discovered about the 'messiness' of holistic care from nursing and patient perspectives. Is there a consensus about specific ways nurses might better intervene in providing holistic care?

### **The Naturalistic Paradigm**

A response to the logical positivism of scientists has been a naturalistic paradigm where reality is not viewed as a fixed commodity, but instead is seen as a construction of the individuals participating (Polit & Hungler, 1999). Postmodernism is a term often associated with naturalistic paradigms and implies a way to take apart or deconstruct old ideas and structures and rebuild or reconstruct them in new ways (Polit & Hungler; Ward, 1997). A postmodern perspective is less about unearthing or labeling an objective existing truth and more about placing things into categories or reframing them in particular ways; it is more about bringing ideas forth and less about discovering distinct qualities (Ward). Researchers who use naturalistic perspectives are inclined to view reality as relative and possibilities of different interpretations of observations. Aims are not to falsify or verify the constructions, merely observe them.

In the past, findings from qualitative research and naturalistic studies were often viewed as less scientific. Presently, qualitative findings are perceived more positively and considered a way to develop middle range nursing theories. Qualitative research provides an opportunity to focus on questions related to social experiences, address questions about the ways life

experiences are created, and describe things that give meaning to life (Denzin & Lincoln, 1994). Simple discussions about a single reality are difficult and qualitative research helps explore the multiple realities that co-exist. Naturalistic perspectives seems an appropriate way to understand family health because it is a complex construct with many seemingly unrelated variables. Nurses come into practice with different perceptual realities based upon prior life experiences, personal values, beliefs, and traditions. These realities create a lens through which knowledge is built and experiences about family health are interpreted.

### **Phenomenology**

In clinical practice, nurses continuously interpret situations and project possibilities. Interpreting requires understanding about what is to be interpreted. Projection of possibilities can only occur after understanding occurs and some might refer to this as circular rather than linear thinking. Nurses who maintain separateness or take aloof positions are at risk for misinterpreting things that others view as meaningful. Prior knowledge and experience can provide frames of reference that may be deterrents to discerning meanings of other's experiences. The term 'bracketing' is often used to imply the need to make visible what one believes and a willingness to set it aside in order to comprehend the phenomenon of interest. Nurses desiring to understand experiences contrary to their own must acknowledge and set aside personal beliefs, values, attitudes, biases, and prejudices and appreciate perspectives of others.

The family context provides information interpreted through experiences and provides a way to appreciate diverse viewpoints. For instance, a recent HBO program entitled "The Corner" provided an alternative point of view about family, drug use, and health. While nurses would generally see being high on drugs as unhealthy, drug addicts in this program saw the 'daily fix' as the way to 'get well.' Other family member saw the inability to obtain drugs as health

negating, while outsiders explained fiendishly seeking drugs as unhealthy. Another's perspective provides a way to reframe situations. Goals and viewpoints of others are often different from those of professional helpers and unless the 'expert' is willing to dialogue about the disparate valuing, it is unlikely that help given can alter behaviors.

Studying family health from contextual perspectives implies coming to understand developing persons within the ways they interpret essences and through their experiences. Family health is a collective memory experienced by individuals within the embedded context and shared in some respects by others. Van Manen (1990) said persons have consciousness and act purposively "in and on the world by creating objects of 'meaning' that are 'expressions' of how human beings exist in the world" (p. 4). He emphasizes that the purpose of phenomenology is not to solve problem, but to understand meanings. Phenomenology is a means to understand family health within the context of experience (Hartwick & Lindsey, 1995). Phenomenology aims to make phenomena explicit and identify universal meanings and describes a way that the nurse can encounter families in naturalistic or household settings.

Georg Hegel (1770-1831), Edmund Husserl (1858-1938), Martin Heidegger (1889-1976), Jean-Paul Sartre (1905-1980), Hans-Georg Gadamer (1900- ), and Paul Ricoeur (1913- ) have been viewed as the foremost philosophers in the study of phenomena or field of phenomenology. Phenomenology begins with concerns about experience and conscious awareness and "is a rigorous science whose purpose is to bring to language, human experiences" (Streubert & Carpenter, 1999, p. 61). Patton (1990) distinguishes between phenomenology as a philosophic perspective and as a research method and notes that phenomenological inquiry focuses on the question, "What is the structure and essence of experience of this phenomenon for these people?" (p. 69). Phenomenology strips away the particular and objective and encourages views of

