FAMILY PROCESSES AND INDIVIDUAL
HEALTH-RELATED DECISIONS
IN RESPONSE TO HEART-HEALTH INITIATIVES

by

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FAMILY INFLUENCE ON INDIVIDUAL HEALTH-RELATED DECISIONS IN RESPONSE TO HEART-HEALTH INITIATIVES

Abstract

Cardiovascular disease, the major cause of death, disease, and illness in Canada, is costly in terms of health, quality of life, and dollars spent on health care. Three decades of trend analysis and evaluation of community-based heart-health interventions indicate that these interventions have been moderately successful most notably with more affluent segments of Western societies. Future success depends on creating supportive environments and policies that make healthful choices easier for all Canadians. Family is one environment not well understood for its influence on individual health-related decisions in response to heart-health initiatives.

The objective of this study was to explore social processes in families that influence individual health-related decisions in response to heart-health initiatives. Grounded theory, informed by critical and feminist perspectives, is the methodology of this study. Twenty-eight families participated, representing considerable diversity with regards to family type, socioeconomic status, age, and geographic location. Participants' accounts are rich and, when analyzed, generate a theory of family influence on individual health-related decisions. Participants were consistent in their view that health decisions made in response to heart-health initiatives are conceived within a broad definition of health of which heart health is a part. Family climate was developed in the analysis as important for health decisions — a climate of comfort enhances self-worth and strengthens the will to be healthy, while a family climate of stress consumes this will. Family climate of stress or comfort is not a binary opposite but rather like the weather, ever-present and changing. Further, family climate may
not be perceived similarly by family members. A family climate of comfort and stress has both relational and contextual dimensions. Family stress has an additional dimension — perpetrated stress, occurring when actions taken by one family member are unwholesome thereby affecting the perceived stress and health of others. Two family processes, talking (either productive, unproductive, or dismissive), and modelling are family action strategies that interact with relational and contextual factors and family climate to determine the ultimate family influence on individual health-related decisions. Productive talking and modelling provide inspiration and rationale for individual health-related decisions. On the other hand, the lack of co-operation characteristic of unproductive and dismissive talking may lead to inaction. Family exerts its influence on individual health-related decisions in response to a heart-health initiative by shaping self-worth and agency with regard to heart health-related responses. In light of the scholarly literature on families and health, participants’ accounts suggest that theory development in health promotion should attend to the family as a unit of concern. Moreover, health promotion practice and research concerned with heart health that considers the everyday lived reality of family life has potential to be effective in working with clients toward healthful change.
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CHAPTER ONE: BACKGROUND TO FAMILIES AND HEART HEALTH

Family influence on individual health-related decisions in response to heart-health messages is the central concern of this dissertation. Cardiovascular disease is the major cause of death, disease, and illness in Canada (Heart and Stroke Foundation of Canada, 1993; International Heart-Health Advisory Board, 1992). Its costs in terms of health, quality of life, and dollars spent on health care are immense (Federal-Provincial Advisory Committee on Community Health, 1987; Health and Welfare Canada, 1992b; Heart and Stroke Foundation of Canada, 1993; Stachenko, 1992). Some of these costs have been contained through the development of individual and community health promotion interventions directed toward modifying cardiovascular risk factors, specifically, smoking, obesity, high dietary fat, hypertension, and physical inactivity (Heart and Stroke Foundation of Canada, 1993; O'Connor & Petrasovits, 1992).

Despite the intent to change behaviour, these interventions have had mixed success. Two decades of evaluation of programmes for cardiovascular risk factor reduction indicate that community heart-health interventions have been successful for some individuals and groups, and for some risk factors, but not for others (Winkleby, 1994). Further, recent evaluations have demonstrated that later programmes such as these have been less successful in accelerating the rate and magnitude of behaviour change than was expected when compared with secular trends and earlier programmes (Green & Ottoson, 1994; Green & Richard, 1993; Leupker, Murray, Jacobs & al., 1994; Winkleby, 1994). Perhaps, it is postulated, risk factor reduction accounts for only a part of the inequality in rates of cardiovascular disease with socioeconomic and psychosocial dynamics contributing substantially to risk for cardiovascular disease (Health and Welfare Canada, 1992a; Heart and
Stroke Foundation of Canada, 1993; Labonte, 1992). An approach that emphasizes the interdependence of an individual and elements of his or her ecosystem — that is, the family and community, or cultural, physical, and social environments (Green, 1986) — is more in keeping with public health and health promotion principles (Federal-Provincial Advisory Committee on Community Health, 1987; Sutherland & Fulton, 1992) than a more strictly biomedical or biobehavioural approach which stresses risk factor reduction. Such an approach may reap benefits for future reduction of cardiovascular disease.

Canada is recognized as a world leader in health promotion advocacy and conceptualization of practice (Pederson, O'Neill & Rootman, 1994) — health promotion for heart health is no exception. A Working Group on the Prevention and Control of Cardiovascular Disease was formed in 1987 in an attempt to explore innovative approaches to addressing the high cost of cardiovascular disease to Canadians. Drawing on public health principles, principles from the Ottawa Charter for Health Promotion (1986), and the Epp document "Achieving health for all: A framework for health promotion" (1986), this group recommended a new approach to the prevention of heart disease in a report entitled "Promoting Heart Health in Canada." The following recommendations were made: Federal-Provincial Departments should address cardiovascular disease prevention through an integrated, multifactorial approach; strategies should target both the population at large and high-risk individuals, emphasizing disadvantaged groups and regions; regional diversities should be accommodated and experimentation fostered with subsequent sharing of experiences among jurisdictions; commonalities of risk factors for major diseases should be acknowledged to facilitate the development of an integrated approach; and prevention
strategies and the health promotion movement should be linked by pursuing the development of healthful public policy and healthful sociocultural and physical environments.

