

Chapter 14:
FAMILY THEORIES

Chapter 14 Content Outline

DEVELOPMENT OF FAMILY THEORY

Family Theories

USEFULNESS OF THEORIES

USEFULNESS OF NURSING THEORIES IN FAMILY CARE

SYSTEMS THEORIES

General Systems Theory

Family Systems Theory

The Framework of Systemic Organization

The Intersystem Model

Calgary Family Assessment Model

STRUCTURAL AND DEVELOPMENTAL THEORY

Comparing Structural Theory and the Family Health Model

DEVELOPMENTAL AND LIFE CYCLE THEORIES

Life Cycle Theories

Comparing Life Cycle Theories and the Family Health Framework

OTHER THEORIES USED WITH FAMILY NURSING

Symbolic Interactionism

Social Exchange Theory

Distance Regulation Theory

Feminist Theories

Chapter Objectives

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

- Describe the value and contribution of various family theories to nursing.
- Identify ways nursing theories that are applicable to family-focused care.
- Use a family systems perspective to understand family relationships.
- Identify ways life cycle frameworks and other family theories are used to understand family relationships.
- Compare and contrast the Family Health Model with other family theories.

DEVELOPMENT OF FAMILY THEORY

Start by doing what's necessary, then do what's possible, and suddenly you are doing the impossible.

Saint Francis of Assisi

Over several decades an expanding body of literature has grown to provide many perspectives about family. This text has described an ecological model to conceptualize a life course perspective of family health with contextual, functional, and structural dimensions. Nurses that aim to view family as the unit of care and practice as family-focused need some understandings about family theory. This chapter presents an overview of esteemed theoretical views by scholars from a variety of disciplines that have provided perspectives relevant to nursing practice and research for many decades. Although many nurse theorists have not emphasized the importance of family in their theoretical frameworks, many are still applicable.

It is vital that family theories relevant to nursing practice and research are uniquely related to a knowledge base that is distinctively nursing (Donaldson & Crowley, 1978). Many family frameworks used by nurses are not nursing models, but nurses have effectively used them. Gale and Vetere (1987) identified several criteria related to family theory development that suggest a basis for considering how family theories should look. They have suggested:

- Family theory should be clearly stated and identify relationships of key variables.
- Variables likely to influence family behaviors or events should be clearly specified and explained.
- The theory should identify family needs viewed as central features and describe ways to make them accessible, and available for self-report.
- Family conflict issues should be identified by source, type, and means for resolution.

- Family roles and functions should be described in terms of emotional impact, decision-making, socialization, and other salient factors.
- Various member perspectives should be recognized.
- Systematic exploration of members' explicit and implicit values and beliefs should be tied to belief structures of extra-familial structures and institutions.
- Families should be viewed over time from perspectives to differentiate predictable changes and stressors that impact developmental periods.
- Repetitive family behaviors should be made explicit.
- Family taxonomy needs to differentiate between acts and actions.
- Family interactions need to be described in terms of individual, dyadic, family, and larger group interactions.
- The family taxonomy devised should describe various family atmospheres and lifestyles; classify family behaviors, family events, and interactional sequences.

If this criteria is used to measure the adequacy of family theory then those critiquing the proposed Family Health Model will likely find gaps and areas that still need to be more fully fleshed out. However, the Family Health Model is not intended to be a comprehensive theory of family, but a framework to steer family-focused practice.

Family Theories

According to Gilliss (1991), theories used to attend to health and illness in family nursing are largely borrowed from other disciplines with the term individual often replaced with family, but the complex family unit and scope of nursing practice often not addressed. A theory is a set of propositions about defined and related constructs that describe the relationships among the variables in order to systematically describe the phenomena of interest (Kerlinger, 1986). Theory involves concepts closely tied to individuals, groups, situations or events and tries to explain

relationships between them (Fawcett, 1993). When ideas are less concrete, the ways phenomena are viewed and organized is sometimes referred to as a conceptual model. Conceptual models have some of the same components as theories, but are more loosely constructed and generally lack the propositions that identify the existence of relationships between concepts. For several decades, nurses have attempted to identify the knowledge that underpins family nursing and provides a foundation for practice. What theories do nurses use with families? How much of the knowledge taught in family nursing courses is derived from nursing research and how much is based upon borrowed theories? What about family health, do theories to guide practice exist? Which frameworks and theories provide the underpinnings needed to enable nurses to provide family-focused care? Many questions still need to be answered.

USEFULNESS OF THEORIES

Presently, family theories provide only weak explanations for behaviors and often lack needed empirical findings to demonstrate how variables should be measured and evaluated. Some suggest that evidence challenges strongly held ideas about the ways families are viewed (Cheal, 1991; Coontz, 1992, 1997; Silva & Smart, 1999). Theory must be formal, systematic, and operate at several different levels to be useful in understanding the complex range of behaviors and environmental relationships that affect families and family health. The usefulness of theory is based upon its ability to explain a wide range of relationships and

an ability to generalize them. In order for theory to be sensitive to today's families it must consider the inequalities found in their embedded contexts, things such as "oppression, racism, sexism, heterosexism, classism, ageism, ethnocentrism, and nationalism" (Allen, Fine, & Demo, 2000, p. 2). A family theory meaningful for educators, practitioners, and researchers must:

- Describe and explain family structure, dynamics, process, and change.
- Describe invariant interpersonal structures and emotional dynamics within the family and the transmission of distress to individuals.
- Account for the family as the interface between the individual and culture.
- Describe the processes of individuation and differentiation of the family members.
- Predict health and pathology within the family.
- Prescribe therapeutic strategies for dealing with family dysfunction.
- Account for the seemingly antithetical functions of stability and change, particularly when viewed within the family's developmental cycle.

(Vetere, 1987, p. 27)

In order for a theory to be useful in guiding family research, Vetere (1987) suggested questions to consider:

- Does the theory integrate and explain the available research data and generate a common research language?
- Does the theory operationally define purposive behavior and the dynamics of change?
- Does the theory specify the conditions under which the elements will be observed and determine how novel observations are collected in order to increase understanding about the underlying principles?
- Does the theory provide common units of measurement that allow cross comparisons of research at different systems levels? (p.21)

Theoretical frameworks organize thinking and give form to our understandings, but they are based upon different points of view. Mistaken

assumptions about conceptual constructions can result in practice that is ineffective in addressing family health concerns or results in using inappropriate or poorly chosen interventions. It is unlikely that a single theory can fully describe family or capture all of the variables relevant to family health. Some may assume that an eclectic theoretical viewpoint is needed to comprehend the many perspectives, worldviews, and paradigms of the world's families. While competing points of view might offer opportunities to explore diversity, it is possible that openness toward too many points of view can result in a schizophrenic perspective that is unable to guide practice or explain conflicting phenomena.

