

## **Chapter 10**

### **CORE PROCESSES AND FAMILY HEALTH**

**Content Outline**

**CAREGIVING**

**CATHEXIS**

**CELEBRATION**

**CHANGE**

**COMMUNICATION**

**CONNECTEDNESS**

**COORDINATION**

**Chapter Objectives:**

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

- Define the seven core functional processes associated with family health.
- Describe the core functional processes and give examples about how they affect family health.
- Identify ways the core functional processes can be used to increase the household production of family health.

*This chapter provides way to think about the functional aspects of family health and identifies ways to employ conceptual ideas into practice. The intent is to provide the nurse with some approaches for thinking about how to consider nursing practice in ways that tangibly address relationships between functional perspectives and health status. In the author's research, findings indicated that families used seven functional processes to incorporate information, values, and beliefs into behaviors, activities, and routines relevant to family health. These concepts are described and examples provided to identify ways they are applicable to family practice.*

Nurses have many ways to think about functional status from previous learning and prior experiences that are applicable to family-focused practice and family health. The goal of nursing is to assist family members optimize processes of becoming, health, and well-being. *Optimize* implies to make as effective or functional as possible. Family-focused care targets actual problems and *health potentials*. Health potentials are inherent aptitudes within individuals, family sub-systems, families, and the embedded contextual systems to increase capabilities and maximize knowledge, space, time, and resources. Health potentials are targets related to goal accomplishment, family identity and themes,

and health routines. Other concepts meaningful to family outcomes (e.g., hardiness, resilience, self-efficacy, cohesion, maturation, individuation, stability, perseverance) are also pertinent to family health.

Nurses' roles are to assist family members interact in ways that optimize abilities and contextual resources as they accommodate life course experiences that affect members' processes of becoming, health, or well-being. Across the life course, families use functional processes to address actual problems, minimize risks associated with health concerns, and maximize health potentials. Several assumptions have been identified that posit nurses can collaborate with families in many ways to produce optimal health outcomes for all members (Box 10.1). *Core processes* (i.e., caregiving, cathexis, celebration, change, communication, connectedness, coordination) is the conceptual idea that describes concepts germane to family's functional status and health that nurses can target as they collaborate with families and others to realize family health potentials. A subject, from one of the family health studies, nicely described some concerns related to functional status and family health also identified by others:

The first thing I would think of would be an emotional state of affairs of the family. I would think of particular medical-physical problems, 'cause to me family health would be a unit of the family and how they are working with each



that are rather consistently adhered to for extended time periods. The dynamic quality of member interactions and potentials for constructing needed accommodations in these routines provides an explicit target for family-focused interventions.

Thirdly, member interactions involve complex networks of embedded systems beyond the immediate boundaries of the household niche. Family members may not be completely aware of reasons for specific health routines and may have conflicting purposes for continuing, altering, or adhering to them. Members may differ in their valuing of processes and behaviors for attaining goals even when the family as a whole agrees that a goal is desirable. Therefore, nurses may need to intervene in different ways with multiple family members to attain desired goals. A family-focused intervention may need to be aimed at agencies, institutions, or persons outside of the family to achieve a family goal. For example, as a result of a degenerative disease a family member becomes blind. The family may agree that the member needs to attain the highest level of independence possible and may be willing to work with the blind member to facilitate learning skills that enhance self-efficacy. However, the family may be greatly impeded if they have no knowledge about services for the blind, have limited information about adaptive devices the blind might use to accommodate losses, and lack financial resources for

obtaining services or devices. Family-focused care implies assisting the family to develop routines that support goal accomplishment. Therefore, nursing interventions may include contacting Services for the Visually Impaired to ascertain if the blind member qualifies, assist the family to identify safety risks associated with blindness, and set up a plan of care that addresses needed changes in family health routines. The plan of care would engage act multiple members and probably require several interactions before goals were completely realized.

Family-focused care implies assisting families to: (a) reduce health risks; (b) maintain optimal levels of wellness; (c) develop routines and achieve goals that enhance processes of becoming, health, and well-being; (d) accommodate changes that maximize health potentials; (e) support family members through normative and non-normative life experiences; and (g) enable family members to obtain information, resources, education, counseling, or other forms of support that enhance health routines. Although nurses might already possess some knowledge and skills related to functional status, it is posited that the core processes provide a foundation for assessing, planning, implementing, and evaluating care specifically linked to health.

Table 10.1 provides an overview of the core processes and identifies potential areas where the nurse might interact while providing family-focused care. Core processes are enmeshed, thus it is often difficult to consider one process without also addressing others. Nurses that understand these processes can use them to impact family interactions, support family needs, and use them to assist families construct health routines that meet family goals.

<<<<<<<INSERT TABLE 10.1>>>>>>>

### **CAREGIVING**

A growing body of evidence about caregiving shows that nurses and others have a keen interest in relationships between caregivers and illness needs. As decreased length of stay continues and reimbursement systems to pay for some forms of care are increasingly limited, needs for family members to care for ill, disabled, and dying members at home will most likely escalate. Needs of those with chronic illnesses place great demands upon caregivers, who are primarily mothers or female. The terms caregiver burden and caregiver strain have been used to describe difficulties associated with meeting long-term care needs. The terms informal versus formal caregiver have been used in the literature to differentiate between professional and family caregivers (Fletcher & Winslow, 1991). If health is viewed from household perspectives, it is family who are the care providers

across the life course. For most families, it is only when the safety net of family support for caregiving fails that other systems are sought.

