

Chapter 9

THE HOUSEHOLD PRODUCTION OF HEALTH

Chapter nine Content Outline

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Chapter Objectives:

Those completing this chapter should be able to:

- Describe features of the family household that affect health.
- Explain the term the 'household production of health.'
- Identify health practices and behaviors as social constructions of families.
- Discuss ways that ecocultural domains influence member functions relevant to health.
- Discuss the importance of intergeneration and heritability as family health factors.

*Great spirits have always found violent opposition
from mediocre minds.
Anonymous*

Most professional encounters occur within institutional settings and many nurses never encounter those seeking health care services where they live. Given that most people spend a large part of their time interacting with family members within a household niche, it seems important to place greater emphasis on the household as the niche where health is defined and practiced. The household production of health is affected by events of ordinary life, member's functional capacities, unique health states, and the contextual systems where the niche is embedded. While initial socialization about health occurs in the family of origin, early ideas are impacted by many factors that may or may not have a recognizable order. Over time adherence to some beliefs and behaviors occurs, but others are modified, some obliterated, and new ones created. Questions about intergenerational transmission and family function relevant to family health across the life course are important for present and future nursing practice. The Family Health Model implies that just as health has many determinants, approaches to the household as the locus of health production has many implications for interventions by nurses and other disciplines.

THE HOUSEHOLD AS THE DEVELOPMENTAL NICHE

Characteristics of the Household as a Developmental Niche

Families have members that share some characteristics, but possess other distinct traits. Within the household, developing persons interact to decide the usefulness of health information, interpret health-related experiences, infer meanings about contextual perceptions, and develop behavioral patterns related to health processes. In earlier chapters, family members were described as part of the context for family health. Fisher and Ransom (1990) suggested that family is more than context and should be viewed as mediums and operators through which the family members experience health. They discussed the family in terms of its ontology or the unity existing between individual and family, ways one embodies the other, yet can be individually described, observed, and treated. Parents and others have enduring influences during critical life periods on children's health beliefs and behaviors and interactions continue throughout life.

Harkness and Super (1994) introduced a theoretical framework that they called the "developmental niche." After studying children's behaviors and development in different cultural contexts, they conceptualized three components of the developmental niche: (a) the physical and social settings of the child's everyday life, (b) the culturally regulated customs of

childcare and child rearing, and (c) the psychology of the caretakers. These subsystems mediate individual experience within the larger cultural context and regulate patterns of health and disease. The household or developmental niche can be viewed as a way to understand child survival and development both from national and international perspectives (Harkness & Super, 1994). Ideas about household may need to include ideas relevant to policy makers such as rules about family formation (e.g., polygamy, divorce, homosexual or heterosexual co-habitation); child care (e.g., adoption, foster care, parentage); responsibilities towards elderly and developmentally disabled dependents; and intra-household allocation of resources (Berman, Kendall, & Bhattacharyya, 1994). Many view marriage as the conjugal unit, but maybe the household needs to be characterized differently to address today's citizens. For example, cohabiting couples are usually not given the same health insurance coverage as those legally married and social values influence employers' decisions about benefits. Thus, some might argue that a disparate employee group is created whose children or cohabiting partner might lack health care benefits.

Children's behavior, development, and health is influenced by the physical and social settings of the everyday life, cultural customs of child care and rearing, and the caretakers. A study

about child's health status found that attitudes about self, health, and well-being were predictors of health behaviors for children regardless of gender (Farrand, 1991). Green, Kreuter, Deeds, and Partridge (1980) categorically classified health behaviors from functional perspectives: predisposing factors (e.g., attitudes, values, outcome expectations), enabling factors (e.g., skills, resources, knowledge), and reinforcing factors (e.g., social rewards/punishments, physical and material benefits/costs, tangible/imagined outcomes). Individual encounters with sick children often overlook the complex household factors that potentially influence present health concerns and future risks. The Family Health Model entails viewing the embedded household as a primary factor related to individuals' health processes and suggests that nursing practice include these implications as plans for interventions are introduced.

Household Production of Health

A variety of models can be used to understand the ways households' function and achieve health-related outcomes. Anthropologists have tried to explain health behaviors in terms of relationships between cultural beliefs and disease and the determinants affecting the household economy (Coreil, 1990; Schumann & Mosley, 1994). Economics provides a way to understand the household production of health based upon a

premise that humans are rational beings and behave according to economic principles (Rosenzweig & Schultz, 1982; Schultz, 1984). Households are repositories for accumulated material goods and are the places where members decide how these goods, time, and other resources will be distributed to meet needs. Members and contextual systems influence these choices. Perhaps the term 'choice' is inappropriate since households are not equally ascribed wealth, privilege, or resources and in actuality most choose among limited possibilities imposed by contextual systems. Health should not be viewed merely as a household production, but also a political construction that affects and is affected by the family (Backett, 1992).