Theory is needed that enables practitioners to consider confounding variables pertinent to family health and ask questions that are aligned with nursing's scope of practice. For example, how does being old, Black, and having a physical disability differ from being young, Caucasian, Hispanic, or Asian, and having a physical disability? What member variables are affected by the embedded context? In what ways do interventions needed altered to meet needs of diverse family groups? How can practitioners best use family routines to optimize the household production of health for diverse family groups? What happens over time? At what points do theoretical frameworks assist ideas about practice to attain more optimal health outcomes?

Unnumbered Box 14.1

Cooperative Learning *****

Mark each corner of the room with one of four points of view (it may be helpful to make signs to place in each of the corners):

- Models and theory have little meaning and little use.
- Models and theory are important as part of education, but have little value in family nursing practice.
- Models and theory are important in education and family nursing practice, but I personally have little idea how to use them.
- Models and theory are important in practice and research and I want to learn how to make them practical in my own practice.

Ask students to choose the corner that best represents how they feel right now and go to that part of the room. When the groups have assembled they should choose a recorder. Ask them to make two lists: one that reflects how they feel and a second list that reflects the potential affects their feelings might have on practice.

After students have adequate time to complete the first part of the assignment, then ask them to identify which position least reflects their feelings or beliefs at the present time. Ask them to move to that corner of the room and again choose a recorder. They should create two lists: one that reflects how they feel and a second list that reflects the potential affects their feelings might have on practice.

When the groups have had time to complete the assignment, ask the recorders from the first round to report for their group and then have the reports from the second groups. Discuss similarities and differences in group responses and implications for family nursing practice.

USEFULNESS OF NURSING THEORIES IN FAMILY CARE

Fawcett (2000) has identified nursing's conceptual models as:

Johnson's Behavioral System Model, King's General System Framework, Levine's Conservation Model, Neuman's Systems Model, Orem's Self-Care Framework, Roger's Science of Unitary Human Beings, and Roy's Adaptation Model. Many nurse theorists responsible for the development of these conceptual models have updated their original ideas and more carefully addressed family and related phenomena. Educators, practitioners, and researchers have used these theories to better understand family perspectives. Some nursing models are discussed here.

Martha A. Rogers' *Science of Unitary Human Beings* (1970) focuses on beliefs about persons, energy fields, causality, patterns, homeodynamics (i.e., resonancy, helicy, integrality), well-being, and nursing. Roger's views nursing's role as promoting human betterment through focusing on the irreducible human being and environment as energy fields. When discussing energy fields, Rogers (1992) said that they "constitute the fundamental unit of both the living and non-living" (p. 30). Winstead-Fry (2000) has noted that several of Roger's ideas are quite consistent with the questions family scientists have been asking about predictability of patterns in healthy families, questions of normalcy, and concerns about family interventions and outcomes. She concluded that Roger's perspectives are helpful in viewing the chaos, change, disorder, communication, sense of rhythm, energy, and unpredictable patterns of families.

Rogers would be quite comfortable with an unconventional or unpredictable definition of normal. She did use the word harmony to suggest health at one point. If one needs a definition of normal, it would be probabilistic harmony between members of the family and between the family and its environment, manifested by patterns of behavior that is rhythmic but not repetitive. (Winstead-Fry, p. 278)

Rogers' ideas agree with many family scientists in the view that causality is not linear. Research is seldom able to account for more than 50% of the variance in a research study and Rogers' theory seems a helpful way to grasp the idea that "human behavior contains probabilistic and unpredictable, non-repeating elements that linear models cannot grasp"

(Winstead-Fry, p.279). It appears that much of what has been suggested in Roger's theory is consistent with current thinking about families and compatible with the Family Health Model being proposed.

Dorothea E. Orem's (1971) self-care framework focuses on individual needs and deficits, abilities to meet personal self-care needs and those of dependent others, and nurses' intentional actions to assist. Orem's model has been widely used by nurses in practice, education, and research. From Orem's perspective, self-care is learned within the family, family is the origin of self-perceptions, and members interdependently function to assist one another to meet needs. Orem (1995) stated:

The good of order is dynamic, leading individuals to consider how their own actions are conditioned by existent arrangements, including patterns of relationships, and how their own actions to fulfill desires conditions the fulfillment of desires of other. The good of order is viewed as an aspect of human intersubjectivity. (p. 166)

Orem identifies that a first step in provision of nursing care is problem identification, and a key part of this identification focuses on individual's self-care deficits. Next, the nurse is to find ways to assist in meeting stated goals that are often caused by lack of resources or a change in roles. Finally, the nurse assists the individual and supportive family members to overcome or compensate for deficits, limitations, and provides abilities that can assist the patient to overcome environmental restrictions and effectively use assets and agencies. Orem's framework encourages views of persons as biological and physiological beings with psychological responses. Orem's perspectives certainly have implications for family care

and provide ways to conceptualize individual member and family needs and consider environmental interactions.

Sister Calistra Roy's (1980) nursing model emphasizes the human adaptive system and the environment. The individual or family are continually interacting with various forms of stimuli and using a variety of behaviors to cope. The nurse's goal in using this model is to assess behavior and factors that influence adaptation and use of the four adaptive modes (i.e., regulator coping subsystem, cognator coping subsystem, stabilizer subsystem control process, innovator subsystem control process) as ways to contribute to health, quality of life, and dying with dignity. The nurse not only enhances adaptive abilities, but also aims to integrate environmental interactions by enhancing conscious awareness and choice (Roy & Andrews, 1999). Nursing intervention is a key aspect of this model and this often occurs as the nurse assists the individual or family increase, decrease, remove or alter environmental stimuli. Roy has expanded her theory of adaptation over the years to include what she calls veritivity and encourages use of the model with groups of persons in relationship with one another (Hanna, & Roy, 2001). Veritivity pertains to purposefulness of human existence, unity of purpose for humankind, activity and creativity for the common good, and meaning of life (Roy & Andrews). Roy's model has been used widely in research with families, as well as within clinical family practices (Hanna & Roy).