In the Family Health Model, *caregiving* is defined as a concern for other family members generated by close intimate relationships and member affections that results in watchful attention, thoughtfulness, and other actions aimed to support members' development, health, and illness needs. Family-focused care implies having knowledge about variations in caregiving needs and intervening in ways appropriate to meet these variant needs. When family health was studied, caregiving was identified as a functional role with a number of associated tasks:

- Manage member's genetic and biophysical heritage.
- Support and sustain member's health.
- Avoid or reduce health risks imposed by the family context.
- Instruct and guide children into healthy behaviors.
- Provide opportunities for family fun, relaxation, and stress reduction.
- Care for member's illness events.
- Enforce family values related to health.
- Obtain supportive resources from the embedded context. (Denham, 1997, 1999a, 1999b, 1999c)

Focus on assessment of caregiving tasks could assist nurses to plan care for needs of multiple household members.

For example, families with ill members may need much support. Over the last few decades, studies about chronic illness in children have increased understanding about needs related to normalization of the illness experience (Deatrick, Knafl, & Walsh,

1998), coping with critical periods of the illness (Clements, Copeland, & Loftus, 1990; Gallo & Knafl, 1998), and identification of adequate support systems (Cohen, 1997). Parents with developmentally delayed children experience a great sense of burden as they cope with children that have severe conditions or functional dependence (Mahoney, O'Sullivan, & Robinson, 1992). Evidence exists that families with the greater needs may have less support available to them (Greenberg, Seltzer, & Greenley, 1993; Leonard, Johnson, & Brust, 1993) and that family caregivers' support needs vary over time (Greenberg, Seltzer, & Greenley; Ray & Ritchie; Teisler, Killian, & Gubman, 1987; Youngblut, Brennan, & Swegart, 1994). Families with members that have extensive caregiving needs face a contextual environment with competing social demands, parental needs, and financial concerns (Turner-Henson, Holaday, & Swan, 1992). Differences between the ways mothers and fathers of developmentally disabled children adapt have been noted; mothers' emotions seem more like chronic sorrow and fathers' reactions are more closely aligned with resignation (Mallow & Bechtel, 1999). The greater the dependency needs for a family member, the greater the needs for broad contextual support at certain time points during the life course (Gallo & Knafl, 1998; Hilbert, Walker, & Rinehart, 2000; Walker, Hilbert, & Rinehart, 1999). Persons that provide caregiving

assistance generally have some level of personal satisfaction and feelings of self-worth linked to the experience (Hilbert, Walker, & Rinehart; Ray & Ritchie, 1993). Clinicians concerned about the burdens of caregiving on the household production of health should consider how family-focused interventions could assist members to optimize time, energy, and resources.

Little in the literature specifically addresses the effects of long-term caregiving on parents of disabled children (Hilbert, Walker, & Rinehart, 2000) and less is known about the caregiving tasks associated with well families; both areas appear meaningful for considering family-focused interventions. A surprising finding in the family health research was that families viewed as well families by health care providers often had members with chronic illnesses or disabilities (Denham, 1997, 1999a, 1999b, 1999c). Assumptions that *well families* have no ill members appear to be erroneous. Increased technological capabilities, medical knowledge, and surgical skills mean that more households have members that require continual or special caregiving. Mothers usually have the primary responsible for caregiving, but others also participate. In well families where mothers were the caregivers of young children, mothers often described bio-physical and mental health concerns (Denham, 1997, 1999a, 1999b, 1999c). The Family Health Model encourages clinicians to view caregiving as

an active accommodation that family members use to assist one another with changing needs over the life course. Nurses need to carefully address caregiving tasks associated with the household production of health.

**Unnumbered Box 10.1**  
**Cooperative Learning**

Divide the class into three groups. One group will focus on caregiving in well families, a second group will focus on caregiving in families with a chronically ill adult, and the third group should consider caregiving in families where a child has physical disability. Each group should identify someone to record key discussion points to later report to the larger group. Groups should answer the following questions:

- What are the unique caregiving concerns?
- What family aspects might a nurse want to assess?
- Who might be affected by caregiving demands?
- How do caregiver's needs differ from those of other family members?
- How might the nurse provide family-focused care?

After groups discuss their answers, they should report conclusions to the class.

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**CATHEXIS**

The term *cathexis* refers to the emotional bonds that develop between a person and those cared about as the developing person invests emotional and psychic energy into the loved one (Rando, 1984). This behavior has also been referred to as the development of affectional bonds or attachments that initially occurs between child and parent and later between adults that results in persons seeking to be near or close to a preferred individual and results in:

- Behaviors mediated by goal-oriented behavioral systems.
- Intense emotions that affect formation, maintenance, disruption, and renewal of attachment relationships.
- Keeping persons in touch with their caregivers.
- Caregiving being viewed as a complementary function of attachment.
- Providing a biological function related to reproduction.
- Deviant behaviors when interrupted or disturbed, especially during infancy, childhood, and adolescence. (Bowlby, 1980)

In the Family Health Model, cathexis refers to the warmth, love, and regard developing persons within a household experience and provide for one another and an essential aspect of emotional well-being. Cathexis can also refer to intellectual and affective energy invested in objects or ideas that might be actualized as healthy activities, but are also risky or unhealthy. For instance, the term fanaticism or even obsession is sometimes used when persons become too attached to objects, activities, and sometimes persons. While many have said that one cannot love too much, extremism in any form may have potential to increase risks.