In response to this report, a blueprint for action was developed: The Canadian Heart-Health Initiative. This policy-level document has stimulated coalition- and partnership-building, the development of a national database on cardiovascular disease risk factors, and the implementation, evaluation, and diffusion of community-level demonstration programmes in every province (Health and Welfare Canada, 1992b). Drafted for a fifteen-year period, the first phase (1985-1989) involved developing a master plan and conducting cardiovascular disease risk factor surveys. In the second phase (1989-1993), the national database was completed and provinces implemented heart-health projects. The focus of the third phase (1993-2000) is evaluation of the provincial British Columbia Heart-Health Demonstration Projects (BCHHDP) and dissemination of findings to communities across the country (Health and Welfare Canada, 1992b). The Canadian strategy links with international strategies reflected in the Victoria Declaration (International Heart-Health Advisory Board, 1992) the Catalonia Declaration (Advisory Board of the Second International Heart-Health Conference, 1995), the World Health Organization (WHO) CINDI (Country-wide integrated non-communicable disease intervention) and MONICA (Monitoring of Trends and Determinants in Cardiovascular Disease) projects.

In British Columbia, a federal-provincial initiative, the British Columbia Heart-Health Demonstration Projects, has been implemented to enhance the heart health of British Columbians. In addition, several other heart-health initiatives that share similar characteristics have been and are being implemented in communities throughout the province. Characteristics of these heart-health initiatives are: the initiative operates within the
province's public health system, the programme has adopted a multifactor approach, and the initiatives are of different types (for example, public and professional education, worksite programmes, school health, community development). In addition, since the mid-1980s an aggressive social marketing initiative has become increasingly evident in the media and lay literature that has bombarded Canadians with messages about exercising more, reducing fat, and maintaining a healthy weight (Freeman, 1996). Evaluation of these initiatives over the last 30 years leaves little doubt about the value of approaches which aim to improve dietary habits, reduce smoking, and encourage exercise. For example, in Canada from 1970-1992, the actual number of deaths from cardiovascular disease was 60,000 compared with the expected number of deaths set at 100,000 (Advisory Board of the Second International Heart-Health Conference, 1995). However, a recent Canadian study indicates that the majority of middle-aged adults do not exercise regularly and only slightly more than 1/2 have a desirable cholesterol level (Hodgson, 1996). However, there has been a decline in cardiovascular disease rates in Canada from 1970-1992 that is attributed to a population-wide decline in the level of risk factors (Advisory Board of the Second International Heart-Health Conference, 1995). A major health challenge for cardiovascular health is to reduce inequalities in death and disability in Canada from heart disease (Advisory Board of the Second International Heart-Health Conference, 1995). Disparities exist because of differences in socioeconomic status and access to health care, or for other reasons (Advisory Board of the Second International Heart-Health Conference, 1995). The challenge on the horizon is to create supportive environments (Joffres, 1992; Winkleby, 1994) and policies (Joffres, 1992; Milio, 1986; Sutherland & Fulton, 1992) that enable people to make healthful choices. To this end, future success of heart-health initiatives can only be achieved by broadening evaluations to
examine elements of the social ecosystem, that is, the family, community, cultural, physical, and social environments that contribute to risk for cardiovascular disease (Green & Ottoson, 1994; Winkleby, 1994). Bloomberg, Meyers, and Braverman (1994) call for a new approach to the study of health that emphasizes the life circumstances as they are perceived and understood by the individual, rather than quantified by objective environmental indicators. Programmes within the Canadian Heart-Health Initiative provide an opportunity to evaluate implementation while developing new knowledge for health promotion practice (Rootman & O'Neill, 1994).

Since heart health depends to a considerable extent on what we eat, how we approach and balance work and play, and whether we choose to smoke, the family unit is a central determinant of heart health (British Columbia Provincial Health Officer, 1994; Doherty & Campbell, 1988; Duffy, 1984; Milio, 1986). Family, the social unit at the heart of everyday life, is a most important venue for the development of health behaviours (Baranowski, Nader, Dunn & Vanderpool, 1982; Cresson & Pitrou, 1991; Gilliss, 1989; Litman, 1974; Maccoby, 1992; Pratt, 1991; Sokalski, 1994; Stokols, 1975). To some extent, family patterns established during childhood as well as on-going family dynamics determine the choices people make about work, play, diet, and smoking (Baranowski & Nader, 1985; Nolte, Smith & O'Rourke, 1983). When a family member decides to change behaviours to more healthful ones, conflict between individual and family goals can lead to stress (Danielson, Hamel-Bissell & Winstead-Fry, 1993). Green and Kreuter (1991) suggest that an optimum mix of responsibility for health promotion is one shared among individuals, families, professionals, private or government agencies, and local or national agencies. However, despite the evident
need for research on family environment, family influence on individual members’ adoption of heart-health behaviours is not well understood (Nader et al., 1989; Nader et al., 1986).

The purpose of this research is to contribute to an understanding of the influence of family processes on individual health-related decisions in response to heart-health messages. It broadens the BCHHDP studies by examining the family context in three heart-health interventions in BC: the Campbell River District General Hospital Heart-Health Project, the Nanaimo Healthy Hearts Programme, and the Vernon Heart Healthy Community Kitchens Programme. Further, it contributes to an understanding of the influence of the family context in families from the general population who have been exposed to heart-health messages through diverse lay and professional communication channels.

This dissertation is presented in eight chapters. In Chapter One, the background context of the relationship of family to heart health has been established. Chapter Two provides an overview of the empirical literature on family influence on heart health. In Chapter Three, the theoretical forestructures and personal situatedness of the researcher are explicated allowing the reader to locate the researcher and the project both theoretically and personally. In Chapter Four, the methodologies, methods, ethical considerations, and the adequacy of the inquiry are addressed. Chapters Five, Six, and Seven are the presentation and discussion of findings. Chapter Five aims to enrich the description of the context within which family influence is exerted by describing participants’ perspectives on receiving heart-health messages. Chapter Six lays out participants’ definitions of health and family, and presents their views on the link between family and health. Chapter Seven presents findings specific to family influence on individual health-related decisions, that is, how family shapes
agency, therein influencing individual health-related responses. Chapter Eight concludes the dissertation with an exploration of the implications of the research.
CHAPTER TWO: SCIENTIFIC EVIDENCE OF THE INFLUENCE OF FAMILIES ON HEART HEALTH

A growing body of literature confirms the link between families and heart health. In this chapter, studies examining this link are reviewed.