essences. Essences are defined as "elements related to the ideal or true meaning of something, those concepts that give common understanding to the phenomenon under investigation" (Streubert & Carpenter, p. 46). Individual and collective thinking about things, persons, and events identifies essences of shared experiences, but may also be a way of speaking them into existence, valuing meanings, and developing a common language to explain experiences. Language helps us name and know things in our experience. Essences are sometimes referred to as viewpoints, perspectives or paradigms and provide opportunities to be present in worlds viewed differently than others. Families encountered in practice are likely to have essences that differ from those of the nurse.

Hermeneutics or the study of interpretation is an important aspect of phenomenology and naturalistic inquiry. Heidegger (1962) said understanding begins when language resists meaning and ends when language yields meaning; thus, we can only project possibilities when we have adequate understanding. Heidegger gave hermeneutics an ontological dimension (Dasein) and described understanding and interpretation as essential features of being. Understanding and interpretation seem somewhat circular as the past is brought into the future. Gadamer (1994) said understanding starts when language resists meaning and ends when language yields meaning. In order to be fully understand family health, projected meanings must be discovered, interpreted, and analyzed. Continual dialogue with the family about their situation results in communication about their particular situation.

Gadamer (1994) described experience as what occurs when we encounter the negative or unexpected and it awakens us to the insights that can be gained from other situations. Insights are realized when statements are seen as responses to questions. The only way to fully grasp the statement is understand the question to which the statement is an answer. The question directs its

own meaning and is realized by the response. According to Gadamer, the search for a question partly involves determinations about the context and community that give rise to the answer. Either the situation or persons who are subjects of inquiry do not always foresee the conclusions. According to Hartwick and Lindsey (1995), nurses have gathered information, but forfeited understanding of the information; diagnosed family functioning, but failed to recognize the experiences and meanings of family health; and focused on diagnosis and treatment, but neglected to address health promotion and healing processes. Nursing has not yet clearly delineated what is meant when the context of family's lived experience is referred to and this can be a problem for describing scope of practice.

#### **Unnumbered Box 5.4**

##### **Cooperative Learning**

List the ways quantitative and qualitative research perspectives can provide different understandings about health and family health. Discuss the differences that should be considered in studying individuals versus families. Compare the benefits and the threats to discovering knowledge posed by each perspective.

Examine two different research studies relevant to family health; one should use quantitative methods and the other qualitative ones. List the benefits and threats identified in each study.

Discuss ways each study contributes to nurses' knowledge about family health.

##### **Contextualism**

Clinical practice lacks appropriate assessment tools, intervention strategies, and evaluation measurements necessary for family as unit of care. Janice Bell (1995) described the

isomorphism of nursing as a situation where the processes in one system influence those in another system with the result being functionally similar outcomes. Whenever isomorphism occurs, repeated patterns interfere with the production of creative thinking, innovative ideas, and new visions. Isomorphism can occur when teachers encourages students to learn in ways that results in lockstep adoption of predominate attitudes and ideas without critically weighing alternatives. Isomorphism occurs when institutions socialize practitioners and discourage questioning traditions or majority actions. Isomorphism can also occur when patients influence nurses to think about family issues in the same ways they do. Dr. Bell said:

Isomorphism describes the suction we fight when it is easiest to simply repeat the pattern of the dialogue that maintains more of the same in family nursing. More descriptions of family responses to health and illness at the expense of describing and testing interventions are more of the same. More descriptive studies of questionable rigor that fail to address the research issues that are unique to the study of families are more of the same. More research reports at the risk of undervaluing clinical practice issues, teaching strategies, or discussions of family theory and policy are more of the same. More bland and safe discussions at the risk of raising controversial issues for critical debate and scholarly inquiry are more of the same. (p. 6)

Family nursing needs practitioners, educators, administrators, and researchers ready to think outside traditions and would dare to be different. Models that conceptualize the multiple threads of the embedded context are needed to supply more succinct understandings about the overt and covert implications of member-family-context relationships. "Contextualism views any events in the context of other events and presupposes a multiplicity of events in which the past,

present, and future form a coherent and interconnected totality" (Hartwick, 1995, p.140).

Ecological perspectives support understanding meanings of past, present, and future phenomenon family experiences.