Individuals work hard throughout life to form attachments, while the inevitability of loss looms on the horizon. As American families have had smaller numbers of children and some wait until much later in life to have the first, parental investment in attachment processes can be profound. Today's parents often make major life investments as they bond with their children and loss can be devastating. For example, life in a society that says problems can be solved means some would-be parents may invest

great amounts of time, financial, and emotional resources in attempts to artificially conceive a child. Although technology enables the process, finances may be an impediment when conception does not occur after several tries. While medical treatment is often effective in curing childhood cancers, the loss of a child is a great source of sorrow for many years. Grief and loss can become the unexpected or non-normative experience that results from the normative experience of attachment in families.

Decathexis is a term often used to discuss the disconnecting or disentangling needed when one is grieving the loss of a close attachment. When the decathexis results from grief associated with death of a loved one, the concern is detaching and modifying emotional ties so that new relationships can be established (Rando, 1984). Other forms of decathexis occur when persons divorce, separate, relocate to new communities, lose a pet, accept new employment positions, see a child off to college, witness the marriage of adult children, or experience social withdrawal of close friends when serious illness occurs. Decathexis is rarely a simple process and in cases other than death often mean leaving the past and establishing new relationships. Worden (1982) discussed four tasks of mourning when death is the reason for the loss:

- Accept the reality of the loss.
- Experience the pain of grief.

- Adjust to an environment in which the deceased is missing.
- Withdraw emotional energy and reinvest in another relationship.

Other losses may evoke similar needs as healing occurs when the grieving person is able to think about the loss without great pain, but retains a powerful long-lasting sense of sadness.

The Family Health Model assumes that persons experience attachment and loss in many ways other than death. Family-focused care aimed at cathexis might initially identify attachments viewed as health potentials. However, because persons are severed from things they attach to over the life course, care must also target decathexis and assist families to achieve balance between the two.

Tasks that might need to be addressed, are things such as:

- Acquire new roles and skills.
- Make room for a world without the person, object or idea in it.
- Redefine one's identity so that it embraces the memories tied to the loss.
- Accept therapeutic changes in the life course.

The term chronic sorrow has been used to describe losses suffered by persons afflicted with a chronic illness or disability and also the grief experienced by their caregivers. Chronic sorrow continues in cyclical patterns of strong emotions and periods of calmer emotions with feelings of intensity that accumulate with new losses and resurge as old losses are recalled (Lindgren, 2000). Meanings of loss may differ depending on the type, age of persons experiencing the loss, and the developmental stages when the loss

is experienced. As a parent of a child that developed juvenile diabetes at the age of 11 years, the losses felt by my daughter and myself have been different. While she grieved losses resulting from the ways her disease management made her different from her peers and created a severe self-consciousness during puberty, my response was more associated with fears related to her brittle condition and future complications with life consequence. Now at 34 years of age, she has severe neuropathy, Charcot's Syndrome, hypertension, chronic renal failure, and blindness. The loss of her sight, the necessity to have dialysis three times a week, and an even more stringent needs for medical management has awakened new forms of sorrow in us both that are very different from those experienced several decades ago. However, although we both live with feelings of chronic sorrow related to her conditions, we experience it in different ways.

Using family-focused care nurses can assess the cathexis-decathexis processes of family members to determine the relevance to health concerns. The attachment-loss experiences of family members are often deep-seated normative functions with potential to affect members' processes of becoming and well-being. When the processes are uncomplicated, individuals and families experience normal loss responses (Bowlby, 1980, Parkes, 1972; Zisook & Lyons, 1988). Although painful and difficult, the loss

experience has somewhat predictable cycles unique to individuals and families. Persons need nurturance, emotional care, and understanding from supportive others throughout the life course. If family members are unable to attach in meaningful ways or fail to provide adequate support during times of loss, it is posited that the functional capacities of the family are threatened and a need for family-focused care exists. Although family members often say that members provide their greatest support whenever loss is experienced, careful assessments may indicate that the support may be less beneficial than reported. Within households, it is likely that several members are coping with issues similar issues simultaneously and differences in their unique coping processes may be a source of misunderstandings with the household and be an area where family counseling is needed.

Medical management or prescription treatments may occasionally be needed to cope with deep emotional pain, but use of drugs should not be the primary way to respond to normative processes. When used, drugs should be short-term adjuncts to other therapeutic interventions. However, when non-normative cathexis-decathexis responses or what might be identified as inappropriate attachments or complicated grief occurs, then the family may need supportive care beyond what a generalist nurse can provide. Inappropriate attachments may occur when persons have mental

illness, mental disabilities, personality disorders, abuse substances such as drugs or alcohol, or participate in abuse and violence. Some incidents may be reportable to law-enforcement agencies or referable to other mental health providers, service agencies, or health care institutions. However, nurses may still be able to provide family-focused care to some family members as they work to meet health goals. Nurses that work with families with problems of complicated mourning must have knowledge and skills to intervene with the associated psychological, behavioral, social, and physical symptoms. Syndromes related to complicated mourning include absent mourning, delayed mourning, inhibited mourning, distorted mourning, conflicted mourning, unanticipated mourning, and chronic mourning and often require professional help (Rando, 1993). Inadequate treatments of complicated grief can result in physical and emotional symptoms with long-term health consequences.