Families are social units in which members frequently share a common genetic heritage, are influenced by each other’s attitudes, beliefs, and values, and share a common history and living conditions. All these factors are basic to health (Doherty & Campbell, 1988; Fisher, Ransom & Terry, 1993a; Friedman, 1992; Patterson et al., 1989; Reiss, 1981). Here, selected studies are reviewed for their contribution to this substantive area. Studies linking families and health can be grouped into categories that reflect these characteristics of families: familial aggregation of risk factors, the influence of family members' attitudes and behaviours, the influence of family processes, effectiveness of family interventions in risk factor reduction, and the impact of the socioeconomic context on health.1

Familial Aggregation of Risk Factors

A number of studies have demonstrated familial aggregation of cardiovascular risk factors. As mentioned previously, the risk factors for cardiovascular disease include smoking, obesity, high dietary fat, hypertension, and physical inactivity. As Doherty and Campbell (1988) put it, "family members share risks for heart disease along with their hearth and home" (p. 32).

1Research reports reviewed for the study were retrieved using CD-ROM searches of CINHAL, Medline, Psychlit, and Sociofile for the years 1980-1995 in five year groupings. Combinations of key words entered for the searches: health promotion, heart health, school-aged children, school health, health education in schools; health promotion, heart health, family health
Laskerzewski, Morrison, Khourey, Kelly, Glatfelter, Larsen and Glueck (1980) examined parent-child nutrient intake in 294 families. Dietary intake was measured using 24-hour dietary recall, the sample was randomly selected from the Princeton School District in the U.S. with the final sample representative of the black and white populations present in the district. Significant positive correlations between nutrient intake of parents and of children ages 6-19 were demonstrated for total carbohydrates, saturated fat, polyunsaturated fat, and calories. When confounding variables were adjusted, the cholesterol intakes of parents and children were significantly associated. Parent-child nutrient interrelationships were greater for black than white parent-child dyads. The strength of the study was the design for sample selection, the ethnic mix, and the large numbers. However, use of a particular measure, a self-reported 24-hour diet recall, introduces a self-report bias, especially with young children in the sample. Multiple measures of dietary intake would balance the weakness of the self-report measure. Nevertheless, the findings contribute to the notion that the family must be included in any intervention aimed at altering dietary habits. Future research is needed to determine why white and black children differ on parent influence.

In a study by Eastwood, Brydon, Smith, and Smith (1982), diet, serum cholesterol, and fecal constituents of 23 healthy spouses were compared. The convenience sample was accessed from a housing tract in North Edinburgh. Husbands' average age was 69 and wives averaged 64 years of age. Dietary intake was measured using a diet diary that was kept by the subject under supervision of a diettian. The pattern of food intake between spouses was similar. Of interest is the finding that only dietary fat and fibre intake showed significant positive correlations and of fecal constituents, only fecal fat correlated significantly in a promotion, family heart-health; and health promotion and workplace/work-site heart health.
positive direction between spouses. The correlation between fecal fat in spouses may relate to similar fat intake and/or similarities in other dietary constituents — for example, fibre. Differences in fecal constituents, in spite of concordance between the qualitative and quantitative components of the diet, may reflect the impact of an intervening variable not identified by the researchers or may reflect the limits of measuring dietary intake under the supervision of a dietician. The relationship between serum cholesterol was not significant. However, significant correlations for cholesterol levels between spouses have been demonstrated elsewhere (Garrison et al., 1979). Perhaps the small sample size in this study precluded replicating this correlation here. This study provides weak evidence that spouses share dietary patterns. Lack of randomization limits the generalizability of the findings: the sample was from an older age group limiting the usefulness of the findings to a range of age groups, and the sample size was small thus constraining the statistical power of the study.

In an analysis of the Minnesota Heart Survey, Venters, Jacobs, Luekper, Maiman, and Gillum (1984) examined smoking patterns in 560 married couples. The Minnesota Heart Survey is an epidemiological study designed to explain the decline in morbidity, risk factors, and medical care in the Twin Cities of Minnesota. Several questions on the survey allowed analysis of smoking patterns in married couples who represented a probability sample of selected Twin Cities households. Surrogate pairs for comparison were created by matching husband-wife pairs with pairs who shared similar characteristics of family income level, beliefs, and lifestyle practices. Married pair concordance was measured against a standard of agreement on frequencies in surrogate pairs. Smoking patterns were found to be significantly

\[ \text{The Twin Cities are Minneapolis and St. Paul, Minnesota, two cities separated geographically by a river but considered a metropolis.} \]
concordant for married pairs: married pairs more than surrogate pairs tended either both to
smoke or both not to smoke; married pairs were more similar in number of cigarettes smoked
per day; and of the married pairs who quit smoking, married pairs were more similar in the
year they quit smoking. These authors found that behaviours showed greater concordance
than beliefs.

A strength of this study is the large number of married pairs selected using a
probability sample. However, a weakness of the study is that 97% of the sample was white,
limiting generalizability to populations of primarily white people, an increasingly rare
phenomenon in North America. A recommendation from this research is that future research
focus on describing and explaining more fully family environment as it relates to smoking
behaviour and health promotion practices.

In a study by Connor, Connor, Henry, Sexton, and Keenan (1984), the researchers
examined the relationship of blood pressure to: 1. urinary excretion of sodium, potassium and
creatine; 2. sodium and potassium intake as estimated by 24-hour dietary recall; 3.
anthropometric measurements; and 4. apical heart rate in a randomly selected sample of 233
family groupings of men, women, and children. The researchers demonstrated a significant
positive correlation between familial dietary patterns (as evidenced by diet recall and urinary
excretions) and blood pressure, body weight, and heart rate. On various parameters,
significant correlations were found between spouse pairs, father-children pairs, mother-
children pairs, but not for sibling pairs.

Several features of the design of this study contribute to its credibility. A large
number of families were included and a variety of measures were taken including
physiological measurements to confirm dietary recall. Limitations of the study include a self-
selection bias in the sample since only 53% of families approached agreed to participate. As well, the majority of families were white middle-class families, further limiting the generalizability of the findings. The findings do, however, point to the family as an important environment to consider in the control of hypertension.

Staessen, Bulpitt, Joosens, et al. (1985) accessed a random sample of 654 individuals from two Belgian cities to study familial aggregation of blood pressure, anthropometric characteristics, and urinary excretion of sodium and potassium. Father-son and mother-daughter correlations were significant for systolic blood pressure. In opposition to the findings of the previous study, sibling correlation for diastolic blood pressure, body mass index, and urinary sodium was found to be significant. Further, there was a tendency for mother-child rather than father-child body-mass index and body weight to be correlated. Only the father-daughter and mother-son pairs were significantly correlated for urinary sodium. The authors expected that mother-child and sibling to sibling correlations would be demonstrated based on the assumption that mothers tend to pass along eating habits to children (Staessen et al., 1985). Thus this finding is unexpected and remains to be explained. No other studies were found that may shed light on this finding. Perhaps in families, fathers’ eating habits have a greater effect on the eating patterns of other family members than is generally assumed.