The 'household production of health' has not been fully described in the literature, but has been discussed as a social construction used by family members to promote, maintain, and regain health (Berman, Kendall, & Bhattacharyya, 1994; Denham, 1997; Harkness & Super; Schumann & Mosley, 1994). The household production of health is defined as:

A dynamic behavioral process through which households combine their (internal) knowledge, resources, and behavioral norms and patterns with available (external) technologies, services, information, and skills to restore, maintain, and promote the health of their members. (Berman, Kendall, & Bhattacharyya, p. 206)

The household production of health facilitates accommodating the processes associated with health as individuals, family sub-

systems, family, and embedded contextual systems interact. The concept has integrating qualities for envisioning the complex factors that mediate family health and it provides a way for various disciplines to organize thoughts about how health can be promoted.

Early childhood is a time when health habits are formed and influenced by the household. A study about how middle-class families children provided a health-promoting environment for young children and the ways they decided how health knowledge, beliefs, and behaviors should be enacted suggested that members had conflict as they attempted to make sense of the social, cultural and moral constraints in daily life (Backett, 1992). Bio-medical knowledge was translated into behavior when:

- Knowledge made sense in its own right.
- Knowledge made sense in relation to daily experience.
- Knowledge had a social legitimacy in terms of cultural and moral context.

Not only are health habits largely taught and defined within the family, decisions about when to seek health care and types of care to seek are also part of the health construction (Thomas, 1990).

Strengthening families with services, advocacy, and resources can facilitate child development and assist parents with their roles (Thomas, 1994).

The Socially Constructed Family Health Paradigm

The socially constructed family health paradigm is a lived experience that reflects beliefs, values, knowledge about health and

illness, ideological views of health, and patterned behaviors. Social constructions are largely based upon what has been experienced and viewed as meaningful. Those considering marriage or anticipating birth of a child may have spent little time considering health practices, but at some point reasons occur to compare similarities and differences. While those with similar cultural contexts may notice fewer differences, most persons establishing a household quickly become aware of traits that they previously had been oblivious about. As individuals are united, a social construction of patterned routines is initiated that over time becomes the distinctive family health paradigm.

Figure 9.1 provides a way to depict the social construction of family health as a summative response to functional and contextual factors. Family members individually and collectively interpret unique life events and complex contextual variables that have potential to affect the health and illness state of single individuals and the family as a whole. Some experiences are perceived as normative (i.e., health producing, health sustaining, health regaining) and others as non-normative (i.e., health depleting, disease producing, risk increasing). Accommodations often occur incrementally as members cope with liminal events (i.e., time periods that warn of pending family developmental changes, such as pregnancy or the recommendation of hospice care

supports (Bernheimer, Gallimore, & Weisner, 1990; Gallimore, Weisner, Kaufman, & Bernheimer, 1989). This theory suggests that everyday activities should be the unit of analysis as they can lead to outcome assessments, are not based on single individuals, are less likely to be linked a priori to variables such as income or social class, and are sustained across a variety of settings, times, and situations. Key theoretical points are:

- They explicitly include family-constructed meanings of circumstances and the proactive responses to those circumstances.
- The ecocultural niche is comprised of the family's material conditions, values, goals, and meanings.
- Family themes and ecocultural domains provide a basis for routines.
- Daily routines or the activity settings are the critical unit of analysis.
- Everyday routine is an adaptation problem common to all families.
- Accommodation is the response process that alters daily routines.
- Ecocultural theory is applicable to all families regardless of culture, race, ethnicity or social strata.
- Families should be compared based upon processes of social construction of activity settings rather than family or child status alone.

These points have strong implications for family-focused care and forms of nursing practice that include household variables.

Families are not viewed as helpless victims of circumstances, they regularly take individual and collective actions to modify or accommodate them. It is the premise of the Family Health Model that families strive to maintain the themes, identity, and patterns of routine that they view as meaningful. For example,

a qualitative study explored the daily routines constructed by mothers in response to the emerging self-care needs of young children with disabilities and findings indicated that family's daily lives were reconstructed to accommodate child needs and the mother's vision for her child's future (Kellegrew, 2000). Values, meanings, and themes related to cultural practices for specific families are more meaningful than mere reliance upon those of dominant members of a cultural group.