### **Unnumbered Box 10.2**

#### **Reflective Thinking**

Think about your life experiences. What kinds of attachments have you in your lifetime? Who are the family members with whom you are closely bonded? What about friends? Have you had other experiences of close attachment, maybe a pet, a place, or some special objects?

Have you experienced the loss of someone to whom you were closely attached? What was this loss experience like? Have you ever had an experience of loss of some pet, object or some other meaningful thing? Were your experiences the same or very different? Recall your losses; are your feelings different now than when they first occurred? Do you have any unresolved losses?

Think about your roles as a nurse. What kinds of assessment of attachment-loss have you done with patients? Can you think of times when they might have been appropriate? What therapeutic interventions might you consider related to attachment-loss that might assist families with their household production of health?

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## **CELEBRATION**

*Celebrations* have existed from the earliest of times and are used to observe life cycle events, family milestones, cultural and ethnic heritage, gender differences, religious beliefs, holidays, special member events, seasonal events, etc. In the Family Health Model, celebrations are defined as tangible forms of shared meaning where family celebrations, family traditions, and family leisure commemorate special times, days, and events to distinguish them from usual daily routines across the life course. Celebrations enable intergenerational transmission of symbolic actions that signify the passing of time, provide reflective points for reminiscing about the past, enable families to share narrative histories, transfer customs and practices from one generation to another, and afford opportunities for meaning-making. Celebrations embrace the past, present, and the future; the tenuous and the tenacious; the contiguous and the distant; the unknown and the transcendent; and continuity and change. Celebrations capture imagination, respect history, and impress humanity with their transitory existence. Symbols are often used in conjunction with

celebrations to express ideas, values, allegiances, emotions, relationships, and aspirations.

Celebrations include formal celebrations, family traditions, and family leisure and are times when family members have occasions that differentiate the usual customary rigors of daily life. *Formal celebrations* have prescribed aspects with expectations that former behaviors will be repeated and used to commemorate meaningful events tied to family identity (e.g., birthdays, anniversaries, weddings, holidays, family reunions, religious practices). Formal celebrations usually involve extended family members and close friends and take extensive member commitment, planning time, and are costly. *Family traditions* are viewed as formally organized family times like vacations, weekend getaways, camping trips, attending children's athletic events or special-interest activities, and other events characteristic of a particular family. Traditional patterns may include special family entertainment, leisure, play, exercise, and recreation that provide family members opportunities for casual interaction, relaxation, laughter, fun, pleasure, and enjoyment. Traditional activities often provide memorable experiences, but require planning time, organization, money, and may occur away from home. *Family leisure* is defined as informal usual home-based activities that have minimal costs connected, but provide multiple members

opportunities to interact in casual relaxed ways as they participate together. Examples of leisure activities might be such things as game playing, watching television or home videos, gardening, or cookouts.

Celebrations are unifying events for families important to family identity, themes, and goals that can be linked to health outcomes. The Family Health Model suggests that families need to be encouraged to participate in wellness or health promoting activities that encourage relaxed times together, foster dyadic and triadic relationships, and provide renewal experiences. Family self-care has been defined as “a specific approach to clinical practice that recognizes the uniqueness and strength of the family constellation and places primary emphasis on the family’s ability to promote and protect health” (Gray & Sergi, 1989, p.69). Therapeutic intervention aims to provide support for family members so that high levels of functioning can be attained, psychological difficulties can be prevented, and normal adjustments to health crises can be anticipated (Danielson, Hamel-Bissell, & Winstead-Fry, 1993). Family-focused care aimed at family therapeutics would include celebration, tradition, and use of leisure time. Increased automation, mechanization, and technology have reduced labor at home and work, while wide availability of transportation of transportation and economic resources have made

leisure a primary focus for many American families. Appropriate use of leisure time can provide common goals that are strengthening and can be measured as outcomes, but can be threats and divisive if they separate members for extended time periods (McGowan, Delamarter, Schroeder, & Liegler, 1989, p. 217).

These authors suggest some concerns that nurses might consider in leisure care:

- Who will be involved?
- When will the activities occur?
- Where will the family go? What will they do?
- Why does the family want to participate?
- How is the able to provide for activities?
- What costs are associated with the activities?

Families with less time and fewer resources may need more assistance in planning therapeutic family celebration. Family-focused care encourages nurses to be creative in assisting families to use leisure as means to potentiate health.

Celebration brings an air of expectation, the possibility of reprieve from the toils and stresses of daily life. Celebration is a time of reprieve from the usual burdens associated with life, a chance to be rejuvenated. Celebration means that the despair sometimes experienced in the mundane and commonplace can be temporarily set aside and substituted with hopefulness. According to Miller (1986),

Hope is a state of being, characterized by an anticipation of a continued good state, an improved state or a release from a perceived entrapment. The anticipation may or may not

be founded on concrete, real world evidence. Hope is an anticipation of a future that is good and is based upon: mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose, and meaning in life, as well as a sense of “the possible.” (p.52)

Miller (2000) identified three levels of hope: (a) superficial wishes, (b) hope for relationships, self-improvement, and self-accomplishments, and (c) hope for relief from suffering, personal trials or entrapment. Family-focused care allows nurses to view these areas as important primary concerns for processes of becoming and well-being. Celebration contains essences of optimism, expectation, and anticipation often associated with hope. Bringing the fragrance of celebration into everyday life experiences may create balms of meaning that can decrease the stress, anxiety, despair, and anguish that too often accompanies the human experience.

