Chapter Objectives

1. Define the family support construct.

2. Describe family needs for support to meet wellness, health promotion, care maintenance, and disease management throughout the life course.

3. Compare the benefits linked with various form of support needed with various health and illness needs.

4. Identify intentional nursing actions that effectively provide family support throughout different health and illness experiences.

Chapter Concepts

Caregiver burden
Compassion fatigue
Coordinated care
Discharge planning
Family health routines
Emotional support
Informational support
Instrumental support
Intentional support
Nurse support
Organizational support
Resources
Respite care
Spiritual support
Support
Support groups

Chapter Introduction

Although family support is often mentioned in conversations, the concept is not often fully defined or explained clearly. In fact, this concept or idea has many definitions and multiple facets that can cause various interpretations. Support can imply a structure such as a column or beam that serves as an architectural brace or buttress. Technical support may trigger thoughts
about calling a repair person to fix something, perhaps someone like the person called when a computer hard drive dies. In the world of politics, one might think about support as a form of advocacy provided by lobbyists or use of resources to influence or sway public policy or political opinion. Support is linked with state initiatives such as child or adult support (e.g., child and adult care food program), caring for others like support groups (e.g., American Heart Association, Alcoholics Anonymous), programs for the poor (e.g., Supplemental Nutrition Assistance Program, Section 8, Head Start), or programs that offer financial supports (e.g., unemployment, social security). Medicine often addresses life supports such as mechanical ventilation or defibrillation to assist critically ill persons. Support also comes to mind when thinking about individual care needs. Ideas about support are many and the meanings and implications greatly vary.

In chapter fifteen, thoughts about ways nurses can give support are discussed. Different support forms are described and ways that thinking family can equip nurses to provide supportive family care are identified. Attributes and support actions can be forms of information, instrumental, emotional and appraisal (Schaffer, 2004). Information or educational support is often addressed by nurses during times of stress, illness, and symptom management (House, 1981; Trecartin & Carroll, 2011). Instrumental support refers to the tangible goods, resources, or services that families need (House, 1981). Emotional support involves the experience of being cared for or feeling loved, admired, or heard and focuses on relational aspects (Norbeck, 1981). Appraisal support refers to affirming actions (Kahn & Antonucci, 1980). Other kinds of support can also be considered. For example, social support comes from family, friend, organizational networks, and community environments. Support can include tangible things like resources and supplies, but organizational and community supports can also offer a broad variety of network...
services to ease a burden linked with an illness or other disability (Looman, 2006). Spiritual support can be given by nurses and others at times of conflict, tragedy, uncertainty, and suffering. Support can be viewed as informational, provisional, emotional or relational, tangible and intangible resources, organizational, and social. This chapter describes many aspects and forms of support needed by individuals and families when health or illness is the concern.

**Needs for Support**

Nurses that establish rapport and open communication with family members can help ease the distress of living with an illness and support one another through difficult times. Humans experience illness and suffering as physical and emotional events, but human relationships can provide valuable support for overcoming various forms of suffering (Wacharasin, 2010; Wright & Leahey, 2013). Adequate social support such as caregiving, adequate coping, a sense of wellbeing, decreased anxiety, and curbed depression can support positive outcomes (Langford, Bowsher, Maloney, & Lillis, 1997; Li & McLaughlin, 2012). Strong individual-nurse-family relationships can offer security and comfort as they assist in the management of the physical and emotional demands tied to illness (Edvardsson, Sandman, & Rasmussen, 2005; Kolcaba, 2003; Meiers & Tomlinson, 2003; Nelms & Eggenberger, 2010; Couture, Ducharme, & Lamontagne, 2012). However, ways to provide appropriate support may not be an intuitive experience for nursing students. They might need instruction, skills, guidance, and directions as they learn to identify optimal ways to provide support for specific needs. Modeling supportive behaviors with students can be a beginning step for their understanding. However, most will need to learn more about conditions, community resources, and methods for communicating with individuals about their family needs. Using unfolding case studies, role play, and simulation can be safe and useful environments for testing approaches and weighing alternatives.
Students need to learn ways to share information about community resources with family members and help them make contacts with supportive social networks. Nurses that *think family* understand the importance of relationships and communication that social networks provide and strive to assist those receiving care access them (Benzies & Mychasiuk, 2009). In a time when technology is everywhere, it is wrong to assume that all have equal access or abilities to effectively use what might seem to be available. While technologies can connect, most people also crave human connections. Conversation, personal interactions, and caring relationships have can affect the ways physical or mental health conditions are managed, participation in positive health behaviors, and promote family health outcomes (Schaffer, 2004; Couture, Ducharme & Lamontagne). A quality social network and the connectedness to others can contribute to the sense that support is available and lessen feelings of isolation (Cleek, Wofsy, Boyd-Franklin, Mundy, & Howell, 2012). Students need to understand the importance and value of social support and recognize the solution is not to merely call for a social worker. Student nurses can be assisted to gain skills in ways to approach support needs.

