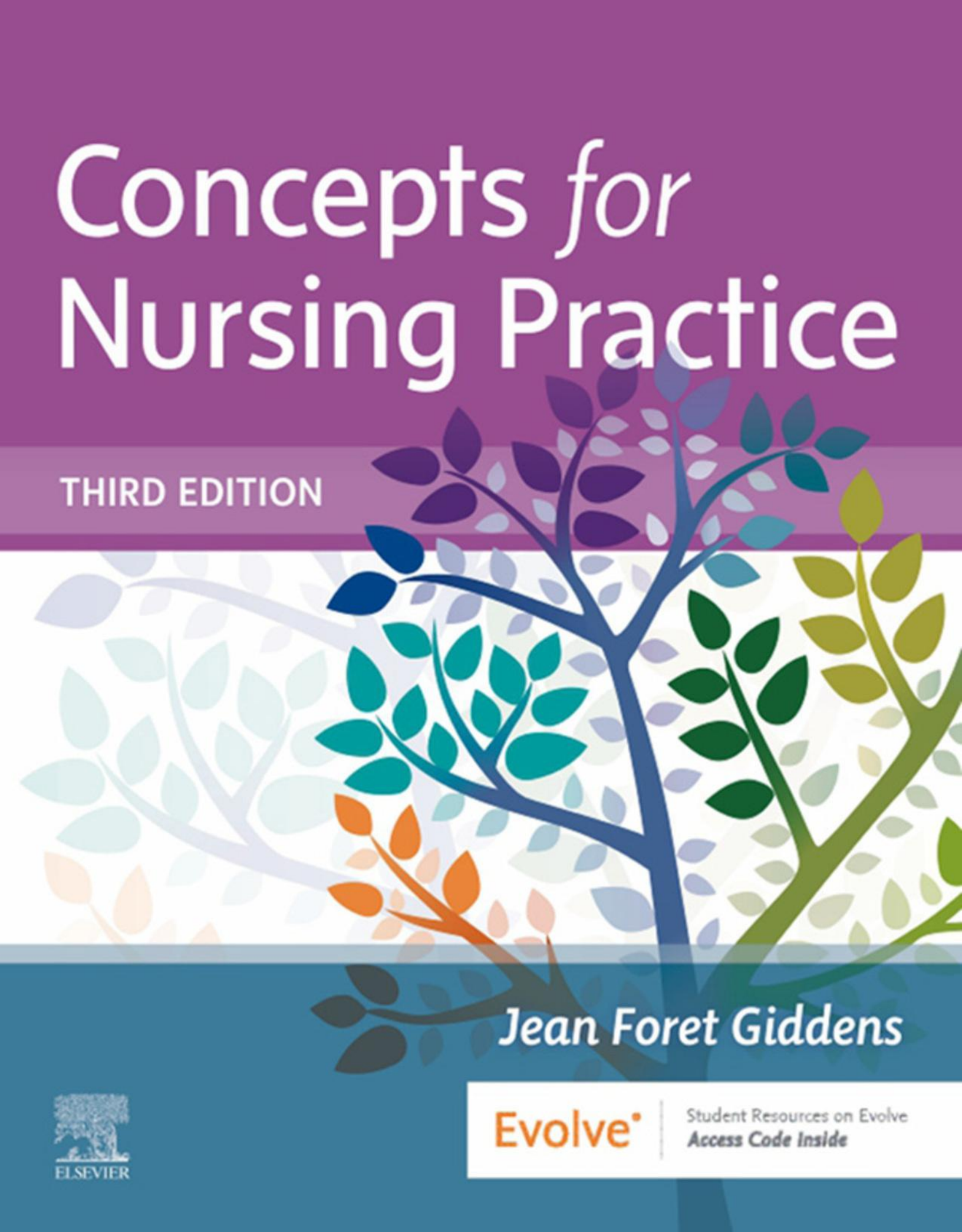
# Concepts *for* Nursing Practice

THIRD EDITION



Jean Foret Giddens

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# Concepts *for* Nursing Practice

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## CONTENT ORGANIZATION

## Health Care Recipient Concepts



## Health and Illness Concepts



# Professional Nursing and Health Care Concepts

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# Concepts *for* Nursing Practice

## THIRD EDITION

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CONCEPTS FOR NURSING PRACTICE, THIRD EDITION ISBN: 978-0-323-58193-6


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**Library of Congress Control Number: 2019949909**

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Printed in Canada

Last digit is the print number: 9 8 7 6 5 4 3 2 1

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# ACKNOWLEDGMENTS

Developing and writing *Concepts for Nursing Practice, Third Edition,* represents an amazing collaboration of educators and clinicians from multiple disciplines across the country. I extend my gratitude and appreciation to the contributors and reviewers for sharing their expertise and wisdom. I also am grateful to my colleagues at Elsevier for their expertise and guidance. Lastly, I extend deep appreciation to my husband Jay—without your friendship, love, and support, I could not accomplish such work.

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# PREFACE

*Wisdom means keeping a sense of the fallibility of our views and opinions, and of the uncertainty and instability of the things we most count on.*

***Gerard Brown***

## INTRODUCTION TO CONCEPTUAL LEARNING

Conceptual learning is increasingly viewed as a major trend for the future of education—not in nursing alone, but across numerous disciplines. This belief is based on the premise that *concepts* can be used effectively as unifying classifications or principles for framing learning while knowledge increases exponentially.

So, what is a *concept*? Simply stated, a concept is an organizing principle or a classification of information. A concept can be limited or complex in scope and can be useful as a basis for education from preschool through doctoral education. In advanced applications, concepts are considered building blocks or the foundation for theory.

By gaining a deeper understanding of a core set of concepts, a student can recognize and understand similarities and recurring characteristics, which can be applied more effectively than memorized facts. Teaching conceptually turns traditional learning upside down, focusing on generalities (concepts) and then applying this understanding to specifics (exemplars), instead of the traditional educational approach that focuses more heavily on content and facts.

## HOW THIS BOOK IS ORGANIZED

The conceptual approach in nursing involves an examination of concepts that link to the delivery of patient care. There are multiple concepts applicable to nursing practice. This book does not attempt to present all nursing concepts, nor does it suggest that the featured concepts chosen are the most important. However, the 57 concepts featured in this book are commonly seen in nursing literature or are representative of important practice phenomena; they are the concepts that apply to the broadest group of patients of various ages and across various health care settings. A simplified concept presentation format using consistent headings is intentionally used so that students will find the approach intuitive; at the same time, an understanding of more formalized conceptual analyses will be fostered. Three overarching groups of concepts, or *units*, are featured:

- **Health Care Recipient Concepts (Unit 1)**—concepts that help us understand the individuals for whom we care
- **Health and Illness Concepts (Unit 2)**—concepts that help us make sense of the multiple health conditions experienced by our patients across the lifespan
- **Professional Nursing and Health Care Concepts (Unit 3)**—concepts that guide our professional practice in the context of health care

These three overarching units are further categorized into *themes,* into which concepts are organized to provide a structured framework. This structured approach promotes a thorough understanding of individual concepts and their important context within related health care concepts.

Each concept provides a full spectrum of information, with separate subheadings for concept definition, risk factors, health assessment, context of the concept to nursing and health care, interrelated concepts, case studies, and examples (exemplars) of concepts in practice. Each piece helps build an understanding of the concept as a whole, which in turn will promote the development of clinical judgment, a key outcome if nursing students are to practice effectively in today's complex health care environment.

## FEATURES

Concept discussions include holistic concept diagrams that help visualize conceptual processes, along with *interrelated concepts* diagrams. These illustrations encourage students to build important associations among interrelated concepts. *Case Studies* provide an example of the concept applied in the context of patient care or practice setting.

An extensive list of *exemplars* (boxes at the end of every concept chapter) is based on incidence and prevalence across the lifespan and clinical settings. The *Featured Exemplars* section provides a brief explanation of some of the most important exemplars. Using a custom technology, direct links to selected exemplars have been embedded into a core collection of Elsevier eBooks. This option of linking directly to a curated list of exemplars in a set collection of titles allows for a seamless user experience by uniting concepts to priority exemplars. Although instructors have complete flexibility to choose those concepts and exemplars best suited to their particular institution, these direct links are provided to allow quick access to those exemplars likely to be used in the majority of cases.

*Interactive review questions* incorporated into a self-assessment student testing engine are provided as an additional feature of this book's Evolve website (http://evolve.elsevier.com/Giddens/concepts). These 250 student questions include multiple-choice and multi-select questions to simulate the NCLEX™ Examination testing experience, along with correct answer options and rationales.

Additional material to support faculty is included on the *Evolve Instructor Resources* site. A number of resources are provided to offer assistance in developing and teaching in a concept-based curriculum. Additionally, TEACH Lesson Plans, PowerPoints, and test banks have all been developed at both the RN and PN level to accommodate all learning needs.

## CONCLUSION

Why use a conceptual approach? An exponential generation of new knowledge and information in all areas of our world (including health care and nursing) has made it literally impossible for anyone to know all information within the discipline of nursing. The study of nursing concepts provides the learner with an understanding of essential components associated with nursing practice without becoming saturated and lost in the details for each area of clinical specialty. If concepts are understood deeply, links can be made when these are applied in various areas of nursing practice.

The conceptual approach also fosters future advancement of the nursing discipline. This book serves as a guide to learning about concepts and their application in clinical nursing practice. The conceptual approach provides the foundation for learning, clinical practice, and research efforts needed to continue to build substantive knowledge to the discipline of nursing. The conceptual approach represents a journey that embraces change. Let the journey begin!

**Jean Foret Giddens**

# CONTENTS

UNIT I

# Health Care Recipient Concepts



In the not too distant past, health care was delivered in a disease-centered model whereby healthcare providers controlled and directed care with little input from patients regarding their desires or their concerns about the impact of the treatment plan on their lives. Patients were apprised of the plan as opposed to discussing options for disease management.

Health care has moved to a patient-centered model of health care in which patients and their families are active participants in their care.[1] Healthcare services are designed to meet the needs and wishes of the individual. Healthcare professionals counsel and provide advice related to healthcare decisions, based on their clinical expertise and evidence.[1] Fundamental to this is the ability to understand the unique attributes of each and every patient. For the successful delivery of patient-centered care, nurses should understand the concepts presented in this unit. The two themes within this unit are Attributes and Resources and Personal Preferences.

*Attributes and Resources* includes concepts associated with unique characteristics of the patient: Development, Functional Ability, and Family Dynamics. *Personal Preferences* includes concepts that influence an individual's attitudes and preferences regarding health care: Culture, Spirituality, Adherence, and Self-Management. These concepts are necessary to understand the decision making and behavior of patients, and they inform providers of strategies necessary to reach decisions that are mutually acceptable and agreeable to patients and providers.

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[1]Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.

CONCEPT 1

# Development

*Leigh Small*

A basic characteristic of all human life is change. Development is a complex process that involves the integration of an expansive variety of gradual changes that occur across multiple domains and result in an individual's functional abilities. These changes usually increase in complexity according to a dynamic, somewhat predictable sequence that begins at conception and continues over the life span until older age and/or death.[1–4] The individual's state of health, environmental context, and/or life experiences may alter an aspect of an individual's development, causing it to stagnate or regress to an earlier stage. The ability to provide patient-centered, quality care requires nurses to understand and assess the different aspects of an individual's development and appropriately adjust the care they provide. It is also important for nurses to recognize when expected developmental progression in any area is not occurring, so that collaborative interventions can be initiated.

## DEFINITION

Development refers to *the sequence of physical, psychosocial, and cognitive developmental changes that take place over the human life span.*[3] Development does not occur as an isolated phenomenon. Rather, it represents the dynamic integration of three aspects of change: growth, differentiation, and maturation. *Physical growth* is a quantitative change in which an increase in cell number and size results in an increase in overall size or weight of the body or any of its parts. *Differentiation* is the process by which initially formed cells and structures become specialized. This is both a quantitative and a qualitative change from simple to complex in which broad global function becomes refined and specific. *Maturation* is the emergence of personal, behavioral, or adultlike physical characteristics or a "ripening." Maturation enables an individual to function in a fully developed and optimal way. Thus maturation increases adaptability and competence for individuals to adjust to new situations.[3] Development, as well as the interrelated processes of growth, differentiation, and adaptation, is significantly impacted by genetics, environmental factors, culture, family values, and personal experiences.[3–6] Therefore the overall concept of development, as defined in this context, affects all aspects of every individual and directs all aspects of nursing care. Times during which development is rapidly occurring (i.e., infancy, childhood, and older adulthood) deserve special attention and in-depth knowledge because nursing care will need to responsively adjust and nurses will need to adapt to the developmental changes of the patient more frequently and on an individual basis.

The unique sets of skills and competencies to be mastered at each developmental stage across the life span for the individual to cope with the environment are called *developmental tasks*.[7] Developmental tasks are broad in scope and are, to a significant degree, determined by culture.[8] The tasks may relate to the individual or to the family. Examples of developmental tasks are stepping up steps unassisted and coping with the loss of a spouse.[9]

The order of developmental task attainment is more important than the chronologic age at which each occurs because, although development is ongoing, its speed varies across individuals. Furthermore, each individual has a unique developmental pace moderated by one's state of health, environment, and social/family context. Rate and level of development are also related to the physiologic maturity of all systems—particularly the neurologic, muscular, and skeletal systems.

## SCOPE

The scope of the concept, or extent to which development influences an individual (i.e., expected, delayed, or advanced development; Fig. 1.1), spans the entire life course—from birth to death (Table 1.1). Normal human development is organized and progressive and usually occurs in a predictable sequence. Based on this expected sequence, stages of development have been identified. The traditional stages of development have been identified by general age groups and include embryologic, infant, toddler, preschool, school age, adolescent (teen), young adult, adult, middle age, and older adult. These stages identify characteristics found in the majority of individuals within a stated age range. Although individuals vary in the time of onset of each stage and in the length of time spent in each stage, the sequence itself rarely varies.

### Types of Development

Development is a complex and interconnected concept that has been distilled into six overarching categories or domains: physical/physiologic, motoric, social/emotional, cognitive, communication, and adaptive (Fig. 1.2). The accelerated and decelerated paces of development occur somewhat independently within each domain (e.g., physical/physiologic, motor, social, cognitive, and communication). For example, while gross motor skills are changing (i.e., infant walking), language skills may not be developing as quickly. Similarly, an older school-aged child may be demonstrating advanced physical maturation but has not achieved advanced states of emotional maturation. Thus age-related developmental expectancies or norms are always based on an age range—never

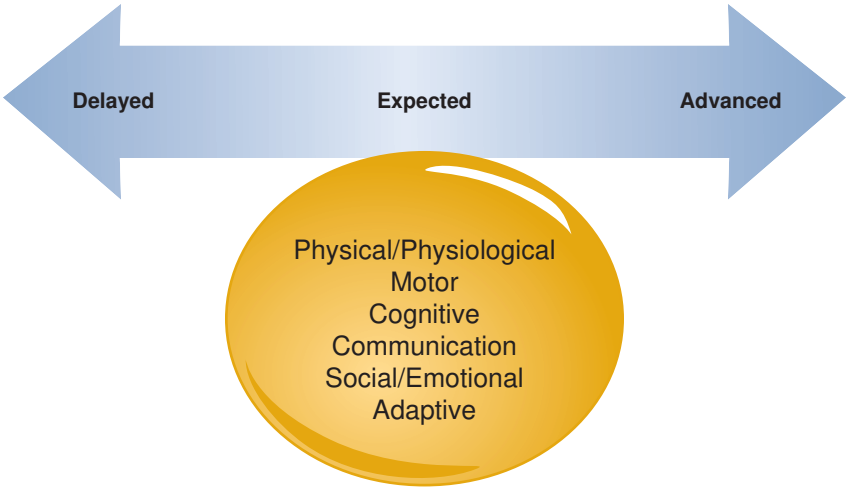


**FIGURE 1.1** Scope of Development.

**TABLE 1.1 Identified Developmental Age Compared With Chronologic Age**

| Developmental Age | Chronological Age |
|---|---|
| Birth | Conception through birth |
| Infant | Birth through 12 months |
| Toddler | 12–36 months |
| Preschooler | 36 months–5 years |
| School-ager | 5–12 years |
| Adolescent | 12–18 years |
| Young adult | 18–35 years |
| Middle adult | 35–65 years |
| Older adult | |
| Young-old | 65–75 years |
| Middle-old | 75–85 years |
| Old-old | >85 years |

an exact point in time when specific skills will be achieved.[1,3,10] Although the pace of development within each of these domains occurs independently, the progression of skills in the subcategories is also interconnected and reliant on the development in the other domains.

## Physical/Physiologic Development

Physical/physiologic development refers to the growth and changes in body tissues and organ systems and the resultant changes in body functions and proportions. Physiologic development includes cellular proliferation, differentiation, and maturation that occurs in each organ and system that allows integrated human functioning necessary for life and health (i.e., infant hematopoietic maturity and secondary sexual characteristic development leading to sexual function). Overall, physical growth and development occur in a bilateral and symmetric way, progressing in a cephalocaudal (head-to-toe) direction (i.e., infants have a disproportionately larger head-to-body ratio compared with that of an adult) and proximodistally (from midline to periphery).

## Motoric Development

Motoric development is frequently separated into two major categories: gross and fine motor. Very generally, motoric development progresses from achievement of gross motor to fine motor skills—a process referred to as refinement.[11,12] Gross motor skills involve the use of large muscles to move about in the environment. Examples of gross motor development include the sequential skills of sitting, standing, maintaining balance, cruising, walking, running, walking up stairs without assistance, and more complex physical tasks such as playing soccer. Fine motor skills involve the use of small muscles in an increasingly coordinated and precise manner. Examples of fine motor development include the achievement of the successive skills of batting at an object, reaching and holding an object, transferring an object from hand to hand, holding a pencil in a refined grasp, making marks with a pencil, writing letters, writing words, and the complex skill of creating masterful artwork. Other fine motor skills using the hands and fingers to eat, draw, dress, and play are all required to achieve optimal functioning.[13,14] Fine motor development is contingent upon cognitive and neurologic development.

## Social/Emotional Development

Social and emotional development includes the development of self-understanding, understanding others, and understanding social interactions.[1,2,11,12] These different elements of social/emotional development usually occur in this order (e.g., self, others, and social interaction). Knowledge of social/emotional skills is critical because it directs effective communication with an individual(s) and may impact suggested environmental strategies for an individual to attain optimal functioning. For example, young preschool children cannot distinguish between their effort and their ability and are likely to overestimate their competence and abilities. Thus caution should be used regarding self-reported ability(ies), and nurses should seek confirmation (e.g., "Johnnie says that he can swallow pills. Have you seen Johnnie take pills before, or is Johnnie better able to swallow liquid medicine?"). Development of an understanding of others (perspective taking) includes a growing comprehension that other people have emotions and intentions and that objects do not. This understanding is foundational to the development of trust, moral development, and the ability to interact with others. These aspects of development underlie the ability of children to discern the difference between a truth and a lie. A complicating aspect of social/emotional development is emotional regulation, which directly impacts relational interactions (i.e., play, work, and social interactions).[15] This complex aspect of development declines during the aging process in an indeterminable rate, underscoring the need to consider and assess areas of social/emotional development across the life span.