Family-focused care could include the use of healing rituals, self-created celebrations generated to cope with and transcend life’s troubling dilemmas, debilitating conditions, and prolonged sorrows. Healing can be defined as “something that facilitates movement toward wholeness, suggests the impossibility of separating what is mental, from what is physical, and from issues that appear to be spiritual in nature” (Achterberg, Dossey, & Kolkmeier, 1994, p. 9). Healing rituals are forms of mind-body treatments that make one whole. Rituals are a form of

empowerment that enables one to get in contact with their spiritual being; a way to integrate mind, body, and soul and transform usual events into sacred moments (Biziou, 1999). Families can create ritual behaviors that are meaningful ways to connect to others, find emotional healing, enhance creativity, usher in new life stages, and acknowledge daily routines (Biziou). Rituals include specific formulas for action, encourage positive family interactions, evoke a sense of transcendence, and empower one to care for self and others. Families of origin that do not include the use of rituals or minimize the values of celebration may fail to inspire their descendants with ideals about creation and continuance and those that have minimized the use of celebrations throughout their life course may require assistance in creating meaningful rituals (Imber-Black & Roberts, 1992). The Family Health Model recognizes that celebration is an area not often emphasized by nurses, but one that could be used in family-focused care to enhance family functioning and promote health promotion and disease prevention.

### **Unnumbered Box 10.3**

#### **Critical Thinking**

Some say that divorce is one of the most difficult experiences in a life experience. Take some time and think about how you might assist a family to create a divorce ritual that is meaningful, one that will help the healing process. What would the ritual include? What would occur? When would it happen? Who should be there to participate? What things are needed to create the ritual? Is it something that is done once or something that needs to be repeated?

After you have constructed your healing ritual, share it with others. Perhaps the class could work together and write a paper or prepare a resource that others might use related to healing rituals.

How do you personally feel about this experience? Do you think divorced families might benefit from healing routines? Is this something you might use in family-focused care?

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## **CHANGE**

Change is an individual, family, and societal phenomena that occur on a moment-to-moment basis and over extended periods. It happens spontaneously in a moment and takes a lifetime to occur. Change is desired and dreaded. Change is enduring and temporary. Change is both predictable and unpredictable. Change begets change. Change can create personal awareness and feelings of complete oblivion. Change occurs on its' own and is provoked by others. *Change* is defined as a dynamic non-linear process that implies altering or modifying the form, direction, and outcome of the original identity by substituting alternatives. Within a family, one member can change or be affected by changes with only small impact on the family as a whole, but some changes affecting individual members intensely affect the entire household.

Change is most productive when it is aligned with individual and family goals. According to Prochaska, Norcross, and Diclemente (1994):

Change has remained enigmatic, and none of the several hundred different therapies can effectively explain just how



chose change techniques dependent upon the situation's demands. These researchers identified six predictable and well-defined stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination.

Family-focused care begins with assessment of the stage of the change process for individuals and families. Although stages are progressive, it does not mean that persons cannot fall back into an earlier one and progression through one stage does not necessarily lead to the next.

Although some persons are highly motivated towards creating positive change, many require assistance to initiate or maintain change. Techniques such as conscious raising, reframing, goal setting, thought stopping, relaxation, and stress management can be assistive in making changes. Wright and Leahey's (2000) suggest these ideas about change:

- Change is dependent on the perception of the problem.
- Change responds to interpersonal, intrapersonal, and contextual influences.
- Change is dependent upon contextual restraints and resources.
- Change is dependent upon coevolving treatment goals.
- Change is not the result of understanding or knowledge.
- Change is not a process that occurs equally in all family members.
- Change is a major reason for family nursing to occur.
- Change is a co-variant process based upon family's readiness and nurses' abilities.
- Change is influenced by variables beyond either the family or nurse control.

The Family Health Model implies that nurses can target change processes as a functional family aspect to accommodate alterations related to meeting health goals.

## **COMMUNICATION**

Communication modes differ widely from family to family, but all use various forms to transfer information within the household and between the household and embedded contextual systems. Communication is the way emotions are expressed and ideas, knowledge, skills, and concerns related to health are transmitted. In the Family Health Model, *communication* is defined as the primary way parents socialize children about health beliefs, values, attitudes, and behaviors and convey information, knowledge, and actions applicable to health; verbal and non-verbal forms are equally meaningful. Communication is the nucleus of interactions and affects member relationships, roles, and responsibilities beyond the parenting years and across the life course. Families that use terms like ‘we’ and ‘us’ rather than ‘I’ may be viewed as healthier families, but all families have some communication needs associated with family health.

Mothers with young children often described teaching young children health related behaviors and suggested that various family and contextual forms of communication were used as reinforcement (Denham, 1997). For example, one mother said she

taught her preschool children about good nutrition by having them in the kitchen with her when she was cooking and showing them what would be healthy snacks. She described how close friends and extended family members reinforced her ideas. A grandmother caring for her young children said she had a place in the refrigerator and in a cabinet where healthy snacks were kept. She described how she thought children's visits to their mother's home threatened her teachings. Both mothers used a variety of communication techniques to accomplish health goals related to nutrition.