Rosemarie Rizzo Parse's Theory of Human Becoming has been referred to as grand nursing theory (Fawcett, 2000). Parse (1997b), in discussing the purpose of her theory stated that it was to be a "journey in the art of sciencing, a process of coming to know the world of human experience" (p. 32). Among the key terms used in Parse's theory are human becoming, meaning, rhythmicity, transcendence, cocreating, imaging, valuing, and languaging. Nursing's role is to be present with people while they cocreate quality of life based upon the family's unique perspective. Parse (1981) defined family as "the others with whom one is closely connected" (p. 81). According to Cody (2000), Parse's view of family "is unbounded by structural, functional, or systematic assumptions" (p. 281) and she does not propose a particular dynamic of family health, but instead views the process as cocreated as the family process is lived. Fundamental beliefs of this theory are (a) human and environment are mutually and simultaneously interrelating as a unity, (b) the human-universe-health process is more than and different from the parts, and (c) health is a continuously changing process (Parse, 1987). Parse's focus is a perspective of quality of life from the point of view of those living the life! "The nurse does not know what kind of family life would be comfortable or rewarding for the persons involved, but is there with persons of the family as they focus on the meaning of the family life situation, dwell with the ebb and flow of the family relationships, and reach beyond the now"

(Cody, 2000, p. 283). It seems that family-focused care is congruent with Parse's ideas.

According to Fawcett (2000), Watson's Theory of Human Caring is a middle-range theory. Watson originally wrote her ideas about nursing as a response to her beliefs that a clearer distinction was needed between the practice of nursing and ideas entrenched in medicine's paradigm of diagnosis, treatment, disease, and pathology rather than caring and health (1979, 1997). Key terms in the theory include carative factors, caring moment, transpersonal caring relationship, and caring consciousness. The theory emphasizes that humans are not objects, but possess a spiritual dimension uniquely linked to self, other, nature, and the larger universe. This humanistic theory suggests that caring is the essence or "core" of nursing is contrasted with the "trim" of nursing, "the practice setting, the procedures, the functional tasks, the specialized clinical focus of disease, technology, and techniques surrounding the diverse orientations and preoccupations of nursing" (Watson, p. 50). The theory has broad implications for nurse-family interactions.

Current development of nursing theory offers a variety of perspectives from which to conceptualize nursing science. While the focus of many theories has been on the individual rather than family or community care, many are now considering applications to family and community health. Nursing has taken some major steps forward in conceptualizing practice in terms of families, but the majority of nurses

continue to consider practice from an individual perspective. Family nurse clinicians, practitioners, and family nurse scientists prepared to address complex family health needs will be increasingly in demand.

Unnumbered Box 14.2 Cooperative Learning

Make a list of nursing theories from which the students can choose and then divide the class into groups of 3 to 4 students. Ask each group to select one of the theories. Groups will each prepare a presentation on the theory and focus on these points:

- Identify how family is defined in the theory.
- Describe important concepts of the theory relevant to family-focused care.
- Discuss the points of the assigned theory pertinent to family as the unit of care.
- Identify how the theory has been used in education, practice, and research in regard to families.
- Suggest ways this theory needs to evolve and/or be tested to further its usefulness for family-focused practice and research.

SYSTEMS THEORIES General Systems Theory

Systems theory gives a view of the whole that functions through interdependence of its multiple parts, a logical perspective for understanding family interactions. Von Bertalanffy (1956) is usually credited with the origins of General Systems Theory. System is often defined as “a set of objects together with the relationships between the objects and their attributes. The objects are the component parts of the system, the attributes are the properties of the objects and the relationships tie the system together” (Hall & Fagen, 1956, p.18). Systems theory describes the whole by classifying the ways its parts are organized, interrelated, and defined. General Systems Theory supplies a way to

describe solar, economic, environmental, and molecular system, as well as human or family as systems with interdependent parts.

Discussions about systems theory are often abstract without clear descriptions of the concepts included or the complexity of interrelated systems fully explained. Systems' thinking implores considering hierarchical order and increasing complexity, thus the biological system may be viewed related to its systems, organs, tissue, cells, and genetics. In families, hierarchy might deem an individual as a separate entity, an individual as part of a family, and family as part of a community. In General Systems Theory, open systems allows for the flow of information, energy, material goods into the system as either an exchange or feedback system between the system and the environment. General Systems Theory implies that an environment exists and it affects and is affected by feedback systems.

General Systems Theory includes thinking about open and closed systems. An open system has greater exchange of information, energy and material between it and its environment, while a closed system is more isolated and has fewer exchanges. Terms often associated with general systems theory include concepts such as negentropy, entropy, steady state, equifinality, and equilibrium. Equilibrium or homeostasis is the system state usually targeted and is influenced by the openness or closedness of the system. For instance, an open system can be more greatly influenced by present events and independent of past conditions, while a closed

system is more likely to have tighter links between the initial conditions and the final state. Although open systems can be influenced by cause and effect relationships, the degree and direction of these relationships is complex and not easily predicted. Hanna and Roy (2001) said “the most useful aspect of systems theory is that it is a process-oriented theory that fosters growth, development, maturation, and the achievement of integrity and transformation of the human person whether that person is an individual or a group of related persons” (p. 11). Ideas grounded in systems thinking have greatly influenced many nursing and family theories.

Family Systems Theory

Family systems emphasize the whole of family, but focuses on member relationships and interactions and the functional status of the system to address needs, goals, and sustain its members. Family systems theory has evolved over the last few decades out of sociology, psychology, and family sciences. While sociologists were initially concerned with describing what they discovered from structural, functional or developmental perspectives, the ideas have now melded and family systems theory has become a more general approach. A key feature of the family systems approach, especially when it is used in family therapy, is that of a unitary conceptualization of family, a whole that is different from the sum of its parts (Whall, 1991).

