

Chapter 8:
FUNCTIONAL ASPECTS OF FAMILY HEALTH

Chapter 8 Content Outline

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Chapter Objectives:

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

- Discuss ways development and health are products of genetics and environment.
- Differentiate between individual and family development.
- Describe potential relationships between functional processes and health.
- Identify the importance of dyadic and triadic member relationships to family health.

ACHIEVING A HEALTHY FAMILY

The term “functional” is often used to describe behavior and interactions within, between, and among persons. Systems function to obtain, store, process, interpret, and use information applicable to health. Family systems have cognitive, utilitarian, and behavioral capacities. For instance, one might discuss members’ mental aptitudes for learning, abilities to solve problems effectively, or success in achieving personal or family goals. Functionality can be discussed in terms of relationships where individuals, family sub-systems, and families live, work, and play and interact with embedded contextual systems. “Family function is the purpose that the family serves in relation to the individual, other social systems, and society” and these processes are influenced by health of individual members and the family as a whole (Ballard, 2000, p. 84). Family function affects members’ development, health, and well-being, but these are also affected by and affect interactions with larger contextual systems. Family members mediate values, beliefs, knowledge, and behaviors that alter many of life’s dimensions and can negate or potentiate health. Functionality provides a way to describe obvious and obscure linkages between persons, processes, and settings. This chapter identifies issues related to functionality pertinent to family health.

As previously mentioned, the terms family health and healthy family are used interchangeably in the literature. In the Family Health Model, the term healthy family refers to the functional abilities of

individuals, family sub-systems, and families as they develop and live, work, and play to optimize development, processes of becoming, well-being, and health. Satir (1972) said healthy families were:

- Untroubled and nurturing.
- Demonstrated patterns of high individual self-worth.
- Used direct, clear, specific and honest forms of communication.
- Had flexible, human, and appropriate rules.
- Practiced open and hopeful links with society.

Curran (1983, 1985) said healthy families communicate well with one another when they listen, share power, use nonverbal messages to express feelings, care, and love, develop patterns of reconciliation, and cooperate to solve problems. Pearsall (1990) suggested strategies to achieve a healthy family through strengthening, comforting, and healing processes.

Healthy family is a process that occurs as members' value one another and act in nurturing ways at specific time points and over the life course. It is possible to have a healthy family at one time, but be less healthy at other times. Some aspects of family interactions might be healthy, while others are not. It might be helpful to think about families on a continuum with the potential to have more and less healthy times and members. Because families have unique capacities to achieve their goals, it may be more meaningful to consider them in terms of abilities to accomplish goals they set for themselves rather than compare them to other families. A family might say they were healthy if the members were attaining their objectives and relationships with one another were satisfactory. Families may see themselves in terms of being healthy

without ever considering things like health, illness, or disease. Even so, nurses can still play roles in assisting individuals and families to achieve functional aspects of a healthy status when they assist them to identify self-worth or empower them to solve problems.

Family health is an abstract construct with gradients of scale, significance, and flexibility. It is possible to be a healthy family, one with nurturing members who value and effectively interact caringly for one another, but still not achieve family health. For example, if a family resides in a poverty-stricken area where food is unavailable, a war-torn region where life is in constant danger, or if they have recently suffered the perils of a natural that destroyed their community one might question whether they have family health. In these instances, context can be a greater predictor of family health than the innate family qualities. While healthy family might imply that family members' functional capacities to achieve family health are available, family health is a more complex process that embraces interactions of multiple members and contextual systems as members individually and collectively seek a bio-physical, emotional, social, and spiritual equilibrium, well-being and maximize processes of becoming. An expanded perspective of family health not only includes cure-oriented medical practices, but a perspective that also addresses the roles of economics and social policy in optimizing population-based mortality and morbidity, prevention of disease and

illness, and generation of health outcomes. Nurses are prepared to attend to the multifaceted aspects of family health.