**Family Coping**

Much research was conducted by nurses and others during the 1980s and 1990s around topics of stress and coping (Werner & Frost, 2000). Research examined stressors and chronic conditions and identified that things such as symptoms of distress (e.g., fatigue, pain, insomnia), life changes and losses, uncertainty, financial concerns, lack of information, and loss of control are often burdensome for individuals and family members (Frost, Orth, & Werner, 2000). In 1997, a synthesis conference held by the Midwest Nursing Research Society focused on stress, coping, and health outcomes. Recommendations from this conference (Werner, Frost, & Orth, 2000) suggested more research was needed about stress in the following areas:
longitudinal processes
changing processes over time,
trait and personality factors linked with stress,
various outcomes that result from different stressor patterns.

While research about stress was widely investigated several decades ago, most work focused on individuals. Additional study pertaining to multiple member or family responses is still needed so that a better foundation to understand support with family households is available. Families often face great stress when health alterations occur, changes occur as a result of illness conditions, and even when individuals choose to form healthier lifestyles.

Coping has long been a topic of great interest to nurses and factors that influence an individual’s ability to manage stressful life situations have been widely examined (Antonovsky, 1979; Lazarus & Folkman, 1983). A review of 71 articles about stress and coping found that 27 of them investigated nurses or nursing students’ behaviors (Underwood, 2000). This literature review identified important internal resources like personality (e.g., hardiness, self-efficacy, self-esteem, locus of control) and personal outlook (e.g., faith, spirituality, hope, education or information, energy) as qualities linked with stress. Hardiness is an important internal personality resources, it has to do with the capacity to endure hardship or unfavorable conditions and abilities to resist stress (Savavarsdottir, & Rayens, 2005). Hardiness is a resiliency factor that helps one cope with painful or difficult life situations. Family hardiness is a resource for family members coping with stress and improves family interactions and processes when a member has a disability or chronic illness (Fink, 1995; Snowdon, Cameron, & Dunham, 1994; Savavarsdottir & Rayens, 2005). However, the significance of coping from family perspectives has been less
thoroughly investigated and ideas about the nursing actions that most encourage family hardiness are still unclear. This an area of family research that could be useful to nursing practice.

Family members and less likely to adapt to needed changes when the caregiver was depressed, had a high level of fatigue, or lacked individual hardiness factors (Clark, 2002). This was also true in families where children had developmental disorders (Weiss, 2002). Research about hardiness has mainly looked at mothers and not considered ways other family members use hardiness to manage shared stressors. Many questions still remain and further research is needed to better understand ways family nurses can work with families to build hardiness, strengthen resilience, and use supportive actions to help them cope with stress.