Reuben Hill (1949), a sociologist, described a family as a group of interrelated persons forming a living system and changing over time as they acted, reacted, and met the challenges of separation, loss, and reunion that resulted from wartime challenges. This early research identified a family stress experience of adjustment that often resulted in a decrease in family functioning, disorganization, and crisis. Hill (1965) later developed the ABCX model of family stress and noted the key factors were stressor, definition or interpretation of the stressful event, and effectiveness of resources that determined whether or not life circumstances were viewed as crisis. McCubbin and Patterson (1983) later expanded Hill's model with what has been called the Double ABCX Model to address coping aspects as predictors in the post-crisis period. McCubbin and McCubbin (1991, 1993) building on these former models suggested what is called the Resiliency Model of Family Stress, Adjustment, and Adaptation. This model is built upon several assumptions about families (McCubbin & McCubbin, 1991):

- Families face hardships and change as natural predictable aspects of family life.
- Families develop strengths and capacities to foster member and family growth and development.
- Families develop unique strengths and capacities to cope with unexpected and normative stressors and foster adaptation following crisis or change.
- Families benefit from and contribute networks of community relationships and resources.

Hanson and Kaakinen (2001) suggest that the “resiliency model provides a way for nurses to facilitate family adjustment and adaptation by looking at family strengths and capacities for responding to stress” (p. 54).

The resiliency model identifies the ways family systems use balance and harmony to meet demands and protection factors affecting family adjustment, while vulnerability and resiliency factors are viewed in relationship to family adaptation. Family stress is certainly a concern central to most families and important when working with coping, change, and crisis. Some family stress models emphasize the importance of interaction of the community in facilitating high-level family health and the importance of members’ abilities to reformulate the embedded social context (McCubbin & McCubbin, 1993). Systems models often address the larger systems, but the predominate focus is often more on the internal nature of the family.

The Framework of Systemic Organization

A gap between grand theories and practice models has resulted in the development of several nursing models aimed at family systems. The Framework of Systemic Organization originated at Wayne State University and suggests a way to understand the nature of families and their members, as well as functional processes within the family’s environment (Friedemann, 1989a). This framework expands the nursing metaparadigm to include family and family health concepts and is a conceptual approach for working with individuals, families, and social

systems like organizations and communities (Friedemann, 1995). This theory differentiates nursing's focus on family from that of other disciplines by (a) considering environmental influences on family health and nursing outcomes related to actions taken on the family's behalf, (b) emphasizing a comprehensive and holistic perspective of health that includes the biopsychosocial, and (c) focusing on well-being rather than pathology (Friedemann, 1989b). Families are viewed as open systems that strive for congruence and balance with potential for health as energy flows between them and other systems with whom they interact. Family is defined as an interpersonal system that individual members view as family and includes the functional relationships between single individuals and others emotionally connected to individuals. The Framework of Systemic Organization describes family health as a dynamic process where family members respond to various systemic changes and continually seek to reestablish congruence between the family system and the environment in the areas of stability, growth, control and spirituality (Friedemann, 1995). Strengths of this theory are the well-defined concepts related to family health, a focus on health rather than illness, and the inclusion of functional and environmental factors germane to nursing practice.

The Intersystem Model

The Intersystem Model was developed at Azusa Pacific University and is based upon the evolution of thinking over several decades about systems (Artinian & Conger, 1997). This model is a way to conceptualize

interactional processes whether the client is an individual, family, institution, or a community. Person is viewed as the recipient of care and may be a biological subsystem, a psychosocial subsystem, or an aggregate such as an individual who is part of several family related sub-systems. “For example, we could examine the relationship of a family to a health care provider and how both the family and that provider relate to other health agencies in the community” (Artinian, 1997a, p. 7). Environment is addressed from both developmental and situational points of view. Health and disease are seen as a continuum. The model strongly leans upon Antonovsky’s (1987) thinking that suggests a person’s sense of coherence that affects their ability to cope and manage stress. The goal of nursing in this model is to “assist the person to increase in the situational sense of coherence when confronted with stressors that cannot be managed independently” (Artinian, 1997a, p. 9). The situational sense of coherence “describes the response that occurs in the period of time in which a client is attempting to deal with a serious life event” and measures potentials for understanding a situation and ability to organize resources (Artinian, 1997b, p. 23). In this model, family is defined as “a system of interacting persons who live together over time developing patterns of kinship and who hold specific role relationships to each other, characterized by commitment and attachment, and who have economic, emotional, and physical obligations to each other” (McGowan & Artinian, p. 130). Family subsystems are viewed as biological, psychosocial, and spiritual. The

strength of this model appears is its positive orientation towards health and resiliency and the opportunity to conceptualize the needs and motivations of autonomous subsystems that interact. This model enables the nurse to envision the family as a system interacting with its many contextual systems.

Calgary Family Assessment Model

The Calgary Family Assessment Model (CFAM), initially introduced in 1984 by Janice Wright and Maureen Leahey, was revised in 1994 with an intervention model added, and revised and amplified in 2000. This model provides undergraduate, graduate, and practicing nurses with guidelines for assessment and intervention to address the family as client. This framework emphasizes structural, developmental, and functional aspects of nursing care and is based upon a theoretical foundation that includes systems, cybernetics, communication, and change theory “embedded within larger worldviews of postmodernism, feminism, and biology of cognition” (Wright & Leahey, 2000, p. 16). Concepts similar to other systems models are incorporated into the model and the family is perceived as individual systems embedded in a larger suprasystem. The strength of the model is its unique way of integrating widely understood theories into a practical guide that nurses can use in clinical practice for family assessment and intervention.

Family Systems Theory and the Family Health Model

The strength of General Systems Theory rests in ease of understanding interacting systems. The latitude and scope of the theory are far-reaching and meaningful. However, the breadth and freedom of systems thinking is accompanied by risks of trivializing and failing to make distinctive links related to interactions and feedback systems. The strengths of the model are often turned in to weaknesses when generalizations are vague, unable to be quantified, infinite in possibilities, and difficult to measure. While systems thinking allows one to view the whole as well as the parts, it is difficult to hold both in mind concurrently and weigh the endless possibilities of independent, intradependent, and interdependent actions. Concentrating too much on the whole can result in over-looking the implications of the parts, while attention to parts risks the possibility of overlooking affects of the whole. While some of these concerns are also true with the Family Health Model, the family model includes things like time, sequence of events, historical and collective experiences, family behaviors, social circumstances, perceived meanings, and other specifics relative to health. The use of environment in systems theory is often loosely interpreted and lacks clear delineations. The Family Health Model suggests that precise identification of factors related to the embedded contextual systems is essential to fully comprehend family health. Unless entities are made explicit, it is difficult to clearly ascertain intentions when things are sometimes viewed as systems and other times viewed as environment.