THE NATURE-NURTURE DEBATE

For more than a century arguments have persisted about whether the greatest factors affecting human development are genetic or environmental. Some suggest that personality and behaviors are derived from innate traits linked to genetics, while others attribute them to environmental influences. Both seem useful in understandings development, but neither seems to offer an adequate basis for fully understanding (Bateson, 1998). He suggests that a connectionist model is needed to consider the idea of imprinting as a highly regulated learning process that occurs as individuals physically grow, mature, and interact with the environment. Imprinting entails indelibly impressing formative ideas about behaviors on the memory at early ages. Thus, developing persons become closely linked to the nature and nurture experiences occurring early in life. One could say that the health experiences occurring in the family of origin and the household niche are imprinted as children develop and serve as a foundation for all further learning and practice. It seems most likely that genetic and environmental factors have additive effects on developing persons over time. A connectionist model provides ways to move away from the reductionist and interactionist ideas that characterize the nature-nurture debates.

Explanations about behavior are often presented in terms of the exclusive importance of genetic or environmental factors. For example,

research about social behaviors has tried to differentiate whether potentials for aggressive behavior are mostly genetic or environmental. Early mice research completed in the 1960s used selective breeding to study aggressive behaviors (Lagerspetz, 1964) and other research later investigated the interactional and developmental controls of aggression (Cairns, 1972, 1976). Mice research has identified: (a) selective breeding within 1 to 5 generations can produce aggressive behaviors, (b) the presence of robust effects of rearing, interactional effects, learning, and social organization regardless of the animal's genetic background, and (c) social behaviors that can be manipulated through development can also be manipulated by genetic selection across generations (Cairns & Cairns, 1995). Although humans are certainly not mice, mice research is frequently used to inform us about human behaviors. Findings seem to indicate that internal and external environments compete and development involves both mediating and accommodating competing factors. Behavior seems to be more fluid than fixed and a feedback system appears to exist between biology and context within and across generations.

Are the findings in mice studies relative to human development?

Longitudinal studies measuring deviance and aggression were found to be reasonably predictive in within-individual factors and when individual and social characteristics were clustered, school dropout, teen parenthood, and other difficulties were predicted (Cairns & Cairns, 1994). Studies about biological effects of early female maturation have shown strong linkages

influenced by the social context (Magnusson, 1988; Statin & Magnusson, 1990). Developing persons appear to have highly predictable trajectories that can be identified in early life, but more fully emerge as they are influenced by the social context over the lifespan (Cairns & Cairns, 1995). It seems that at least in some ways nature-nurture are part of the whole rather than purely dichotomous.

Over the last few decades, the field of early intervention has provided evidence about ways physiology and environment impact learning and behavior. For instance, children with hearing loss identified that when fathers were present in the home children had significantly better academic and language outcomes than those without a father present (Calderon & Low, 1998). A study about the impact of school-based, teacher-rated parental involvement found that while parental involvement was a significant positive predictor of early reading skills, mothers' communication skills and the level of the child's hearing loss were also important predictors (Calderon, 2000). In this study, mothers' use of support services was the strongest predictor of social-emotional adjustment. It was not just the child's intelligence that was the predictor of success, but also social interactions. A study about implications of parent-provider discussions about developmental problems found that those parents seeking health care for their children seem to have more developmental concerns than those without providers (Glascoe, 1997). Parents were most likely to discuss concerns about expressive language

when they thought their child had health problems and when parents of disabled children discussed them with health care providers, children were more likely to be enrolled in special education services. Children with disabilities may have innate physiological characteristics that affect learning outcomes, but parental concerns and behaviors were important variables in the types of care children receive.

Nature and nurture seem to interplay in child learning, development, and physiological capabilities, but both processes have implications for the entire life course. The Family Health Model suggests that early learning about health within the household niche influences health values and behaviors across the life course. While genetics and family heritage are viewed as important predictors of potentials related to health, the model suggests that embedded contextual systems and social behaviors are equally influential.