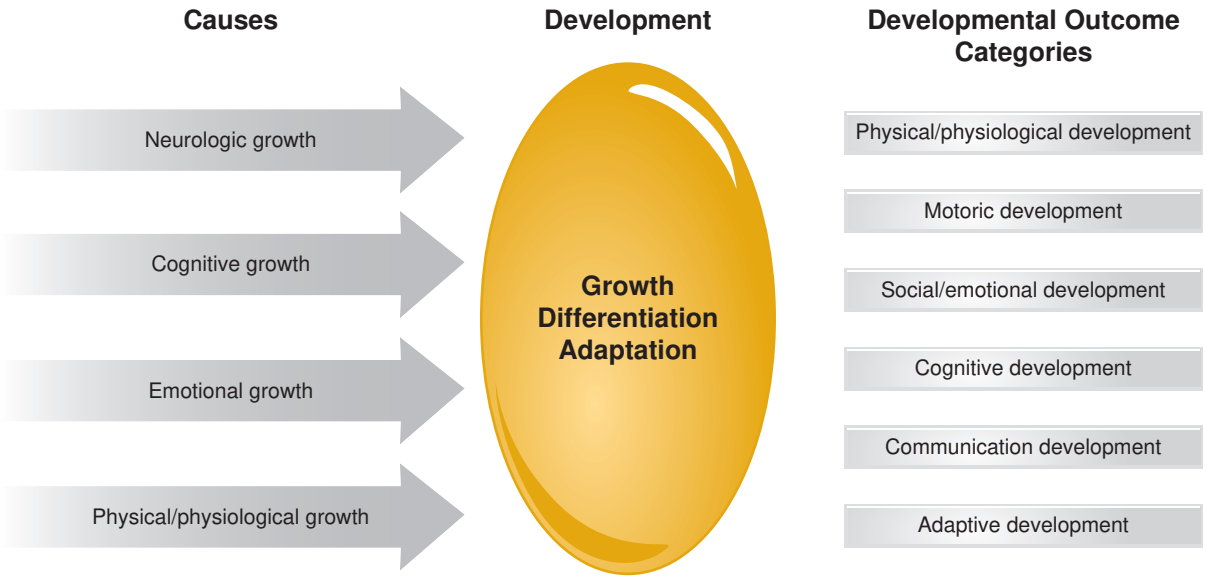


**FIGURE 1.2** Development Concept Categories.

### Cognitive Development

The cognitive dimension of development relates to working memory capacity, cognitive self-regulation, and the processing and use of information about the environment and objects in the environment. In addition, individuals have an increasing understanding of relationships between self-understanding and information over time. These processes underlie the development of critical thinking skills and executive functioning, which includes learning, forming concepts, understanding, problem solving, reasoning, remembering, and thinking abstractly. Ultimately, these complex aspects of cognitive development, in combination with advanced social/emotional developmental stages, enable moral and spiritual development.[1]

Some have suggested that there are different aspects of intelligence that include analytical, creative, and practical components,[11,12] whereas others have conceptualized intelligence to include many different types of intelligence.[16] Because the brain has reached 90% of its adult weight and has completed the majority of synaptogenesis and myelination by 6 years of age, the individual is deemed to be at an optimal ready state for formal education—a process thought to stimulate cognitive development. In late adulthood, maintenance of cognitive abilities is affected by a decline in the speed of processing, decrements in executive functioning (e.g., attention and memory), and potentially by reduced or limited cognitive stimulation, which leads to continued synaptic pruning and decreased synaptogenesis. Life span cognitive development and "brain science," including the impact of the environment and trauma, have become a primary focus of research recently.

### Communication Development

Speech is the spoken expression of language. The three components of speech are (1) articulation, which refers to the pronunciation of sounds; (2) voice, which refers to the production of sound by the vocal cords; and (3) fluency, which refers to the rhythm of speech. Language involves a set of rules shared by a group of people that allows the communication of thoughts, ideas, and emotions. Communication is a process that requires both receptive and expressive skills. Receptive language function is the ability to hear and understand what others say. Expressive language function is the ability to develop and express one's own thoughts, ideas, and emotions.[17] Speech and language development synergistically occurs with cognitive, neurologic, and fine motor development and requires optimal sensory function (e.g., hearing), sensory integration, and interactional relationships to develop and refine.

Simple speech begins with utterances of consonants, increases to include vowels ("ba-ba" and "da-da"), then single words are formed ("no" and "me"), and two- and three-word combinations arise ("me do" and "you up"), leading to the development of meaningful phrases and sentences. This language explosion or "period of exuberance" is an outward demonstration of frontal lobe development and typically occurs in children 18 months to 3 years of age. This is a specific example of a critical developmental time point, meaning that if significant speech and language gains are not made during this time, the delay may have resultant sequelae (i.e., a variety of learning disorders). Speech and language continue to increase in complexity during the life span until older adulthood, a time during which communication and speech may decline or become impaired as a result of health impairment or disease (e.g., expressive aphasia that results from a stroke).

### Adaptive Development

Adaptive development refers to the acquisition of a range of skills that enable independence at home and in the community. Adaptive skills are learned and include self-care activities such as dressing/undressing, eating/feeding, toileting, and grooming; management of one's immediate environment; and functional behaviors within the community, such as crossing the street safely, going to the store, and following rules of politeness when interacting with others.[18] Demonstration of skills in this developmental domain requires advanced and complex skills in each of the other developmental domains previously discussed and efficient sensory integration processes. Examples of adaptive development include cooperation; a level of moral and ethical decision making; and abilities to follow social and cultural folkways, mores, taboos, rules, and laws.

## ATTRIBUTES AND CRITERIA

### Expected Development

A person who is considered to have *normal* development is one who is demonstrating the expected developmental and physical maturation, physiologic function, and/or expected tasks within or across the developmental domains (e.g., physical/physiologic, motor, social, cognitive, and language) that are associated with the individual's chronologic age.

*Developmental level* refers to an individual's stage of development (e.g., stage of epiphyseal closure in long bone development, Tanner stage of pubertal development, and stage of cognitive development) or ability to independently achieve an outcome (e.g., perspective taking and abstract reasoning).

A *developmental milestone* is an ability or specific skill that most individuals can accomplish in a certain age range.[1,10] The categories of age ranges typically include those individuals who are experiencing rapid developmental change, such as infants, toddlers, preschoolers, school-aged children, and adolescents (teens), with emphasis on the growing child. However, milestone attainment and loss are appreciated across the life span. Common use of the term "developmental milestones" typically refers to changes that involve *motor*, *social*, *emotional*, *cognitive*, and *communication* skills. In the context of this concept presentation, development also includes *physical/physiologic milestones* (Box 1.1). For example, every aspect of physical and physiologic growth and maturation has been carefully mapped and normed to the general population and to several subpopulations (e.g., weight for age, body mass index for age and gender, and kidney and liver growth and development). Classically defined, developmental milestones occur when a confluence of critical changes (i.e., neurologic, cognitive, emotional, and physical) occurs, marking a significant or critical point of maturation. As a result, these milestones provide a basis for developmental assessment and serve as major markers in tracking development.

## Abnormal Development

If an individual does not accomplish milestones within a specified age range, or a critical period, he or she may be identified as being *developmentally delayed*, signifying that an essential element of neurologic and/or cognitive maturation has not occurred within an age range and should be investigated. The definition of developmental delay varies, but it usually involves a delay of at least 2.5 standard deviations in one or more areas or subcategories of development. In other words, a developmental delay would be identified if a developmental change was not found in an individual that can be found in 95% of others of the same chronologic age range. Certain individuals may demonstrate advanced development in one or more developmental domains/categories (see Fig. 1.1). The developmental changes assessed would include physiologic and physical development, motor, cognitive, communication, social/emotional, and adaptive development.[19] Individual delays within a developmental domain may be demonstrated in subtle ways and may not affect overall functioning unless the delays are pronounced and developmental progress continues to lag over time.

An individual who has accomplished a developmental milestone rarely loses this ability unless the individual encounters a significant stressor (e.g., hospitalization or a new disease diagnosis). For example, once a child learns to sit or stand or becomes toilet trained, it is unusual for such skills to be lost without cause. The loss of developmental milestones, or *developmental regression*, is very subtle, and parents often miss this occurring in their own children. Recognizing the loss of a previously attained developmental milestone is as important of an assessment finding as the identification of achieving milestones. When developmental regression has occurred, the underlying cause must be identified with the goal of ameliorating the situation, addressing underlying health conditions impacting development, and restoring developmental gains as soon as possible.

*Developmental arrest* is the plateau of developmental change in some category and is noted when chronologic age continues to progress but developmental change does not. Developmental arrest can be differentiated from lagging or slowed development because of its significant effects on an individual's functioning. Physical or growth arrest can be the result of underlying health abnormalities or social conditions (e.g., abuse, neglect, or social isolation) that may or may not have been diagnosed. Cessation in physiologic development (organ or system maturation) frequently results in significant functional limitations or chronic health conditions. For example, some believe that developmental arrest that occurs in utero results in a congenital anomaly.[13]

It is estimated that at least 8% of all children from birth to age 6 years have developmental problems and/or delays in one or more areas of neurocognitive development. A *global delay* refers to lag in multiple neurocognitive developmental areas—speech and language, gross and fine motor skills, and personal and social development.[20] Some individuals are identified as having a *pervasive developmental disorder* (PDD), which means that they have a significant developmental delay in many basic milestones and skills that often cross developmental domains. PDD is usually identified by 3 years of age, which is a critical time in an individual's development. Frequently, children with PDD have delays that affect the ability to socialize with others, to communicate, and to use imagination—all skills that usually emerge during this age. Thus children with these conditions often demonstrate confusion in their thinking and generally have problems understanding the world around them—challenges that continue throughout their life. Specific types of developmental delays are presented in the "Clinical Exemplars" section later in this chapter.

There are periods within each of the domains of development that are characterized not only by critical periods (mentioned previously) but also by susceptible or sensitive periods. These are points in the life span when there is greater susceptibility to positive or negative influences (e.g., genetic, environment, culture, family values, and personal experiences), with resulting beneficial or detrimental effects.[7] One example of the latter is the finding that young children with rapidly occurring frontal lobe development, the "period of exuberance," are particularly vulnerable to environmental toxins (e.g., lead intoxication) and exhibit marked detrimental effects from such exposures (e.g., stunted cognitive abilities or learning disabilities).[21]

### BOX 1.1 Attributes of Development

**Physical/Physiologic Development**
- Growth
- Physical characteristic development
- Organ system maturation

**Motoric Development**
- Fine motor development
- Gross motor development

**Cognitive Development**
- Critical thinking
- Executive functioning

**Communication Development**
- Speech
- Language

**Social/Emotional Development**
- Social skills
- Emotional control

**Adaptive Development**
- Adaptive skills
- Functional skills
- Environmental Management

## THEORETICAL LINKS

Several theories have been developed throughout the years to understand different domains of neurocognitive development and define different developmental levels and/or stages within each domain. Four of the classic theories are presented: Freud's theory of psychosexual development (1930s and 1940s), Erikson's eight stages of psychosocial development (1940s), Piaget's theory of cognitive development (1960s), and Kohlberg's theory of moral development (1980s). Caution should be taken when considering each of these theories because controversy exists regarding their accuracy and applicability.

### Freud's Theory of Psychosexual Development

The term *psychosexual*, as used by Freud, refers to any sensual pleasure. Freud believed that at different ages, particular areas of the body provide the chief source of sensual pleasure and that experiences with these pleasure centers significantly impact the development of personality. He outlined five stages of development: oral (birth to 1 year), anal (1 to 3 years), phallic (3 to 6 years), latency (6 to 12 years), and genital (puberty to adulthood). He identified conflicts associated with each stage that must be resolved for development to occur. Under stress, individuals were thought to regress temporarily to an earlier stage. If resolution was not satisfactorily achieved, an individual may become fixated in the stage and personality development would be arrested.[22,23]

The validity and applicability of Freud's theory and associated underlying assumptions are frequently contested because his work was based on adults with mental health diagnoses and their reflections of past life experiences (retrospective data). However, the conceptual view that an individual matures and develops over time in a stagewise process and the environment impacts those changes (i.e., relationships) was novel at the time and proved to be a critical step for the field of psychology. It resulted in other theorists developing and testing hypotheses regarding specific aspects of cognitive and psychological development over the life span (i.e., psychosocial and moral development).

### Erikson's Theory of Psychosocial Development

Erikson's theory of development focused on the psychosocial development of an individual across the life span. Erikson was a protégé of Freud, and the theory he developed was an expansion and refinement of Freud's theory specific to psychosocial development. Erikson identified eight stages of psychosocial development thought to occur between birth and death. These stages were identified by the conflict confronting the individual and included trust versus mistrust (birth to 1 year), autonomy versus shame and doubt (1 to 3 years), initiative versus guilt (3 to 6 years), industry versus inferiority (6 to 11 years), identity versus role confusion (11 to 18 years), intimacy versus isolation (18 to 25 years), generativity versus self-absorption and stagnation (25 to 65 years), and integrity versus despair (65 years to death). He also had a stagewise philosophy (every individual moves only in a forward sequential way through each stage or development ceases), in which each stage had a particular task, identified in the form of a conflict, that must be resolved to progress to the next developmental level.[22,24]

### Piaget's Theory of Cognitive Development

Piaget's theory of cognitive development sought to explain how children innately organize their world and learn to think.[25] In this theory, cognitive development is viewed as progressing from illogical to logical, from concrete to abstract, and from simple to complex. Underlying assumptions of this theory are that cognitive development is a product of inborn intellectual capacity, nervous system maturation, and perceptual ability, and exposure to new experiences serves as a stimulus for cognitive development. The theory posits that there are four general periods: sensory motor (birth to 2 years), preoperational (2 to 7 years), concrete operational (7 to 11 years), and formal operations (11 years to adulthood). Each period is composed of a number of stages that are age related, sequential, and stepwise forward.[15,26] These pioneering theories resulted in years of debate regarding the influence of nature versus nurture during a person's development; however, more contemporary theories allege that both play an important role.

### Kohlberg's Theory of Moral Development

Kohlberg developed a theory that expands on Piaget's cognitive theory to address the development of an individual's moral reasoning across his or her life span.[27] According to Kohlberg, when a conflict in universal values occurs, a moral choice must be made. This choice is based on moral reasoning, which is postulated to develop progressively over three levels: preconventional (18 months to 5 years), conventional (6 to 12 years), and postconventional (12 to 19 years). Each level is composed of two stages. In this theory, development of moral reasoning is dependent on cognitive skills and neurologic maturation, but it is not definitively linked to specific developmental stages.[27] This theory furthered thought regarding other areas that undergo change and development during one's life.

### Contemporary Theories

More contemporary scientists and students who study development appraise theories with regard to three main aspects: Does the theory suggest that development is continuous (uninterrupted change over time) or discontinuous (stepwise progression)? Does the theory suggest that there is only one path of development for all children? What is the relative influence of nature and nurture according to the theory being discussed? Careful review and appraisal of those early developmental theories have given rise to many current theories, such as the ecological systems theory, Vygotsky's sociocultural theory, and theories of multiple intelligences.

## CONTEXT TO NURSING AND HEALTH CARE

Because of the frequency and intimacy of their patient contact, nurses are uniquely positioned to gain information about (assess) their patients and holistically intervene to improve patient health and functioning. Assessment of all six domains of development is well within a nurse's scope of practice and significantly impacts the care that nurses and other healthcare providers offer. Care modified or directed by a person's development will be most appropriate and more likely to bring patients to optimal well-being and functioning. Therefore it is important to recognize risk factors and age-sensitive time periods during which developmental progress may be threatened.

### Risk Recognition

Developmental progress, delay, arrest, advance, or decline occur in all social classes and ethnic groups and across ages. Most frequently, these concepts are discussed in terms of pediatric populations (infancy through adolescence) because change in all categories of development is occurring rapidly.[28,29] Because development in all areas is interdependent, a delay, arrest, or decline during a period of rapid developmental change may place an individual at risk. Several types of risk exist, including the following:

- **Prenatal:** Genetic conditions, congenital infections, and prenatal exposure to environmental toxins, illicit drugs and/or alcohol, or cigarette smoking
- **Birth risk:** Prematurity, low birth weight, birth trauma, and maternal infection

- **Individual risk:** Ill health, malnutrition, physical or mental disabilities, and cognitive impairments
- **Family risk:** Low parental education, poor health of family members, and large family size
- **Situational risk:** Acute life stress, acute mental or physical health crises, acute school/social problems, bullying, interpersonal violence, sexual abuse, and acute conflictual or violent family relationships
- **Social determinants of health:** Poverty, environmental toxins, adverse living conditions, rural or urban living, areas with high prevalence of disease, community with low cohesion, limited access to health-promoting foods and safe physical environments that facilitate healthy activity, and limited access to health care
- **Toxic stress:** Strict or authoritative parenting, child abuse or neglect, exposure to domestic violence, chronic social isolation, and chronic everyday stressors
- **Health status:** Chronic illness (e.g., congenital heart disease, cancer, brain injury, and cystic fibrosis), traumatic or severe injuries, and conditions requiring prolonged bed rest and/or multiple/prolonged hospitalizations[14]

Stressors, as perceived by children, may differ greatly from the stressors that caregivers may sense exist for a child. For example, loss of a pet, a move, integration into a new school, alterations in household members, and/or illness of sibling, family member, teacher, or friend may be extremely stressful for a child. In some cases in which children spend time with different adults in different contexts (e.g., child care and split time with a divorced parent), caregivers may be unaware that their child has experienced these stressors.

## Developmental Assessment

Development, as a concept, has implications for all aspects of nursing practice across all populations and healthcare settings. A thorough developmental assessment of all domains and recognition of risk factors that may impact development are essential for early identification of developmental problems. These assessments are also necessary to determine goals for rehabilitation and strategies to compensate and thus optimize function and overall health when limited progression is identified and/or following illness or injury.

Assessment of development should independently occur for every domain of development. These critical assessments require focused attention and intervention, particularly when working with preverbal or young children and older adults with limited abilities to articulate accurate information, in situations with an absent primary caregiver, or in chaotic living situations in which limited historical data are available.

### Infants and Children

Gross screening for developmental risks and lags or delays primarily occurs as a part of well-child health visits.[28] These assessments should be completed by healthcare providers with specialized training in child development and require direct observation with planned developmental challenges and parent report of development task accomplishment. Valid and reliable screening instruments are used and frequently involve documentation of specific skills, parent and/or teacher reports, and child reports. A classic tool used to measure developmental status is the Denver Developmental Screening Test II (DDST II). The DDST II is designed for use with children from 1 month to 6 years of age and has been standardized for minority populations. It assesses gross motor, fine motor, language, personal-social skills, and milestones. The two primary limitations to the use of the DDST II involve the limited sensitivity (83%) and specificity (43%) of the tool,[30] leading to a number of referrals for further evaluation of children suspected of being developmentally delayed but who are not truly developmentally delayed. In addition, the use of this tool does not identify children who have other diagnoses (e.g., cerebral palsy) that may affect the developmental changes anticipated in a child's early years.[3,9,31] Thus the DDST II is recognized as a gross screening tool with inherent error and not a diagnostic tool.

When delay is suspected in any specific area of development, a more in-depth assessment with a valid, reliable, and highly sensitive and specific tool for that particular area is needed for diagnostic purposes. For example, an in-depth language assessment may be needed after a gross screening by the DDST II. Given this situation, a tool such as the Early Language Milestones Scale (ELM Scale-2)[32] may be used to assess auditory visual, auditory receptive, and expressive language in children between the ages of 1 month and 3 years. Assessment of social/emotional development may include the Modified Checklist for Autism in Toddlers–Revised (M-CHAT-R). This tool has been found to be valid and reliable and to have strong sensitivity and specificity.[33] Other examples of developmental screening tools that include parental report are the Ages and Stages Questionnaire (ASQ),[9] the Parents' Evaluation of Developmental Status (PEDS),[34] and the Learn the Signs/Act Early Interactive Milestones Checklist program sponsored by the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention (CDC).[35]

Detailed information and several assessment tools focused on child development are available from pediatric and developmental textbooks and from reliable websites such as that of the CDC.[35] The Bright Futures website, developed by the American Academy of Pediatrics, includes specific information for healthcare providers.[36] Many internet resources are appropriate for parents and interested care providers (e.g., child care providers), but it should be emphasized that screening tools do not provide a diagnosis. A diagnosis requires a thorough neurodevelopmental history, physical examination, advanced testing and assessment for specific delay, and assessment for potential underlying associated health disturbance.[20]

### Adolescents

Routine physical examinations monitor continued development in all areas into the adolescent years. During the adolescent years, teens' major developmental milestones include advanced cognitive thinking and risk-taking behaviors that accompany psychosocial, moral, and sexual development. To assess these areas of development, a HEADSS Adolescent Risk Profile may be used.[37] HEADSS is a screening tool that assesses the teen's *h*ome, *e*ducation, *a*ctivities, *d*rugs, *s*ex, and potential for *s*uicide for the purpose of identifying high-risk adolescents and the need for more in-depth assessment, counseling, and/or anticipatory guidance. Other general adolescent screening tools can be used, including CRAFFT (*C*ar, *R*elax, *A*lone *F*orget, *F*riends, *T*rouble), which is a behavioral health screening tool for use with children younger than age 21 years to assess for behavior health risk, and RAAPS (*R*apid *A*ssessment for *A*dolescent *P*reventive *S*ervices; http://www.possibilitiesforchange.com/raaps),[38] or GAPS (*G*uidelines for *A*dolescent *P*reventive *S*ervices) developed by the American Academy of Pediatrics.[39] It is important to note that teens often develop mental health issues. Some may be the result of the tumultuous social and emotional changes encountered during adolescence, as well as many chronic mental health conditions first manifest during prepubescence or adolescence (e.g., schizophrenia, substance dependence, and bipolar disorder). There are a multitude of specific, high-quality (valid and reliable) assessment tools that can be used with older school-aged children and adolescents to detect the presence and acuity of depression, anxiety, attention-deficit with/without hyperactivity disorder, and other mental health and developmentally associated issues.