A problem with systems thinking is the assumption that variables viewed independently from the whole remain the same as when they are part of the whole and that there are clear-cut rules governing the way parts are assembled (Vetere, 1987). Even if the parts can be viewed and understood singularly, questions remain about the ability to use reductionist methods to explain the complexity of the whole. If the whole is more than the sum of the parts, then how does one explain or fully understand the complexity of the whole without fully understanding the complexity of its multiple interrelated parts? If humans and families have behavioral systems, then is it truly possible to understand the complexity of these systems without also considering the affects freedom of choice has on entities themselves and the outcomes result from the choices? It seems that a situational or ecological analysis is needed to fully understand the relationships and variables associated with the environmental systems and that general systems laws may be ineffective. For instance, although individual or human and family systems have freedom of choice, the choices are limited by perceptions about availability and environmental factors that may be predisposing factors for humans or family. While freedom of choice might be viewed as a system attribute, varied situations suggest that the possibilities of choices and potential outcomes are predicated upon contextual factors. Systems thinking might overlook unique values and attributed meanings related to subtle innate influences embedded in feedback systems and contextual

systems. For example, a family may have well educated members who have financial capacities that exceed the ability to provide for usual needs. However, if the family lives in a geographically isolated region where specialists are unavailable, then they may never gain access to some existent medical options that are not locally available. If medical professionals do not share information about other options, fail to refer to other providers, and the family system has limited information about other choices, then the perception might be that the family is doing everything possible when other knowledge or options could result in different choices. When family members are unaware of limitations, then members and even practitioners may be unaware of the restricted choices. Furthermore, systems theories often ignore the impact of changes over time even when they may seem to be accounted for in referring to feedback systems.

The main flaws in systems theory are inadequate methods of analysis, lack of synthesis of systems, and inadequate formulation of rules for applying system principles (Vetere, 1987). Vetere identified several problems in using systems theory as the way to understand families:

- Individuals are more than physical objects and possess non-physical attributes (e.g., self-reflection) that also modulate behaviors singly and with others.
- Families are living systems with modulating boundaries that result in changing memberships, family roles, and relationships.
- Levels of family change based upon feedback loops are often anecdotal and fail to consider the variety of complex alternatives possible (e.g., a family may respond to output related to child disobedience, but be immobilized if faced with substance abuse).

- Clear conceptual and operational definitions are often lacking with loose definitions leading to empty conclusions (e.g., concluding that biological and social organizations are similar in some ways fails to encompass the many parameters of family behaviors).
- Empirical research only provides weak links between abstract systems concepts and the reality of family interactions.

While systems theories contribute much to understanding about the ways systems interact, they are not without some shortcomings when the issue of concern is family health as they lack focus on health parameters, variables, and dimensions. Although family health can be included in a systems analysis, the balance of functional and contextual variables relevant to family health and the household production of health are not easily conceptualized.

STRUCTURAL AND DEVELOPMENTAL THEORY

A large amount of overlap of ideas occurs when theoretical perspectives are examined and the interactions resulting from decades of thinking in single disciplines influencing other disciplines as well.

Minuchin's (1974) is often credited with the foundational thinking that has led to structural-functional models. He based his structural ideas about families on his clinical work with families in distress and developed a framework consistent with systems theory. His theory is an open systems approach to the family as a unit rather than the sum of individuals.

Optimal family functioning occurs when the family has the ability to flexibly adapt and restructure itself as new demands are encountered. This theory has several principle features:

- Family is a system with transactional patterns.

- Family system functions are affected by its subsystems.
- Family subsystems are comprised of individuals, either temporarily or permanently.
- Family members can be part of one or more system and have different roles in each.
- Subsystems are hierarchically organized with power structures within and between them.
- Stress in one part of the system affects other parts of the system.
- Families are characterized by qualities of cohesiveness and adaptability.
- Changes in family structure relate to changes in individual behaviors.
- Individuals are influenced by and influence constantly reoccurring interactions.
- Individuals reflect the system of which they are a part.

Minuchin suggests that the whole of family must be approached and understanding must include ideas of evolving and unpredictable patterns as change occurs in response to internal and external forces. Change from his viewpoint is more probabilistic and less cause and effect, as growth and change are experienced simultaneously. The theory has been widely used in family therapy with larger family system to achieve individual changes.

In structural theory, the spouse system is generally antecedent to the development of other sub-systems and includes decision-making, gender roles, power, economics, and affectional relationship. The hierarchy of the spouse system is expressed with parents having power over children. The family nurtures and socializes members and is the seat of transactional interactions that influence the growth and development of individuals and the family as a whole. Sub-systems include the parental sub-system, the parent-child sub-system, and the sibling sub-system.

These categories are not mutually exclusive and some functional overlap exists among the sub-systems. Minuchin (1974) uses terms such as boundaries, adaptation, stress, equilibrium, enmeshed, disengagement, alignment, and under-organization to describe member interactions. Minuchin described systems' boundaries necessary to maintain functional roles in terms of their clarity, rigidity, and diffusion and by sub-system rules intended to protect integrity and limit interference. Clear boundaries are explicit statements and understandings about what is and is not permissible; rigid boundaries are firm, less flexible, and immutable; and diffuse boundaries are variable, inconstant, and changeable. Minuchin also emphasized ideas about family cohesion, degrees of enmeshment, and levels of disengagement.

The Circumplex Model used to describe marital and family systems has evolved from Minuchin's concepts (Olson, Sprenkle, & Russell, 1979). This model uses the two central dimensions of cohesion and adaptability, but Olson (1986) later suggested that communication is a facilitative factor for the central dimensions. The model identifies a total of 16 marital and/or family systems. Key constructs of the Circumplex Model are:

- The dimensions of cohesion, adaptability, and communication.
- A taxonomy of family types (balanced, mid-range, extreme).
- Aspects of family adjustment (stressors, family coping, family resources).