This study had a number of strengths: the large, random sample from two different communities, and attention to eliminating bias and confounding variables. As well, the response rate was high, about 70% for both towns. The ethnicity of the sample was not discussed. Evidence of inattention to gender issues is apparent in the report of the findings.
This study provides further evidence for familial aggregation of risk factors for cardiovascular disease.

Another study examined the aggregation of dietary calories, fats, and sodium in Mexican-and Anglo-American families (Patterson, Rupp, Sallis, Atkins & Nader, 1988). These researchers examined the aggregation of dietary fats, sodium, and calories in 95 Anglo-American and 111 Mexican-American families who volunteered to participate from 12 randomly selected schools in a large American city. Dietary intake was measured using a 24-hour recall, a three-day food record, and a food frequency questionnaire, along with a measure of sodium-potassium ratio. Evidence of moderate aggregation of all dietary variables was found in both ethnic groups. Similar to the Connor et al. (1984) study, in Anglo families spouse-spouse but not sibling correlations were significant. Perhaps siblings are less alike in their food preferences than spouses. Diets of younger (not older) children were related to parents' diets. In the Mexican-American families, dietary patterns of spouses were similar as were dietary patterns of siblings. Mothers' diets were more highly correlated with children's diets than were the fathers' diets.

Sallis, Patterson, Buono, et al. (1988) examined physical activity with the same sample of families using a standardized interview. Results indicated moderate intrafamilial aggregation of physical activity, higher in the Mexican American families and higher correlations between mother and child than between father and child (Sallis et al., 1988). This study was designed to address some of the shortcomings of previous studies. In the aspect that examined dietary variables, multiple measures of several dietary variables were made, both nutrient intake and types of food were assessed. Further, there was an attempt to include non-white families living in lower socioeconomic circumstances in the study. The weakness
of the design was the homogeneity of the sample in terms of socioeconomic status (SES). The study findings confirm that health-related dietary and exercise behaviours aggregate within families. The studies, however, shed no further light on what dimensions of family life contribute to this.

One study assessed six cardiovascular risk factors in seven father-mother-son groups using a white middle-class sample (Proia, Hester & Connor, 1987). The risk factors assessed were family history of cardiovascular disease, hypertension, obesity, lack of exercise, smoking, and stress. Although the small sample size precludes generalization from the findings, the investigators report several tendencies in the data regarding family behaviour. Fathers and sons tended to underreport cardiovascular risk factors when compared with mothers. Fathers and mothers differed in their tendency to consider themselves obese, with obese fathers considering themselves the right height for weight and ideal weight, mothers considering themselves obese. Exercise patterns in these data suggested that mother-son pairs reported the same exercise behaviour, either exercising or not. As well, if both parents exercised, so did the sons. This study calls into question the method of using self-report of risk factors and emphasizes the influence of role modelling in exercise behaviours. Further, no rationale is given for excluding daughters.

That family members share a propensity for risk of cardiovascular disease has been demonstrated in the empirical literature. Which family members share the propensity, what contributes to the clustering of effects, and what dimensions of family life contribute to the aggregation of risk factors is far from clear. As well, future research should seek samples of participants from a variety of ethnicities and socioeconomic circumstances.
Influence of Family Members' Attitudes and Behaviours

There is empirical evidence that family members' attitudes and behavior influence other family members smoking behaviour, attitudes and behaviour related to physical activity, and dietary intake. A number of studies that have examined parental influences on children's smoking behaviour illuminate the link between family members' attitudes and behaviours and health-related practices (Chassin et al., 1981; Hunter, Baugh, Webber, Sklov & Berenson, 1982; Nolte et al., 1983).

In a study by Nolte, et al. (1983) of 4,409 white middle-class urban and rural grade 7-12 students, it was found that parental attitudes exert a greater effect than parental behaviours. In a similar population with a sample of 4,638 students in grades 6-12, Chassin et al. (1981) found that parental and older sibling smoking behaviour were important to subjects' actual smoking status. These studies confirm the importance of family influences on adolescent smoking behaviour. With regard to strengths, both studies used large sample sizes. However, in the Nolte et al. study, all students in the district were included and in the Chassin et al. study, one-third of the subjects were randomly selected. This could produce a better population estimate than the 100% sample with lower participation rates. In both studies, white middle-class students comprised the sample. Reports of the validity of instruments used in the studies were deficient for both studies. So, the findings are generalized with caution to the appropriate groups.

Hunter, Baugh, Webber, Sklov, and Berenson (1982) surveyed a convenience sample of 3,014 children ages 8-17 to determine factors associated with trial and later adoption of cigarette smoking. This sample included a mix of races and family types. Reliability and validity reports demonstrated rigorous attention to these issues. The researchers found that
beliefs about social influences such as parental approval contribute to smoking behaviour after trial. Distinct race and sex differences were seen, with white children demonstrating a greater parental effect, a finding that echoes the results of the Laskerzewski et al. (1980) study reported previously. The authors conclude that the number of people who smoke in the child's environment influences experimentation with smoking, while beliefs about rewards of smoking influence current behaviour. They suggest that a better understanding of the diffusion-adoption principle is called for. I would add that understanding the intrafamilial diffusion-adoption process would be a contribution. Although the first two studies of family influences on smoking behaviour have weaknesses related to measurement, these studies suggest that the family influence on children's smoking behaviour is significant.

Physical activity in children is also influenced by parental attitudes and behaviour (Butcher, 1983; Melcher & Sage, 1978; Overman & Rao, 1981; Wold & Anderssen, 1992). Melcher and Sage (1978) and Butcher (1983), using similar designs with demographically different subjects, found parental influences on daughters' physical activity. Whereas Melcher and Sage worked with white upper-middle-class American female students, Butcher involved ethnically diverse grade 6-10 Canadian students. Using similar measurement tools, both studies reported acceptable psychometric properties of their measurement scales. Melcher found low positive correlations between daughters' attitude scores and both parents' attitude scores. Butcher found that parental influences were most important for community-organized activities. She also found that a family-related variable, socioeconomic status, was most important for total activities adopted.