### Adults

In adulthood, physical examinations and assessments should continue to monitor normal developmental patterns. However, the focus of these

interactions frequently involves minor acute or chronic health disturbances. Physical/physiologic, psychological, and cognitive characteristics of individuals are assessed relative to age. For example, older females' reproductive organs are monitored for the normal decline in function. This physiologic change may result in associated symptoms that are disruptive to the individual (e.g., "hot flashes"). In addition, mental health is an aspect of health and wellness that should be assessed in all individuals (e.g., depression). Screening tools designed for use with adults include the Recent Life Changes Questionnaire, the Life Experiences Survey,[15] and the Stress Audit, all of which aim to identify adults in need of supportive interventions and/or services relative to stress and coping.[31]

### Older Adults

When adulthood is reached, often there is limited focus on developmental assessment until individuals reach the older adult stage, unless an adult has a serious mental or physical illness or injury or suffers a traumatic event. When this is the case, frequently the focus is on functional assessment (or functional ability)—that is, an assessment of an individual's ability to carry out basic activities of daily living (BADLs) and instrumental activities of daily living (IADLs).[40] BADLs include skills such as hygiene, toileting, eating, and ambulating. IADLs are skills that are needed to function independently and include preparing meals, shopping, taking medications, traveling within the community, and maintaining finances. Functional assessment is described in greater detail in Concept 2, Functional Ability.

## Care Delivery

Knowledge of the individual's development in all areas (i.e., physical/physiologic, motoric, social/emotional, cognitive, communication, and adaptive) is critical to nursing care even when no developmental problems exist. It determines appropriate communication strategies, teaching levels and techniques, safety provisions, assistance with activities of daily living, and approaches to therapeutic interventions. An individual's developmental level also determines need for anticipatory guidance, health promotion, and accident or illness prevention interventions. To provide appropriate information on recommended health screenings, immunizations, and chemoprophylaxis, as well as counseling on health topics such as injury prevention, cigarette smoking, alcohol and drug abuse, diet, exercise, and sexual behavior, the developmental level of all areas must be known.

Early identification and intervention are among the most important points when developmental delay(s) is present. In general, regardless of the type of developmental delay, the earlier that intervention occurs, the better the outcome. Management of neurocognitive developmental delay truly requires intradisciplinary collaboration. Early intervention services can include one or more of the following services: nursing, medicine, physical therapy, occupational therapy, psychological intervention, individual and/or family counseling, nutritional consulting, speech and language services, play therapists, audiology services, and assistive technologies. All of these services have as their interprofessional goal to maximally develop a specified area and develop other areas to compensate for an identified disability to optimize future development and functioning (e.g., readiness to learn in a preschool-aged child).

Physical/physiologic developmental limitations and/or challenges are not addressed in this chapter, although the effects of such problems have been suggested and will affect each of the health and illness concepts and thus impact nursing care. For example, glucose regulation of a newborn is affected differently from that of an adult because of the inability of the newborn to feed itself, the limited amount of brown fat for calorie stores, and the differential caloric loss due to temperature instability.[14] Similarly, tissue integrity in an infant is significantly different than that of a teen, middle-aged adult, or older adult. Premature and young infants have a greater degree of skin barrier dysfunction resulting in a higher transepidermal water loss, increased percutaneous absorption of chemicals, and higher risk for injury and/or bacterial invasion/infection.[14] Therefore the effect of physical/physiologic development should be considered with review of each of the health and illness concepts contained in this text.

# INTERRELATED CONCEPTS

Concepts used to describe the human person do not represent isolated phenomena but, rather, phenomena that interrelate with one another. The strength and direction of the impact of one conceptual phenomenon on another vary, given the central concept under consideration. The interrelated concepts are presented in Fig. 1.3. Concepts representing major influencing factors and hence determinants of development include **Functional Ability**, **Nutrition**, and **Culture** with its unique variations in practices and expectations. These appear in green at the top of the diagram, and their influence on development is indicated by the arrow pointing in the direction of the concept. **Family Dynamics** and the concepts associated with **Mood and Cognition** have a reciprocal relationship with development, represented by the red ovals with double-headed arrows. The concepts below the influencers (identified in purple at the bottom of the diagram) are the health and illness concepts significantly impacted by development. Note that there are only a few concepts not affected by development. The relationships are indicated by an arrow pointing from development to each of the concepts.

# CLINICAL EXEMPLARS

Conditions resulting from problems with development are many and varied; common exemplars are presented in Box 1.2 and can involve any of the developmental domains. Problems may result in a specific problem or deficit affecting one domain, or they may be pervasive or global, affecting many aspects of multiple domains. Causes of developmental problems are similarly complex. A small number of them are clearly identified as genetic or chromosomal problems. However, the causes of the vast majority are unknown, with numerous environmental conditions proposed as probable factors influencing their occurrence. Neurocognitive and physiologic developmental problems may be diagnosed in utero (e.g., Down syndrome diagnosed via amniocentesis, congenital heart disease diagnosed with a sonogram, and kidney development [hydronephrosis] diagnosed by ultrasound). Alternatively, developmental concerns can be diagnosed at birth (e.g., neuromuscular immaturity), or they may become evident with age and ongoing development (e.g., intellectual disability, leg length discrepancies, learning disabilities, and autism).[13] With advances in science and technology, causes of developmental disorders may be more easily identified and understood in the future, resulting in earlier diagnosis with increased accuracy. These advances should improve health outcomes related to developmental disruptions.

## Featured Exemplars

### Failure to Thrive

One of the most common physical development problems is that of failure to thrive/grow, a condition in which there is a deceleration or loss in weight and subsequent loss of linear growth (height/length). This has many etiologies categorized into three types: endogenous or organic (e.g., diagnosed/undiagnosed disease process, condition of the gastrointestinal tract, and inadequate nutrition), exogenous or nonorganic (e.g., inappropriate or dysfunctional feeding practices), or mixed type.[14] Weight/height loss or deceleration may be the result of emotional

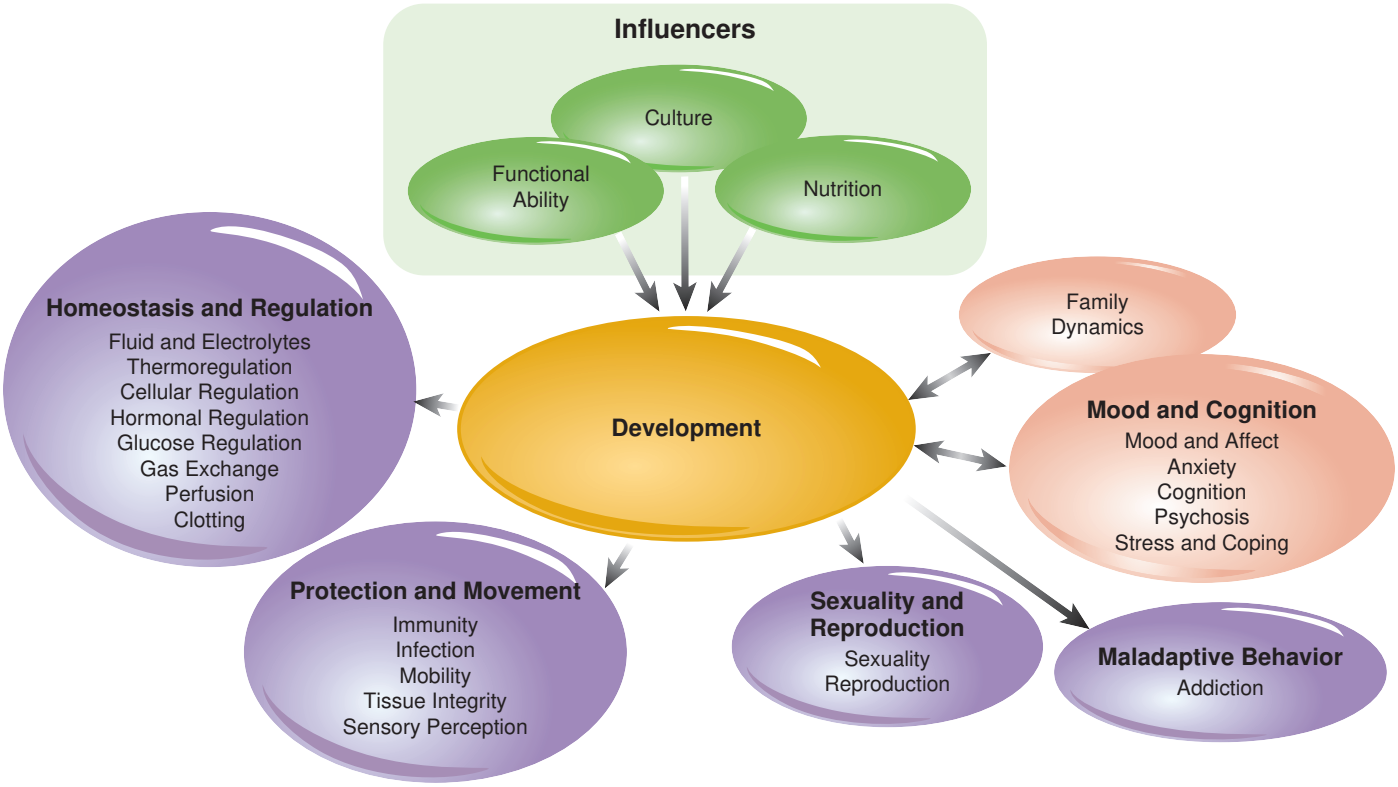


**FIGURE 1.3** Development and Interrelated Concepts.

## BOX 1.2 EXEMPLARS OF DEVELOPMENTAL DELAY/DISORDERS

### Physical/Physiologic Developmental Delay/Disorder

- Angelman syndrome
- Bladder exstrophy
- Hydronephrotic kidney disease
- Cleft lip/palate
- Congenital heart disease
- Cystic fibrosis
- Developmental hip dysplasia
- Down syndrome
- Failure to thrive
- Fragile X syndrome
- Hydrocephaly
- Klinefelter syndrome
- Prader-Willi syndrome
- Spina bifida and other neural tube defects
- Turner syndrome

### Motoric Developmental Delay/Disorder

- Cerebral palsy
- Developmental dyspraxia
- Duchenne muscular dystrophy
- Hypertonia
- Hypotonia

### Social/Emotional Developmental Delay/Disorder

- Autism spectrum disorder
- Asperger syndrome
- Childhood (pediatric) disintegrative disorder not otherwise specified (PDD-NOS)
- Failure to thrive
- Aggressive/bullying/violent behaviors
- Dysfunctional attachments
- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Reactive attachment disorder
- Separation anxiety disorder

### Cognitive Developmental Delay/Disorder

- Attention-deficit disorder
- Attention-deficit/hyperactivity disorder
- Fetal alcohol syndrome
- Rett syndrome

### Speech and Communication Developmental Delay/Disorder

- Central auditory processing disorder
- Deafness/conductive hearing loss
- Expressive language disorder
- Receptive language disorder

### Adaptive Developmental Delay

- Blindness
- Oppositional defiant disorder
- Traumatic brain injury

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stress related to social isolation (e.g., neglect) or mental health difficulties (e.g., depression).

### Cleft Lip and Palate

Physiologic developmental problems often have their origins in intrauterine development or embryologic formation and/or cellular division. There may be subtle or overt manifestations that are detected by thorough assessments. One exemplar would be a soft palate abnormality identified through physical examination of the oropharynx. This represents a midline deformity with its beginning in embryologic development. This defect can be demonstrated subtly (e.g., soft palate deformities) or overtly (e.g., cleft lip). It may result in significant functional impairment (inability to suckle from a breast or bottle) and emotional distress (facial deformity), or it may cause little effect on an individual's functioning.

### Duchenne Muscular Dystrophy

A classic example of problems with gross and fine motor development identifiable by impaired motoric developmental milestone achievement is Duchenne muscular dystrophy. In this example, a preschool-aged boy may be identified as having difficulty climbing stairs or pedaling/balancing a two-wheeled bicycle. Closer assessment of the young child may identify positive Gower sign, which signifies impaired lower limb motoric development and/or developing weakness. This is a genetic recessive X-linked disorder that involves progressive proximal muscle weakness of the legs and pelvis.

### Autism Spectrum Disorder

Perhaps the most commonly occurring impaired social/emotional development problem is autism spectrum disorder (ASD). Children with ASD demonstrate deficits in social communication and interactions across multiple contexts. Associated manifestations include repetitive patterns of behavior, activities, and focused nonhuman interests. These children are most often identified in the toddler or preschool years, and despite intensive interventions, they have symptoms that cause impairment in social, occupational, and interpersonal functioning that persist throughout their life span. Some children suffer mild impairment from their symptoms, whereas others are severely disabled.

### Attention-Deficit/Hyperactivity Disorder

Cognitive and intellectual disabilities often evidence themselves in early childhood. One common cognitive disorder is attention-deficit/hyperactivity disorder (ADHD). This is considered to be a minor impairment or learning disability. Symptoms include inattention, impulsivity, and excessive motor activity. Children must demonstrate symptoms prior to age 7 years and have persistent symptoms that cross settings (e.g., school and home) to have this diagnosis. Impairments in executive processing result in disorganized behavior and difficulties with memory, planning, and problem solving.[12] ADHD may also result from injury or disease.

### Central Auditory Processing Disorder

Impairments of speech and language are often recognized as learning disabilities. The diagnosis of central auditory processing disorder (CAPD) has become more commonly applied. This disorder affects how the brain receives and processes what is heard. This, like other learning disabilities, is a lifelong problem and often affects an individual's social interactions. Children demonstrate symptoms of this disorder differently based on their age and level of cognitive development. For example, young children may appear to have a speech delay, whereas school-aged children often have difficulty following spoken instructions, do not understand people who speak quickly, and cannot find the right words to say in conversation.

### Traumatic Brain Injury

Adaptive development is the result of a complex integration of the multiple skills and abilities easily impacted by injury, illness, substance use, exposure to trauma, or an accumulation of toxic chronic stressors. Traumatic brain injury (TBI) is an example of an adaptive developmental disability defined as an external mechanical force resulting in permanent or temporary brain injury and associated cognitive, physical, or psychosocial dysfunction. Immediate symptoms associated with TBI include deficits in motor coordination, confusion, and irritation. However, persistent symptoms include deficiencies identifying, understanding, processing, and describing emotions; impulsivity; and mood swings. These chronic problems can result in lifelong cognitive and social deficits.

## CASE STUDY

### Case Presentation

A first-time mother and father bring their 3-month-old daughter to a clinic appointment. When the nurse asks the parents if they have any concerns about the baby, the mother responds, "I'm worried because she is still so small. She does lift her head up when she is on her stomach but she doesn't turn over from stomach to side. My neighbor says her grandchild was starting to turn over when she was about 4 months old and my friend's baby who is just about the same age weighs a pound and a half more than mine."

As part of the assessment, the nurse gathers the following information:

- Length at birth: 46 cm (18.4 in.)
- Current length: 57 cm (22.4 in.; increase of 11 cm in 90 days)
- Birth weight: 2786 g (6 lb, 2 oz)
- Current weight: 5100 g (11.2 lb; increase of 2314 g in 90 days, or 25.7 g/day)
- Motor (gross and fine): Kicks when placed on back; holds head up 90 degrees and chest off floor when prone; bears weight on legs when feet placed on solid surface; rudimentary reach/swipe toward objects; pulls objects toward midline
- Reflexes: Moro, tonic neck, and stepping reflexes readily elicited
- Social/emotional behavior: Child attends to faces within 8 to 10 in. away and appears expressive with eye and mouth movements at site of mother or positive expressions of others
- Neurologic/cognitive: Follows a moving object past midline 180 degrees
- Speech and communication: Turns head toward sound; babbles

## CASE STUDY—cont'd

Based on knowledge of the different areas of development, the nurse assesses the infant's physical growth by comparing the birth weight and length with the current weight and length. The infant was born at 40 weeks of gestation; therefore the physical growth is determined to be slightly less than the average height and weight for a female infant but with consistent growth acceleration from birth.

Follow-up is needed to review the mother's prenatal and birth history inclusive of intrauterine ultrasound tests, α-fetoprotein test, screens for prenatal infections and immunization titers, and the hospital newborn hearing screening result and newborn screening for inborn errors of metabolism and congenital diseases.

The nurse reviews the assessment findings with the mother and explains that the infant's development falls within the normal ranges at this point. The nurse also explains the different elements of development and the individualized nature of developmental milestones achievement, emphasizing that children normally differ in size, growth, and speed of development. Realizing the importance of providing anticipatory guidance to parents as a way of outlining expected developmental gains over time to decrease unusual expectations and anxiety, and to educate parents regarding abnormal or concerning changes, the nurse provides the parents with a list of developmental milestones for reference and tracking and a list of primitive and postural reflexes with their onset and extinction times. The nurse goes on to explain that even though biologically related, children in the same family normally differ in growth and speed of development.

### Case Analysis Questions

1. Consider the length and weight of the infant. At what percentile is the infant for weight and length? Are these findings considered normal?
2. Consider the assessment findings for gross motor, fine motor, social/emotional, neurocognitive, and speech. Which of these milestones are met?

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CONCEPT 2

# Functional Ability

*Lana Sargent*

Health is seen as the level of functional ability for an individual's mind and body. Historically, to be considered in "good health" meant that an individual was free from injury, disability, illness, or pain. A challenge to this view occurred when the World Health Organization (WHO) broadened the definition of health as a "state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity."[1] Expanding and refining the definition of what is considered "good health" or "healthy" is a paradigm shift that is inclusive and more representative of the human population, especially those individuals with disabilities or chronic health conditions. The expanded view of health as it relates to functional ability is supported by one of the four overarching goals of *Healthy People 2030*—to promote healthy development, healthy behaviors, and well-being across all life stages.[2] A key factor in quality of life, and therefore in health, is an individual's ability to function. This view is further supported by the Institute of Medicine report *Crossing the Quality Chasm: A New Health System for the 21st Century*, which emphasizes that a goal of the U.S. healthcare system is "to improve the health and functioning of the people of the United States."[3] Thus the concept of functional ability has implications for collaborative health care across all populations and settings.

## DEFINITION

Functional ability refers to the individual's ability to perform the normal daily activities required to meet basic needs; fulfill usual roles in the family, workplace, and community; and maintain health and well-being.[4] Specifically, it reflects the adaptive dimension of development, which is concerned with the acquisition of a range of skills that enable independence in the home and in the community. For the purposes of this concept presentation, functional ability is defined as the *cognitive, social, physical, and emotional ability to carry on the normal activities of life.*[5] Functional ability may differ from functional performance, which refers to the actual daily activities carried out by an individual. Functional impairment and disability refer to varying degrees of an individual's inability to perform the tasks required to complete normal life activities without assistance.