The Circumplex Model focuses on normal patterns of family interactions and emphasizes family strengths rather than weaknesses (Olson et al., 1983). Cohesion refers to boundaries, space, bonding, decision-making, and interests and is defined as “the emotional bonding members have with one another and the degree of individual autonomy a person experiences in the family system” (Olson et al., 1979, p. 5). Adaptability refers to power structure, role relationship, and relationship rules. Communication is a facilitating dimension and includes both positive (e.g., reflective listening, empathy) and negative (e.g., criticism, double messages) dimensions. Developmental stages viewed in family are courting couples, couples with children, childbearing families with preschool children, families with school-age children, families with adolescents at home, launching families, empty nest families, and retirement families (Olson et al, 1983).

According to this model, families can be disengaged, separated, connected, or enmeshed. Enmeshment has to do with the degree of intensity in system relationships and a closeness among members that tends to discourage individuation, autonomy, and difference. In contrast, disengaged families live together within a context, but have divisive communication, tend to have more independent members who view themselves as more detached from the family. Based upon this model, adaptable families use communication to alter roles and relationships when change is needed, are more likely to be viewed as flexible, willing to

negotiate changes, and usually cooperate more effectively in problem solving tasks.

Marilyn Friedman (1998) stressed that many theories applied to family are what she calls structural-functional theories. This perspective “is comprehensive and recognizes the important interaction between the family and its internal and particularly its external environment” (p. 99). The structural-functional approach views families as open social systems and a sub-system of society. Relationships between the family and its social systems are understood as family organization and ability to function. Friedman sees the usefulness in a structural-functional framework as its ability to assess family life holistically, in parts, and interactionally from a systems perspective. She has used structural-functional theory as the organizing framework for her family nursing text, one widely used in many nursing education programs. Friedman emphasizes four structural dimensions in her assessment model: role structure, value system, communication processes, and power structure. She defines function as “outcomes or consequences of the family structure” or “what the family does” (p. 102) and identifies five important functional areas: (a) affective functions, (b) socialization and social placement functions, (c) reproductive functions, (d) economic functions, and (e) the health care functions.

Comparing Structural Theory and the Family Health Model

In some ways structural theory has limitations as a useful way to conceptualize family health. Diminished abilities to separate the roles and functions of one sub-system from another make drawing conclusions about attribution of sub-systems to the whole troublesome. While independent measurement of family's specific sub-system attributes can be helpful in some cases, they can also become obstacles when trying to understand the whole. For instance, individuals learn relational behaviors that may be characteristic of the ways they act in the presence of others, but may not be manifest if some members of the sub-system are not present. If an individual is not engaging in the activities relevant to a specific sub-system and is isolated from the family context, the characteristics observed or reported may not include the full repertoire of behaviors available within the whole of family relationships.

Today's allowance for negotiated roles within families means that fewer distinctions exist making it increasingly difficult to generalize what family roles are indeed optimal. More and more women are employed outside the home with most only taking time off for pregnancy, and then returning to work. At one time U.S. males were viewed as primary economic providers for the family. Even though men's salaries still exceed women's, traditional families are increasingly depending upon dual-incomes and would experience great disparities in comfort without earnings from both wage earners. When families are dependent upon the

woman's income, the sharing and distribution of household tasks may look different from families in the past.

Structural theory has less focus on normal family processes and seems to have some limitations regarding what explains functional behavior in families. Minuchin (1974) developed his theory out of his work with problem families, thus many ideas seem aligned with reinstating the hierarchy of family sub-systems, member roles, and power in the parental role. The theory mostly describes the present state of family, but less enables understandings about causative or underlying processes of the present state and has limited scope for predicting future states. This theoretical perspective might mean approaching the family as an observer or participant observer, but mostly focuses on internal processes while over-looking affects of the embedded context. For example, the theory seems to possess somewhat limited ability for envisioning family care related to prevention or health promotion.

Friedman's (1998) structural-functional assessment provides a wealth of information about a variety of family needs. Integration of developmental, general systems, and structural-functional theory to see family from many perspectives are the strength of the model. However, when family health is the concern, the model is less clear about what assessments should be made and might encourage nurses to collect assessment data that may not be pertinent to the health concern. In some ways, assessment using this model is a bit like fishing in strange waters,

never knowing for sure what might bite on the hook and uncertainty about what might be dredged out of the waters. Although expert family nurses may use this model to assess and analyze data applicable to health concerns, the novice nurse may collect much data that proves useless or poorly connected to problem. This model has only a piece that directly addresses the health care function. Although other aspects of the framework might be useful for counseling and education, the model fails to provide the nurse with clear directions regarding the scope of practice and the health related interventions. The model fails to clearly link the family to its embedded context and does not suggest how the dynamics of time affect development of multiple interacting members or how complex variables affect the household production of health. The model's emphasis on traditional families or nuclear forms may be restrictive when considering ways to use the framework to address the world's many family types and needs throughout the life course related to processes of becoming, health, and well-being. Societal changes that have prolonged longevity imply that nurses need models that assist them to better conceptualize childless years, how parenting relationships are transformed to new forms of caring relationships over the entire life course, caregiving and coping with chronicity, and healthy promotion that spans all of the individual and family developmental stages of the life course.

Unnumbered Box 14.3**Cooperative Learning**

Identify several family theories from which the students can choose.

Divide the class into groups of 3 to 4 students and assign each group a

theory. Groups will each prepare a class presentation that focuses on these points:

- Discuss the theoretical perspective and the fit with family.
- Explain how theory differentiates individual from family.
- Describe the important concepts of the theory and their pertinence to family health.
- Identify how this theory has been used in education, practice, and research in regard to families.
- Suggest ways this theory needs to evolve and/or be tested to identify its usefulness for family-focused nursing practice and research.

DEVELOPMENTAL AND LIFE CYCLE THEORIES

Life Cycle Theories

A number of theories relevant to family include perspectives that might be viewed as life cycle approaches. Examples of individuals who have provided life cycle perspectives widely included in practice, research, and education are Erikson (1959, 1965) developmental theory, Piaget's (1971) social learning theory, Freud's personality theory, and Kohlberg's (1981) stage theory of moral adjustment. Theorists describe life cycles in terms of critical developmental phases thought to contain important elements that increase understanding about individuals:

- Individual development means passing through stages where sensitivity to particular types of stimulation and experience occur.
- Individuals are open to certain experiences for specifiable time periods.
- Individuals who have interacted with others in appropriately stimulating ways acquire specific skills that enable movement to the next stage.
- Inappropriate stimulation leads to maladaptive behaviors or developmental stunting. (Gale & Vetere, 1987).