The *ecocultural niche* pertains to the ways families interact and organize their lives within their embedded households to address health needs. Many contextual determinants (e.g., proximity of kin, health risks imposed by the environment, stresses intrinsic to neighborhoods, employment opportunities) influence functional status and member interactions. The ecocultural niche is influenced by the unique ways members incorporate traditions, spirituality, and symbols into everyday life. While the niche may predominately have a hierarchical nature, it can be altered and reordered. It is the safe place or schema members use to cope with unpredictable factors and integrity integral to health. While some may possess great latitude in choosing where to live, work, or play, others experience have constraints due to lesser education, opportunity, or marginalizing factors.

Weisner (1984) identified 12 domains related to family that had some impact on child development (e.g., family work, public health, home safety, childcare tasks, peer groups). Families make accommodations related to careers, work schedules, jobs, and residences in order to sustain valued patterns of behavior. Members may be willing to learn new skills, participate in activities, seek assistance from those outside the family boundaries, redistribute household tasks, attend to or neglect faith practices if the implications are strongly related to meaningful needs associated with health needs. Parents use resources and constraints to construct everyday routines that accommodate values and goals pertinent to health outcomes (Gallimore, Weisner, Kaufman, & Bernheimer, 1989). Everyday routines are affected by *ecocultural factors*, positive and negative variables initiated by the context or resulting from interactions with or within the context. Ecocultural factors are themes that families use to organize daily behaviors and family health routines. For example, families often use religion or faith explanations to coordinate and arrange practices related to diet, alcohol avoidance, and activities that should be shun. Another family theme pertains to what is esteemed as 'normal' behavior. For instance, some families think spanking is violent and choose to discipline by using "time out," taking away privileges, or "grounding." Other families may tolerate regular

screaming or yelling behaviors and even hitting, shoving, and beating as ‘normal.’ Family themes may have to do with expectations about gender behaviors, acquisitions of material goods, social appearances, family togetherness, meaningful childhood, and parental behavior. Family members may not always clearly articulate their themes, but they are incorporated into the fiber of daily life and routine behaviors (Denham, 1997, 1999a, 1999b, 1999c; Gallimore, Weisner, Kaufman, & Bernheimer, 1989). Those choosing to practice using the Family Health Model would consider the implications of the family’s themes and routines in providing family-focused care.

Unnumbered Box 9.1

Reflective Thinking

Consider your family of origin experience and think about the concept of an ecocultural niche. What are the pertinent aspects that a stranger might use to define your family’s ecocultural niche? What are the family themes present in your family of origin when you were in grade school? High school? What about now, have the themes changed over time? Are you currently establishing a family of procreation? If so, how are the themes different from those in your family of origin? Be prepared to participate in a class activity sharing some of your personal experiences.

Ecocultural Domains

Based upon ideas reflected in the literature (Bernheimer, Gallimore, & Weisner, 1990; Nihira, Weisner, & Bernheimer, 1994), 12 *ecocultural domains* have been identified as potentially influential contextual and functional categories of family life that

define the themes and routines pertinent to functional roles related to health (Figure 9.2). Resources and constraints, values and goals, and member abilities to accommodate changes impact these domains. The family-of-origin experience is often used to measure future values, roles, and practices. Some domain aspects may remain unchanged during the life course, but others are altered. The diagram presents the focal as if they were segments of an orange that appear to be unique delineations that closely approximate one another, but in reality the domains are enmeshed, integrated, and difficult to separate making domain analysis especially difficult. However, domains provide ways to conceptualize systemic interactions among members and their contextual systems. If a biological system is envisioned, then a frame of reference is the circulatory system of health beliefs, a skeleton of health knowledge, and a musculature of health routines.

<<<<<<<INSERT Fig. 9.2>>>>>>>>

Knowledge, traditional practices, and values relevant to domains are slow to change, but accommodations are made when a reason strong enough is encountered. For example, a young woman growing up lived in a home where her parents practiced faith healing and she held fast to similar beliefs throughout her adult life. Now in her early 40s she is faced with breast cancer and

though she always said that she would never undergo a surgical procedure, the gravity of her diagnosis, uncertainty of her prognosis, and promise of other's successes leads her to choose medical pathways she never thought probable. Beliefs and behaviors associated with health may be resistant to change and not very pliable, but when themes are threatened and accommodations needed openness to new information or interventions may occur.

The Family Health Model suggests that strongly adhered to beliefs and behavioral patterns related to family themes and identity is not quickly amenable to interventions. However, when nurses collaborate with members to achieve meaningful family goals it is probable that some accommodations will occur. Family-focused care implies ascertaining family needs in relationship to health concerns and providing supportive assistance that enables them to accomplish goals. Factors affecting ecocultural domains are:

- Member's genetic predispositions
- Member's social hereditary factors
- Individual and family developmental variations
- Broad environmental conditions

These factors are antecedent to and contiguous with the ways members' function, assume roles and responsibilities, interact, and organize their ideas about health practices.