**Making Changes to Support Care Management**

Many years ago Fishbein and Ajzen (1980) suggested that behavioral intentions are often tied to personal motivation, but gaps often occur between individual intentions and corresponding actions. In other words, while persons know something is the right thing to do, the corresponding actions are not always compliments to changes. Self-efficacy has to do with abilities to exercise control over health functions; this is not just an individual matter, but also a social one (Bandura, 2004). Positive health outcomes include qualities like positive self-worth, perceived control and self-efficacy, ability to manage needed care situations, a sense of wellbeing, and less anxiety or depression (Langford, Bowsher, Maloney, & Lillis, 1997). Although many different models of change linked with health or illness behaviors exist; three models seem especially useful when discussing support issues (i.e., *Health Action Process Approach, Transtheoretical Model of Behavior Change, Health Belief Model, Illness Belief Model*). These models can be useful in teaching students ways to think about people make changes and the nursing approaches that might be taken to support people through change. Models can help students and nurses identify
ways to view a problem and plan actions. Create a class activity that involves giving the class a case study, breaking them up into three groups, and having them decide approaches to be taken based upon the four different models.

**Health Action Process Approach (HAPA)**

The *Health Action Process Approach* (HAPA) is a psychological theory engages the personal trait of motivation and volition or deliberate intention to act (Schwarzer, 2008). Motivation has to do with a stimulation or inspiration that creates an internal desire to move towards a desired goal. Motivation is a critical aspect of self-management and self-control and is linked with maximizing pleasure and minimalizing pain. On the other hand, volition has to do with free will or choice. Volition might also be associated with a willful decision to take action or not. Things like self-efficacy and strategic planning can help bridge gaps between intention to change and actual change. Risk perception, action self-efficacy, and positive outcome expectations help form the intentions to act (Schwarzer, 2008). Once the intention to act occurs, then there must be planning for action and coping. The decision to act is often based within an understanding that taking an action is within the best interests of persons. HAPA has two phases (i.e., goal setting, goal pursuit) and has five distinct principles:

1. Motivation and volition are two separate phases in the behavior change process.

2. The volitional phase has two different groups, those that have not moved from intention to action and those that have not.

3. Those that intend to change, but have not yet moved to action and can best be aided by planning.

4. The planning phase consists of action planning and coping planning.
5. Self-efficacy differs depending upon what phase the person is in (i.e., pre-action, coping with change, maintenance of change).

In giving support or assuring that an individual has adequate support, nurses need to identify the mindset of individuals involved in care and the kinds of support that family members are able or willing to give. Tailored nursing actions that fit personal needs and mindsets can suggest supportive responses for change rather than using a “one size fits all perspective.”

**Transtheoretical Model of Behavior Change**

The second model for considering nursing actions that support behavioral changes is the *Transtheoretical Model of Behavior Change* or what many call the stages of change (Prochaska, Norcross, & DiClemente, 1994). Some discussion about this model occurred in several earlier textbook chapters, you might want to encourage students to return and review some of these ideas. This model suggests that change is a process that occurs over time using a series of stages (Table 15.1). Things to support changes vary, but things like consciousness, commitments, preparation, abilities to manage changes, environmental supports and threats, and helping relationships are included. Decision-making or weighing the pros and cons of action are important factors in this model. A personal conviction of need to change based upon information about healthy behavior can be a first step. When coupled with fears about inaction or knowledge that others have been successful in making the change, a sense of self-efficacy or one’s ability to be successful is heightened.

As an individual recognizes that the behavior change is important to them or sees how their non-action could negatively effect others, then the intentional commitment to making change becomes stronger. However, the environments and persons surrounding individuals facing needs for change can provide support or threaten the change. Family nurses can assess an
individual’s and family members readiness to make change when thinking about support issues.

However, the individual alone may not have the volition to pursue and follow through on the change if family support is lacking. Therefore, individuals and family members need to understand reasons why change is important and the family unit must support one another and agree to use available resources for this purpose over time. In other words, it is not enough to merely teach a single person about the ways changes need to occur. It is equally as important to engage the family unit and assure that they have the needed information, a plan for change, and needed resources to attain, maintain, and sustain change over time.