## SCOPE

On the broadest and simplest level, the scope of functional ability represents a continuum from full function to disability (Fig. 2.1). This simple linear perspective is useful to acknowledge that a functional ability is a continuum that varies from person to person and within the same person at different points in time. However, the interaction between the health of an individual and disability is a complex process that is influenced by developmental and biologic factors, including current state of health, as well as by psychological, sociocultural, environmental, and politicoeconomic factors. Within the conceptual framework known as the disablement process, the term *function* refers to the positive or neutral interaction between a person's health condition and ability to perform social or physical activities.[6,7] At the other end of the spectrum, *disability* refers to the negative aspects to a person's health condition and social or physical limitation. *Impairment* refers to the physical abnormality that underlies these limitations and is caused by some type of disease process.[7] The scope of conceptualizing function as a complex process that changes based on life span, health, and environment is essential to nursing care and assessment across the entire life course from birth to death.

### Life Span Considerations

Functional ability changes across the life span as a function of development (occurring predominantly during the infant, toddler, preschool, school age, adolescent, and young adult developmental stages), although changes in environment, lifestyle, and technology require some continued development of functional skills across the entire life span. In infants and young children, expected development of functional ability is indicated by achievement of developmental milestones. Specialized age-appropriate tests of development are used when indicated to determine developmental delays (see Concept 1, Development). During young and middle adulthood, identification of problems with functional ability requires careful assessment of each developmental milestone. For older adults, functional status ordinarily refers to the safe, effective performance of activities of daily living (ADLs) essential for independent living.[8] For this age group, intentional screening focused on factors known to contribute to a decline in functional ability is essential. A comprehensive, interprofessional assessment, focused on observed functional, social, or cognition changes, should be performed for all individuals not exclusive of environment (institutionalized or community dwelling) or disease state.

## ATTRIBUTES AND CRITERIA

Functional ability has two dimensions: attributes and antecedents. Attributes are defining characteristics of functional ability, and


**FIGURE 2.1** Scope of Concept Functional Ability Ranges From Full Function to Disability.

antecedents are events that must happen before functional ability can exist. Attributes of functional capacity include the following:

- The capacity to perform specific functional abilities
- The actual or required performance of functional abilities

Antecedents of functional capacity include the following:

- Development of physiologic process: neural, cognitive, endocrine, musculoskeletal, and metabolic
- Acquisition of developmental milestones and skills

At any given time, an individual with the capacity to perform a self-care activity may not complete that activity because of developmental, cultural, environmental, or social factors. Functional ability is further characterized by gradations of capacity or performance. It is not simply a matter of whether the individual *can* or *does* perform the activity but, instead, under what circumstances, with what type and amount of assistance, and in what length of time and with what degree of effort the person *can* or *does* perform the activity. All aspects of this concept presentation are based on these attribute and antecedent principals.

## THEORETICAL LINKS

Functional ability is important across the life course because it is a major contributing factor to quality of life. It allows independence and participation in activities that are fulfilling to human nature. Functional ability is also important to healthcare providers and healthcare financers because it can indicate the existence and severity of disease, signal the need for services, monitor success of treatment/disease progression, and facilitate cost-effectiveness in the provision of care.[9] Several theories can be used to translate the complex interaction and dynamic process of functional ability across the life course.

A model of nursing with the concept of functional ability as a cornerstone is the *Roper-Logan-Tierney model of nursing*. According to this model, 12 ADLs are central to human life; these are presented in Box 2.1. This model was developed in Edinburgh and is used throughout Europe and in many other areas of the world to guide nursing education and practice by providing a framework to organize and individualize care. It has a focus on health rather than illness and promotes care directed toward health promotion and wellness. Ongoing patient assessment and facilitation of independence in the patient's normal activities of living are central to the model.[10,11]

The International Classification of Functioning, Disability and Health (ICF) is a framework created by WHO to describe this dynamic (rather than linear) process that occurs between functional ability and disability (Fig. 2.2).[12] The ICF focuses on the changes in functional level; these may be temporary (e.g., recovering from an illness or injury) or long term (e.g., spinal cord injury). The ICF highlights the complex interactions of environment and personal factors and the effect they have on the domains of body function, activity, and the person's ability to participate in hobbies, sports, work, shopping, and driving. This criterion is used in the featured exemplars discussed later to illustrate the complex dynamic process of impairment or limitation in functional ability for certain health conditions.[12]

### BOX 2.1 The 12 Activities of Daily Living According to the Roper-Logan-Tierney Model of Nursing

- Maintaining a safe environment
- Breathing
- Communication
- Mobilizing
- Eating and drinking
- Eliminating
- Personal cleansing and dressing
- Maintaining body temperature
- Working and playing
- Sleeping
- Expressing sexuality
- Dying

Data from Roper, N., & Logan, W. W. (2004). *The Roger–Logan–Tierney model of nursing: Based on activities of living*. London: Elsevier/Churchill-Livingstone.

## CONTEXT TO NURSING AND HEALTH CARE

Nursing practice has three major dimensions of concern relative to an individual's functional ability: (1) risk recognition, (2) functional assessment, and (3) planning and delivery of individualized care appropriate to level of functional ability. Functional ability is a complex concept that represents the interaction of the physical, psychological, cognitive, and social domains of the human person. Alterations in functional ability occur as primary or secondary problems. Primary problems are those in which the ability to perform a particular function never developed. In contrast, secondary problems occur after functional ability has been attained. Thus secondary problems represent a loss of functional ability.

Two examples of functional ability are the basic activities of daily living (BADLs or ADLs) and the instrumental activities of daily living (IADLs). The BADLs relate to personal care and mobility and include eating as well as hygienic and grooming activities such as bathing, mouth care, dressing, and toileting. IADLs are more complex skills that are essential to living in the community. Examples of IADLs are managing money, grocery shopping, cooking, house cleaning, doing laundry, taking medication, using the telephone, and accessing transportation. BADLs and IADLs are essential to independent living.[13]

Functional ability is a critical consideration in virtually all areas of health care and to all members of the healthcare team representing interprofessional interest. It is a critical element in discharge planning from healthcare facilities. Successful transition is dependent on the functional level in combination with supportive services such as home care services, inpatient or outpatient rehabilitation services, or placement in a long-term care facility. In the rehabilitation setting, the focus is on restoring functional ability and evaluating the functional outcomes of treatment by means of a functional assessment. For long-term care

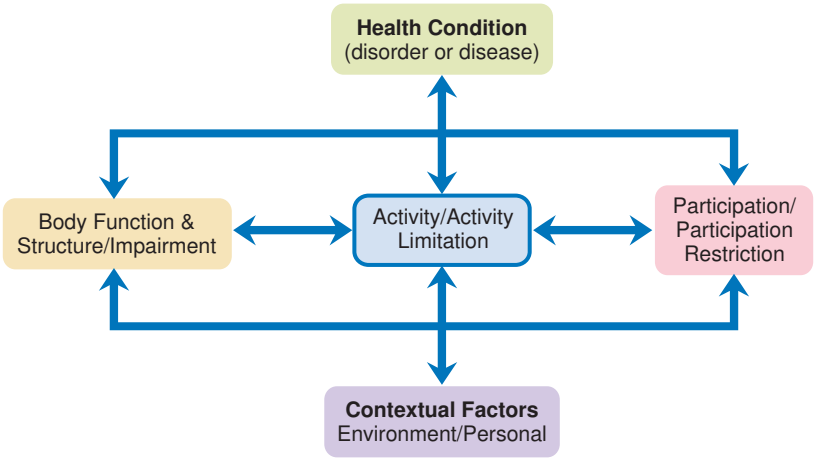


**FIGURE 2.2** The International Classification of Functioning, Disability and Health Model (ICF). (Redrawn from World Health Organization [WHO]. [2002]. *Towards a common language for functioning, disability and health.* Geneva: WHO. http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf.)

services, functional impairment—defined as needing assistance with a minimum of two or three ADLs—is a common eligibility criterion.[14]

## Risk Recognition

Risk recognition is essential to the early identification of factors that affect function. Actual functional deficiencies lead to subsequent mobilization of resources and support to enhance functional ability. The early identification is critical to the health status of individuals because research has shown that functional deficits are associated with poor health outcomes, whereas good functional ability is associated with positive outcomes. For example, a study of stroke patients revealed that major predictors of independence 5 months after stroke were independent living status and independence in ADLs.[15]

There are multiple risk factors for impaired functional ability because of the numerous variables that impact function, including developmental abnormalities, physical or psychological trauma or disease, social and cultural factors including beliefs and perceptions of health, and physical environment. Research has repeatedly documented age,[15] cognitive function,[16] and level of depression[17] as risk factors for and predictors of functional impairment. Comorbidities and socioeconomic factors have also been implicated. Preclinical disability, defined as task modification without report of difficulty in performing a specific activity, has also been found to be an important predictor of future functional decline and disability in the elderly. In a study of postpartum women, those with postpartum depression (PPD) were 12 times less likely to achieve prepregnancy functional levels than those without PPD. PPD predicted lower personal, household, and social functioning but without deficit in infant care.[18] Sudden onset of functional decline is often indicative of acute illness or worsening of a chronic disease.

Risk reduction should be the focus of care for patients with identified risks. Teaching patient and family about factors associated with maintenance of high-level functional ability is required. These factors include well-balanced nutrition, physical activity, routine health checkups, stress management, regular participation in meaningful activity, and avoidance of tobacco and other substances associated with abuse.[19] In addition, patients need teaching and guidance to develop effective action plans designed to decrease their specific risks. Finally, ongoing assessment of an individual's functional ability can provide continual adjustment of recourses to maximize independence rather than dependence.

## Functional Assessment

Comprehensive functional assessment is a time-intensive, interprofessional effort requiring use of multiple assessment tools. Comprehensive functional assessment is indicated under specific circumstances. As discussed for Concept 1, Development, children who are delayed in meeting developmental milestones and accomplishing developmental tasks are referred for assessment across domains of development including that of adaptive behavior, which is analogous to functional ability. Functional abilities are best assessed by observing the function of the child or adult. A comprehensive assessment of functional ability in older adults is indicated when the individual has demonstrated a loss of functional ability, has experienced a change in mental status, has multiple health conditions, or is a frail elderly person living in the community. Screening for functional deficits in older adults should be a part of routine care[19] just as screening for meeting developmental milestones is for children.

An individual's performance of ADLs is basic to functional assessment. ADLs as indicators of functional ability evolved in the late 1950s with the identification of a group of basic physical activities, the performance of which was to be used to evaluate the success of rehabilitation programs. A decade later, IADLs were identified as indicators of ability to live independently in the community. This led to the use of ADLs as a measure of need and eligibility for long-term care and other support services and to the development of an array of assessment tools.

### Assessment Tools

The two basic types of assessment tools are self-report and performance based. Self-report tools provide information about the patient's perception of functional ability, whereas performance-based tools involve actual observation of a standardized task, completion of which is judged by objective criteria. Performance-based assessments are preferred because they avoid potential for inaccurate measurement inherent in self-report. They also can measure functional ability with repetition and with consideration of time on task. Potential problems with self-report measures of functional activity stem from the effect of an individual's personal characteristics and preferences as well as environmental factors. Interpretation of what is meant by the question can vary from person to person. Even when vocabulary is correctly understood, the phrasing of the question can lead to an ambiguous response. For example, if a

person is asked, "Can you …?" the answer is based on the person's perception of his or her ability to perform the task, not necessarily on actual ability. Thus overstatements of ability may occur because of a lack of awareness that gradual changes in ability have occurred. Understatements of ability are possible when an individual has not attempted to perform the activity in question because of culture or preference or mistakenly believes that he or she is unable to perform the task. Ability can also be overreported or underreported by individuals based on personal reasons. Pride and the desire to be seen as self-sufficient, fear of losing independence, and fear of long-term care placement are common reasons for overstatement of ability, especially among elders. The 36-Item Short Form (SF-36) remains a "gold standard" as an instrument to measure physical, mental, and social domains in older adults.[20]

Meaningful measurement of functional ability also has to address the areas of dependency and difficulty. Dependency refers to the amount of assistance needed to function, whether it involves the assistance of an adaptive device or another person. *No assistance, partial assistance*, and *total assistance* are examples of common options related to dependency used when scoring functional assessment tools. Common scoring options related to difficulty are *some, a lot*, or *unable to perform*. In addition to functional assessment tools that focus on complex, multidimensional abilities such as ADLs, there are tools designed to assess a specific area of function such as mental status, mobility status, or hand function. There are also tools designed for use with specific populations and age groups.[21–28] The Functional Analysis Screening Tool (FAST) is a 16-titem questionnaire designed to measure social and behavioral functioning validated for assessment of young adults.[29] The FAST measures domains of functioning related to injury (physical or emotional) risk and can provide a verbal report of symptoms. The limitation with behavior function-based scales is that primary behavior and motor stereotypes are maintained with labels. Therefore such tools should simply be a way to gather information during a structured interview that focus on target behaviors.[29]

Table 2.1 presents examples of the wide variety of functional assessment tools. Table 2.2 presents questions and observations associated with functional assessment.

**TABLE 2.1 Examples of Functional Assessment Tools**

| Functional Assessment Tool | Function Assessed/Target Population |
|---|---|
| Barthel Index[30] | Activities of daily living |
| FIM Instrument | Self-care, sphincter control, transfers, locomotion, communication, and social cognition |
| Functional Independence Measure[31] | |
| Dartmouth COOP Functional Health Assessment Charts[32] | Adults: Comprehensive functional and social health<br>Adolescents: Comprehensive functional and social health |
| Now, Growth & Development, Activities of Daily Living, General Health, Environment, and Documentation (NGAGED)[33] | Children ages 2–12 years with physical disabilities: Assesses engagement in life activities—personal, family, social, and school parameters |
| Functional Activities Questionnaire (FAQ)[34] | Older adults: Assesses IADLs |
| Folstein Mini-Mental Status Examination (MMSE)[35] | Older adults: Cognitive function |
| Long-Term Care Minimum Data Set (MDS)[36] | Nursing home residents |
| 36-Item Short Form Survey (SF-36)[20] | Adult patients: Quality-of-life instrument to measure physical, mental, and social domains in older adults |
| Functional Status Scale (FSS)[26] | Hospitalized children |
| The Edmonton Functional Assessment Tool[37] | Cancer patients: Functional performance |
| 24-h Functional Ability Questionnaire (24hFAQ)[21] | Outpatient postoperative patients: Functional ability |
| Geriatric Depression Scale[38] | Older adults: Depression |
| Inventory of Functional Status after Childbirth[18] | Postpartum women: Functional status |

*IADLs*, Instrumental activities of daily living.

### Care Delivery

Knowledge of an individual's functional level in the physical, social/emotional, cognitive, and communication dimensions is essential to planning and implementing effective patient care. Functional level determines the patient's need for assistance and the type and amount of assistance required. It guides the nurse in helping with activities while ensuring use of adaptive equipment and maximizing the patient's independent function. This goal of optimal independent function along with the prevention of functional decline is essential to the improvement of health-related quality of life, which as an outcome of care is an objective for individuals of all ages with chronic illness or disability.[39]

Management of functional activity impairment involves a multidisciplinary effort. Early intervention can include one or more of the following services: nursing, medicine, physical therapy, occupational therapy, psychological intervention, individual and/or family counseling, nutritional consulting, speech and language services, audiology services, home health or homemaker assistance, community services (e.g., day care), support groups, and assistive technologies. When functional activity is impaired, early intervention is critical because generally the earlier the intervention, the better the outcome.[40]

## INTERRELATED CONCEPTS

The human person is a complex integrated whole that is greater than the sum of its parts. Therefore it follows that concepts used to describe aspects of the human person represent interrelated rather than isolated phenomena. The strength and direction of the impact of one conceptual phenomenon on another vary with the central concept under consideration. Because functional activity depends on the interplay of multiple elements within the physical, psychological, social, and cognitive dimensions and because it allows for purposeful interaction with the environment, a multitude of concepts can be identified as influencing and/or being influenced by it. Fig. 2.3 depicts the most prominent of these interrelationships. Concepts representing major influencing factors and hence determinants of functional ability are **Development**, **Cognition**, and **Culture**, with its unique variations in practices and expectations. These appear at the top of the diagram, and their influence on functional ability is indicated by the arrow pointing in the direction of this concept. **Family Dynamics** and **Stress and Coping**, as well as the physiologically focused concepts of **Mobility**, **Nutrition**, **Sensory Perception**, **Gas Exchange**, and **Perfusion**, have a clearly reciprocal relationship with functional ability. These concepts surround either side of the concept with double-headed arrows because of their mutual interaction with it. The concepts of **Elimination** and **Sexuality** are shown at the bottom of the figure with arrows pointing from functional ability to them because of the primarily unidirectional relationship of these concepts.

**TABLE 2.2 Guide to Functional Assessment Screening**

| Functional Assessment Component | Sample Questions | Observations/Examinations |
|---|---|---|
| Vision | Do you have any difficulty seeing? Do you wear glasses or contact lenses? Do you use any special equipment to help you see, such as a high-intensity light or magnifying glass? When was your last eye exam? | Observe for signs of impaired vision during interaction with patient: turning head to one side in an effort to see better; nonapplicable comments about room seeming dark; feeling for items. Have patient hold a magazine or newspaper and read a line of print. Have patient read a wall clock or sign at a distance. |
| Hearing | Do you have difficulty hearing? Does anyone tell you that you are hard of hearing? Do you have to ask people to repeat what they say? Can you hear well in crowds? Can you hear when the area is noisy? | Note patient's apparent hearing during your interaction with him or her. Rub your thumb and forefinger together in front of each of patient's ears; patient should easily hear the sound. |
| Mobility | Do you have any trouble moving? Do you feel steady when you walk? Do you use anything to help you walk? Do you have trouble getting out of bed? Do you have difficulty sitting down or standing up? | Observe patient's general movements; look for obvious limitation of movement in any body part. Have patient put hands together behind neck and then behind waist to assess external and internal rotation of shoulder. Assess lower extremity function, balance, and gait by asking patient to arise from a straight back chair, stand still, walk across room (approximately 10 feet), turn, walk back, and sit down. Note ability to stand up and sit down; balance when sitting, standing, and walking; gait; and ability to turn. |
| Fall history | Have you had any falls? Have you had any near falls? Do you take any precautions against falling? | |
| Continence | Do you ever lose control of your bowels? Do you ever lose control of your urine and wet yourself? Do you wear any type of protective pad or underclothes in case of an accident with urine or bowels? | |
| Nutrition | Have you gained or lost 10 pounds in the past 6 months without trying? What do you typically eat in a day? Do you have difficulty chewing or swallowing? When was your last dental visit? | Note general appearance as related to nutritional status: well nourished, undernourished, emaciated. Obtain weight and determine body mass index. |
| Cognition | Do you have any trouble with your memory? | Note patient's ability to respond appropriately to questions and directions. Three-item recall at 1 minute; if patient fails this test, follow with MMSE. |
| Affect | Do you often feel anxious or overstressed? Do you often feel sad or down? | Note patient's expression and if this matches mood. |
| Home environment | Who do you live with? What type of house do you have: single home, multiple family, apartment? How many floors does the home have? Are there stairs you must use? | |
| Social participation | What keeps you busy all day? How often do you go out? How often do you have company? | |
| Activities of Daily Living (basic and instrumental) | Use a reliable, valid assessment tool to assess function related to grooming, toileting, dressing, eating, walking, shopping, meal preparation, housekeeping, travel/driving, money management. | |

*MMSE*, Mini-Mental Status Examination.
From references 13, 35, 38.

## CLINICAL EXEMPLARS

Alterations in functional ability may affect one very specific area of function or may be global and affect widespread function. Impaired functional ability is often complex and may involve an array of environmental and individual factors. Furthermore, similar alterations in function can be the result of very different causes.

