Title: Family Theory

Name of Student:

Institution's Name:

Name of Course:

Date submitted:

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Introduction

The family system remains a crucial component of today's nursing practices. Friedemann (1989) views the family as a human social system possessing distinct characteristics, composed of individuals possessing equally distinct characteristics. The family can have a positive or negative effect on an individual depending on the prevailing family values, beliefs, and ability to accept and carry out change.

Nurses have been using genograms, ecomaps and family assessment tools in order to understand family systems and relationships. One of the models used in nursing is structural-functional theory. This theory assists nurses to understand the role of family in nursing, thereby helping them know how to work with families. This paper is a description, analysis and critique of this theory. Recent research on structural-functional theory is also discussed in detail. The paper also analyzes the skills required by nurses in order to improve their practice while working with families in the context of this theory.

Structural-functional theory

Background

The structural-functional theory was first proposed in 1951 by Talcott Parsons. Since then, this theory has been developed and used in families in many disciplines, including nursing

(Friedman, 1999). The structural-functional theory concentrates on the family as a social system and the underlying sub-systems that have functional requirements. Emphasis is on the arrangement of all family members into a strong functional system.

According to Artinian (1994), a family is a system that possesses interacting elements. The interrelationships and interdependence among individuals is what makes it a system. Within this system, there are many sub-systems take the form of interpersonal relations between family members. The main strength of these systems, according to Artinian, is openness. Open exchanges are always taking place both inside and outside every family. The level of interaction in a family system varies depending to the extent of interaction with the environment.

Family boundaries do not take a physical form; rather, they are evident in values, attitudes, beliefs and rules that guide the nature of the family's interaction with the immediate environment. The energy level of a family is determined, to a large extent by the nature of this interaction (Artinian, 1994). The term 'energy' may be equated to 'strength' as far as the structural-functional theory is concerned. If this is the case, the strengths are determined through interactions, valuing, decision-making, goal-setting and problem solving.

Concept of family structure

The main structural components of a family include power structure, roles, communication, values, and patterns, Functions are what the families work on together to achieve and they are an outcome of family structure. Research on the role of families in nursing has been going on for decades. Psychologists, counselors, psychiatrists, family educators and

social workers appreciate the role that the family plays in safeguarding the health of the members who constitute it.

Otto (1963) lists the various factors that determine family strength in execution of its functions: parental discipline, support, encouragement of growth and maturation, meaningful participation, spiritual wellbeing, good communication and problem-solving skills. Otto's (1963) work was based largely on an analysis on analyses of discourse on family theory from the viewpoint of psychology, psychiatry, and sociology, written between 1940s and 1960s. In this literature, 15 categories of functioning were identified from the perspective of structural-functional theory, whereby four categories were identified. These categories include family as strength in itself, strength as parents, strong marriage, and parents offering help to children as they grow up.

According to Sittner, Hudson & Defrain (2007), contributions to the structural-functional theory continued throughout the 1970s. The issues addressed during this time included characteristics of strong families, qualities of family strengths, and the qualities that make families succeed. Stinnett and DeFrain (1985) found out that strong families were characterized by commitment, appreciation of affection, positive communication, spending enjoyable time together, a sense of spiritual well-being and ability to cope and unite in times of stress and crisis. Today, many developments have taken in the family theory, both in the cultural level and internationally. Findings over the decades have been consistent in highlighting the need maintaining family strengths in all cultural settings (Olds, 2006).

Friedemann, (1989) adopts a system-based approach to family nursing, whereby three system levels form the basis of nursing practice. The first system level entails individual members whereby a family is viewed in the context of the individuals in it. The other two levels,

structural and systems, are based on an interpersonal approach. Nurses need to understand the intricate relationships that exists family members within all these system components (Friedemann, 1989).

Families that continue to experience psychosocial problems as a result of chronic illness have to rely on nurses for assistance in the management of situational crisis. Therefore, these nurses need to understand all psychosocial that relate to the functioning of families in such circumstances. Recent studies have confirmed that nurses can understand families best within their immediate context as opposed to studying every individual family member in isolation (Sittner, Hudson & Defrain, 2007).