Communication is more than language acquisition, but it is tied to linguistic aspects acquired in the early months of life. At age 10 months, a low functioning group of infants could understand 10 words but say none of them, but a high functioning group could understand 150 words and say 10 words (Fenson, Dale, Reznick, Bates, Thal, & Pethick, 1994). At 16 months, lower functioning toddlers understood about 90 words and said about 10, while a high functioning group understood about 350 words and spoke about 180 words. However, early patterns may not tell the total story of language acquisition and may not always indicate future learning as children tend to be more individualistic in language development and do not necessarily parallel the group (Bates, Dale, & Thal, 1995; Bates, Marchman, Thal, Fenson, Dale,

Eznick, Reilly, & Hartung, 1994). Some children tend to be slow and steady as they develop language, while others experience bursts of expressiveness. A longitudinal study found that infants scoring higher in intelligence and having more social skills had parents that directed more language towards them (White, 1993). While parents influence early language acquisition, as children mature exposure to increasing numbers of persons and a larger society also influences language development.

Gender differences in forms of articulation, verbal interchange, and social interactions have been noted. However, differences in the ways boys and girls interact may be more like ends of a continuum rather than discrete dualism as girls choose play that involves talking and sitting together while boys roughhouse, threaten, and clobber one another (Tannen, 1998). Two recent books about the emotional lives of boys suggest that the family, institutions, and society places distressing expectations on boys to act macho, confident, and tough while they ignore an emotional abyss that is often disabling (Kindlon & Thompson, 1999; Pollack, 1998). While girls seem to be gaining voices as society empowers them, some boys may be emotionally crippled by gender expectations about ways to communicate feelings and express ideas. Pollack says, “we want our boys to be sensitive New Age guys and still be cool dudes” (p. xxv). What are the

relationships between communication and health? How does society influence communication patterns? What are the appropriate targets, goals, and interventions that need to be included in family-focused care to address processes of becoming, health, and well-being? The Family Health Model suggests that communication is an important functional aspect corresponding to health processes. Family-focused care requires that nurses be highly skilled in areas of communication to address individual, family, and group health needs.

**Unnumbered Box 10.4**  
**Coordinated Learning**

Get a partner and take turns sharing with one another about some personal experiences in your family when you thought that you were misunderstood. It might be something recent or something that happened a long time ago. How did you feel when it happened? What did you do? How do you feel about it now? What might you have done differently?

Have a class discussion about family communication and identify some areas where nurses might intervene. In what areas could nurses assess needs, plan intervention, and evaluate outcomes? How does family communication influence health processes?

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**CONNECTEDNESS**

Affiliations, associations, bonds, friendships, acquaintances, and relationships are all concepts relevant to connectedness. The ways individuals co-exist with peers, colleagues, neighbors, agencies, institutions, and helping others affects many life aspects including health. In the Family Health Model, *connectedness* is defined as the ways individuals are

committed and linked to family, educational, cultural, spiritual, political, social, professional, legal, economic, or commercial interests. Roles and responsibilities are often outward expressions of personal commitments, but provide tangible ways for nurses to discuss expectations about family relationships. Connectedness has to do with household boundaries and their modulation in response to needs for resources and supports over time, the division of labor related to family needs, and may indicate the degree of tolerance for ambiguity. Wright and Leahey (2000) suggest that careful observation of the connections within and between systems is an important nursing role.

In the family health research completed by this author, partner relationships and kin networks were primary indicators of the household production of health. Family connectedness implied ways members accepted tasks related to household needs and were open or closed to supports outside the household. Families that agreed to hospice services were open to ideas and services from a variety of multidisciplinary care providers and incorporated skills and knowledge derived into family routines (Denham, 1999b). Families with young children seemed willing to accept assistance from various providers referred to them by those who provided prenatal and well-child care (Denham, 1997, 1999a, 1999c). For example, a mother said:

My mother-in-law helps too! If she knows that we are trying to potty train or she knows it is time to start, she'll go ahead and start without me. Like I wasn't really thinking about my daughter being old enough at the time for her to begin wiping her own self, but my mother-in-law decided that she could do that.... and so she began! She was doing it downstairs and I said, "That's fine, we'll do it upstairs too." We work together!

In Appalachian families, it is common to find kin networks where members have daily or regular interaction. In this family, grandparents and great grandmother lived downstairs and the adult family with three youngsters lived upstairs. Information about who comprises the family network is a concern for nurses interested in providing family-focused care.

Friendship circles that evolve through peers, colleagues, alliances, clubs, gangs or other social networks are influential. The ways members connect with others inside and outside the family has potential to affect processes of becoming, health, and well-being. Friendships affect actions, knowledge, experiences, perceptions, behaviors, and emotions. Friendships can occur because of shared interests or expose new areas of awareness. Friendships that are health enriching or devastating may be time and content dependent. For example, a father in the family health studies thought that it acceptable his preschool age son to play with toy guns because that had been his own youthful experience, but the boy's mother believed it was not in her son's best interest. This

father described connections to persuade the mother it was a harmless activity:

I think she is going to give in now because I think it is about time for him to do that. All of his other friends are playing with guns... cowboys and Indians... and things such as that. I think she will relinquish here shortly!