<table>
<thead>
<tr>
<th>Change Stage</th>
<th>Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Not yet acknowledging a problem behavior exists</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Acknowledging there is a problem, but not prepared to make a change</td>
</tr>
<tr>
<td>Preparation</td>
<td>Getting ready to change</td>
</tr>
<tr>
<td>Action</td>
<td>Beginning to change behaviors</td>
</tr>
<tr>
<td>Maintenance</td>
<td>maintaining the behavior change over time</td>
</tr>
<tr>
<td>Relapse</td>
<td>Returning to old behaviors and failure to maintain new changes</td>
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</tbody>
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* Prochaska, Norcross & Diclemente (1994)
The Health Belief Model was originally developed in the 1950s by researchers investigating prevention at the United States Public Health Service. The model’s main constructs focus on perceived susceptibility, barriers, and benefits. The model suggests that an individual’s health beliefs are related to risks, seriousness of a condition, and the perception of benefits outweighing barriers. These three factors influence or predict the likelihood that a particular action will be taken. The Health Belief Model has focused thinking and research on modifiable psychological prerequisites of behavior (Rosenstock, Strecher, & Becker, 1988). An introduction to this model was provided in chapter six of the textbook. Encourage students to return to this section and the model to consider ways support for changes needed by individuals and families should be delivered.

Illness Beliefs Model

The Illness Beliefs Model (Wright & Bell, 2009) is a clinical practice model that addresses the illness experience as a relational phenomenon and suggests that the beliefs about health and illness are critical to a health and illness experience. This model indicates that nurses who strive to support families must direct attention to the intersection of beliefs of the individual with the illness, family members of the ill individual, and the nurse (Wright & Bell). A practice foundation based on the Illness Beliefs Model involves using therapeutic conversations to create a context for changing beliefs by identifying facilitating and constraining beliefs (Wright & Bell, 2009). To support a family, the nurse helps create a context for changing beliefs and explores the individual family member’s and family’s illness beliefs. Nursing practice then strengthens facilitating beliefs that invite possibilities and healing to decrease suffering. While practice also challenges those constraining beliefs that limit possibilities for resolving challenges and increase
illness suffering (Wright & Bell). A collaborative relationship between the nurse and family provides support for a family by reinforcing beliefs that encourage a healing environment.

**Support for New Nurses**

A section in the latter part of the textbook chapter discusses some concerns nurses might find difficult, things that could require some personal support. Topics about self-care are not always discussed with students. Transitions from classroom to workplace setting can be filled with shocks and surprises. Encouraging students discuss their fears, anxieties, and uncertainties will likely assist them be better prepared when it comes time to making the transition. You might ask several faculty and perhaps some nurses from a clinical setting where students are engaged to give a brief talk to the class about how it was for them as they transitioned from student to nurse.

It could also be useful to ask students to think about what might happen when they work with family units in practice. You might want to tie this to some discussion about appropriate documentation, becoming part of an interdisciplinary health care team, managing legal and ethical issues, and understanding criteria mandated by credentialing agencies like the Joint Commission for Accreditation of Hospitals. Additional issues pertaining to pressing concerns faced in daily practice (e.g., length of stay, reimbursements, changing expectations, staff availability) can produce questions and uncertainty (Box 15.1). Talking about barriers to motivation and volition or supports for change could also be useful. Students need to understand ways to fit supportive relationships into a working day. Whether the concern is single persons or family units, concerns can produce stumbling blocks to effective care delivery. Finally, you might want to discussion the importance of staying current in clinical practice and changing technologies. Discuss the benefits of regularly reading current journals, the value of intentionally focused continuing education, joining a research study group, or joining a list-serv that
automatically pushes information through the internet or smart phone about changes in practice.

Students need to understand that ideas about family focused nursing practice are still forming and that they can be part of this effort. Stress the importance of building knowledge to serve as evidence of the benefits of thinking family and family focused nursing. Lead a discussion about ways students can take leadership roles as they graduate and move nursing practice forward by using ecological thinking that addresses family unit and societal health care needs.

**Box 15.1 Hurdles in Providing Support**

*For example, these are usual concerns for new nurses:*

- Efficient time management that allows completion of all tasks.
- Ways to maintain a safe clinical practice and avoid mistakes.
- Prioritization of tasks and meeting multiple demands.
- Relationships with physicians and other health care professionals.
- Development of meaningful and supportive relationships with co-workers.
- Further develop critical thinking skills.
- Ways to continue learning and stay current with changing practices.

**References**


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