

PREFACE

The Family Health Model described in this text evolved from a knowledge of current literature, the author's professional nursing practice and life experiences, and findings from a series of three qualitative studies about how Appalachian families defined and practiced family health within their households (Denham, 1997, 1999a, 1999b, 1999c). This research was completed to learn about family health from a household perspective, rather than institutional ones. The aims of the research were to:

- Identify the ways families' defined family health.
- Identify the routine family patterns, behaviors and daily activities perceived as part of the family health construction.
- Describe behaviors perceived as deleterious and adjuncts to family health.
- Identify the ways families modified their family health construction.
- Identify the contextual influences that affected family health.

Over a period of five years, three ethnographic studies about family health were completed with Appalachian families in two southeastern Ohio counties. Taped and later transcribed, interviews (n = 125) lasting 1 to 2 hours captured data about 24 families (80 interviews), eight families in each study, and a total of 45 community informants (Denham, 1997, 1999a, 1999b, 1999c). Participants were well families referred by informants at community agencies. A series of semi-structured questions guided

the data collection. Approximately 6 to 9 months were spent collecting data for each study.

The length of time for the series of interviews to be completed varied (i.e., 6 weeks to 6 months), with either 3 or 4 interviews conducted with multiple members of each family in their homes. Ethnographic methods were used to investigate family health from a community perspective. Data were analyzed using HyperResearch, a qualitative software package. Spradley's (1979, 1980) ideas about domains and Yin's (1994) ideas about continuous comparison and cross case analysis provided the basis for analysis. Expert checks with those familiar with the Appalachian culture facilitated interpreting cultural inferences and identifying themes.

Participants in two studies were Appalachian families with school age or pre-school children (Denham, 1997, 1999a, 1999c) and subjects in the third study were bereaved families who had recently experienced a member's death (Denham, 1999b). Families consisted of operationalized individuals who were committed to the general well-being of one another and identified themselves as family (Landesman, Jaccard, & Gunderson, 1991).

The first study, dissertation research about family health in rural Appalachian families with preschool children, was conducted in a rural southeastern Ohio county where employment was limited

and a consistently high poverty rate prevailed for several decades (Denham, 1997, 1999a). The other two studies were conducted in a more urban county within the same region. The dissertation provided findings pertinent to family health, but other dimensions also seemed important to enhance understandings (i.e., family health during change or transition, family health of economically disadvantaged families) and resulted in the follow-up studies.

The second study, funded by the American Nurses Foundation, provided a chance to learn about family health after hospice families had cared for a dying member and were experiencing the losses from deaths (Denham, 1999b). While nurses often work with ill individuals when they seek cure or care from health care systems, but most have less understandings about the ways families incorporate prescribed care into households to meet members' health needs. Participants were members from different generations, used hospice services while the member was dying, and some were still receiving bereavement support.

Findings indicated differences in health patterns and changes in routines as a result of the terminal condition and member's death.

Research is often completed with middle class Caucasian populations and fails to include minorities or vulnerable populations. The third study, funded by the College of Health and Human Services at Ohio University, inquired about the ways

economically disadvantaged families defined and practiced family health in their households (Denham, 1999c). These Appalachian families had at least one elementary school age child and received public assistance either when the study was conducted or in the recent past. While all mothers were Caucasian, fathers of several children were Black, and some families included biracial children. Several households were single parent families, all families had experienced socioeconomic constraints, and most families had members with chronic health problems or disabilities. Findings identified family health as a dynamic household construction affected by multiple member and contextual stressors.

The findings supported much of what is described in the literature about health, but also provided some new knowledge about family health from structural, functional, and contextual perspectives. Findings emphasized the complexity of the variables that comprise family health and suggested ways to conceptualize family health as a household process influenced by family context, family functioning, and daily routines. While socio-demographic factors such as age, employment, economic status, and education were important, some cultural themes related to family health were different from what some have identified about Appalachians (Denham, 1996)). For example, fatalism is often identified, but when family health was studied the participants seemed focused on

the present as praxis or a way to cope with the stresses and needs of daily life. Rather than living lives directed by future goals, subjects were centered on the present and used it as a positive way to cope with life as it was encountered. While sense of place and strong kin relationships were visible in families, they were not geographically isolated, unaware of the larger world context or unexposed to difference and diversity. Families were apt to consult extended members about non-emergency situations health concerns and often took a “wait and see” attitude prior to actions. While some cultural differences existed, many responses were similar to those identified in non-Appalachian families.

In all three studies, mothers were the key health care providers and gatekeepers for health resources. Many speak of male dominance as characteristic of Appalachian families, but when family health was the concern mothers played primary roles.

The findings provide ways to conceptualize family health from process and system perspectives, provide evidence for contextual, functional, and structural points of view, and define a scope of practice for family-focused care. Contextual perspectives include members and their characteristics, household niches, embedded neighborhoods, situated communities, and larger societal systems. Functional perspectives are the processes members use to care for one another’s processes of becoming,

health, and well-being. Structural perspectives are related to the socially constructed routines that families use to organize health knowledge and behaviors. The Family Health Model provides a framework to describe, explain, and predict health outcomes and a means to circumscribe the boundaries of household production of health for family-focused.

The book is divided into five parts. Part I introduces the Family Health Model and describes domains and variables relevant to the schema. Chapter 1 provides an overview about the usefulness of ecological models in considering family health and introduces many ideas used in the Family Health Model. Chapter 2 describes some conceptual ideas relevant to using a model to guide practice. Chapter 3 discusses the family concept and talks about its relevance to nursing and chapter 4 discusses interpretations of health concepts.

Part II focuses on the contextual aspects of family health with Chapter 5 describing concepts related to family context, Chapter 6 emphasizing the family microsystem, and Chapter 7 providing information about the larger contextual systems that affect family health.

Part III focuses on the functional aspects of family health with Chapter 8 providing an overview about functional processes and the relevance to family health, Chapter 9 describing functional

perspectives related to the household production of health, and Chapter 10 targeting the core processes members use that are especially pertinent to the household production of health.

Part IV focuses on the structural aspects of family health with Chapter 11 providing arguments for considering family health routines as the structural aspect of family health, Chapter 12 suggesting some of the factors pertinent to assessment and interventions related to routines, and Chapter 13 supplying an overview of the family health routine categories.

The final section of the text focuses on family-focused practice with Chapter 14 supplying an overview of relevant family theories and Chapter 15 discussing findings from the family health research applicable to mother's roles. The final two chapters provide some considerations for conceptualizing and developing family-focused practice for the 21st century.

The book is intended to initiate conversations about family-focused care from nursing perspectives and suggest a Family Health Model that might be useful for conceptualizing practice and initiating a research agenda more central to family care.