Unnumbered Box 8.1 **Cooperative Learning**

Everyone seems to have some opinions about the questions of nature and nurture. Ask students to find a partner with whom they can discuss their beliefs about these issues. After allowing time for some reciprocal sharing, form the students into four groups and assign each a topic:

- Nature is the most positive influence on child development.
- Nature is the primary influence on child development, but nurture plays important roles.
- Nurture is the most positive influence on child development.
- Nurture is the primary influence on child development, but nature plays important roles.

Ask the groups to choose a recorder to report their conclusions. Allow groups time to formulate their ideas, identify arguments that either support or refute the position, and provide some rationale for their conclusions. Have each group discuss ideas with the class.

HUMAN DEVELOPMENT

Theories of Human Development

Volumes have been written about developmental processes and nurses have studied them throughout their nursing education. A brief discussion of a few of the most influential thinkers about developmental processes is provided to suggest the many important insights pertinent to developing persons. For instance, Erikson (1968) described individual development in terms of eight stages of development, Bandura (1982) suggested personal experiences and socialization processes are important for understanding competence and mastery, and Vygotsky (1978) explained ways that historical and cultural changes in children's environment influenced cognition. Piaget (1971) considered ways children at different ages approached problems and saw thinking as a series of increasingly complex stages where learning is revised and incorporated into current thought. He described thought in terms of direct learning, social transmission, and maturation and used ideas of assimilation, accommodation, and adaptation to describe experiences, ideas, and encounters were changed as the child developed. Kohlberg (1981) discussed children's moral development in terms of sensitivity to what is right and wrong. Gilligan (1982) later challenged Kohlberg's ideas that were based on male subjects. She suggested that male identity was primarily identified with separation and autonomy, while females focused on attachment and emotional connectedness; boys thought in terms of

general ethical principles applied to specific situations, but girls developed an ethic of care that integrated principles with the contexts where decisions were made. Bowers (1995) discussed the abstract reasoning that allows adolescent idealism, limits ability to appreciate logical points of views different from their own, and permits egocentric behaviors. These theorists and many others have focused on various aspects of developmental processes seeing them as series of continuous changes over time with distinct stages vital to generativity, productivity, and achievement. Nurses can extract from their previous learning about developmental processes the knowledge and skills needed to meet health needs through family-focused care.

Unnumbered Box 8.2

Critical Thinking Activity *****

Assign a different developmental theorist (e.g., Erikson, Piaget, Kohlberg, Gilligan, etc.) to either individual or groups of students. Ask them to identify the key premises of the theoretical framework and list reasons why these premises might not be correct or concerns they may deduce from alternative possibilities or other knowledge areas. Students can present these ideas to the class and discuss ways nurses might use developmental theories to meet health needs.

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Human Development

Developmental processes have implications for health across the life course. In the Family Health Model, development is defined as “person’s evolving conception of the ecological environment and his relation to it, as well as the person’s growing capacity to discover, sustain or alter its properties” (Bronfenbrenner, 1979, p. 9).

Human development is the process through which the growing person acquires a more extended differentiated, and valid conception of the ecological environment, and becomes motivated and able to engage in activities that reveal the properties of, sustain, or restructure the environment at levels of similar or greater complexity in form and content. (Bronfenbrenner, p.27)

A healthy child matures and moves from total dependence and only interaction with the family microsystem to greater independence and interaction with larger contextual systems.

The ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded. (p. 21)

Development affects all aspects of individual and family life and processes once affected at any time point possess the potential to cause other changes at other times and places. In other words, development is not only influenced by unique traits and characteristics, but also by the context where households are situated.