The American Academy of Nursing, through the Child Family Expert Panel, acknowledges the need for incorporation of structural-functional theory into contemporary nursing practices. Family strength is one of the core values that the American Academy of Nursing recognizes as a key indicator of quality and outcome in nursing (Sittner, Hudson & Defrain, 2007). Nurses can offer help to families in order to strengthen the existing family relationships in times of sickness.

However, a nurse needs to start by assessing the level of family strengths. The strengths can be determined through focusing on various elements such as dependability, honesty, commitment to long-term relationships, and consistent physical and emotional presence. In the presence of commitment by family members, it becomes easy for them to cope. The structural-functional theory places emphasis on the role of the nurse in encouraging families to spend time together often, especially when one of their members is acutely or chronically ill. The main reason for maintaining such a relationship is to maintain mutual support and trust, attributes are essential in coping with stress and crisis (Sittner, Hudson & Defrain, 2007).

Concept of family function

Public health nurses were the first ones to recognize the crucial that the family plays in an individual's growth, development and most importantly, recovery from illness (Friedemann, 1989). This recognition led to a shift in the understanding of family nursing. It started being understood as the care offered to the total family unit or system as opposed to the individuals in the family. Therefore, a family nurse's client started being conceived as the family system and not the individual family members. However, nursing scholars continue to face many challenges in their efforts to bring about integration in the concept of family nursing (Friedemann, 1989).

Robinson (1994) steers away from various theoretical frameworks on family nursing, and instead, chooses to focus on three orientations to various nursing interventions with families. They include orientations are traditional, non-traditional, and transitional orientations. These orientations are based on the underlying perspectives on objectivity as well as linear versus systematic thinking. Additionally, they are distinguished with regard to the various beliefs highlighted in intervention literature.

The analysis given by Robinson (1994) fails to provide a clear link between these orientations and various theoretical frameworks used in family nursing. Nevertheless, differences between various orientations can be assessed in relation to the structural-functional theory. The traditional orientation, for instance, differs from the structural-functional theory by virtue of placing emphasis on the role of an individual family member in influencing other family members' health. In other words, the 'singular family response' is determined by a single family member's response, in most cases the mother (Robinson, 1994).

The transitional orientation also differs from the structural-functional models in that the family is considered as a group and not a system. Therefore, the focus of attention is not interaction and reciprocity among these members. Although emotional feelings such as grief among the group members are treated as resulting from 'unconnected' responses, Robinson's analysis fails to assess the reciprocal influence of these emotional expressions.

In the non-traditional orientation, focus is on both the individual as well as the family in which he belongs (Bomar, 2004). When this simultaneous analysis is carried out, focus is put on interaction and the resulting reciprocity. This scenario is similar to what happens within the structural-functional theory. Within this perspective, emphasis is on the need for nurses to pay attention to the reciprocal relationship between the functioning of the family and an individual's chronic condition. In order for a context for change to be created, families need to be set free to seek their own solutions, through therapeutic conversations. Although the nurse needs to be curious about each family's point of view, he needs to adopt a non-blaming and non-judgmental approach to the outcome or solution that the family chooses (Robinson, 1994).

Limitations of the Structural-Functional Theory

Different scholars have carried out studies that hint at the inadequacies of the structural-functional theory with regard to its application in the family nursing practice. Anderson (2000) notes that the structural-functional perspective ought to be integrated into the Family Health System approach (FHS). He demonstrates that it is possible to integrate the theoretical models so that a comprehensive assessment and delivery of care to families facing health problems can be carried out. In this context, Anderson assesses families through the use of the FHS approach in order to determine areas where concerns on the structural-functional theory lie on the basis of the

different realms of human family health (Anderson, 2000). On this basis, he suggests the creation of a nursing care plan that documents family outcomes as well as family nursing interventions. Such a plan would ensure that the theoretical suggestions of structural-functional theory are put into good use by family nurses during their practice. The main goal of this methodology is improvement of family health, family management of illnesses and transitions, as well as achievement of outcomes in different areas of family health concern.