Connections also have implications for the ways families are influenced and incorporate information into the household production of health. In the first family health study, a local public health initiative had focused on lead screening (Denham, 1997). Parents in 5 of the 8 families had been informed about lead risks, had taken their children to the health department for well-child care, and their children were tested. The influence of the media, school systems, public health agency, and others in the community had increased awareness about lead in these families living in older homes. One mother said:

There is one area that kind of scares me. There is a space underneath the house, they call it grandma's basement. There is a dirt floor in one area underneath an old porch, but it has been filled in some... but it then goes down into a very small basement area. Now that dirt area, the children like to play in it and I got rather concerned about lead poisoning and stuff. They were tested for lead at the health department. I don't know, probably a year and a half ago and they said that their lead levels were a little high.

Although a year had passed, this mother recalled what she had previously learned and continued to vigilantly monitor children's play. Connections pertain to family rules about boundaries. The Family Health Model suggests that nurses providing family-

focused care consider connections related to health as functional processes for assessment, intervention, and evaluation.

## **COORDINATION**

Coordination occurs when individuals cooperate rather than compete to accomplish goals and when family members have a sense of sharing in rewards or punishments. In the Family Health Model, *coordination* implies cooperative sharing of resources, skills, abilities, and information within the family and larger contextual systems to optimize health potentials, maximize the household production of health, and achieve family goals.

Coordination requires acceptance of diversity, presence and support during critical times of family need, and interaction with social entities outside the family's boundaries. Coordination promotes shared learning, but varies as members negotiate tasks, juggle time commitments, and differentiate between willingness and abilities to contribute. Coordination concerns members' loyalties to family ideals and rules and occurs when members unite to accomplish tasks.

Coordination needs may vary dependent upon things such as unique contextual circumstances, prior member and family experiences, and consensus about family goals. A perplexing dilemma in working with families is the difficulty some members might have in naming family goals or identifying important family

themes as these may be rather abstract notions embedded in behaviors. Another quandary is that sub-system interactions are often silently orchestrated and unconscious behaviors that members may have difficulty discussing. Another concern related to coordination has to do with the innate member traits that affect the ways time is used and activities are valued.

In the family health research, Appalachian families often worked together to accomplish health goals. Coordination was implied by who had what tasks and abilities to work together. Goals were accomplished when members shared beliefs and had strong filial attachments. For example, a teenage daughter had lived in her mother's home since her parents divorced, but some problems with her mother's boyfriend meant that she decided to move to her father's household, a blended family. The stepmother said:

Her lifestyle and our lifestyle are so different from where she was raised. That was hard for her to adjust to! There are rules here.

Coordination of daily tasks to meet health needs took a great deal of family cooperation to achieve common goals. Some family members discussed their inability to cooperate. For example, a mother in another family said:

I have a sister, and my husband says she tries to run my life. I think she does have a role on some of my decisions. She is supportive when it comes to the kids and stuff... to

health and things like that. She is always there for us, but a lot of other things she kind of sticks her nose in!

In a later interview, this same mother said this about her extended family:

You know, we live so close and they would be so controlling... I think we have a big stress factor there. They try to run our lives, especially when it comes to the kids. I'll tell the kids "no" and she'll... She's got one of these swimming pools... And I'll tell them they can't get in it. She'll allow them to get in it! They'll get in trouble 'cause I told them no or she'll give them junk food after I told them no.

Family coordination was inextricably linked to stressors internal and external to the home and this family was challenged by the problem solving needed to maximize the household production of health. The family had limited economic resources and counted upon extended family for transportation, childcare, and emotional support. Coordinating activities, retaining extended family supportive relationships, and limiting stress were major concerns for the family.

Coordination often plays out in decision making about daily activities. How do families decide what gets done and when? Who is responsible to do what? What gets done today and what gets left uncompleted or postponed? Families may be continuously shuffling among choices and possibilities related to conflicts between individual needs and needs of others. Families may lack experience, skills, knowledge, or resources necessary for coordinating the household activities. For example, if a working

mother has limited time, but the family thinks that it is important for school age children to be actively engaged in social activities, then how do parents maintain good nutrition for multiple members on those days when everyone seems to be going in different directions? Mothers may also be conflicted when coordinating demands that mean choosing between caring for self or caring for others. When family members are caregivers for chronically ill or dying members, they may have their usual tasks plus assume additional responsibilities. Coordination of multiple roles adds stress, tests coping skills, and can threaten health. The Family Health Model implies that family-focused care aimed at families' functional processes to coordinate demands relevant to daily living can threaten or potentiate processes of becoming, health, and well-being.

## **SUMMARY**

The core processes have to do with functional capacities of multiple member households and are intricately related to health. Family-focused care presents nurses with challenges as they strive to work with complex families to achieve goals relevant to members' well-being. While basic nursing education equips nurses with knowledge and fundamental skills relevant to family functional status, expert family nurses will require additional experiences, knowledge, and skills for working with the complex

interactions of families and their embedded contextual systems.

Although nurses may focus on family's core functional processes,

goals of care are aimed at outcomes related to family health. The

Family Health Model encourages nursing care that targets

interactional processes to accomplish family goals. Box 10.2

provides some propositions related to family's functional status

and health that can be tested through practice and investigated

through research.