A concern related to developmental models is that they mostly focus on psychosocial concerns and are less likely to make connections with bio-physical changes or health as a developmental process. Research has mainly investigated relationships between family functioning and psychological health, but only limited studies about family functioning and the physical health of family members has occurred (Campbell, 1986; Van Riper, 2001). Although we know much about developmental variables linked with individuals and parenting, less is known about the

impact of the embedded household context on these traits. Kohn (1995) said:

Social structure had consistent effects on all facets of personality that we studied, and the consistent explanation of these consistent effects was that position in the social structure decidedly affected occupational self-direction and that occupational self-direction decidedly affected personality. (p.156)

The Family Health Model suggests the use of developmental theories for not only considering individuals' functional capacities, but verifying relationships to health behaviors and outcomes.

Family Development

Several have described ways to view development from a family perspective. For example, Carter and McGoldrick (1989) provide a six-stage perspective for use in family therapy that describes family stages:

- Between families (e.g., unattached young adults)
- Newly married couples
- Families with young children
- Families with adolescents
- Launching children
- Families in later life

Duvall and Miller (1985) have identified eight-stages of family development:

- Beginning families
- Childbearing families
- Families with pre-school children
- Families with school-age children
- Families with teenagers
- Families launching young adults
- Middle-aged parents
- Families in retirement and old age

Klein and White (1996) described the developmental tasks of families as: (a) meeting families' biological requirements, (b) addressing families' cultural imperatives, and (c) accomplishing families' aspirations and values. The Family Health Model suggests that developmental tasks are more helpful for addressing family health than family stages.

Several problems seem inherent in stage perspectives. First, neither Carter and McGoldrick (1989) nor Duvall and Miller (1985) ideas are adequate for fully understanding family diversity. For example, blended families often have both infants and adolescents developing at the same time; homosexual families may raise children belonging to one partner; and some families wait until their late 20s or early 30s to begin childbearing. Family variations or alternative family types could imply different family stages. A second problem is related to a lack of understanding about the development that occurs after in middle age through the oldest old. The U.S. Census Bureau projects that the presently 35 million persons over 65 years of age, will increase 5 million by 2010 and double to 70 million by 2030 and the number over 85 years of age will double by 2030. Attention has mainly on development during parenting stages, but much less is known about development prior to and following retirement age. Persons now have the potential to live far more years in developmental processes after parenting tasks are completed than years spent engaged in those activities. What effects do altered parent-child relationships in mature life have on child, parent, and family

development? What developmental changes occur as parents modify their lives as they approach mid-life? How do interactions between grandparents and grandchildren affect development? What developmental changes occur in adult children when they become caregivers for their parents?

Carter and McGoldrick (1999) have identified concerns related to aging and discuss needs to view developmental progression and interdependence. While parenting and mother-infant bonding have been described as interdependent processes (Bowlby, 1969), increased thought needs to be directed to the developmental and functional needs that occur across the life course. Inclusion of larger contextual systems and broader health variables push providers to consider alternative relationships germane to development. Learning about complex interacting variables is costly and time consuming, but some work in this area might provide better ways to articulate deep-seated quandaries intrinsic to health processes.

Unnumberedf Box 8.3

Reflective Thinking

Think about childhood development in terms of your experiences and those of your siblings. Try to list some differences and similarities between you and your siblings related to individual health. Do you see yourselves more alike or more different? Think about those differences as they relate to individual health. Do you think you are more or less healthy than your siblings? What processes do you think might have contributed to the similarities and differences that you identify?

As you consider these qualities, try to think about what might have accounted for them. Next, try to identify what various developmental processes occurring within your household niche might have contributed to these qualities. What were there different contextual factors that might

have contributed? Think about different time periods in your life. What stands out in your memory?

If you have the opportunity, discuss these ideas with your siblings and get their perspectives. Do they see things differently? How might these relationships affect family health?