Bohn (2003) indicates that whenever chronic or life-threatening illness arises, the lives of all individuals in the family are affected. The beliefs that are held about this illness can affect the manner in which individual family members cope with the health problem. In this context, Bohn (2003) highlights the inadequacy of structures that reinforce negative beliefs about about the illness. Bohn (2003) gives the explanation using what he refers to as 'the illness beliefs model'. This model proposes that a therapeutic conversation and constraining beliefs about an illness can have a powerful and profoundly sustaining influence on the ability by individuals and family members to integrate the illness into their daily lives.

Bohn presents the example of a therapeutic conversation that took place during two different sessions at the University of Calgary's Family Nursing Unit, involving a woman experiencing 'a feeling of being overwhelmed and stressed'. The *woman was undergoing these experiences six weeks after being diagnosed with* myocardial infarction. The resulting family nursing intervention was successful in challenging the constraining beliefs that could have been diminishing her perceptions of strength, thereby increasing suffering.

In a pilot study, Goudreau (2006) examined the influence that family systems have on the perceptions of psychiatric nurses engaged in a nursing educational program. After one year, the nurses were requested to describe the family nursing interventions that they had adopted and

their perceptions on how the educational program influenced their way of practicing in family nursing care. The nurses expressed satisfaction with the program. Additionally, the nurses were found to have successfully integrated the family systems approach into their practice. Although this confirms the workability of the conception of family systems as described in the structural-functional theoretical framework, it does not provide practical solutions on how to solve the problems that families face.

According to Simpson (2006), the concept of family as the basic unit of mental health care is new in Hong Kong. Instead, focus among family nurses tends to be on the individual. Simpson assessed the manner in which a family systems nursing project is planned, implemented and evaluated in a psychiatric setting using the Calgary Family Assessment Model. He noted that significant changes were taking place in the way nurses were critically appraising their clinical practice. However, the project also put into question the relevance of the structural-functional model for psychiatric nurses caring for individuals with mental illness as well as their family members. Meanwhile, the study also failed to highlight the various strengths that may have enabled the individuals cope with the family health problem (Simpson, 2006) within this theoretical framework.

Tanyi (2006) proposed a guideline for families to use in matters of spiritual interventions and assessment on the basis of the unique spirituality of every family member. Additionally, Tanyi notes that majority of guidelines in use today fail to appreciate the difference that exists between family spirituality and individuality in health care. Sometimes, these guidelines only offer brief analyses of family spirituality. According to Tanya (2006), such guidelines have a potential to be problematic. Likewise, proponents of structural-functional theory are convinced that such an approach makes nurses to pay attention only to individual spirituality while

neglecting family system spirituality. In this kind of situation, the nurses cannot appreciate or contribute to solving conflicts that emanate from spiritualism within the family.

As a solution to the family solution problem, Tanya (2006) proposes that guidelines for spiritual assessment of the family as a single unit should be emphasized. Such guidelines would require to be interpreted as family strengths and not as sources of structural and functional antagonism in the face of stress and crisis caused by health problems. This is because as nurses continue to strive in order to offer assistance to families with regard to their health needs, they also need to contribute to their spiritual growth. Furthermore, it is not possible to assess a family holistically without focusing on its spirituality.

Indeed, spirituality contributes greatly to a family's level of resilience in the face of adversity. Black (2008) defines resilience as successful coping by all family members under adversity, enabling them to continue flourishing in support, warmth and cohesion. However, according to Boris & Larrieu (2006), an increasingly critical realm of family structures and functions seem to be changing in order to accommodate the roles of identification, enhancement, and promotion of family resilience.