There are multiple exemplars of situations that change an individual's functional ability. Examples of specific exemplars are presented in Box 2.2 using two major categories of problems for distinction: primary and secondary. Causes of primary problems of functional ability may be genetic in origin (i.e., the result of a congenital defect) or may be a result of trauma, disease, or negative environmental factors occurring during the early years of development. Often, however, as with many developmental problems, the cause is unclear.

Secondary problems of functional activity are more commonly identifiable as the result of aging, disease, trauma, or negative environmental factors. Sudden onset of functional decline is a sign of acute disease such as pneumonia, urinary tract infection, or fluid and electrolyte imbalance. Alternatively, it can be a sign of worsening chronic disease such as diabetes, chronic obstructive pulmonary disease, or heart failure.[41] Depending on the extent of alteration in functional ability, the problem may be termed an impairment, a disability, or a handicap.

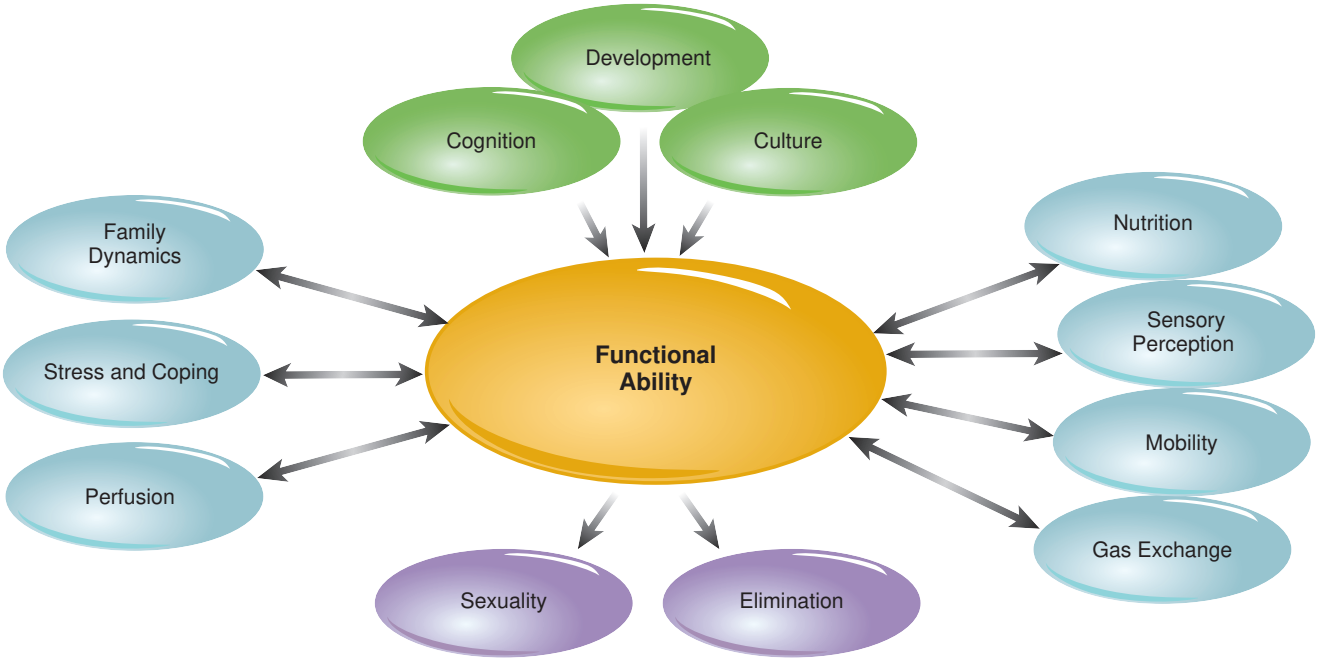


**FIGURE 2.3** Functional Ability and Interrelated Concepts.

## BOX 2.2 EXEMPLARS OF IMPAIRED FUNCTIONAL ABILITY

### Causes of Primary Problems

- Angelman syndrome
- Autism spectrum disorder
- Cerebral palsy
- Down syndrome
- Duchenne muscular dystrophy
- Fetal alcohol syndrome
- Hypoplastic limb
- Malnutrition
- Receptive or expressive language disorder

### Causes of Secondary Problems

- Alzheimer disease
- Blindness
- Brain injury
- Cardiovascular disease
- Chronic pain
- Chronic fatigue
- Chronic obstructive pulmonary disease
- Deafness
- Malnutrition
- Multiple sclerosis
- Osteoarthritis
- Parkinson disease
- Rheumatoid arthritis
- Schizophrenia
- Spinal cord injury
- Skeletal fracture
- Stroke

**ACCESS EXEMPLAR LINKS IN YOUR GIDDENS EBOOK**

## Featured Exemplars

### Cerebral Palsy

Cerebral palsy (CP) refers to a group of neurologic disorders that affect body movement, posture, and muscle coordination. It is caused by abnormal development or injury to the developing brain in the area responsible for muscle control. This disorder occurs before birth, during the birth process, or within the first years of childhood, and it represents the most common motor disability in childhood. There are four main types of CP (spastic CP, dyskinesic CP, ataxic CP, and mixed CP); thus the severity of symptoms is highly variable. Prevalence estimates of CP range from 1 to 4.5/1000 births.[42]

### Autism Spectrum Disorder

Autism spectrum disorder (ASD) refers to a broad category of conditions with a wide range of impairments and disabilities affecting children in early childhood that lasts throughout life. Two general areas of dysfunction are social impairment and repetitive behaviors. Although the cause is not well understood, it is suspected that genetic and environmental factors may be involved. ASD represents a primary problem in functional ability because affected individuals have difficulties meeting BADLs or IADLs. The Centers for Disease Control and Prevention (CDC) estimates that 1 in 68 children have ASD; the rate in males is four or five times higher than in females.[43]

### Alzheimer Disease

Alzheimer disease, an irreversible progressive brain disease, is the most common cause of dementia among older adults, affecting an estimated 5 million in the United States.[44] This disorder is characterized by the loss of cognitive functioning (memory, thinking, reasoning, and problem solving) and behavioral changes resulting in a decline of functional ability. The degree of symptoms and functional limitations is directly related to the progression of the disease. Because this occurs in older adults, it is considered a secondary problem in functional ability.

### Rheumatoid Arthritis

Rheumatoid arthritis (RA) is a systemic autoimmune condition with genetic predisposition that creates an inflammatory process in the synovial membrane of the joints and other body tissues. Over time, the joint inflammation leads to erosion of the membrane cartilage, causing pain, swelling, and joint deformity; significant impairment in functional ability and mobility results. Affecting less than 1% of the general population, RA is most common among women and individuals older than age 60 years.[45] This is considered a secondary problem in functional ability.

### Parkinson Disease

Parkinson disease (PD) is a neurologic disorder caused by a loss of dopamine-producing cells in the brain and resulting in motor disability. Four primary symptoms are tremors, rigidity, bradykinesia, and impaired balance and coordination. This condition most commonly occurs in adults older than age 50 years, with a higher incidence among men than women. Although symptoms are subtle and mild initially, these become more pronounced as the disease progresses and interfere with functional ability.[46] An estimated 1 million Americans have PD, with an estimated 50,000 to 60,000 new cases of PD diagnosed each year.

## CASE STUDY

From Kirstyokeeffe/iStock/Thinkstock.

### Case Presentation

Mrs. Rose Finney is an 85-year-old woman with ovarian cancer. She presented at the oncology clinic for a scheduled appointment 6 weeks after surgical removal of her ovaries, uterus, a section of large bowel, and as much tumor mass as possible from other areas of her abdomen. The purpose of the visit was a postoperative checkup and planning for chemotherapy. Mrs. Finney was accompanied by a niece with whom she had stayed while recovering from the surgery. The niece lives out of state, and the patient will be returning to her own home after this follow-up appointment.

At this visit, the nurse interviewed the patient to obtain detailed self-report information related to functional ability. The following information was gathered:

- Alert, well-groomed, well-spoken, fiercely independent elderly woman recuperating remarkably well from extensive surgery
- Uncontrolled glaucoma with limited vision in one eye; 20/80 vision with glasses in other eye
- Slightly hard of hearing
- Arthritis in fingers along with lack of strength makes some tasks difficult (e.g., opening jars, using telephone)
- Uncertain walking outdoors, particularly in unfamiliar areas and when ground uneven; no assistive devices
- Medication: Synthroid every morning for 47 years
- Never married, no children
- Lives alone in a single home; bedroom on first floor but laundry facilities and garage are on basement level
- Does not drive
- Only living relatives in addition to the niece are two nephews: One lives out of state and other lives half an hour away
- Telephone contact with closer nephew daily, occasional visits and trips for shopping and other errands
- Three friends in neighborhood, each of whom calls or visits on average every 2 weeks

### Case Analysis Questions

1. Based on the information provided, what functional challenges put Mrs. Finney at risk for injury?
2. In addition to managing risk factors within the home, what additional help does she need?
3. What interdisciplinary healthcare team members would be helpful to Mrs. Finney and her family?

**ACCESS EXEMPLAR LINKS IN YOUR GIDDENS EBOOK**

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CONCEPT
3

# Family Dynamics

*Jean Giddens*

The *family* has been viewed traditionally as the primary unit of socialization, the basic structural unit within a community. A family is a group of people who are related by heredity, marriage, or living in the same household. Thus a family consists of (1) parents and their children; (2) those related by blood, such as ancestors and descendants; or, in a less restricted definition, (3) any group living together as if they were related by blood. A family is who they say they are.

There are a variety of family configurations: the nuclear family, married-parent families, extended families, married-blended families, cohabiting-parent families, single-parent families, no-parent families, and same-sex families. These are not mutually exclusive classifications. For example, gay couples with children can be represented by the classification of married-parent family, cohabitating-parent family, and married-blended family. For this reason, it is again important to emphasize that a family is who they say they are.

Because families are the foundation of social context and family members act either as a support system or demonstrate a lack of support for members of the family, nurses must understand and appreciate for the ways in which family dynamics influence the delivery of health care to individuals. This concept presentation includes the definition, scope, attributes, theoretical links, and exemplars of concept in the context of professional nursing practice.

## DEFINITION

Although *family life* is a universal experience of all people, the term *family* has a different meaning for people because of the varied experiences within families.[1] The wide variability in the configurations of families and the experiences individuals have within families makes it impossible to achieve a universally agreed-upon definition of family. However, the simple definition offered by Kaakinen is helpful: "Family refers to two or more individuals who depend on one another for emotional, physical, and economic support. The members of the family are self-defined."[2, p.5]

Family dynamics is a term that refers to how families interact and behave with one another. For the purposes of this concept presentation, the term family dynamics is defined as *interrelationships between and among individual family members or "the forces at work within a family that produce particular behaviors or symptoms."*[3, p.675] The dynamic is created by the way in which a family lives and interacts with one another. That dynamic—whether positive or negative, supportive or destructive, nurturing or damaging—changes who people are and influences how they view and interact with the world outside of the family. Influences on family dynamics are many and varied. These include such factors as the family configuration, relationship between the parents, number of children in the family, parental presence or absence, other people living in the home, chronic illness, disability, substance abuse, physical abuse, death, culture, socioeconomic status, unemployment, family values, and parenting practices.

When examining family dynamics, ages within the family should be considered. Young people often have ideas at variance with their parents. Grandparents will likely have views different from those of their grandchildren. The history of the people in the family is important. When a couple marries, they bring with them the culture and norms of their family of origin. This will influence the family dynamics. The role each member plays in the family is significant; it may be important to exchange roles to increase understanding among family members and decrease resentment.

## SCOPE

Currently, one emphasis in nursing is providing wellness-oriented family-centered care and empowering families to achieve control over their lives. Wherever nurses practice, they will work with families and observe family dynamics across the life span. Family dynamics occur between couples, with parents and children, and with extended family members. As implied by the word "dynamic," the interactions between family members are fluid and change with growth and development, time, and circumstances. Thus the scope of family dynamics ranges from positive/healthy to negative/dysfunctional (Fig. 3.1) and is shown on a continuum because these dynamics evolve and change over time.

Common traits of families that are positive and healthy include positive and balanced communication and interactions among family members; support, respect, trust, and shared responsibilities; shared rituals, traditions, and religious core; strong sense of right and wrong; sense of play and humor; and shared leisure time.[4] Dysfunctional family dynamics refers to "Family functioning which fails to support the well-being of its members."[5, p.290] Traits associated with dysfunctional family dynamics include behavioral (such as blame, criticizing, enabling, manipulation, power struggles), feelings (such as anger, fear, depression, loneliness, mistrust, rejection), and relationships (such as change/disruption in role, denial, neglect, triangulation).

Multiple variables influence family dynamics. Three key variables include the quality of relationships among family members, the roles


**FIGURE 3.1** Scope of Concept on a Continuum from Positive/Healthy to Negative/Dysfunctional.

of family members (and these change over time), and the evolving complexity of the family. These three variables are explored further.

### Quality of Relationships

Positive, healthy family dynamics are characterized by relationships that are loving and respectful. Family members support each other, provide nurturance and assistance, and form a unit within society. Family interactions and communications can become negative and dysfunctional as a result of social isolation, perceptions that are inaccurate, and faulty personal interpretations of information.[3] A husband may berate his wife for perceived shortcomings or denigrate a child for having difficulty with school. Siblings may squabble and place blame for incidents. In some instances, a parent and siblings may abuse one child. Observing dysfunctional interactions and communications of parents can lead children to imitate those negative behaviors.

### Roles of Family Members

Within the family, individuals assume or are assigned roles: spouse, parent, child, sibling, grandchild, disciplinarian, leader, scapegoat, nurturer, enabler, hero, and so on. Healthy families are able to adapt and adjust to roles that may change over time. For example, as children grow and develop, crises are encountered, illnesses develop, or family members leave home. It may be difficult for family members, especially children, to understand roles, changes in roles, the way changes affect the balance of relationships within the family, and the effects of one family member's actions on the remainder of the family.

### Evolving Complexity of the Family

The dynamics change between a married couple when their first child is born. This is because the dynamics in a triad are more complex than those in a dyad (Fig. 3.2); further increases in complexity occur when additional children are born. Extended family relationships add to the complexity, as do divorce, remarriage, and stepchildren. Same-sex families may not be accepted by, or may be estranged from, their families of origin, which precludes receiving support from them. In times of illness and stress, family interactions may change—sometimes for the better and sometimes for the worse. Family members can express concern for the ill member; extended family may gather and provide assistance and support. Old quarrels can be resolved, hurts can be forgiven, love can be expressed, and memories can be shared. At other times, quarrels can arise over past slights, the perceived or real burdens of caregiving, and the strain on family finances. Ill family members can become more demanding, believing they deserve special treatment and care. Death must be faced, burial details settled, and assets divided.

## ATTRIBUTES AND CRITERIA

Defining attributes of family dynamics include the following:

- Family, however that is defined, is involved.
- The group of people, the family, have relational obligations.
- Communication, verbal or nonverbal, among family members occurs.
- Interactions among family members are fluid, flexible, and changeable (dynamic).

The family, whether a couple or a multigenerational group, communicates and interacts. The more members involved, the greater the complexity of interaction and communication. Communication and interaction are dynamic and changing and can be positive or negative. Positive interactions and communications are growth producing and produce cohesion. Negative interactions and communications are divisive and disruptive and lead to dysfunction and alienation.

## THEORETICAL LINKS

### Family Systems Theory

Wright and Leahy describe family systems theory as allowing nurses to "view the family as a unit and thus focus on observing the interaction among family members, and between the family and the illness or problem rather than studying family members individually."[6, p.22] The following are key characteristics of family systems theory: (1) A family system is part of a larger suprasystem and is composed of many subsystems, (2) the family as a whole is greater than the sum of its individual members, (3) a change in one family member affects all family members, (4) the family is able to create a balance between change and stability, and (5) family members' behaviors are best understood from a view of circular rather than linear causality.[6]

Because a change in one family member affects all family members, a change in family dynamics occurs. For example, when Tama, a mother of three children, gives birth to her fourth child, the father and the siblings of the baby experience change and the relationships among the members of the family change. The father, Peter, has to assume additional responsibilities for care of the family while the mother recuperates from the birth. He can prepare meals and do laundry; he can assume some care of the newborn. Siblings must share their mother's love and time with this new member; sibling rivalry may occur. The family attempts to balance this change and restore stability. As the newborn is incorporated into the family, the siblings resume their previous activities.

Because one family member changes, the family changes, and in turn this change affects the member who changed (circular causality). The mother is now the mother of four children, with the additional responsibilities of caring for a newborn and three other children while maintaining her relationship with her partner.

### Structural-Functional Theory

The origins of structural-functional theory are in social anthropology.[7,8] In this theory, the family is a social system. Family members have specific roles, such as the father role, mother role, and daughter or son role. Maintaining equilibrium between complementary roles is accomplished through family dynamics. This permits the family to function within the family unit and in society. Some families establish rigid boundaries, and outsiders are kept at a distance. Some families may be isolated and

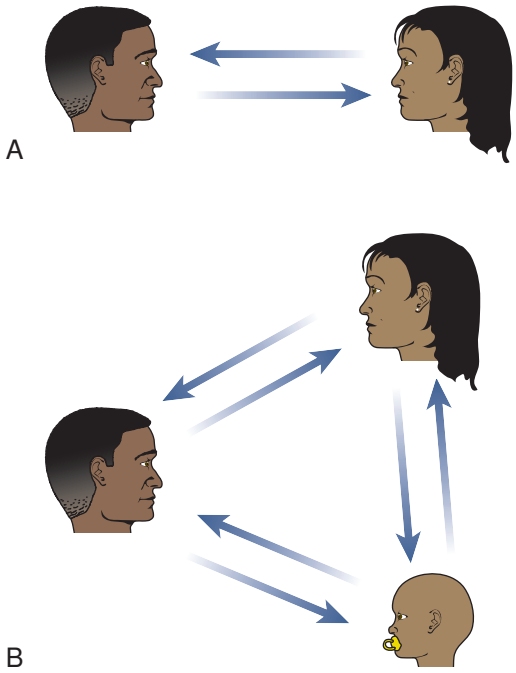


**FIGURE 3.2** Complexity of Relationships Within the Family. (A) Dyad. (B) Triad.

may find that in times of crisis their resources are inadequate. Other families maintain open boundaries and give and accept assistance when needed. Some reciprocal relationships within the family can be detrimental, such as designating one member as the family scapegoat or viewing another family member as weak or dependent. Another family member may be identified as the strong or responsible one, and undue expectations may be placed on that member.

### Family Stress Theory

The focus of the family stress theory is on the way families react to stress.[9] When faced with a significant stressful event, some families adapt and other families deteriorate; the response is driven by a number of variables, including how the stressor is perceived, other stressors that may also be affecting the family, the resilience of the family as a unit, as well as among individual members, the level of commitment family members have to one another, and availability and accessibility of resources.

Stress of families can also be studied in the contexts in which the family is living, both internal and external. Internal context events are those that the family can change or control (e.g., family structure, psychological defenses, and philosophical values and beliefs). The external context is composed of the time and place in which a family finds itself and over which the family has no control (e.g., culture of the larger society, time in history, economic state of society, maturity of the individuals involved, success of the family in coping with stressors, and genetic inheritance).

### Family Life Cycle (Developmental) Theory

Families pass through stages. Relationships among family members move through transitions. Although families have roles and functions, a family's main value is in relationships that are irreplaceable. Developmental changes to the family are part of the life-cycle process, but they also represent adjustments that must be made within the family.[10]

As an example, a couple who goes through stages of dating and then forms a family initially have an exclusive relationship with one another. The relationships change when the family expands and the couple becomes parents to a child. When another child is introduced to the family, the relationships expand. The firstborn child has to relinquish his or her role as an only child and develop a relationship with his sibling. The complexity of relationships increased exponentially as the size of the family increased. Children grow and develop within the family and expand the cycle of their relationships through play groups, school, church, and social club activities. As they mature and change, family relationships will change. As time goes on, the couple grows older and relinquishes their places as primary in the lives of their children. Role reversals may occur as they age; their children as adults may need to care for them and, eventually, deal with their deaths.