Overman and Rao (1981) analyzed parental influence on involvement in, and motivation toward, sport. In a convenience sample of 297 mixed black and white high-school
seniors from four Jackson, Mississippi schools, they found that male gender, mothers' educational level, and fathers' athletic experience were the most influential independent variables. Psychometric properties of the instruments were reported at levels suggesting that this is a reliable and valid study.

In a qualitative study by Snyder and Purdy (1982) with 43 fathers and 28 mothers, parents' view of socialization into sport was studied. While parent to child socialization effects were evident, a reverse effect was apparent. The majority of parents indicated a greater interest in, but not necessarily greater participation in, sport because of their child's participation. This suggests that future research could focus more on this reverse and reciprocal socialization effect.

Wold and Anderssen (1992) conducted a survey on health behaviour with a focus on physical activity, sport, and lifestyle in school children ages 11-16 in ten European countries. Findings suggest that sport participation of parents, siblings and peers is related to children's participation in sport. Sport participation of same-sex family members is more strongly associated with children's participation in sport than that of opposite-sex family members. The authors conclude that programmes aiming to increase sport participation in school-aged children may be more effective if efforts to enhance sport participation of parents and significant others are included in the design.

Not only do parents' and children's attitudes influence each other but spousal attitudes and behaviours have been shown to influence partner behaviour. Shattuck, White, and Kristal (1992) investigated the long-term effects of wives' low-fat diets on husbands' dietary intake. Using a sample derived from the Women's Health Trial, 225 husbands and 225 wives were randomly selected for this study from both the control and intervention groups. The Women's
Health Trial was designed to assess the feasibility of a large multi-centred randomized trial of low-fat dietary intervention among women with a moderately increased risk for breast cancer. An absolute difference in fat intake between groups was found among intervention husbands and control husbands. The wives' attitudes and fat intake were the most important predictors of husbands' fat intake. Although this study design was well conceived, future research of this nature would be strengthened by including a variety of family forms in the design — for example, partners who are not necessarily husbands.

In sum, research suggests that family members influence each others attitudes and behaviours, specifically those related to health. More research is needed to better understand the diffusion-adoPTION process in families as this pertains to health-related attitudes and behaviours and the influence of gender and socioeconomic status. Moreover, more research is needed that includes a variety of family forms in the design.

Influence of Family Processes

Research suggests that intimate family processes have the potential to influence health-related behaviours of individuals. In a study of family environment, the investigators demonstrated a relationship between individual eating behaviours and intimate family processes (Kintner, Boss & Johnson, 1981). Using a snowball technique, a sample of 42 families, with family defined as husbands and wives and at least one child under 12, was asked to complete questionnaires about nutritional adequacy and family environment. Only husband and wife pairs completed the questionnaires. The sample was young, with an average age of 29, and lower to middle socioeconomic class. Ethnicity was not reported. The Moos Family Environment Scale (Moos & Moos, 1986) was used to measure Family
Environment and the Nutritional Adequacy Reporting System was used to measure dietary intake. Once again, psychometric properties of the measurement instruments were not reported, although the Family Environment Scale has been widely used and tested. Using canonical correlation in the analysis, a significant negative relationship between the families' dysfunctional environment (as indicated by high conflict, control, and organization) and adequacy of family dietary intake was evident. A significant positive relationship was apparent between the family's cohesive and independent environments and appropriateness of dietary intake. These findings suggest that there is a link between family relationships and dietary habits. However, several aspects of the design and study report weaken the generalizability of the findings: small sample size, lack of randomization, and inadequate reporting of psychometric properties. Also, using only parental data when family is defined more broadly raises conceptual issues.

Another study on weight loss also demonstrated the link between family support and successful treatment of obesity (Barbarin & Tirado, 1985). The purpose of the study was to examine family processes and enmeshment in relation to long-term maintenance of weight loss. Family processes included: 1. how families organize interpersonal relations, manage interdependence, and strike a balance between family unity and individual autonomy; 2. how families respond to change and provide for members' needs for continuity and predictability in family life; and 3. how families promote the physical and psychological development of their members. A convenience sample of 45 couples with one obese member completed the Barbarin Family Process Scale at the beginning of treatment of an overweight family member. Most overweight participants were in a supervised weight-loss programme consisting of calorie reduction and exercise. Two participants had fat reduction surgery and
one had an intestinal by-pass operation. At one year, weight and family support were again measured comparing scores from couples assigned by researchers to one of two groups, successful or unsuccessful maintenance of weight loss, based on established criteria. Participants were further assigned either to an "enmeshed" or a "disengaged" group based on their scores on the family differentiation-enmeshment scale. Psychometric properties as reported were acceptable for the scales used. No differences in family processes were observed between successful and unsuccessful maintainers from disengaged families. However, successful maintainers from enmeshed families reported higher levels of family support and satisfaction with family life than unsuccessful maintainers. Although this study uses a small sample size, it provides reasonable evidence to suggest that in families in which members are close, family processes can make a difference between the success and failure of a weight loss programme. Perhaps individuals in disengaged families are apt to be less influenced by family processes than individuals from enmeshed families.

The California Family Health Project (Fisher, Ransom & Terry, 1993b) was a large, rigorous study undertaken to illuminate the link between family processes and health. This study identified and examined four domains of family life — World View, Structure/Organization, Emotion Management, and Problem-Solving and specific dimensions of health of the husband/wife pairs. Self-report questionnaires and ratings of couple and family interaction measured these family domains. In addition, 14 aspects of health were measured in a sample of 225 husband/wife pairs, 278 adolescents, with 141 males and 137 females comprising the largely white, middle-class sample of families selected from the community rather than from clinical settings. Psychometric properties reported for this study indicate that tools used were reliable and valid. This was an extensive study using a range of
sophisticated statistical analyses. For both husbands and wives, the family world-view reflecting family coherence (defined as the confidence that the family can effectively comprehend, control, and respond to the environment), family optimism, and family religiosity were correlated with positive health states of husbands and wives. A family structure characterized by organization in combination with cohesiveness also was correlated with positive health states of husbands and wives. Gender differences were evident particularly in the domains of structure/organization and emotion management. For example, for women the balance between shared family activity and personal privacy was positively correlated to health evaluation and self-esteem, a pattern not evident in the data from males. The findings represent a complex mosaic of relationships that suggests that health is multidimensional, that family structure and dynamics influence individual health-related outcomes such as anxiety and depression, and that the effect of family variables on health may be experienced differently by different members of the family (Steinglass, 1992). The study contributes to an understanding of the domains of family life that are relevant to health and points to specific interrelations that may be central to guiding future research on families and health—for example, family attitudinal domains (Steinglass, 1992).