FUNCTIONAL PERSPECTIVES AND FAMILY HEALTH

Functional Perspectives and Developing Persons

The Family Health Model is concerned with processes that occur in the household niche, as developing persons experience a variety of contextual settings across the life course. Hertzman (1998, 1999) described interactions between childhood development, socioeconomic differences in the early life experiences, and psychosocial conditions over the life course as contributors to subsequent health status and system defense factors. Evidence derived from intervention studies in early childhood suggests that cognitive and social-emotional childhood experiences affect health status and vitality and can be modified in ways that improve health, well-being, and competence in the long-term (Hertzman & Wiens, 1996). Although early developmental experiences are powerful health determinants, they are mediated over a lifetime through a variety of contextual interactions. Assumptions about the functional processes relevant to the Family Health Model suggest relationships that nurse clinicians and researchers can tackle (Figure 8.1).

The functional status of families aids understanding processes related to health. However, some family models have not successfully described, explained or predicted family behaviors (Keltner & Ramey,

1992; 1993). Friedman (1998) describes the structural-functional approach as an organizing framework to understand the arrangement and organization of the family and a way to describe family purposes for its own development and societal good. She suggests that the five family functions are: affective, economic, reproductive, socialization, and health care. The health care function “entails the provision of physical necessities: food, clothing, shelter, and health care” (Friedman & Morgan, 1998, p. 404). Artinian (2001) said that a structural-functional framework provides nurses with ways to understand how illness affects the family, which processes are needed to optimize functioning, and where to provide interventions. Hanson (2001b) notes that this model encourages a view of family as one of the basic units of society with activities, purposes, organization, and relationships to other social systems that enables nurses to assess the system as a whole, as a societal subunit, or as an interactional system. The Family Health Model is not in direct conflict with ideas depicted through a structural-functional model. However, the Family Health Model makes some different distinctions between context and function and views many ideas in the structural-functional model as function related to health processes. However, nursing roles viewed with either model related to functional status could include things such as:

- Teaching and counseling.
- Securing knowledge, services, and resources.
- Organizing and providing for daily health and illness care needs.
- Advocating for what is lacking and needed.
- Finding supports for change, processes of becoming, and well-being.

Family members living in the same household may have different needs or goals, use different interactional processes, and respond differently to similar embedded contexts. A study that compared siblings where one was obese and the other within normal weight found that even when the genetic relationship was close and the environment shared, differences in the amounts of food consumed and physical exercise were still identified (Richard, Adams, & Hunt, 2000). In observing family dietary patterns, family members in the same household consumed very different diets and had great variances in the foods consumed (Denham, 1997). Nurses must understand needs unique to families and individual member, as well as the interactive functional processes affected by embedded contextual systems that contribute to or limit health outcomes.

Unnumbered Box 8.4
Cooperative Learning

Divide the class into five groups and have them choose a recorder. Each group should consider a family role that might affect family health. Group members should then brainstorm and identify 10 interventions that nurses might consider if addressing needs related to this role. For instance, the group discussing teaching and counseling, should identify specific ways that the family nurse could intervene with families to positively influence individual and family health. After about 10-15 minutes of small group discussions, have a member of each groups share their lists with the class.

Dyad and Triadic Relationships

Families are comprised of multiple sub-systems that can be identified as dyads or triads. As developing persons form close relationships with family members, dyads are initially formed. Each member within the household forms dyadic relationships. *Dyadic units* are dynamic interactions between members with diverse characteristics and meanings. Dyadic relationships are initially formed due to the family context, but persons outside the family boundaries may also become dyad members (e.g., boyfriend, friends, colleagues). Family dyads are tenacious and tend to persevere over the life course, but strengths of the relationships may vary with time. Intact dyads with shared goals possess innate potential to mediate factors relevant to health, but less cohesive dyads may threaten health.

Once a family forms dyads, these dyads tend toward resilience. Information from the larger contextual systems is often interpreted by dyads in relationship to personal meanings, goals, and family identity. Whenever health needs are encountered, intact dyads use core family processes to *adapt* and *accommodate* factors imposed by member interactions and the larger contextual systems. Adaptation is a passive response to interactions occurring within the household and larger contextual systems that contradict, threaten or compete with accepted family norms. It is a way to understand how actions, behaviors, and even biological responses are modulated. Accommodation is an active response

to existing schemes of thinking and action that occur when members are faced with events or situations where old behavioral patterns are ineffective. While accommodation can result in some fixed patterns, the process is fluid over the life course with continual feedback responses made to information and messenger.