Unnumbered Box 9.2

Cooperative Learning

Divide into the class into three groups. Select one of the ecocultural domains (see Figure 9.2) then discuss possible family themes that may affect aspects of that domain with potential to affect functional processes, family roles, and health outcomes. What are the possible themes for the newly formed family? The family expecting its first child? A family with pre-school, school age, or adolescent children? What happens if the family seems to be trying to accomplish multiple tasks simultaneously? Groups should report their ideas to the class and be prepared to respond to questions from their classmates.

INTERGENERATIONAL TRANSMISSION OF FAMILY

HEALTH

Individual and family health is a concern that extends beyond a single generation. Genetically linked or inherited disorders may be of immediate concern or not realized until later in life. Options are now available for generic testing for many single-gene disorders such as Huntington's disease, Down's syndrome, and polycystic kidney disease. Genetic testing may be fraught with ethical questions and concerns about exploitation and misuse, but it also offers great possibilities for treatment and prevention of many conditions and diseases. Many unresolved questions still await answers, but the development of future medical technologies and completion of clinical trials hold great promise for the future with some intergenerational disorders.

Intergenerational Relationships

Family developmental processes, systems of knowledge, and beliefs over time have on-going affects on knowledge, beliefs,

and behaviors related to present and future health conditions. Functional processes of the individuals and family-subsystems residing within the household niche are affected by concerns such as individuation, family cohesion, member resilience, personal and family boundaries affect family's capacities and interactions with larger contextual systems. The interaction of the family membership within the household niche creates a family narrative that affects present and future generations. Member's collective memories affect functional processes internal and external to the household as past, present, and future events are interpreted and past recollections persuade meanings from generation to generation. The collective memory holds potential for present and future choices. In addition, embedded contextual systems provide formal institutions (e.g., government agencies, health care systems, religious organizations, educational settings) and informal structures (e.g., class, ethnicity, neighborhood, social networks) that influence age cohorts and generations.

Generations differ from one another and potentials for health and risk may be related to historical periods. For example, while many parents of today's "baby boomers" were neither born nor raised during the "great depression," their parents' were and carried the memory of fears associated with the time to children born in the late 1940s and early 1950s. Many "baby boomers" can

still recall parents telling them to clean their plate because children in China or some other nation were starving! Many “baby boomers” might respond that thankfulness was not what they felt, but instead they were willing to ship those leftovers to the starving children! The earlier generation learned to “save for a rainy day” and strongly believed that if you did not work you should not eat; maxims taught to the parents of “baby boomers” were in turn taught to the boomers. However, the embedded context provided more relevant messages to the children of the ‘60s and ‘70s than those of grandparents or parents as the “baby-boomers” came of age in a time of opportunity and opulence. This generation eats at fast food restaurants and silently disposes of children’s uneaten food into the trash bins with nary a whisper about starving children in distant lands. A cultural context that encourages spending, materialism, and debt has convinced “baby-boomers” that the present is important and many have not saved for retirement. Human development occurs within a context of time, culture, and history that gives meaning to beliefs and practices. While older generations feared infectious disease and used quarantine as a means for coping, today’s families fear violence and the effects of media and social pressures on children’s’ choice to use drugs, alcohol, or smoke. Children encounter life filtered through the

experiences of prior generations and then parent in ways that respond to these earlier events.

A life course orientation emphasizes trajectories, transitions, and timing that influences not only the present generation, but connects the past with the future (Elder, 1995; Moen & Erickson, 1995). Developmental processes have been extensively studied in children, but less is known about adult developmental processes or how they provide latent influences across generations. Although generations are greatly influenced by family of origin factors, they are equally affected by contextual experiences and serendipitous circumstances. Valuing of developmental processes from birth through death entails re-thinking influences and meanings on members' roles, relationships, responsibilities, and functions. While much is known about parental influences on child development, less is known about the ways adult children continue to develop and influence the developmental processes of their peers and aging parents or how grandparents influence development of grandchildren or grandchildren affect grandparents. As the "baby boomers" become the 'elder boomers,' much about health potentials and *health constraints* is yet to be learned. Health constraints are forces imposed by persons, structures or systems that impede, restrict or

inhibit processes of becoming, health, and well-being that intergenerationally affect individuals and families.