The studies surveyed above suggest that there is a link between family processes and individual health practices and outcomes. The California Family Health Project identifies the complexities of the link between families and health, and suggests that family influence on individual health may be experienced differently by family members. Further, it indicates that gender may be a salient variable in explaining these differences.
Effectiveness of Family Interventions in Risk Factor Reduction

In response to evidence that cardiovascular risk factors aggregate in families, family-based cardiovascular risk reduction programmes using behavioural approaches have been developed, implemented, and evaluated. One research programme designed to examine interventions for obesity that targeted combinations of children and adults was shown to be more effective if both parents and children participated in the programme (Epstein, Valoski, Wing & McCurley, 1994; Epstein, Wing, Koeske, Andraski & Ossip, 1981; Epstein, Wing, Koeske & Valoski, 1987; Epstein et al., 1985; Epstein, Wing, Koeske & Valoski, 1984). At the University of Pittsburgh, subjects were randomized into one of four weight-control groups. Inclusion criteria were children age 6-12, 20%-100% overweight for age and height, and one parent willing to participate. The sample was 158 middle-class families with no ethnicity reported. When both parents and children were targeted for the programme, significant effects were observed. Evidence from this programme points to a link between long-term weight loss in children and the importance of family and other sources of support for eating and activity change.

In two studies that evaluated school-based cardiovascular risk reduction targeting families in Mexican- and Anglo-Americans, Nader, Sallis, Rupp, Atkins, Patterson, and Abramson (1986) and Nader et al. (1992) concluded that family-based educational interventions that are offered in schools are feasible and produce meaningful changes not only in white middle-class families but also in non-white families from lower socioeconomic groups. Baranowski, Simon-Morton, Hooks, Henske, Tiernan, Dunn, Burkalter, Harper, and Palmer (1990) designed and implemented an aerobic activity community centre programme for Black-American families and found that programmes that target families and are offered
in community centres have limited value possibly due to problems of access. The Nader et al. (1992; 1986) and Baranowski et al. (1990) studies suggest that the success of a family-based programme may be related to the venue in which the programme is offered — either school or community centre. Behavioural programmes targeting families have demonstrated moderate to impressive success in reducing cardiovascular risk factors (Johnson, 1988).

An evaluation of a children’s health promotion programme for heart health compared school-based and home-based programmes (Perry et al., 1989; Perry et al., 1988). The school-based programme, Hearty Heart and Friends targeted third-grade children and involved 15 sessions over five weeks. The home-based programme, Home Team, involved a five week correspondence course with third graders where parental involvement was included as an essential aspect of the programme. Outcome measures included anthropometric, psychosocial, and behavioural assessments at school and dietary recall, food shelf inventories, and urinary sodium data in the home. Participation rates were high with 86% of parents participating in the Home Team programme with 71% of families completing the entire five week course. The sample accessed for the study was Caucasian, middle-class, and urban. Students in the school-based programme gained more knowledge at post-test than students in the home-base programme. However, students in the home-based programme reported more behaviour change, had reduced the total fat, saturated fat, monounsaturated fat, and had more of the encouraged food on their shelves. Changes derived from dietary recall did not maintain after one year. The results suggest that, in this population, parent involvement may initiate changes in eating patterns. Further, findings suggest that parental involvement is feasible.
Another school-based study, CATCH (Child and Adolescent Trial for Cardiovascular Health) targeted families. In the process evaluation, investigators found that across 28 sites, 64% of the students attended the programme with at least two family members each. The authors concluded that school-based programmes targeting families diffuse health information into homes (Johnson et al., 1994).

Evaluations of family-based cardiovascular risk reduction and health education interventions demonstrate that these programmes are not only feasible and effective in reducing obesity in children, but that they also diffuse health information into homes. Findings from these evaluation studies suggest that an understanding of family issues related to health education and health patterns will be important if family-based interventions are to be successful.

Impact of the Socioeconomic Context on Heart Health in Families

In the course of demographic data analysis in some studies, the influence of socioeconomic factors on health-related behaviours is evident. In one study, it was determined that mothers' educational level influenced children's physical activity (Overman & Rao, 1981). Another study found that the socioeconomic status of the family influenced children's involvement in community sports activities (Butcher, 1983). In yet another study, an inverse relationship between socioeconomic status and overweight mothers was found (Garn, Bailey, Solomon & Hopkins, 1981). Analysis of demographic data from studies of families and heart health indicates that there is a strong relationship between the presence of cardiovascular risk factors and socioeconomic circumstances (Millar, 1993; Millar & Wigle, 1986; Ministry of Supplies and Services, 1994; Nelson, 1994). One investigator noted that
family processes in female-headed, single-parent families (healthy and non-healthy) are a response to the societal options that women perceived to be available (Duffy, 1984).

A research programme that was designed to examine the causes and cessation of smoking in disadvantaged women provides evidence that cardiovascular risk is related to socioeconomic circumstance (Stewart et al., 1996). The objective of the study was to identify social and psychological factors that influence the smoking behaviour of disadvantaged women and to identify strategies, interventions, and agencies that contribute to reduced smoking levels. Research teams at two Canadian health-promotion research centres gathered data using focus group interviews with 254 disadvantaged women, face-to-face interviews with 134 disadvantaged women, and telephone interviews with 22 disadvantaged women. Participants were predominantly poor, unemployed, geographically isolated, and single parents. Content analysis seeking themes and sub-categories was conducted by the research team. It was found that barriers to smoking were closely related to the social and economic circumstances of these women’s lives. The disadvantaged women in the study smoked to cope with the chaos and crises in their lives. Many participants reported that they had smoking spouses and partners who were not supportive of their cessation attempts. Participants in this study believed that social support would help them to cut down or quit smoking. Many disadvantaged women in the study connected their smoking to a lack of control in their environment. Most did not perceive health professionals as supportive. The gaps in economic status and education between disadvantaged women and health professional posed barriers to trust. Rather, the study suggests that interventions should mobilize support from family, peers, and professionals. This extensive study demonstrated that women’s smoking was inextricably linked with the social context and related stresses of
their lives. The methodology demonstrated the power of qualitative research, informed by feminist perspectives, to generate knowledge about the influence of the socioeconomic context on risk for cardiovascular disease and the perceived efficacy of professionals to work with smokers to address health issues.