## **FAMILY AS CONTEXT**

### **Family's Multiple Contexts**

The family itself is a context for its members, but it is also embedded into multiple contextual systems in ways that all family members may not experience simultaneously, consistently, or congruently. In other words, individual members within families have different experiences; thus each member and the member interactions contribute to the exchanges that comprise the family's contextual view. Members' views of their context are fluid, evolve and change over time and they have contrasting views that together provide insight about family health. The family configuration and membership has myriads of possibilities. Assumptions about who comprises the family should be avoided and instead the reported information provided by members should be identified. Families are composed of members who may be related through marriage, blood, or numerous situations resulting from choice. The likelihood of meeting Western families of the more traditional genre or what we have called nuclear families is far less likely than in earlier historical periods. Regardless of the immediate family state, the trajectory of members' lives together over time and includes situational changes that may have profound, lasting, distinct, uncommon, and diverse affects upon members.

The family is a context for its developing members, but it is dynamic and evolves over the life course. Members do not always perceive or interpret alterations in similar ways. While the family is evolving, the larger societal environment or the embedded context creates direct and indirect affects that also impact members. The family consists of individual developing



at the precipitating family history, past or present member relationships, or future goals or expectations. When the family is viewed as context, the care provided usually implies treatment, education, and counseling have addressed the symptomatic needs of singular persons with minimal input of family members. Caring from this perspective seldom seeks to identify the strengths, resources, needs, relationships, and behaviors of the entire family in relationship to the needs of the individual. From a practical sense, nurses that see the family as context often ignore the strength or threats imposed by family as members impact one another and the affects of interactions on the family as a whole (Table 5.1). When the family is the context of care, clinicians often make assumptions about families based upon the needs and perceptions of a single individual. Family as context may include some assessment of family related information, but interventions are mainly aimed at singular individuals. Considerations of alternative care forms that include the entire family or at least some other members seldom occur.

<<<<<<<INSERT TABLE 5.1>>>>>>>>

When family is viewed as the unit of care, the scope of family takes on a more holistic and inclusive view of the multiple members and their inter-related strengths, unique limitations, and shared resources. Individuals have distinct differences that include biophysical characteristics, perceptions, valuing, behaviors, and meaning-making that may be similar to others in the family, but may also differ. Family as the unit of care implies an understanding about potential health impacts resulting from member relationships, interactions, and transactions. Family members perceive a family identity and often view members as connected to or separated from this identity. This family identity often has links to multiple members' beliefs about health, wellness, disease, illness, and health care services. Viewing the family as the unit of care implies that the family includes individual members even when they are not

currently dwelling within the household. For example, if a mother gives up a child for adoption or if a member dies, the affects of these relationships continue even years after the occurrence. Likewise, adults retain linkages to families of origin even when they have relocated and families of procreation affect members even when they do not live within the household. Family as unit of care creates long-lived associations that linger over the life course and are pertinent to individual and family health.

The family context is largely embedded. In other words, although family members have some awareness of the multiple realms that characterize their ecological context, few individuals could fully describe linkages without some prompting through an assessment process. Assessment requires a high level of communication expertise in order to interact with families and their members at individual, relational, and transactional levels. Wright and Leahey (2000) provide an excellent discussion of communication skills and interview techniques for conducting family assessments and is highly recommended as an adjunct source for learning about family communication, interviewing, and counseling.

### **Assumptions about Family Context**

Assumptions about the family context form are foundational to the Family Health Model. Assumptions are the notions or axioms that are usually taken for granted, but assumed to be true. The author has attempted to make visible underlying assumptions related to family context that were instrumental in conceptualizing the family as context in the model (Table 5.2). They identify the bias that family health is directly and indirectly influenced by the embedded context where families dwell. Context begins with the members themselves, but also includes all aspects of the larger societal systems. The context is the stage for interactive relationships and discourse, the places where functional relationships occur, and settings for enacting family health

routines. The family context is integral to health and provides multiple settings where members are positively and negatively influenced over the life course. The context not only includes family members and the household location, but also includes the politics, social and public policies of the historical time that impact a given context. As the context is altered over time, family health is influenced by factors related to the multiple life contexts. The length of time in a given context may influence members and even brief periods can have profound and lasting affects. Older persons have been significantly impacted by the context of family of origin and this continues to be an important influence across the life course.