The character of dyads is altered whenever other family members or persons enter the context. For example, a mother and toddler may be playing in a usual pattern, but when the father returns from work the relationship is somewhat altered. While the father has a dyadic relationship with both the mother and the child, his presence forms a triad and interruptions affects the play previously occurring between the mother and child. Dyadic characteristics impact the family's functional capacities. For example, if the father comes in angry and demands to know why the mother is playing rather than cooking his dinner, the context changes from a mother-child dyad to a mother-father one. If the father comes home and begins to play with the mother-child dyad, a triad is formed. It is posited that the strength of a triad is greater than that of a dyad. Entrance of a short-term visitor (e.g., extended family member, friend, neighbor, stranger) into the household may alter usual dyadic patterns, but these behaviors tend to resume after the visitor's departure. Family ideas about things like boundaries, identity, and traditions influence interactions. Families form complex webs of relationship. Some triads are built upon dyadic links; thus the strengths and weaknesses of the dyads are inherent

in the triads. Each individual has unique views about the strength, value, and effectiveness of the various member relationships.

The formation and interruption of dyads and triads create family interactional patterns through which members adapt and accommodate to create interactional patterns with potential affects on development, health, and well-being . While frequently disrupted dyads may result in altered patterns that threaten family cohesiveness, resiliency, hardiness, or health, congruent dyads or triads have great potential for use in family interventions to mediate or potentiate health. Over time dyadic interactions form a gestalt or pattern of beliefs, attitudes, and behaviors that become the context for health routines. The cohesiveness and permeability of dyadic or triadic boundaries have potential to alter members' health beliefs, knowledge, and behaviors.

Member needs may result in forming temporary, semi-permanent, or permanent relationships with nurses or other health care providers. The extent of the felt need may determine the strength and extent of the relationship. For example, an infant born with cystic fibrosis may require frequent physician visits. The child and mother may form close bonds with the physician or nurse relevant to meeting the child's health care needs. This mother may form a semi-permanent relationship with a schoolteacher who needs to know about specific medical regimes to which the child adheres. This same mother may also form a dyadic relationship with a scout leader to assure that her child can participate in activities similar to

other children, but she wants to be sure that the leader knows what to do in emergency situations. Nurses can use the potential strengths of family dyads and triads to assess need and intervene in ways that reduce risks and promote health. It is proposed that interventions that target dyads and triads rather than single individuals have greater strength and potential to support family accommodations associated with health concerns. For example, nurses often teach individuals about illness and health care needs. Teaching seldom includes family needs or multiple members in either a systematic or comprehensive way. It is posited that family functional processes targeted at health care needs are enhanced when interventions include dyads and triads rather than single individuals.

Unnumbered Box 8.5

Reflective Thinking *****

You have had multiple opportunities to form many dyadic and triadic relationships. Depending upon your age and contextual status, you may still consider yourself a member of your family of origin household, you may be part of a family of procreation, or you may live in a variety of alternative forms of households. It is possible that you have lived in several different contexts.

Think back over your life course and recall the dyadic and triadic relationships you have formed within your household niche(s). How would you characterize these relationships? Have they changed over time or do they remain unchanged? In what ways did dyadic relationships influence your health beliefs, health knowledge, and health behaviors? Were there positive effects of these dyads or triads on your personal development, health, or well-being?

What about triadic relationships within your family? Ask yourself the questions listed above about your triadic relationships. Would you say the triadic relationships are different than dyadic ones? In what ways? How might nurses use the idea of family triads to influence health beliefs, health knowledge, and health behaviors?