Few studies target lower socioeconomic, cross-cultural, or rural groups. The minimal involvement of such people in family studies perpetuates the invisibility and marginalization of non-white and impoverished groups (hooks, 1984; McAdoo, 1993).

Summary

Research on families and heart health is apparent in a number of disciplines, including nursing, health promotion, medicine, psychology, education, nutrition, health education, and physical education/sport/leisure. Although there is considerable body of literature on interspouse communication and its influence on such health-related issues as family planning, childrearing, and alcohol use, this literature review focused on family influence on risk factors for heart disease. A small number of nursing studies have investigated health promotion in families (Bomar, 1990; Duffy, 1988; Hayes, 1993; Whall & Loveland-Cherry, 1993). The studies reviewed represent a number of geographic areas including Great Britain, Europe, Canada, and several areas in the United States (Appendix A). That family members share a propensity for risk of cardiovascular disease has been demonstrated. However, which family members share the propensity, what contributes to the clustering of effects, and what dimensions of family life contribute to the aggregation of risk factors are far from clear. Research suggests that family members influence each others attitudes and behaviours but few studies have captured the ways in which family processes influence health-related
behaviour. With regards to family interventions for health-related behaviour change, family appears to be important but under-investigated. Attention to developing theory that describes family processes which influence health-related decisions in response to a heart-health programme would be a contribution. The review of the literature suggests that future research should seek samples of participants from a variety of ethnicities, socioeconomic circumstances, and family forms.

Several authors suggest that qualitative examination of the sociocultural context of daily family life has potential to contribute an understanding of family influence on individual health experience (Backett, 1992; Gilliss, 1993). A qualitative study representing diverse family types and socioeconomic and ethnic circumstances informed by feminist and critical perspectives has the potential to contribute a different kind of knowledge for nurses and others involved in health promotion practice.
CHAPTER THREE: THEORETICAL AND PERSONAL FORESTRUCTURES

Heart disease is the leading cause of morbidity and mortality in Canada. Considerable resources have been allocated for heart-health promotion programmes that focus on risk factor reduction. The community-based risk reduction approach has been effective in reducing the incidence of heart disease; however, recent studies demonstrate that the effectiveness of these approaches is levelling off. While research shows that environmental factors are critical to the development of heart disease, and family is recognized theoretically and validated empirically as an environmental factor, surprisingly little is known about family influence on individual health-related decisions. There is a need to generate theory that pertains to the influence of family processes on health-related decisions in response to heart-health interventions. Qualitative research, specifically grounded theory, has potential to develop such theory and is used in this study.

This chapter is an overview of the theoretical and personal orientations that I bring to the research. Specific elements of my theoretical and personal forestructure are made explicit to ground the unfolding study in my values, beliefs, and personal situatedness. Since the researcher is an instrument of the research (Baker, Wuest & Stern, 1992), the theoretical and personal orientations to the research are explicated to demonstrate how the theoretical and personal context contributes to the development of the research question, methods, and interpretation of the findings. Situating the researcher theoretically and personally is a strategy that alters the voice of the researcher from that of an objective, autonomous, and invisible voice to a reflexive one (Hall & Stevens, 1991). While it is necessary to present the theoretical perspectives in sequence, the relationship between these perspectives is not
hierarchical or linear. Rather, theoretical and personal perspectives inform and build on each other creating a theoretical web that informs the process and methods of the study.

Theoretical Perspectives

In this section, theoretical perspectives on nursing and health promotion that are relevant to the conceptualization of this study are discussed. Then, reflections and critique of theoretical perspectives on the family are presented to clarify the researcher’s orientation to family theory. In addition, the theoretical assumptions of symbolic interactionism are discussed as a background for a methodological approach to family research. Trends in social science encourage scholars to consider the broad social context within which phenomena occur. Critical and feminist perspectives are enlisted for this project and explained here.

Perspectives on Nursing

This study advances from nursing’s focus on health as constructed through the process of interaction between the person and environment (Meleis, 1991). This philosophical viewpoint about nursing inquiry prioritizes asking questions about specific arenas in which health is constructed with the purpose of identifying a focus for the nursing practice of supporting and fostering health. The family is viewed by some nurse theorists as a prime environment in which health is learned and developed (Gottlieb & Rowat, 1985; Kravitz & Frey, 1989) and is therefore a social entity of concern for nurses.

Whall (1993) identifies four distinguishing characteristics of family nursing theory development; 1. a holistic view — nursing is interested in family psychic phenomenon and also their physical, social, and other needs; 2. an educational approach that seeks to inform
families of their options and alternatives and one that supports them in making decisions and choices; 3. a focus on changing the environment to bring about health; and, 4. a focus on supporting health rather than disease or illness primarily, a direction that leads to an optimistic rather than a negative view of families (p.14). These characteristics are based on assumptions about health, family, and the role of nursing.

For the purpose of this study, the following assumptions are made about health, family, and the role of nursing in family care. (See Appendix G for definitions of health and family.) Health is viewed as more than the absence of disease and is determined by cultural, social, and political factors (Allen, 1986). Family is viewed not as an object but instead conceptualized in terms of descriptive practices that are the everyday communicative processes through which realities are produced and made meaningful (Holstein & Gubrium, 1994). The role of nursing focuses on health promotion in family care (Hartrick, Lindsay & Hills, 1994). Health promotion is conceptualized as a process of enabling people to increase control over and to improve their health... a mediating strategy between people and their environment, synthesizing personal choice and social responsibility in health (WHO, 1984). Nursing not only has a role in health promotion that is shared with other health professionals in health promotion activities at the community and population level, but nursing has a specific role in promoting health with individual families in homes or clinical settings.

Perspectives on Health Promotion

Health promotion has, in recent decades, emerged as a promising movement in health care in Canada. The novelty of the health promotion movement is that it emphasizes health-
care rather than illness-care, and that it recognizes the interpersonal and contextual nature of health-related behaviour.