<<<<<<<INSERT BOX 10.2>>>>>>>>

### **Test Your Knowledge**

1. Define and give an example of the core process of caregiving.
2. Define and give an example of the core process of cathexis.
3. Define and give an example of the core process of celebration.
4. Define and give an example of the core process of change.
5. Define and give an example of the core process of communication.
6. Define and give an example of the core process of connectedness.
7. Define and give an example of the core process of coordination.
8. Describe how core processes might be used to address family needs when a member smokes and risks related to second hand smoke are a concern for the premature infant.
9. Explain how core processes might be used to address family concerns about risks associated with genetic inheritance of Huntington's Disease.

**Box 10.1**

**Assumptions about nurses' roles and functional outcomes relevant to health**

- Nurses can collaborate with families to effectively transition from one social, cultural, spiritual, economic, political or physical spaces and increase health potentials.
- Nurses can collaborate with family members to use knowledge, space, time, and resources in ways that optimize health potentials.
- Nurses can collaborate with families to gain access to resources needed by members that are located in the embedded contextual systems.
- Nurses can collaborate with families to access social, cultural, spiritual, economic, and political information beneficial to health.
- Nurses can approach families in culturally sensitive ways and assist them as they incorporate health information and skills into routines that maximize processes of becoming, health, and well-being across the life course.

**Table 10.1**  
**Functional processes related to family health**

<b>Functional Process</b>	<b>Definition of the Process</b>	<b>Potential Functional Areas of Concern</b>
<b>Caregiving</b>	Concern for family generated from close intimate relationships and member affections resulting in watchful attention, thoughtfulness, and actions linked to member's developmental, health, and illness needs.	Health maintenance Disease prevention Risk reduction Health promotion Illness care Rehabilitation Acute episodic needs Chronic concerns
<b>Cathexis</b>	The emotional bond that develops between individuals and family as members invests emotional and psychic energy into the loved one.	Attachment Commitment Affiliation Loss Grief and mourning Normative processes Complicated processes
<b>Celebration</b>	Tangible forms of shared meaning where family celebrations, family traditions, and leisure is used to commemorate special times, days, and events to distinguish them from usual daily routines across the life course.	Culture Family Fun Traditions Rituals Religion Hobbies Shared activities
<b>Change</b>	A dynamic non-linear process that implies altering or modifying the form, direction, and outcome of the original identity by substituting alternatives.	Control Meeting expressed needs Meanings of change Contextual influences Compare and contrast Similarities and differences Diversity
<b>Communication</b>	The primary ways parents socialize children about health beliefs, values, attitudes, and behaviors and use information, knowledge, and actions applicable to health.	Language Symbolic interactions Information access Coaching Cheerleading Knowledge and skills Emotional needs Affective care Spiritual needs
<b>Connectedness</b>	The ways systems are linked together through family, educational, cultural, spiritual, political, social, professional, legal, economic, or commercial	Partnering relationships Kin networks Household labor Cooperation

	interests.	Member roles Family rules Boundaries Tolerance for ambiguity Marginalization
<b>Coordination</b>	Cooperative sharing of resources, skills, abilities, and information within the family and with the larger contextual environment to optimize individual's health potentials, potentiate the household production of health, and achieve family goals.	Family tasks Problem solving Decision-making Valuing Coping Resilience Respect Reconciliation Forgiveness Cohesiveness System integrity Stress management

**Table 10.2**  
**Change process techniques pertinent to family health**

<b>Process</b>	<b>Goals</b>	<b>Techniques*</b>
<b>Consciousness-Raising</b>	Increasing information about self and problem	Observations, confrontations, interpretations, bibliotherapy
<b>Social Liberation</b>	Increasing social alternatives for behaviors that are not problematic	Advocating for rights of repressed, empowering, policy interventions
<b>Emotional Arousal</b>	Experiencing and expressing feelings about one's problems and solutions	Psychodrama, grieving losses, role playing
<b>Self-Reevaluation</b>	Assessing feelings and thoughts about self with respect to a problem	Value clarification, imagery, corrective emotional experience
<b>Commitment</b>	Choosing and committing to act, or belief in ability to change	Decision-making therapy, New Year's resolutions, logotherapy
<b>Environment Control</b>	Avoiding stimuli that elicit problem behaviors	Environmental restructuring (e.g., removing alcohol or fattening foods), avoiding high-risk cues
<b>Reward</b>	Rewarding self, or being rewarded by others, for making changes	Contingency contracts, overt and covert reinforcement
<b>Helping Relationships</b>	Enlisting the help of someone who cares	Therapeutic alliance, social support, self-help groups

\* These are primarily professional techniques used by psychotherapists.

\*\*\*\* Need to get permission from Prochaska, Norcross, & Diclemente (1994, p. 33)

**Box 10.2**

**Propositions about relationships between functional processes and family health**

- Children that learn health values and behaviors in early life will continue many of these patterns over the life course.
- Families with dyads and triads that share health beliefs, attitudes, and behaviors will provide greater support for individual's health care needs than families who lack this congruence.
- Health interventions targeted at family dyads and triads will result in more optimal health outcomes than interventions aimed only at individuals.
- Interventions that target core family processes, family goals, and contextual systems will result in more optimal health outcomes than interventions aimed at solitary individuals.
- Families with intact core functional processes will describe more optimized processes of becoming and well-being.
- Families with well-functioning dyads and triads will have higher levels of well-being for individual members and greater health for the family as a whole.
- Health of individuals and families is increased when congruency exists between member abilities, family health goals, and supportive contextual systems.