## CONTEXT TO NURSING AND HEALTH CARE

The family influences and is influenced by other people and institutions. This plays a pivotal role in health care. There are many situations in which the nurse interacts with the family while providing care. Understanding family dynamics and how these dynamics relate to health is important to nurses for the provision of quality nursing care.[11] The family, whether present or absent, influences the patient, either positively or negatively. For nurses to be effective in their care of the family, they must be skilled at conducting a family assessment (including risk recognition) and planning and delivering care appropriate to the situation.

### Risk Recognition

During interactions with patients and families, nurses must recognize situations that place families at risk for dysfunction—a number of situations place families at risk. Some of the most common include when the family expands, a situation whereby a family member violates the trust of one or more family members, loss of financial stability, abusive behaviors, substance use and addictions, a severe injury or illness, or death of a family member. A number of disruptions and changes within the family may occur, including changes in roles and relationships of family members, the home and/or living arrangements, finances, priorities, and obligations. These may occur singularly, but in many cases, one issue leads to another or are corelated. As one example, a family member who provides the primary financial support hides a drinking problem from her partner. Due to her addiction, she loses her job and the family is unable to pay outstanding bills. In this scenario, a violation of trust and loss of financial stability occur as a result of the addiction.

### Conducting a Family Assessment

A number of culturally sensitive tools have been developed to assess or measure family dynamics (Table 3.1). These and other models are often used in studies of family dynamics. The following example uses the Calgary Family Assessment Model (CFAM) to illustrate a system of family assessment.

The CFAM[6] is widely used by nurses to assess families. Wright and Leahy caution that the nurse must recognize that such an assessment is based on the perspective of the nurse (based on personal and professional life experiences) and interactions with interviewees. The assessment is not "the truth" about the family but is just one perspective at one point in time.

The model is used to ask family members questions about themselves to gain understanding of the structure, development, and function at a point in time. Not all questions within the subcategories are asked at the first interview, and not all questions are appropriate for all families.

**TABLE 3.1 Models and Tools to Assess Family Dynamics**

| Model | Purpose/Description |
|---|---|
| Calgary Family Assessment Model[6] | A multidimensional framework with three major categories: *structural, developmental*, and *functional*. It is embedded in larger worldviews of postmodernism, feminism, and biology of cognition. Theory foundation of model includes systems, cybernetics, communication, and change. Diversity issues are included. |
| Circumplex Model of Marital & Family Systems[16] | Family model grounded in family systems theory. Includes dimensions of *family cohesion* (emotional bonding that couple and family members have toward one another), *flexibility* (amount of change in its leadership, role relationships, and relationship rules), and *communication* (includes family as a group in relation to listening skills, speaking skills, self-disclosure, clarity, continuity tracking, and respect and regard). |
| Family Adaptability and Cohesion Evaluation Scales (FACES IV)[17] | Updated version of self-report scale designed to assess full range of cohesion and flexibility dimensions of Circumplex Model. |
| Dyadic Adjustment Scale[18] | Self-report 32-item questionnaire administered to both members of a couple. Scales include *dyadic consensus*, *dyadic satisfaction*, *affectional expression*, and *dyadic cohesion*. |
| Chinese Family Assessment Instrument (C-FAI)[19] | Self-report measure to assess family functioning in Chinese populations. Contains five dimensions: (1) *mutuality*, (2) *communication and cohesiveness*, (3) *conflict and harmony*, (4) *parental concern*, and (5) *parental control*. |
| Family Dynamics Measure II (FDM II)[20] | Based on eight bipolar dimensions of Barnhill.[21] First six of dimensions were selected for inclusion: (1) *individuation versus enmeshment*, (2) *mutuality versus isolation*, (3) *flexibility versus rigidity*, (4) *stability versus disorganization*, (5) *clear communication versus unclear or distorted communication*, and (6) *role compatibility versus role conflict*. |

Although individuals are interviewed, the focus of a family assessment is on the interaction among the individuals in the family.

The three major categories of the CFAM are structural, developmental, and functional.[6] There are several subcategories for each category. In this brief explanation of the model, only the major categories are addressed.

### Structural Assessment

Gaining an understanding regarding the family structure and function is the first step toward understanding the interactions within the family. Assessment of the structure of the family includes determining the members of the family, the relationship among family members in contrast to relationships with those outside the family, and the context of the family. Questions to assess the structure include the following:

- Who is in your family?
- Does anyone else live with you?
- Has anyone moved out recently?
- Is there anyone you think of as family who does not live with you?

Genograms and ecomaps are useful tools to outline the family's internal and external structures. These tools can be hand drawn, or computer programs and apps are available to construct genograms. The ecomap provides a visual depiction of the social and personal relationships of the family members. An example of an ecomap is presented in Fig. 3.3, which shows that the family includes a 35-year-old male (shown as a square in center circle), a 33-year-old female (shown as a circle in center circle), and two children—a boy age 4 and a girl age 2 weeks (shown in center circle). In addition, a number of people with important relationships to members of the exemplar family are shown as purple circles (outside the center circle).

### Developmental Assessment

Most nurses are knowledgeable about the stages of child development and adult development, and there is increasing literature about development during senior years. However, family development is more than concurrent development of individuals in a family and is different from family life cycle. Family development considers the vicissitudes of living with both predictable and unpredictable events. Family life cycle describes the typical trajectory followed by most families. The CFAM uses family life cycle to organize the assessment of family development.[6]

### Functional Assessment of Family Relationships

Functional assessment addresses how individuals actually behave in relation to one another. The two basic aspects of family functioning are instrumental and expressive. Instrumental aspects include routine activities of daily living, such as preparing meals, eating, sleeping, doing laundry, and changing dressings. Expressive aspects include communication (emotional, verbal, nonverbal, and circular), problem solving, roles, influence and power, beliefs, and alliances and coalitions.[6] The categories are not used to define a family's emotional health; it is the family's judgment of whether they are functioning well that is important.

## Care Delivery

Conducting a family assessment and assessing for risks (discussed earlier) are used to determine the current state of a family's function (positive to negative family dynamics). This assessment is used to determine appropriate goals and interventions. Interventions exist to support positive family dynamics and intervene when family dynamics become dysfunctional. Understanding the quality and appropriateness of family dynamics enables nurses to work with families to set goals, create a plan of care, and provide that care while continuing to assess the family. Evaluation of the plan provides the opportunity to make any changes necessary based on observed dynamics of communication and interactions of the family. The nurse's scope of practice, context of the practice setting, the complexity of the issues identified, and experience in family-based care will influence the interventions offered. In some cases, the nurse will identify appropriate referrals; in other cases, the nurse may offer interventions directly. Furthermore, the family's openness to interventions offered by the nurse (or other healthcare providers) is influenced by the relationship and level of trust between the family members and the nurse and other healthcare professionals.

### Core Interventions

Core interventions to support families are those that all nurses, regardless of area of practice, should be able to offer. Goals are first determined by the family with the support of the nurse, and then interventions to reach those goals are applied. Core interventions include offering education, facilitating conversation among family members, enhancing understandings, sharing observations, and validating information, perceptions, or feelings (Box 3.1). These may initially seem rather simple;

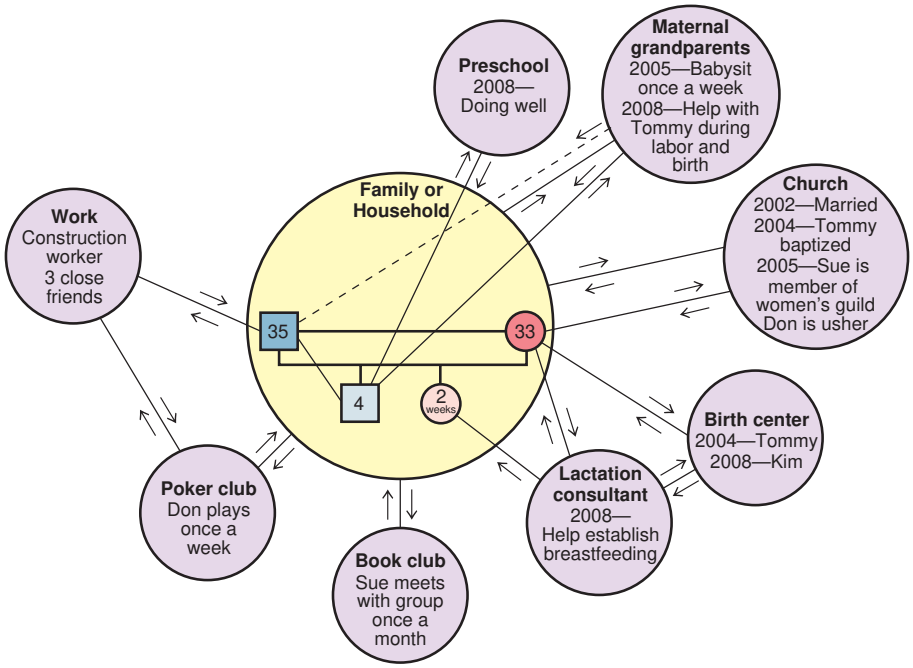


**FIGURE 3.3** Example of Ecomap Describing Social Relationships and Depicting Available Supports. (From Lowdermilk, D. L., Perry, S. E., Cashion, K., & Alden, K. R. [2016]. *Maternity and women's health care* [11th ed.]. St Louis: Elsevier.)

**BOX 3.1 Core Interventions**

- Providing education
- Facilitating conversations
- Enhancing understandings
- Sharing observations
- Validating information, perceptions, or feelings

however, the complexity becomes clearer when considering that interventions must be tailored to the specific situation and context. Every family and every situation are different, thus the intervention is uniquely applied. In addition, nurses must avoid falling into the trap of thinking "I know what is best for the family." Such an attitude generally does not resonate with families and negatively affects the effectiveness of goals and interactions that could be helpful. Positive rapport and trust must be established and maintained, with an underlying acceptance of the family and their values.

### Advanced Interventions

When family dynamics are dysfunctional, significant complexity may exist, making it difficult to determine what is needed and the interventions to offer. In addition to the core interventions (listed earlier), advanced interventions may also be needed. Advanced interventions are carried out by healthcare professionals (nurses, physicians, social workers, psychologists, etc.) with expertise working with families.

***Intervening questions.*** As part of the Calgary Family Intervention Model, interventive questions refer to a systematic approach to introducing questions to the family with the intent to elicit change in three domains of family functioning: cognitive, affective, and behavioral.[6] Two types of interventive questions include linear and circular. *Linear questions* are used to provide the nurse additional information to better understand the problems the family is experiencing; they tend to direct the conversation for information gathering and tend to focus on cause and effect. As an example, a family consisting of two adults and three children has a young child, Dylan, with a diagnosis of cancer. His prognosis is poor. Since Dylan's diagnosis, the interactions among family members have become dysfunctional. Directed questions might include:

- When did Dylan's illness first affect the family?
- What specific situations following his diagnosis that have been particularly challenging?

*Circular questions* aim to uncover an explanation of problems and the family's understanding of the problems. These also tend to tease out differences in relationships. Using the same previous scenario, circular questions might include:

- Who in the family is concerned about Dylan's illness and why?
- How have your family routines and interactions changed since Dylan's diagnosis?

There is an art to applying intervening questions. Like most things, it takes time, practice, and experience working with families. Thus the application of interventive questions is most effective among experienced nurses and other healthcare providers who specialize in family nursing.

***Other advanced interventions.*** A number of other interventions are offered for families. These interventions are dependent on situational factors within the family and the underlying issues. Examples include caregiving, family counseling, family therapy, psychiatric care, support groups, palliative care, and hospice. Each of these are interventions beyond the scope of this concept presentation but are addressed throughout this book and from other resources.

## INTERRELATED CONCEPTS

The following concepts are related to family dynamics. Fig. 3.4 illustrates how these concepts are related.

**Development** affects the number and type of interactions within a family and influences the complexity of those interactions. Infants are born; children grow and leave home; marriages occur; parents age and

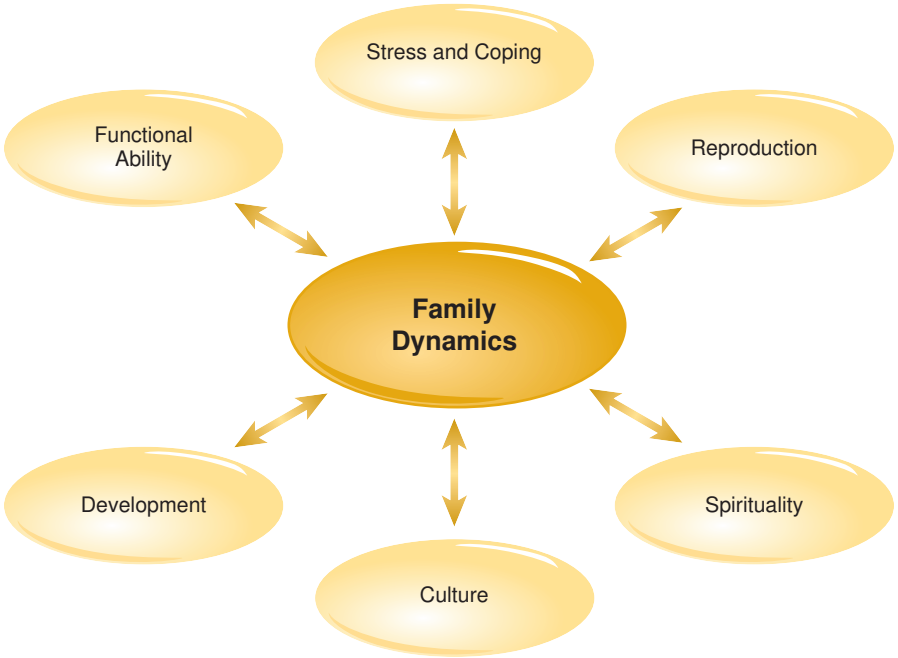


**FIGURE 3.4** Family Dynamics and Interrelated Concepts.

die. Families expand and contract as a consequence, and family dynamics change with each of those changes. The presence or absence of the **Functional Ability** of family members affects the self-concept of the family members lacking that ability, and it places stress on the members of the family who are expected to provide assistance. Whether the assistance is offered or not, resentment can occur and lead to dysfunction in the family.

**Culture** is passed from generation to generation and can affect relationships among family members; for example, the male is always the decision maker; childbirth is the affair of women. Second-generation members of the family may not share the values and customs of first-generation members. Culture has a direct effect on health behaviors. Beliefs, values, and attitudes that are culturally acquired may influence perceptions of illness, healthcare–seeking behavior, and response to treatment.[12] **Spirituality** encompasses a mental or metaphysical belief system, often including belief in a higher being and participation in organized religion. Families often share similar beliefs, but when beliefs diverge, conflicts can occur. Spirituality can bring great comfort in times of stress, illness, and hardship. It can also cause distress when expectations for assistance are not met.

A fundamental purpose of a family is **Reproduction**. The addition of children, whether by birth, adoption, or blending of families, increases the complexity of interactions in a family, introduces stress, and provides the potential for growth and maturation. Infertility creates different stresses through inability to have desired children, through the many tests and procedures undergone to ascertain the cause of the infertility, or through the procedures to try to achieve pregnancy. **Stress and Coping** is a common concept because of the multitude of challenges faced by one or more members of the family. Stress may be from disease onset or sequelae of addictions or substance abuse. It may exist over a period of time such as from an acute infection or for a lifetime, as with a diagnosis of diabetes. Effective coping from within family can provide a source of support for the family member experiencing stress or, conversely, add to the stress by the family's lack of support.

## CLINICAL EXEMPLARS

Positive and negative exemplars of family dynamics provide opportunity to see the wide variety of situations in which family dynamics can be observed (see Box 3.2). The importance of understanding family dynamics when caring for families should lead the nurse to study the factors involved, practice observation of families, and learn appropriate intervention techniques. A detailed discussion of each of these is beyond the scope of this text, but several important exemplars are briefly presented here. Refer to other references for further information about these exemplars and specific interventions for each.

### Featured Exemplars

#### Expanding Family

The family expands by the birth or adoption of a child or by blending families with children through marriage or cohabitation. The family can also expand by incorporating parents or other extended family members. The complexity of communication and interaction is increased in these instances in proportion to the number of individuals involved.

#### Sibling Rivalry

Sibling rivalry is competition or animosity between and among siblings. It is common with the birth of an infant when the older child competes with the infant for the time and attention of a parent but is usually quickly outgrown. As children grow, the rivalry may be heightened, resulting in arguing and fighting. Sibling rivalry may persist into adulthood. At times, the rivalry is healthy, encouraging the siblings to excel. At other times, lifelong animosity may persist.

## BOX 3.2 EXEMPLARS OF FAMILY DYNAMICS

### Changes to Family Dynamics

- Expanding family (birth or adoption of an infant; blended family)
- Caregiver role for family member
- Change in socioeconomic status of family
- Chronic illness of family member
- Marriage, divorce/remarriage
- Traumatic injury of family member
- Disability of family member
- Aging of family members
- End-of-life care
- Death of family member

### Positive Family Dynamics

- Assistance with child care after birth of new infant
- Respite care for a caregiver
- Support after injury or death of a spouse
- Presence during surgery
- Family reunions
- Celebrations of birthdays and other significant events
- Praying together
- Supportive in-laws
- Sharing care of a dependent family member

### Negative/Dysfunctional Family Dynamics

- Child abuse
- Codependency (related to substance abuse by a family member)
- Interfering in-laws
- Intimate partner violence
- Marital infidelity
- Placing blame for birth of a preterm infant or for death of a young child by SIDS
- Sibling rivalry
- Adolescent pregnancy

*SIDS,* Sudden infant death syndrome.

**ACCESS EXEMPLAR LINKS IN YOUR GIDDENS EBOOK**

### Intimate Partner Violence

Intimate partner violence is physical, sexual, emotional, or psychological abuse, threatened or actual, by a current or ex-spouse, current or ex-boyfriend or girlfriend, cohabiting partner, or date. Both women and men can be victims. It involves social isolation, emotional distress, and personal safety.[13]

### Child Abuse

Child abuse is intentional physical or emotional abuse or neglect, including sexual abuse, of a child, usually by an adult. It is a significant social problem affecting children and can result in disability or death. Child abuse is significantly underreported, so actual incidence is unknown.

### Codependency

Codependency is characterized by a relationship in which a person is controlled or manipulated by another who has an illness or addiction. It is a dysfunctional pattern of living and problem solving. It occurs in a setting in which there is addiction, physical or emotional abuse, neglect, or a dysfunction that causes pain and stress.[14,15]

### Absent Extended Family

The mobility of contemporary society means that many children move away from their family of origin or retired parents move to a retirement area, often hundreds of miles away. Extended family members often provide child care; help with cooking or cleaning in the event of illness or disability; provide transportation; and, by their presence, have the opportunity to pass on family stories and traditions. When they are absent, there is a void in support and limited opportunity for young children to know their grandparents, aunts and uncles, and other family members.

### Aging of Family Members

For many people, healthy aging occurs with retention of their mental and physical capacities. For others, as they age, their capacities and roles may change. Disability and the need for care often come with aging. Hearing and sight may become impaired; mobility may decrease. The aged person may no longer be able to drive. Mental capacity and memory may decline. Adult children may have to provide care for their aging parents.

### Death of a Family Member

As part of the cycle of life, family members will die. The death of an infant, child, young parent, middle-aged or older adult, or the aged will have different effects on the family. Tradition, culture, and spiritual beliefs will influence the response to death. Grief may be manifested in a variety of ways and may last a significant length of time.

## CASE STUDY

From Jupiterimages/Photos.com/Thinkstock.

### Case Presentation

Erin is a 22-year-old single parent with two children (Stacie, age 5 years, and Monica, age 2 years). Erin dropped out of high school to marry Andrew when she was 17 years old and pregnant. She recently divorced Andrew because of his drinking, affairs, and lack of support of her and the children.