Relationships of Proximal Processes to Family Functional Processes

Functional processes have direct relationships with other simultaneous processes occurring within the household. Bronfenbrenner and Ceci (1994) proposed some ideas for a model that includes a genetic paradigm, direct environmental measures, and organism-environmental interactions. They suggested that the genotype or genetic constitution of an individual is influenced by the environment to present a phenotype or an organism with properties attributed to the genotype and environment. They proposed that heritability increases markedly with the magnitude of *proximal processes* and results in synergistic effects. Proximal processes are the mechanisms through which the genetic potentials for developmental processes are actualized or the ways individuals take their genetic inheritance and actualize them as they mature and interact within larger contextual systems over the life course. It is posited that enhancement of proximal processes and environmental quality can increase genetic potentials, developmental competence, and health. Full realization of genetic potential is strongly influenced by interactions with contextual factors.

The Family Health Model suggests that health is related to genetic or inherited factors that are affected by individuals' proximal processes and the diverse environments they encounter. Family-focused care addresses the functional and interactional processes occurring within the family household as members interact with embedded contextual systems

to meet their health needs. Family-focused care implies a need for collaborative relationships to assist individuals, family sub-systems, and families with their accommodation processes to attain desired goals.

Nurses assist individuals and families to:

- Cope with crisis or stress;
- Choose between competing knowledge objects;
- Make decisions that influence well-being;
- Develop satisfying and meaningful relationships;
- Select behaviors that are health promoting;
- Avoid behaviors that are health negating;
- Modify perceptions of self, others, symbols, and environments that are risk producing;
- Acquire resources that promote, maintain or assist to regain health;
- Use immediate and remote environments to potentiate individual and family health.

Nurses empower as they assist families to actualize their full genetic potentials by actively engaging their dynamic processes and interactions with larger contextual systems.

SUMMARY

Nurses generally are well prepared to address functional processes with individuals, but it is an area where they may lack skills for interacting with families. It is the daily and cumulative effects of behavioral processes and interactions over the life course that mediates, impedes, and facilitates development, processes of becoming, well-being, and health. Functional status pertaining to health outcomes is not fixed, but malleable as genetic and environmental potentials intersect through the life of interacting family members. Dyads and triads hold promise for rethinking the ways interventions are provided to address family health. Internal familial

bonds, ties to extended kin networks, and links with others external to the household niche may be keys to addressing health risks and potentials.

Nurses can best address functional needs related to family health by interacting with family sub-systems, identifying family goals, and collaborating with them to address needs related to the embedded contextual systems.

Test Your Knowledge

1. Describe what is implied by developmental processes and discuss ways nurses might intervene to promote health.
2. Explain two ways that family's functional processes can enhance family health.
3. Discuss how ineffective functional processes within a family might threaten well-being.
4. Identify how an embedded contextual system might threaten family health even when the family shares optimal functional processes.
5. Compare and contrast potential affects of dyadic and triadic relationships on family health.
6. What is meant by the idea of proximal processes? Give one example to show how they might be a health threat and another example to demonstrate a positive health affect.
7. List 3 ways a nurse might intervene when working a family that has a child with chronic asthma using the idea of functional processes.

Box 8.1

Assumptions about functional processes and family health

- Individuals develop over the life course in response to genetic and contextual traits.
- Individual health is a result of genetic, interactional, and contextual potentials.
- Individuals have beliefs, perceptions, and behaviors that affect health outcomes, but these are mediated by genetic dispositions, family interactions, and environmental contexts.
- Processes of becoming and well-being are influenced by family members interactions with one another and their embedded contextual systems.
- Initial socialization about health occurs within the household niche and evolves over the life course as developing persons, family sub-systems, families, and larger contexts interact.
- The quality, meaning, and effectiveness of core family processes affect health.
- Individual and families use core family processes to attain, maintain, sustain, and regain health as they interact with internal and external contextual influences.
- Perceptions about what comprises health vary as individuals mature, accommodate change, and encounter contextual influences across the life course.