Intergenerational Interactions

Social class, culture, ethnicity, family economics, and education are often cited as factors affecting individual status, but the implications are less often considered across generations. For instance, in the Appalachian culture, many families have close ties to immediate family and extended kin networks (Denham, 1997). These ties tend to be closest when members live near one another, have the life-long opportunity for regular interaction, share similar educational background, employment status, personal interests, and have similar value orientations. However, a person of Appalachian heritage may discover that while aspects of heritage are retained, college graduation, marriage, and employment in a high-technology position in a large city could well mean that ideas from childhood are less meaningful in new contexts. A young male aspires to participate in the Olympics, but finds himself far from home in a social context very different from his family of origin and shares peer interactions in sharp contrast to friends at home. A young female becomes a parent and gains new understandings about her mother and parenting activities that creates harmony and communication in sharp contrast to what was experienced during the teen years. Life's disruptions and changes foster new directions

or opportunities that may affect intergenerational interactions with potentials to alter health.

Earlier generations make important contributions to family health histories and the ways families define and practice health. Intergenerational relationships hold keys to genetic and health heritage, knowledge about where reservoirs of support exist, facts about stress and coping, and particulars about resilience, hardiness, and well-being. A family genogram might provide keys to complex inherited patterns intergenerational related to member concerns and timing of events. An eco-map can provide data about family relocation, residences, social networks, employment, and other data about environment and contextual influences over the life course. A socio-map could provide facts about peer groups, supportive resources, and threats occurring over a lifetime. The Family Health Model encourages nurses to think about the usefulness of intergenerational data for understanding and intervening in family health.

Unnumbered Box 9.3
Cooperative Learning

Each person should think about their family and identify 3 to 4 traits that have been passed on in their family; identify personal traits linked to parents and previous generations. One trait should be related to physical appearance, one genetic, one personality, and one a food preference. After everyone has had time to identify the traits, have students list them on the board by category.

When everyone has listed their traits then have a class discussion about patterns of intergenerational transmission. What happens when children are adopted and do not know anything about their

parents? What about children who are conceived through artificial insemination? How do families use information related to their heritage? What information is useful for families to know? What information would be helpful for family nurses? How can nurses use information about prior generations in family-focused care?

SUMMARY

More needs to be known about the ways family function and contextual systems interact across generations to affect health processes. Greater understandings are needed about functional determinations influenced by the household economy (e.g., child-care, child poverty, employment patterns, health service utilization) versus those perpetrated by the household context (e.g., employment opportunities, legislative mandates, community resources). What are the key influences of family function related to health? In what ways can nurses collaborate with families to potentiate the household production of health? How do multiple generations impact and influence health processes? The Family Health Model provides nurses with ways to conceptualize practices that include household and intergenerational perspectives of families.

Test Your Knowledge

1. Describe what is meant by the 'household production of health' and give an example that suggests how nurses might intervene.
2. Explain 2 ways that the family household can potentiate health and 2 ways that it might introduce negating factors.
3. Discuss how a nurse employed in homecare or a community health setting might use an idea about the 'household production of health' as a way to assist a patient.
4. Identify what is implied by the idea social construction of health.
5. Select an ecocultural domain and compare and contrast ways nursing practice might differ with a newly married couple, a family with two school age children, parents sending their last child off to college, and a family facing the retirement years.
6. Parents who are concerned about risk for Down's syndrome in their newly conceived child are seeking guidance about what to do. As the nurse working with them, how would you counsel them? What family interventions would you suggest?
7. How does the idea of intergenerational transmission of health factors potentially affect the 'household production of health?'

Figure 9.1
Social construction of family health (see fax)

Figure 9.2
Ecocultural domains of the family microsystem (See FAX)

LEGENDS

FIGURE 9.1

The social construction of family health can be viewed as a summative response to functional and contextual factors.

FIGURE 9.1 TEXT

Family health definition
Family health practices
Social construction of family health
Normative accommodation
Family routines
Health producing
Health sustaining
Health regaining
Non-normative accommodation
Family routines
Health depleting
Illness producing
Risk increasing
Dyadic/triadic relationships
Environmental niches
Family function
Ecocultural domains
Family context
Microsystem
Mesosystem
Exosystem
Macrosystem

FIGURE 9.2

LEGEND

Ecocultural factors are themes that families use to organize daily behaviors and family health routines.

TEXT

Child Care Tasks
Caregiver Roles
Role Relationships
Child Play Mates
Sources of Family Information
Family Workload
Family Economics
Access to Health Services

Home/Neighborhood Safety
Social Support
Cultural Influences
Community Influences
Mesosystem
Exosystem
Macrosystem