Andrew has a part-time job delivering pizza and spends most of his free time with friends. He only sporadically provides monetary support. Erin and the girls live in a small apartment. Because she has a minimum wage job, Erin relies on food stamps and other types of assistance. Babysitters and rent are major expenses, and Erin continually worries about being able to pay her bills. She would like to earn her GED to get a better job, but she lacks the time and resources to make that happen. Andrew sees the girls only occasionally—usually when Erin asks him to keep the girls so she can work extra shifts. He dislikes spending his time babysitting his daughters and openly verbalizes his frustration with the "whiny girls."

Erin has a strained relationship with her parents. They were angry when she became pregnant, they were against her dropping out of high school to get married, and they consider Andrew a "deadbeat." They do not help Erin financially, citing concerns for their own retirement. Although they live in the same community, they do not babysit the girls very often and have been critical of Erin's parenting style. Erin has always believed that her parents liked her older brother, Dominic, better. He is married and has three children who spend a great deal of time with Erin's and Dominic's parents. Dominic rarely interacts with Erin because they "don't have anything in common."

Recently, after the girls spent time with their father, Erin noticed bruises on the arms and the buttocks of Monica. When she asked the girls what happened, Stacie said, "Daddy got mad when Monica wet her pants and spanked her." A week later, while at a free health clinic getting Stacie immunized for school, Erin shared with the nurse practitioner details of her life and situation: lack of money and support, working too many hours, fear of losing her apartment, and now—Andrew hurting Monica. She said she does not know what to do and began crying.

### Case Analysis

1. How would you describe Erin's various families?
2. What findings are indicative of negative or dysfunctional family dynamics?
3. How should the nurse respond to Erin?

**ACCESS EXEMPLAR LINKS IN YOUR GIDDENS EBOOK**

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CONCEPT 4

# Culture

Susan Caplan

Human beings need to construct meaning from their experiences, and this construction or created reality is known as culture.[1] For most people, culture is defined by its outward manifestations—the foods people eat, the holidays they celebrate, and their countries of origin. However, culture encompasses much more. Culture forms a person's worldview and values, which in turn shapes his or her beliefs about health and illness. The concept of culture is an important aspect of understanding human behavior[2] and, in particular, is a critical part of understanding how to provide person-centered nursing care.

## DEFINITION

For the purpose of this concept presentation, culture is defined *a pattern of shared attitudes, beliefs, self-definitions, norms, roles, and values that can occur among those who speak a particular language or live in a defined geographical region.*[2] These dimensions guide such areas as social relationships; expression of thoughts, emotions, and morality; religious beliefs and rituals; and use of technology.

A discussion of culture includes the subconcepts of enculturation, acculturation, assimilation, biculturalism, ethnicity, and ethnic identity. *Enculturation* is the process by which a person learns the norms, values, and behaviors of a culture, similar to socialization. *Acculturation* is the process of acquiring new attitudes, roles, customs, or behaviors as a result of contact with another culture. Both the host culture and the culture of origin are changed as a result of reciprocal influences. Unlike acculturation, *assimilation* is a process by which a person gives up his or her original identity and develops a new cultural identity by becoming absorbed into the more dominant cultural group.[2] Usually, when a minority group or individual assimilates, they do not have a choice about what aspects of the dominant culture they will adopt; rather, the dominant culture's values and practices are imposed upon the less dominant group. In contrast, in the case of *biculturalism*, the individual has a dual pattern of identification and chooses which aspects of the new culture he or she wishes to adopt and which aspects of the individual's original culture he or she wishes to retain.

*Ethnicity* refers to a common ancestry that leads to shared values and beliefs. It is transmitted over generations by the family and community. Ethnicity is a powerful determinant of one's identity, known as *ethnic identity*. Race is sometimes thought of in biologic terms (for some people, it has a biologic meaning) based on the erroneous belief in the existence of hereditary physical differences among people that define membership in a particular group.[3] However, there are no genetic characteristics that distinguish one group of people from another, and, in fact, there are more genetic differences among people who are labeled "black" than there are differences between "blacks" and people labeled "white."[3]

## SCOPE

The concept of culture is very broad and influences the shared beliefs, values, and behaviors of a group. Cultural norms impact all aspects of life, including everything from interpersonal relationships, family dynamics, and childrearing practices to gender roles, dietary preferences, communication, dress, and religious practices. Cultural norms also significantly influence how people make decisions about treatment preferences, medication adherence, self-care, and perceptions of illness, which in turn affects nursing care and healthcare delivery. The scope of these influences, in the context of health and illness, is illustrated in Fig. 4.1. Kleinman makes the distinction between the Western biomedical model of disease and traditional models of illness.[4] Disease is a response to physiologic causes explained by pathophysiology and manifested by symptoms and signs.[5] In contrast, traditional health beliefs define illness in terms of mind, body, and spiritual and social connections.[5] Therefore all illnesses reflect the influence of the environment, including an individual's cultural experiences.

### Causal Beliefs About Illness

Cultural differences can result in different explanations for illness.[5,6] In non-Western cultures, explanatory models of illness might include natural causes (e.g., bacteria, viruses, climate, and environmental irritants), the social world (e.g., punishment for individual behaviors or negative social interactions), or the supernatural world (e.g., ancestral spirits and deities). Western cultures are more likely to endorse solely biomedical causation theories, whereas many non-Western cultures have theories of disease causation that can be characterized as an imbalance with natural, social, or spiritual realms in addition to biomedical causes.[7,8]

### Symptoms and Expression of Illness

The manifestation and symptoms of illness can be unique for different cultures. These "culture-bound syndromes or cultural idioms of distress"[6] occur in specific societies and have a constellation of symptoms that are recognized in that culture as a disease entity. For example, *ataque de nervios* is a Latino-Caribbean culture-bound syndrome that usually

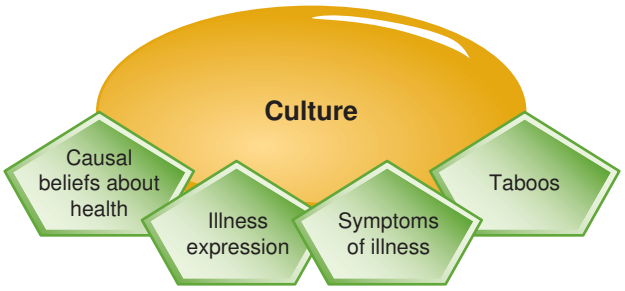


FIGURE 4.1 Scope of Culture Related to Health Care.

occurs in response to a specific stressor and is characterized by disassociation or trancelike states, crying, uncontrollable spasms, trembling, or shouting.[9] *Shenjing shuairuo* or "weakness of nerves" in Chinese culture is described in the *Chinese Classification of Mental Disorders* as a condition caused by a decrease in vital energy that reduces the function of the internal organ systems and lowers resistance to disease.[10] Its symptoms include fatigue, weakness, dizziness, and memory loss. A similar disorder, neurasthenia, has been primarily identified as occurring throughout Asia but can also be found in other cultural groups.[11] The *International Classification of Diseases and Related Disorders* defines this disorder as characterized primarily by extreme fatigue after mental effort and bodily weakness of persistent duration.[12] Neurasthenia is a more socially acceptable illness label in Asia than is depression, which might be considered a mental illness or illness label that is very stigmatizing.[11] Although many Americans would not consider anorexia nervosa or bulimia to be culture-bound syndromes, they may conform to the definition of a culture-bound syndrome[13] because major risk factors for these illnesses are social pressure to be thin and media messages equating beauty and thinness that are more prevalent in Westernized, developed countries.[14]

### Taboos

In many cultures, certain illnesses or behaviors that may be characteristic of illnesses are highly stigmatized and are often not revealed to healthcare providers. A patient may deny the existence of socially disapproved symptoms and/or decide not to seek treatment. This is particularly true for mental illnesses (e.g., schizophrenia and depression), suicidal thoughts, behavioral disorders in children (e.g., attention-deficit/hyperactivity disorder [ADHD] and autism spectrum disorders), sexually transmitted infections (e.g., herpes or syphilis), and potentially fatal illnesses (e.g., Ebola and AIDS).[15] In some countries (Malaysia, Singapore, Ghana, Bangladesh, Saudi Arabia, Nigeria) the social stigma of suicide is replicated in the legal sanctions against it. When suicide is outlawed, there is an additional deterrent for an individual contemplating treatment.[16]

## ATTRIBUTES AND CRITERIA

The following attributes are related to the concept of culture—that is, conditions common to all cultures: *Culture is learned* through families and other group members; *culture is changeable* and adaptive to new conditions; and cultural values, beliefs, and behaviors are *shared* by all within a group.

### Culture Is Learned

Culture may be transmitted to individuals during childhood and adolescence by the process of socialization or enculturation. However, a culture is not limited to members who share the same country of origin or ethnicity and may not be determined solely in childhood; rather, it may encompass any group whose members share certain roles and values, norms, and attitudes—sometimes referred to as subcultures. Subcultures can include members of racial and ethnic minorities; people of indigenous or aboriginal heritage; professions, such as nursing; people of different socioeconomic levels, such as the "culture of poverty";[17] individuals who are bisexual, gay, lesbian, or transgender; individuals affiliated with particular religious or spiritual groups; age groups, such as teenagers or the elderly; and persons with disabilities. Culture is determined by self-identification, and most people identify with a mix of cultures.

### Changing and Adapting

Since the beginning of human history, culture has been constantly changing as people adapt to environmental and technical innovations and in response to globalization and influences of diverse cultural groups. Population migration occurs as a result of regional overpopulation, changes in economic circumstances, the occurrence of catastrophic events (e.g., earthquakes, floods, and famines), and the existence of religious or ethnic conflicts. These migration processes result in ongoing encounters between individuals of different cultures, with subsequent changes and acculturation in both groups.[18]

### Shared Beliefs, Values, and Behaviors

Language, rituals, customs (e.g., holiday celebrations), dietary practices, and manner of dress are among the most overt attributes of culture that are readily apparent to non–group members. Some of the less visible attributes of culture, such as values, relationship to authority, social interactions, gender roles, and orientation toward the present or future, are probably the attributes of culture that are most relevant to health care and communication. These kinds of cultural attributes were examined in several landmark studies by Hofstede[19–21] that yielded five dimensions of these attributes. Four of the five dimensions, in addition to religiosity, have particular significance for health care and are presented in the following sections.

#### Individualism Versus Collectivism

This attribute places value on the degree of closeness and the structure of social relationships, as well as whether loyalties belong to immediate families or to the extended family or clan. The differences in these interpersonal interactions can be thought of as interdependent versus independent and are reflected in the concept of self. Western Europe and the United States are characteristic of individualist societies. Child-drearing practices and a "family model of independence" produce a separated or independent sense of self.[21, p.20] The concept of self is distinct and separate from the "non-self," which includes the environment and social worlds.[22] Collectivistic cultures foster development of an interdependent self-concept. People who have an interdependent sense of self consider their social worth in relation to others. The value of collectivism or interdependence in self-concept is most clearly exemplified by Asian cultures, but it also applies to African, Latin American, and some southern European cultures and some minority cultures within the United States.[22,23] Cultural differences in social practices are apparent in the differences in colloquialisms heard in the United States and Japan. For example, in the United States, "the squeaky wheel gets the grease," whereas in Japan, "the nail that stands out gets pounded down."[23, p.224]

#### Power Distance

Power distance is the acceptance of an unequal distribution of power as legitimate or fair versus illegitimate from the point of view of the less powerful. In cultures that value a more equal distribution of power, people have the expectation that their opinions will be heard and equally valued. People who are less powerful have the right to criticize those in power. In contrast, in cultures in which a greater power distance

is observed, people are unlikely to overtly challenge or disagree with people in positions of authority because such power is the result of longstanding formal and hierarchical arrangements. For example, a study of patient/provider communication in respect to HIV adherence revealed that patients were equally divided between preferences for collaborative styles of communication and provider-dominant styles of communication and messages that were delivered using supportive "soft" communication, and tough talk or more demanding kinds of communication.[24]

### Masculinity Versus Femininity

Masculinity versus femininity describes how gender roles are conceived and how greatly male and female roles differ. Some societies place greater value on masculine attributes (as defined by Western culture), such as achievement, material success, and recognition, versus more feminine attributes, such as harmonious relationships, modesty, and taking care of others. In some cultures, only men can enact masculine roles, whereas in other cultures gender roles are more flexible. In cultures with more fixed gender roles, women are usually given the role of caretaker for aging relatives and may suffer the stresses of caregiver strain.

### Long-Term Versus Short-Term Orientation

Long- versus short-term orientation is the degree to which a culture is oriented to the future and long-term rewards versus the degree to which a culture is oriented to the past or present.[25] Long-term-oriented cultures favor thrift, perseverance, and adapting to changing circumstances. Short-term-oriented cultures are oriented to the present or past and emphasize quick results; they favor respect for tradition and fulfillment of social obligations, although status is not a major issue in relationships and leisure time is important. Among the most long-term-oriented countries are China, Hong Kong, Taiwan, and Japan, whereas the United States, Great Britain, Canada, and the Philippines are among the most short-term-oriented countries.[25]

In a healthcare context, a long-term orientation would be evidenced by the patient who comes in for preventive care visits, receives all of the recommended screening tests and immunizations, and is an active partner in his or her care. A short-term orientation might be evidenced by the individual who seeks treatment for healthcare problems only when the symptoms of an illness become unbearable.

### Religiosity

Another cultural dimension is religiosity, which varies according to how much religion permeates one's day-to-day existence and to what degree religious practices can be separated from nonreligious practices. Religion provides a sense of meaning and coherence to help cope with illness and other life adversities.[26] Religion differs from spirituality in that religiosity is an organized and institutionalized practice associated with particular beliefs, whereas spirituality is an individualistic connection to a higher power, which may or may not entail belonging to an organized religion. The majority of people in the United States believe in God (74%), miracles (72%), and heaven (68%), although this has been diminishing over time and with each succeeding generation.[27] Thus religious beliefs are in a state of flux in the United States.

## THEORETICAL LINKS

The importance of culture and its influence on human behavior has not always been an accepted theoretical premise. Theories of human behavior have been dominated by the underlying premise of the "psychic unity" of humankind, a theory that states that all human social behavior is derived from evolution.[28] Scientists who believe in these concepts claim that through evolution and natural selection, certain genes in the species that enhance survival are most likely to be passed down from one generation to the next, and these genes specify cognitive functioning and the manner in which people perceive the world.[29] Therefore thoughts, behaviors, and emotions develop universally and account for such diverse behaviors as favoring relatives (i.e., altruism), creating and following rules, or adopting specific beliefs about religion and warfare.[30] Language, culture, and religion are incidental to or an outgrowth of these genetically determined behavioral processes. Karasz and McKinley[31] refer to "the 'culture-free' approach of traditional health psychology." However, many theorists currently believe that the recognitions of emotions, the social display of emotions, the cognitions and interpretations of emotions and the associated bodily experiences are culturally determined rather than culture free.[32] Relatively recently, behavioral geneticists have shown us how the social environment has a major influence on how genes are expressed. Although there might be inherent biologic factors that produce emotions and behavior, genes interact with the environment to produce differences in emotional responses.[33]

### Leininger's Theory of Culture Care Diversity and Universality

Berry and Leininger emphasized the importance of understanding human behavior in the context of culture.[34,35] They applied the concepts of "emic" and "etic," which referred to an approach to understanding behaviors. The term *emic* refers to an approach to understanding culture from within (i.e., the insider's viewpoint), whereas *etic* refers to the application of constructs external to a culture to discover universal characteristics common to all cultures. The assumption of universality can also imply an imposition of an outsider's values, rules, and understanding to another culture or subculture. The concepts of emic and etic are essential aspects of Leininger's theory of culture care diversity and universality.[36]

The central tenet of this theory is that both emic and etic approaches could lead to more responsive approaches to caring, the most important focus of nursing. To provide meaningful and holistic care, social structure factors, such as religion, economics, education, technology, ethnic background, and history, have to be taken into account because these factors have major influences on health, well-being, and illness. This comprehensive approach to nursing formed the basis of Leininger's development of transcultural nursing, the "formal area of humanistic and scientific knowledge and practices focused on holistic culture care … to assist individuals or groups to maintain or regain their health (or well-being)."[36, p.84]

### Interprofessional Theory of Social Suffering

The interprofessional theory of social suffering states that relationships and social interactions shape our illness experiences and beliefs about the meaning of suffering. Memories of trauma and suffering exist collectively within a group or culture and are transmitted through shared experiences and learning.[37] All illnesses are a form of social suffering, mediated by cultural and political institutions. Technological advances can treat an individual's disease, but they do not address the root causes of illness, including poverty and the global political economy. Tuberculosis, depression, sexually transmitted infections, substance abuse, domestic violence, posttraumatic stress disorders, and AIDS are not individual problems but, rather, a reflection of social structure and healthcare and political inequities. It is also important to understand the individual's cultural interpretation of illness and suffering. These cultural representations of suffering and the response to it comprise the diversity of human responses to illness and pain. In some cultures, silent endurance is valued, whereas other cultures rail against unjust gods.[37, pp.ix–xiv] Some cultures place a high priority on the well-being and

health of their members, whereas other societies are characterized by greater inequities in the health status of their populations.

## CONTEXT TO NURSING AND HEALTH CARE

Many nursing students have asked, "Why is there such an emphasis on culture in health care? That's all we keep hearing about." Culture is an essential aspect of health care because of the increasing diversity of the United States. In 2016 the U.S. population was estimated at 323 million. In that year, the non-Hispanic white population of the United States represented 62% of the total population, a drop of five percentage points since 2008.[38] This is due to the aging of the white population and a postrecession decrease in fertility among white women. Currently, children aged 0 to 9 are more likely to be minorities than white.[39] By 2050 the non-Hispanic white population is expected to decrease to 50%, assuming the rate of immigration is constant.[41] Half of the population will be composed of people who identify themselves as belonging to a racial or ethnic minority population, including black, Asian, and Pacific Islander; American Indian, Eskimo, and Aleut; and Hispanic.[40]

In 2016, approximately 12.5% of the U.S. population, or 39 million people, had a disability.[41] Persons with disabilities identify themselves as part of a culture based on shared life experiences; this identification has led to music, publications, and media products unique to that culture, as well as to the disability rights movement to address discrimination in housing, employment, and health care. An estimated 4% of the U.S. population ages 18 to 44 years identified themselves as lesbian, gay, bisexual, or transgender.[42] Persons who are lesbian, gay, bisexual, or transgender experience societal discrimination, societal stigma, and human rights abuses that have led to higher rates of mental illness in addition to higher rates of HIV and sexually transmitted infections.[43,44]

### Health Disparities

The increasing cultural diversity in the United States has resulted in the national health objective proposed in *Healthy People 2030:* achieving the highest level of health for all people and communities. Health and well-being is achieved by strengthening physical, social, and economic environments.[45] One of the major goals of *Healthy People 2030* is the elimination of healthcare disparities, and achievement of health equity, which is closely allied with nursing's basic tenet of social justice, which is the belief that all people deserve quality health care and access to care is a basic human right. *Healthy People 2030* emphasizes the need to provide culturally competent healthcare services and to improve health literacy and health education among non-English-speaking populations. This is presented in greater detail as Concept 52, Health Disparities.

### Cultural Competency in Nursing

Cultural competence is an expected component of nursing education and professional nursing practice. Culturally competent care means conveying acceptance of the patient's health beliefs while sharing information, encouraging self-efficacy, and strengthening the patient's coping resources. The scope and standards of nursing practice specifically identify cultural competency as it relates to assessment, outcomes identification, planning, and implementation.[46] Cultural competency is currently more of an imperative as we begin to understand that healthcare providers' unconscious biases contribute to disparities in treatment,[47] even though nurses and physicians continue to deny that their own behavior is a factor in healthcare inequalities.[48]

As a nursing student, you might be thinking, "Yes, but we are taught how to communicate with our patients and if I treat everyone with respect and understanding, isn't that sufficient?" By treating everyone the same, we are not providing quality care because we are ignoring societal factors that contribute to worse health outcomes among vulnerable populations. It is true that communicating respectfully is an essential aspect of communication and every patient is an individual with unique needs. However, failure to recognize the fact that people identify themselves as members of certain groups who have shared experiences of social injustice and who are currently treated differently in health care will result in an inability to understand some of the most essential human experiences of our patients.