Role of the Structural-Functional Theory in Nursing Practice

Black's (2008) research review reveals the similarity between the functions of resilient families and those of families that are considered to be strong by proponents of the structural-functional theory. These functions include spirituality, positive outlook, family communication, flexibility, financial management, family member accord, family time, support networks, routines and rituals and shared recreation. A family resilience orientation is based on the

conviction that every family has inherent strengths and a high potential for growth. This orientation gives the family nurse an opportunity to continue facilitating protective and recovery factors for the entire family (Black, 2008). Family nurses need to understand this orientation in order to secure the most efficient extra-familial resources necessary for fostering resilience.

Segaric & Hall (2005) observe that despite recognition of the crucial role that the structural-functional theory plays in healthcare and recent progress in development of family theory, very limited family theory is being transferred to the nursing practice. The existing family-theory is clearly discernible even in the structural-functional framework, whereby nurses appear unwilling to consider family strengths, instead choosing to pick out strengths of individual family members when carrying out family assessment (Segaric & Hall, 2005).

Skills Required for Applying this Theory to Nursing Practice

In the academic environment, nursing students need to be exposed to the structural-functional theory and how it should be applied in both acute and community settings. Traditionally students tend to be taught about the expected outcomes for both individuals and populations, to assess variances among patients, to identify proper diagnosis, evaluate care management and plan interventions. A similar approach be adopted to enable nurses interact with families and understand their structures and functions, understand expected outcomes and respond proactively to different situations.

The structural-functional theory emphasizes a clear understanding of the strengths of a family. In this sense, the family ought to be understood as a single unit whose members maintain linkages through complex relationships. In order for a nurse to understand these relationships, he needs to be an excellent communicator at the interpersonal level. The communication techniques

employed must address all the unique family processes that are applicable in every situation, including decision making, definition of family roles and limit setting.

Knowledge of the interpersonal system by nurses is necessary, since it is a crucial subsystem of each individual family system (Munoz & Luckman, 2005). The number of individual systems that the nurse needs to assess varies depending on the number of family members that are interacting with each other at any time (Munoz & Luckman, 2005). Whenever there is a conflict between individuals on a nursing issue, or a family matter, the nurse should use his knowledge of the family's strengths in his mediation efforts.

The need for a nurse to reconcile the nursing goals and those of the family members is of utmost importance (Henderson, 1978). Respect for the opinions of every family member is necessary for mutual understanding to arise. Interactional harmony creates an environment where individuals learn from each experience. This role of the nurse places him at a position where he can influence and change a family's interpersonal system (Friedemann, 1 999).

Friedemann (1999) notes that nursing for a whole family requires creative processes; although he adds that this issue is still a subject of controversy and lack of consensus. Either way, family system nursing is always practiced in an environment whereby the client is a total system and not an individual. Therefore, nursing goals must involve changes in structure and processes of systems that are ordinarily applicable to individuals. It is impossible to focus on family strengths using nursing practices, routines and processes that are designed for individual clients. On the basis of the structural-functional theory, it is clear that nursing actions that are undertaken at the system level alone are not enough. Focus should also be put on the interpersonal subsystems that form the building blocks for repeated behaviors within the family system.

The immediate environment is always of interest to the nurse. Corrections in the master plan may be necessary as part of the necessary interventions, which may be triggered by dissatisfaction with or rejection of external resources (Horis, 2006). Furthermore, family systems interventions transcend simple referrals of individual family members to a medical clinic or a support group (Horis, 2006). A nurse needs to have a systems change in mind. Additionally he needs to pay attention to the strengths of the family so that these two elements can be integrated in order to be of benefit to all members (Patterson, 2002).

Conclusion

In conclusion, the structural-functional theory contributes greatly to the contemporary family theory. However, direct discussions of and references to this theoretical perspective remain scanty in family nursing literature. Additionally, nurses are yet to put into practice the principles highlighted in the structural-functional theory. Specifically, there is need for a change of perception of the family with regard to the dynamics and cohesion of structures and functions. Rather than think of the family as a group of individuals with unique abilities, they need to view it as a single, cohesive unit or system made up of interrelated subsystems with inherent strengths. Such understanding should be the main point of focus for family nurses during their practice.

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