A common idea in life cycle theories is that a sort of check-off list exists that enables one to identify stages of developmental progress at specific time points in months and years of life.

For example, Erikson (1965) identified eight stages of development for understanding challenges, risks, and achievements.

Comparing Life Cycle Theories and the Family Health Framework

Present concerns with diversity, culture, and global communities mean the value of norms based upon life stage thinking may be less meaningful as variations in family health are considered from racial, ethnics, religious, or regional perspectives. Life cycle theories are often bound to norms viewed from a Western perspective and are less helpful for envisioning development in untraditional families. Life cycle models seem less helpful for life perspectives beyond child bearing and parenting and fail to consider the entire life course. Gale and Vetere (1987) recommended that models include: (a) clear definitions, (b) show the ways key concepts are related, (c) provide a formal way to operationalize the model's key constructs, and (d) answer questions about whether a model's measurement tools allow for a formal analysis of the model's key constructs. While life cycle models aid thinking about family processes, these models often focus on distinct areas of individual and/or family life, but do not necessarily encourage comprehension of the whole as much as parts of the whole. Models sometimes seem to approach the family as a homogenous group, fail to account for member differences, and ignore

conflicting member needs. Life cycle theories are helpful for assessing stages and development, but they do not account for the impact of interpersonal relationships, interactions between persons and environments, the vast number of alternative contextual influences, and the effects of time. It seems that neither individuals nor families are passive actors, but are better viewed as transitional participants oscillating within contexts for periods of time.

Aggregation of family data to understand life cycles has often been related to single dimensions (e.g., moral choices, language, physical growth, etc.). Attempts to be scientific have resulted in studies looking at isolated variables while ignoring affects of the whole. For instance, it is difficult to consider family strengths or coping in terms of static characteristics, as these variables are only pertinent when interactions and context are considered. Life cycle theories can mistakenly give the impression that it is possible to move smoothly from one stage to another or that one stage is completed before another commences. Life seldom offers such efficient transitions! While developmental cycles are important for understanding member interactions, the context and interactions of bio-physical or health factors relevant to multiple member households across developmental period must not be ignored. While family health can be understood at single time points, it also needs to be considered over the life course. Longitudinal designs rather than cross-sectional analysis are

needed to capture the multiple influences and transitions occurring at different time points of the family life course.

OTHER THEORIES USED WITH FAMILY NURSING

Symbolic Interactionism

The basic tenet of symbolic interactionism is that the world is both physical and symbolic and individuals interact within the larger society based upon meanings attributed to symbols. Individuals learn these meanings based upon the values a specific culture affirms and socially construct their reality. Credit for this model is given to George Herbert Mead (1934). The model suggests that one begins to know who they are and how they fit in the world based upon their interactions with others. An infant is born without any attachment to symbols, but birth implies an immediately active and on-going interaction with surrounding symbols. Interaction with symbols and others enable the developing child to acquire personal identify, differentiate from others, and ascribe meaning to the world. Characteristics of symbolic interactionism are:

- The importance of symbols and their meanings.
 - The notion of public and personal self.
 - Concepts of role, role enactment, role transition, and role strain.
 - Human beings as actors as well as reactors.
- (Gale & Vetere, 1987, p. 47)

Symbolic interaction theories imply that change occurs as persons are exposed to symbols, but that they also change the meanings of the symbols. Hence, this means when operational definitions differ based upon person and situation methodological difficulties are created.

Accounting for the validity of observation and the interpretation of the transaction is based upon perceptions and constructions. While this theory is useful to family nurses because of the focus on “internal processes of social interaction within families, rather than on the outcomes of these interactions,” the theory is problematic in that “the family is seen as existing in a vacuum, with no consideration of the environment or the family’s history, culture, or socioeconomic status” (Hanson & Kaakinen, 2001, p. 44). However, the theory has utility for understanding communication processes within family units and affirming possibilities of family meanings being socially constructed into family routines and patterned behaviors.

Gedaly-Duff and Heims (1996) introduced the family interaction model derived from symbolic interaction and developmental theory. This model focuses on a variety of concepts related to family such as career, aging, marriage, middle age, launching, and school age. However, individual development is also viewed in relationship to patterns of health, disease, and illness. Family career includes family tasks and parenting of children, but also embraces ideas about the diverse life that occurs across the life course. These authors considered eight stages of family development (Duvall & Miller, 1985b) as ways that nurses can plan with families related to reorganization needs at various family life stages to accomplish family life tasks related to food and shelter, development of emotionally healthy members, meet member’s socialization needs,

contribute to the next generation, and promote member health and care during illness. Transitions are viewed as predictable changes congruent with movement through the family life cycles, but families are unique and may not follow anticipated trajectories.

Social Exchange Theory

Exchange theory is a rational theory based upon costs and rewards (Thibaut & Kelley, 1959). The general premise behind exchange theory is that persons and families are attracted to pleasurable experiences and agreeable roles, while seeking to avoid distasteful experiences and loathsome roles. Individuals in relationships aim to maximize their resources and benefits and minimize the possibilities of losses. Perceptions about costs and rewards of experiences and roles drives choices made and satisfaction derived. Key features of the theory are:

- The concept of rational choice.
- A set of rewards that family members seek.
- The costs of efforts members seek to avoid.
- The means individuals use to derive the type and kind of reward believed to be deserved.
- The notion of reciprocity in interpersonal relationships.
(Gale & Vetere, 1987)

A key idea in this theory is that persons will generally continue engaging in a given experience, remain in a relationship or maintain a particular behavior as long as it is not viewed as too costly. Costs and benefits of relationships are dynamic and continually reevaluated in light of change and conflict. Research about economic changes affecting families is embedded in a social exchange framework where “couples in intimate

relationships organize themselves to adapt to their social and economic surroundings” (Teachman, 2000, p. 34). Rewards may come in the many forms and include such things as affection, social support, status, power, security, money, and satisfaction. Costs might include things such as financial concerns and debts, undesirability of personal attributes, social skills, discomfort related to lack of material goods, and poor health conditions. The worth and supportiveness of the relationship is continuously weighed against the costs associated with continuance of the relationship. The theory recognizes variations among the ways individuals and groups value rewards and costs.