Now, you may be saying to yourself, "Yes, I understand cultural competency is important, but really, there are so many other things that we need to learn as nurses."

Rubin defines expert nursing as the ability to recognize qualitative distinctions between patients.[49] The ability to make qualitative distinctions, or to be able to understand differences in the patient's life experiences, requires empathy. Empathy is necessary to understand the individual's self-perceptions of how he or she came to feel that way. Nurses who lack empathy are not practicing evidenced-based care, defined as comprising research-based information, clinical expertise, and patient preferences.[50]

In a cultural sense, this could be illustrated by the description of one nursing student's health assessment and history taking. She writes, "His parents are from India and he practices Hinduism. He goes to Mosques regularly and is a lot like my patient from Sudan, who is also very religious and celebrates Ramadan." This assumption of similarity between Muslim and Hindu practices and the confusion between the two evidence an inability to make qualitative distinctions in a person's history or to really attempt to understand that person's experience of religion. Individualized care or "patient-centered" care is facilitated by cultural competence that respects and acknowledges the patient's values, needs, and preferences.[51]

### Developing Cultural Competence

The process of developing cultural competence consists of four interrelated constructs—cultural desire, self-awareness, cultural knowledge, and cultural skill—thus forming the broad components of cultural competency.[52,53]

#### Cultural Desire

A pivotal construct is *cultural desire*.[52] Cultural desire refers to an interest and intent to understand people who are different from oneself. Cultural desire is a personal choice; this interest is foundational to cultural competence and provides the means for overcoming one's biases and their effect on care. Cultural desire leads to patient-centered care as the nurse becomes more attuned to differences between individuals. Like any other effort to master new skills and knowledge, motivation or cultural desire is a prerequisite.

#### Self-Awareness

*Self-awareness* involves identifying and understanding one's own cultural identity. You might think about some aspects of your own cultural identity. Did you grow up with people of the same ethnic background as yourself? Did you gather with extended family and engage in traditional activities? Do members of your family make frequent visits to their country of origin or old neighborhood? Do you participate in ethnic cultural events? Do you speak another language? Do you have pride in your cultural background?

Perhaps you are saying to yourself, "But I grew up in an area where everyone is the same as I am, and we don't have traditions from the countries where my great grandparents came from and we just eat normal American food and celebrate the same holidays as everyone else. *I don't have any cultural identification*." If you feel that way, ask yourself, "What about the place I grew up? Is it like every other place

in the United States? What about the meals I prepare? Does everyone in America celebrate the same holidays? Are all Americans the same? What are my own values and beliefs?"

Perhaps you are saying to yourself, "But I grew up in an area where everyone is from a different culture and I'm very comfortable interacting with other cultures." If you feel that way, ask yourself, "How would I feel living next door to a family with two parents of the same sex or a halfway house for people with chronic severe mental illness? How comfortable do I feel interacting with homeless people? How would I feel if my son or daughter married someone from a religion that I know nothing about? What are my own biases?"

Biases not only are negative stereotypes but also can be any tendency to act, think, or feel in a certain way toward other people. For example, you may believe that Vietnamese people are hardworking, they want their children to do well in school, they expect that their children show respect to their parents, and they stick together. Many nurses believe, "But that really doesn't apply to me, because I know that even if I personally don't like someone or something they've done, I will treat everyone in a professional manner and will treat everyone the same." Nurses grow up with the values and beliefs of their cultures and the society around them. Perhaps you believe that abortion is wrong, that it is immoral to have same-sex relationships, that people with depression could really snap out of it if they wanted to, or that people with substance abuse do not have a mental illness—they make choices. Perhaps you feel angry that some people receive health benefits that are "free" and are paid for by your tax dollars. After all, you work hard to earn money, "Why can't they?" "Why do all of those refugees who have moved into my community get Medicaid and can get medications that I can barely afford?" Is it possible to separate all of these feelings from our practice? Many studies in many fields indicate that those feelings carry over into the care we provide.

Even when one's own values and beliefs are directed against a particular group of people, they may still reflect the biases of the dominant cultural group. For example, nurses from independent cultures will develop nursing objectives based on the cultural value of autonomy—developing one's own potential and maintaining one's independence—and equate "more" of such traits with better health. A patient from a more interdependent, collectivist culture might not share such values. For this patient, it might be expected that he or she is dependent on other family members in times of ill health. Moreover, the family's needs and desires might be valued more highly than obtaining one's own personal goals. The use of the concept of "self-esteem" as part of a nursing diagnosis may reflect the bias that the self is construed similarly in all cultures. As Markus and Kitayama[23] explain, in interdependent cultures, the essence of self is defined by one's relationships to others rather than the inner self. Internal attributes such as desires, abilities, and personality traits are viewed as situation dependent and therefore unreliable. Self is not a constant but, rather, is fluid and changes according to the situation or the relationship. It is important for the nurse to assess the patient's own values and definition of health and to develop mutually agreed upon nursing care plans.[54]

### Knowledge

*Knowledge* as a domain of cultural competency does not imply learning facts about every culture but, rather, exposing one's self to other cultures and being motivated to learn. Knowledge can be acquired by reading journals that represent different groups; visiting ethnic neighborhoods and sampling different foods; learning a foreign language; attending community or professional nursing meetings representing diverse coalitions; speaking with someone from another culture; walking into botánicas, ethnic grocery stores, or herb shops; attending a service at a mosque or synagogue; speaking with a hospital translator; going to a gay pride march or Puerto Rican day parade; or reading a novel about someone growing up in another culture.

**BOX 4.1 Eight Questions Associated With the RESPECT Model**

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a long or short course?
6. What kind of treatment do you think you should receive?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?

From Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley, CA: University of California Press.

### Skill

*Skills* are acquired over time by careful attention to the nurse-patient relationship. One element of cultural skill is communication. Collaborative decision making and patient engagement are key aspects of health outcomes, but culturally and linguistically diverse populations require specific strategies to overcome the barriers of language, distrust, low health literacy, and stigma. There are many resources available to learn basic medical terminology on the web, including internet and smartphone applications that serve as translators. There are also assessment questions designed to understand the sociocultural contexts of people's healthcare needs. The RESPECT model of cultural assessment, based on a series of eight questions developed by Kleinman,[55] provides a blueprint to develop skills needed to become culturally competent (Box 4.1).[56] RESPECT is an acronym for *r*espect, *e*xplanatory model, *s*ociocultural context, *p*ower, *e*mpathy, *c*oncerns and fears, and *t*herapeutic alliance/trust.

*Respect* and *empathy* are attitudes that demonstrate to the patient that his or her concerns are valued and he or she is understood. The nurse can further assess for the patient's *explanatory model*, or understanding of what is the cause of his or her illness, and the *sociocultural context*, which comprises factors in a person's life that may contribute to the current state of health and expectations for treatment, such as poverty, stress, and social support. *Power* refers to the importance of acknowledging that the patient is in a vulnerable position and that there is a difference between patients and healthcare providers in terms of access to resources, knowledge level, and control over outcomes. The loss of power and control that a patient faces can contribute to *concerns and fears* about treatment, illness outcomes, and the future. Bearing in mind the meaning of these concepts in the nursing relationship enhances communication and assessment skills between patient and nurse and creates a *therapeutic alliance and trust*.

## Conducting a Cultural Assessment

Assessment has long been recognized as the foundation for competent, patient-centered nursing care. It should be no surprise that cultural assessment is an expected component of nursing care. A cultural assessment helps nurses gain an understanding of the meaning of the illness to the patient, expectations the patient has regarding treatment and care, and the patient's perception about the process. The patient history includes many questions that link to a patient's cultural perspectives and preference. It is most important to apply elements previously described into the history and assessment so these critical data are recognized and understood. Data gained from an interview as it relates to cultural assessment are included in Box 4.2. In addition to data

collected as part of an interview, the nurse should observe the patient's behavior (e.g., personal space and eye contact), clothing, and presence of articles as cues for additional or clarifying questions.

## INTERRELATED CONCEPTS

Several concepts within this textbook are closely related to the concept of culture and are shown in Fig. 4.2. **Health Disparities** adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial, ethnic, or cultural group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[57] Culture affects **Family Dynamics** in many ways, including the manner in which sick family members receive care, beliefs about sharing information with outsiders about a family member's illness, gender roles, and beliefs about appropriate childrearing practices. For example, the dominant practice in America of letting an infant cry himself or herself to sleep to learn how to self-soothe may be construed as a form of neglect, particularly for people of cultures that believe in sharing a bed with an infant.

The concept of **Ethics** is interrelated because of the different interpretations and values around appropriate behaviors and actions; in some cultures, practices considered appropriate may be considered unethical in others—thus ethics may be nested in cultural context.[58]

Another cultural dimension is **Spirituality**, which is an individualistic subjective experience of transformation or connection to a higher power. Spirituality may or may not entail belonging to an organized religion. Spirituality is closely interrelated with culture because many spiritual beliefs are embedded within cultural groups.

The concept of **Communication** is closely related to culture because communication patterns, both verbal and nonverbal, are determined by cultural norms. Degree of eye contact, personal space, and the acceptability of touch all vary by cultures. Culture dictates the nature of relationships and the degree of hierarchy and structure in relationships. In some cultures a high degree of formality and reserve is expected when addressing people of greater social status, whereas in other cultures there is less stratification by age or social standing and it is acceptable to be direct and open with everyone. Similarly, in some cultures, personal revelations or discussion of family problems are taboo, whereas in other cultures there are no such restrictions on communication.

**Stress and Coping** involve dealing with life's difficulties and are, to a large extent, culturally determined. Cultural belief systems form the basis of a coping strategy by creating a redefinition of negative circumstances.[59] These belief systems may encompass religious beliefs and religiosity, which may have a beneficial effect on health by fostering positive emotions such as hope, gratitude, and reverence.[60] Religiosity may result in decreased symptoms of distress and may help with coping by decreasing loneliness and fostering cultural identity.[61]

The expression and meaning of some symptoms such as **Fatigue** are influenced by culture. Some cultures seek a biomedical explanation for the medically unexplained symptom of fatigue (such as chronic

### BOX 4.2 Data Collected as Part of Cultural Assessment

**Origins and Family**
- Where born; if in other country, length of time in United States and circumstances
- Decision making within family
- Cultural group(s) identified with; presence of social network
- Important cultural practices

**Communication**
- Language spoken at home; skill in speaking, reading, and writing in English
- Preferred methods to communicate with patient and/or family member (how to be addressed, to whom questions are directed, etc.)
- Ways respect is shown to others
- Eye contact, interpersonal space

**Personal Beliefs About Health, Illness**
- Meaning and belief about cause of illness
- Perception of control over health
- Practices or rituals used to improve health
- Perception of severity of illness
- Expectations for treatment; use of folk remedies, alternative medicine
- Practices that violate beliefs (taboos)
- Concerns or fears about illness or process of treatment

**Daily Practices**
- Dietary preferences and practices; forbidden foods
- Beliefs about food that pertain to health and illness
- Spiritual beliefs; religious practices
- Special rituals

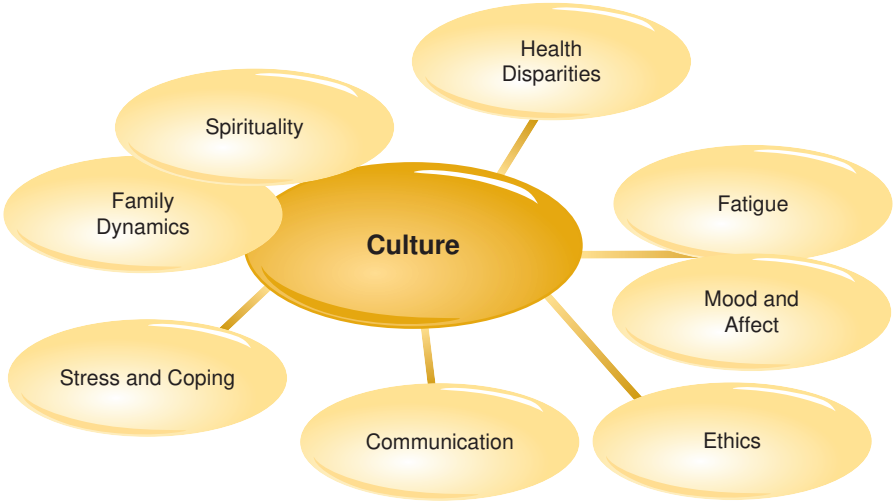


**FIGURE 4.2** Culture and Interrelated Concepts.

fatigue syndrome and depression) or a lack of fulfillment, whereas other cultures view fatigue as an imbalance of essential energies.[31] Likewise, **Mood and Affect** have a strong interrelationship to culture. Depression is the leading cause of nonfatal disease burden and years of life lived with disability worldwide.[62] Rates of depression are highest among the most vulnerable populations—people living in poverty, immigrants, and refugees.[63–65] Experiences of immigration may also contribute to mood disorders because immigrants experience depression from the stress of adjusting to a new culture, loss of family and traditions, loss of social status, and memories of severe deprivation or political violence in their countries of origin.[66] Racial and ethnic minorities are less likely to receive treatment for mood disorders, and when they do receive treatment, it often does not meet the standard of care.[67] Patients have better outcomes when they are culturally and linguistically matched with their mental health provider.[68] Cultural values and beliefs, including the reluctance to share personal problems outside of the family, disclose personal problems, a value on self-sufficiency, recognition of mental health problems, and stigma about mental illness, also create barriers to treatment engagement.[69–72]

## CLINICAL EXEMPLARS

There are multiple exemplars of culture in the context of healthcare delivery. These are best presented using the framework of healthcare practices and beliefs, family roles, and patient-provider communication. The most common exemplars of culture as it relates to healthcare and nursing practice are presented in Box 4.3.

### Featured Exemplars

#### Language Preference

An estimated 63 million Americans (21%) speak a language other than English in the home, and 8.5% report that they do not speak English well (U.S. Census Bureau).[38] Patients with limited English proficiency (LEP) face many healthcare barriers in terms of understanding healthcare information, adherence to treatment plans, and follow-up care due to impaired patient-provider communication. Healthcare providers must ensure that health care is delivered in a manner that takes into account the needs of patients with LEP, often through the use of interpreters. The Agency for Healthcare Research and Quality has a number of tools and guidelines available to help nurses provide quality care to LEP patients.[73]

#### Decision Making

The values of individualism versus collectivism form cultural differences in the role of the family in determining how people decide to obtain treatments and medical care. For independent cultures, an individual will put himself or herself first in the case of a life-threatening illness, whereas even in such dire situations, members of collectivist cultures may still consult other family members for the best course of action.

#### Taboo

A taboo is a prohibited or forbidden action or behavior based on moral judgment and/or religious beliefs in the context of one's culture. Taboos are present in all cultures, and what is considered taboo in one culture may not be considered taboo in another. Healthcare providers must maintain awareness that some procedures and treatment practices considered standard of practice may be considered taboo in some cultures. Examples include physical touch of a female patient for an examination without the consent of the husband and administration of blood products.

#### Power Distance

People from cultures with greater inequality of power distance may be unwilling to disagree with or question the authority of a healthcare provider, whereas people from cultures in which there is an expectation of equality of relationships may not be hesitant in expressing their wishes and needs for their own health care. Therefore when a nurse provides education to the patient who is from a culture that values greater power distance, it might appear that the patient is willing to accept all the nurse's suggestions, when further prompting might elicit additional questions or concerns of the patient.

#### Symptoms of Illness

The symptoms of an illness may vary depending on how a culture understands and perceives the illness. Thus healthcare providers must consider the possibility that their view of "expected symptoms" associated with certain disorders may be different from that of people from other cultures. For example, in some cultures, it is acceptable to verbalize that one is in pain, whereas in other cultures, the verbalization of pain is seen as a sign of weakness or control. As another example, mental health illnesses are described in bodily terms such as backaches, headaches, and fatigue rather than disturbances in mood and affect.[74]

#### Beliefs About Illness Control

Beliefs about control one has over health and illness are highly variable depending on one's culture and can impact decisions about health promotion practices or care during times of illness. Individuals who hold a belief that they have control over the course of an illness may "appear" to be more engaged in and actively pursue health screening and treatment options. In some cultures the predominant belief is that what happens is out of one's control, sometimes referred to as fatalism or an external locus of control. In some contexts an external locus of control can be a culturally protective mechanism and serves to preserve a sense of peace and well-being in situations that are out of one's control, such as a terminal illness.

### BOX 4.3 EXEMPLARS OF CULTURE

**Health Care Practices/Beliefs**

- Symptoms of illness
- Treatment preferences
- Meaning of illness
- Control over health and illness
- Consequences of illness/preventive care
- Dietary practices
- Religious healing practices
- Complimentary alternative or integrative medicine

**Family Roles**

- Birthrights
- Childrearing practices
- Gender roles
- Family structure
- Decision making
- Death and dying
- Caregiver roles

**Patient-Provider Communication**

- Language preference
- Nonverbal communication (eye contact, personal space, touch, body posture)
- Power distance
- Taboos
- Revealing personal information
- Expression of emotion

ACCESS EXEMPLAR LINKS IN YOUR GIDDENS EBOOK

## CASE STUDY

From Tomwang112/iStock/Thinkstock.

### Case Presentation

Mr. Wong is a 78-year-old male from mainland China who has been admitted for rehabilitation following total hip replacement surgery. He has a poor appetite, has experienced weight loss, and has been unable to participate in physical therapy. Thus he is not meeting his goals for rehabilitation. No evidence exists to suggest an underlying disease process.

Ms. Faye, the nurse assigned to care for Mr. Wong, is interested in learning what might be going on with Mr. Wong to better meet his treatment outcomes. Ms. Faye considers the possibility that he does not have adequate pain relief, which could affect his appetite and cause poor participation in physical therapy. She reviews his history to learn more about him. According the health history, Mr. Wong is a widower of 3 years; he has a son and daughter who live in distant cities. Mr. Wong emigrated from China at the age of 38 years and speaks only Cantonese. He has lived in an ethic neighborhood with other Chinese Americans and has worked as a short-order cook in a Chinese restaurant since arriving in the United States 40 years ago.

Ms. Faye arranges for Mr. Lee, a Cantonese translator who is also Chinese, to help her ask Mr. Wong a few questions. She first asks Mr. Wong if he is in pain. When he responds no, she follows with another question, asking him if he is depressed or anxious. Again, Mr. Wong responds no, that he is fine. During the interaction, Ms. Faye observes that Mr. Wong does not look at her or Mr. Lee, the translator.

After leaving the room, Ms. Faye expresses her frustration to Mr. Lee, mentioning how difficult it will be to help Mr. Wong when he will not communicate. Mr. Lee responds, "Elderly Chinese people believe that they must be stoic about pain and there is a stigma about talking about any mental health problems." This explanation had not occurred to Ms. Faye, who then recognizes her approach may have been offensive and that she had failed to consider the underlying cultural differences beyond language.

Ms. Faye asks Mr. Lee to share more about traditional Chinese beliefs. She then asks Mr. Lee to help her ask Mr. Wong additional questions using a cultural assessment form as a guide. After gathering additional information from Mr. Wong and gaining additional insight from Mr. Lee, Ms. Faye incorporates strategies that include changes to how his food is prepared and served, changes in approaches to pain management, and involving Mr. Wong's son and daughter in his care.

### Case Analysis Questions

1. In what way does this case exemplify the concept of culture in the context of health care?
2. Referring to Fig. 4.2, what interrelated concepts are exemplified in this case? What additional concepts apply that are not included in Fig. 4.2?

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