<<<<<<<INSERT TABLE 5.2>>>>>>>

#### **Unnumbered Box 5-4**

##### **Cooperative Learning**

Assumptions provide a foundation for understanding implications of comprehensive assessment of family members and their ecological context. Form a small group of 3 to 4 persons. Each person should read through the list of assumptions related to the contextual aspects of family health and make notes about their immediate impressions. After everyone has had time to review the assumptions, then the group should spend some time discussing them, sharing their impressions, and identifying where they agree or disagree. Each group should reach consensus about the two most important assumptions a family nurse should consider and be able to defend a rationale for their selections. After groups have adequately discussed their ideas, they should take turns sharing their ideas with the entire class.

## **SUMMARY**

Nurses often overlook contextual perspectives when they consider health. Assessment that ignores pertinent factors imposed by the embedded context often results in conclusions and interventions that overlook important health determinants. Focusing on pathology, while ignoring pertinent contextual factors too often leads to care that treats symptoms, but ignores causes. Failure to see the impacting causation as possibly environmental, systemic, and outside the individual results in seeing events as solitary ones rather than contextually embedded. At times individuals are blamed for causes of problems while the impact of community or environment as causative agents is overlooked. Thus, responses too often are only in terms of the individual with inadequate responses to community, social, and political events that may be germinating agents. Family-focused care must include family as the unit of care. Primary care needs to include families where members live, work, and play. Views of family households as a primary context for health broaden the scope of possibilities for causation and cure. In order to address the health needs of families, nurses must acquire knowledge, skills, and experience that are based upon broader understandings about affects of embedded contextual systems.

Nurses prepared at the generalist level may not be adequately equipped to fully implement care plans appropriate for family as the unit of care. While diseases and illnesses may be central in individual care, today's concerns involve systemic issues such as violence and abuse, substance abuse, early intimate sexual encounters, peer pressures, caregiving for members with chronic illnesses, lack of resources, and inadequate supports. Health risks are often related to problems such as income disparity, educational inequities, family fragmentation, under-employment, lack of skills, poor housing, and risks imposed by the environment. Nurses require better understandings about the family context if they are going to be equipped to address family needs. High costs associated with health care compel practitioners and care providers to envision

alternative ways to meet demands. While medical management will always be appropriate, possibilities related to family as the unit of care need to be more carefully conceptualized.

### **TEST YOUR KNOWLEDGE**

1. Thoroughly describe what is implied when nurses speak about providing holistic care.
2. Describe what is meant by the idea of family context. Give three examples.
3. Identify differences between the ideas of empiricism and naturalistic inquiry.
4. Discuss the advantages and disadvantages of objective empirical data.
5. Discuss the advantages and disadvantages of subjective qualitative data.
6. Explain what is meant by the idea of family as the context of care.
7. Operationalize the idea of family as the unit of care and list three ways nurses might intervene if the family member receiving care has asthma.

**Figure 5.1**

**Family as context**

\*\*\*\*\* diagram of this context needs to be drawn\*\*\*\*\*

**Table 5.1**

**Assumptions Related to Family Context**

- Family context has robust implications for individual and family health.
- The family context is dynamic and interacts with individuals, family systems, and families.
- Individuals are affected by the family context even when they are not present in it.
- Some aspects of family context can be directly observed as well as manipulated, but some aspects are more discreet, less observable, and difficult to manipulate.
- Actions and/or responses affecting any single-family member or aspect of the family context have the potential to affect the actions and/or responses of other members.
- Assessment of the family context includes data about individuals, family sub-systems, family, and the embedded household context.
- Context contains traits related to persons, places, events, situations, mores, and time.
- Culture, tradition, religion, and social values are contextual determinants.

**Table 5.2****Family as context versus family as the unit of care**

<b><u>Family as Context</u></b>	<b><u>Family as Unit of Care</u></b>
Individual is focus of care	Individual and family are target of care
Family is in the backdrop	Family is in the forefront
Family is comprised of individuals	Family is a unified whole
Individual data reflect family	Family data reflects individuals
Care of individual	Family-focused care includes family group, individual, family subgroups, family contextual systems

LEGEND

Fig. 5.1(to be drawn)

The family consists of individual developing members, dyads, and triads embedded in household, neighborhood, community, and greater societal contexts