Distance Regulation Theory

The Distance Regulation Theory is a systems theory through which family can be viewed as complex, open, adaptive, and continuously processing new information (Kantor & Lehr, 1975). This model uses distance in both literal and metaphorical ways to describe ways information is processed. Components of this model include: (a) family subsystems, (b) target family goals, (c) dimensions for achieving goals, (d) mechanisms for implementing the target and access dimensions, (e) a taxonomy of family types, and (f) roles family members may play. Family behavior takes place within a social space through target dimensions (i.e., affect, power, meaning) and access dimensions (i.e., space, time, energy). Although for any given interaction one of these dimensions may be predominate, all six dimensions interface when

members interact. Affect has to do with individual needs for nurturance and positive support. Power is related to member's expressions of rights, status, responsibility, dominance, and submission. Meaning has to do with valuing, sense of purpose, and personal identity. Space refers to the boundaries and distances between individuals and groupings. Time identifies individual and family views about the importance of past, present, and future. Energy is viewed as the overall intensity of the family experience in terms of uptake, storage, and discharge and provides a dynamic mechanism to understand bio-behavioral processes, activities, and change.

Families can be viewed as open, closed or random in style. Four family roles are mover, follower, opposer, and bystander. Movers propose actions. Followers use the actions of others to support personal needs. Opposers may propose action or resist change. Both movers and opposers require the support of followers. Bystanders reflect upon the actions of movers and opposers, but remain independent and free to express beliefs or act without aligning themselves with either movers or opposers. As events change, individuals may change roles. The theory has many strengths, but they gaining access to the observation of usual life experiences of families, the discomfort some feel about personal disclosures, and the subconscious, undisclosed, and private worlds of family life might limit the use of this theory for understanding family health.

Unnumbered Box 14.4

Reflective Thinking *****

Ask students to reflect about the ideas of feminism and list reasons why they mostly agree or disagree with this point of view.

Have students view several feminist sites on the Internet such as:

The National Organization for Women (NOW):

<http://63.111.42.146/home/>

Feminist Women’s Health Center: <http://www.fwhc.org/>

Feminist Majority Foundation Online: <http://www.feminist.org/>

Women in American History: <http://women.eb.com/>

Military Women Veterans: <http://userpages.aug.com/captbarb/>

Aviva: Women’s World Wide Web: <http://www.aviva.org/>

Women’s International Center: <http://www.wic.org/>

After students have reviewed the Internet sites, have them identify their arguments for or against a feminist point of view. Ask them write 2 to 3 paragraphs that describes what they learned from reviewing the feminist sites and describe the implications for family nursing.

Feminist Theories

Feminist theories assume that privilege and power are inequitably distributed based upon gender, race, and class. A discussion about feminism begins with sexism, a picture of social reality where male perspectives have ruled in shaping the social, political, economic, and intellectual environments (Eichler, 1988). According to Ackelsberg and Diamond (1987), feminism aims to transform our ways of knowing so that male and female qualities, reason and emotion, thought and experience, and individuality and connectedness are integrated into the life experience of men and women. Four core assumptions underlying feminist perspectives:

- Age, class, race, ethnicity, presence of disability, and sexual orientation define women and other groups.

- Personal experience implies political or social action to promote change and justice.
- Multiple realities exist.
- Issues are holistic and contextual. (McPherson, 1983)

Beginning in the 1960s and 1970s, the feminist movement primarily focused on the conscious raising of younger women, but ignored some important issues related to mothers' caregiving roles across the life course and how aging, gender, race, and social class affected caregiving roles. A feminist perspective assumes that gender, vocation, race, and class should have equitable distribution of power and benefits. As awareness of women's caregiving responsibilities began to shift due to issues of caring for those with disabilities, chronic health problems, and the oldest-old feminism has taken on some different perspectives (Hooyman & Gonyea, 1995). Although family-care as a women's issue was an important step in raising awareness of policy makers, researchers, and service providers, early discussions emphasized the stress and burden associated with tasks and ignored women as a group. A feminist perspective that clearly articulates needs for basic structural changes in the ways society is organized is necessary in order to achieve gender justice (Hooyman & Gonyea). "Family diversity must include individuals' subjective perceptions about oppression and privilege, such as their right to define and describe their own experiences in the world" (Allen, Fine, & Demo, 2000, p. 6). Feminist theory assists in reframing the current structure of the world and family life in order to scrutinize it from more impartial and less biased points of view. When family-focused care and

family health are the concerns, it appears appropriate to include feminist theory to increase understandings about the affects of social imperatives on the family life course and gender.

SUMMARY

Theories germane to family and family health continue to be developed and evolve. Many theories presented in earlier times have served nursing well as the discipline has described its scope of practice. When care was mainly centered in the patient-nurse relationship, many life cycle theories were especially pertinent and as holistic views of patient-environment became greater concerns then systems thinking was an asset for conceptualizing practice. A new wave of thought today has to do with embedded systems and ecological contexts. Theories used in the past continue to have meaning, but nurses need models that reflect the discipline's ethos and provide a framework to consider the vocation and goals of nursing. While singular perspectives and causal effects still predominate much thinking, need exists to include potentially powerful dynamic interactions, alternative hypotheses, and unpredictable phenomena related to family health. The proposed Family Health Model uses a nursing perspective to reflect on family as the unit of care, conceptualize the impact of dynamic embedded contextual interactions on families and their members, consider the complex factors that shape social constructions of family health, and reflect on the implications of the household production of health across the life course.

A paradigm shift to family-focused care does not entail disregard for theoretical ideas that have previously served the discipline well, but it does imply that frameworks used to address family health consider the impact of complex embedded interactions over time, value multiple viewpoints, encourage reflection about paradoxical understandings, and not only exhibit tolerance for diversity, but respond to it in morally just ways. Family nursing needs models that incorporate complex relationships among health, the family client, nursing, and environment.

TEST YOUR KNOWLEDGE

1. Identify a nurse theorist and describe how that theory is applicable to family-focused care.
2. Define family from structural and functional perspectives.
3. Describe what a family systems perspective means.
4. Explain the ways a family systems perspective might assist a nurse to provide family-focused care.
5. Discuss the different ways a nurse might approach family care using a family system theory versus a life cycle model.
6. Discuss benefits and risks with using non-nursing theories in family health care.