Illness-care gained prominence in North America with the introduction of technological advancements in medical care that occurred after World War II (Green & Kreuter, 1991; Rachlis & Kushner, 1994). Eventually, an infrastructure developed that was "primarily biomedical rather than health in its orientation" (Green & Kreuter, 1991, p.6). As it became ever more costly, the infrastructure of the Canadian health care system became a focus of concern with regard to its effectiveness for improving population health (Evans & Stoddard, 1990). Historically, population health has been determined primarily by conditions of living: nutrition, housing, working conditions, neighbourhood cohesion, and preventive practices (Illich, 1975; McKeown, 1971). In response to concern about the cost and effectiveness of this infrastructure, systems, policy frameworks, and theoretical perspectives have been developed to guide reorientation of the infrastructure of the Canadian health-care system (Baumgart & Larsen, 1992; Evans & Stoddard, 1990; Rachlis & Kushner, 1994).

The 1974 report, A New Perspective on the Health of Canadians (hereafter called the Lalonde Report), signalled the beginning of the current vision for health care in Canada. This report introduced lifestyle and environment as key determinants of health, re-introducing the notion that health is tied to overall conditions of living, a long-standing position of the public health tradition (Lalonde, 1974; Raeburn, 1992). The central argument of this report was that health is not achievable solely from health care but rather from the interplay of determinants from four health field elements: human biology, lifestyles, the environment, and health care (Labonte, 1994). Thus, the Lalonde Report focused attention on health-care rather than illness-care. The view of health promotion put forth in the Lalonde Report is consistent with
health promotion as the “art and science of helping people change their lifestyle to move forward to an optimal state of health” (O'Donnell, 1986, p. 4). Health promotion so viewed assumes that individuals have a great deal of control over their personal lifestyle choices and that changing personal behaviour can effect health outcomes (Minkler, 1989).

Experts in the health promotion field in Canada soon identified major flaws in the Lalonde Report: it challenged the medical monopoly but not its worldview, it failed to mention well-being, a key component of health, and it defined the environment in narrow physical terms (Labonte, 1994). Primarily, this report was criticized for its victim-blaming, individualistic approach (Labonte, 1994; Labonte & Penfold, 1981). While the individual approach to health promotion has yielded some success in changing behaviour, it is criticized for absolving society of responsibility for such factors as environmental toxins and power relations that contribute to ill health (Green, Richard & Potvin, 1996; McLeroy, Bibeau, Steckler & Glanz, 1988; Navarro, 1978).

In contrast to the individualistic approach, ecological models in health promotion do much to highlight broad contextual factors (Green et al., 1996; McLeroy et al., 1988). Ecology is concerned with the relationships between organisms and their environment (Kleffel, 1991a; Kleffel, 1991b), and social ecology is concerned with the nature of the relationships between humans and their social, institutional, and cultural worlds (Herrin & Wright, 1988; Stokols, 1992). Health promotion from this perspective presents health as the consequence of the interdependence between the individual and the family, community, culture, physical, and social environment (Green et al., 1996; Moos, 1979; Syme, 1986). Health promotion practised from an ecological perspective is directed toward developing
interventions that target interpersonal, organizational, community, and public policy factors which influence health behaviour (Green et al., 1996; McLeroy et al., 1988).

The Lalonde Report shifted the focus of a vision for the health of a population from illness care to health care and advanced health promotion as a science. Ecological perspectives on health promotion highlight broad contextual factors that influence health, including family. These theoretical perspectives suggest that health-related problems are important to investigate to advance the health of Canadians and that interpersonal and contextual factors influence health behaviour.

**Perspectives on Family**

Formal theoretical perspectives on family theory have their roots in sociology and anthropology. In the current theoretical climate, there is considerable debate about the usefulness of traditional theoretical perspectives on family. These theoretical perspectives derive from the empirical-analytical paradigm and assume law-like regularities that are identified and manipulated for the purpose of social control (Allen, Benner & Diekelmann, 1986; Duffy, 1985). On the traditional side, scholars and researchers hold to traditional theoretical views of family and knowledge development. It is argued that this approach builds on existing theory, optimizes theory development, and produces valid knowledge because of the demonstrated rigour of quantitative methods (Klein & White, 1996; White, 1991).

Traditionalists in family theory and research undertake to explain a particular social group, the family, with the objective of solving social problems (Klein & White, 1996; White, 1991). Focusing primarily on social problems, these theories attempt to identify norms and to explain dysfunction in terms of deviance from an established norm (White, 1991).
rather than focusing on the strengths and abilities of families. Feminists, critical theorists, and qualitative researchers in family theory development and research are pushing family theory and research toward an emphasis on plurality, difference, and marginality, a trend now widely referred to as pluralism (Baber & Allen, 1992; Doherty, Boss, LaRossa, Schumm & Steinmetz, 1993; Klein & White, 1996; Sprey, 1990; Thorne & Yalom, 1992). Characteristic of pluralism in the field of family research is: 1. the impact of feminist and ethnic theories; 2. the realization that family forms can change dramatically over time; 3. theoretical and methodological diversity; 4. a concern for meaning and language; 5. a movement toward constructivist and contextual approaches; 6. an increased concern for ethics, values, and religion; 7. a breakdown of the dichotomy between the private and public spheres of family life and between family science and family interventions; and 8. greater recognition of the contextual limits of family theory and research knowledge development (Doherty et al., 1993). This shift is viewed as chaotic, a “curious and shifting mixture of consensus and conflict over theories and theory-building” (Klein & White, 1996, p. 55). Klein and White (1996) suggest that family scholarship will not converge on any grand theoretical scheme such as traditionalism or pluralism, but rather there will be a proliferation of theories, theories that combine elements from different theories, and variations on and transformations within existing theories.

Sprey (1990) suggests that theoretical thinking about families is stuck within traditional metaphors of family and calls for new metaphors which release the imagination of family theorists to enrich or develop new family theory. Moore (1992), remarking on the effect academic formulations of the family have had on our ways of thinking about the family, says, “The family has been ‘etherized’ on the table” (p.29). The soul of the family, he
believes, evaporates into the thin air of this kind of reduction. He urges new ways of thinking about families, but warns that, “It takes extreme diligence and concentration to think differently about family” (1992, p.29).

Some scholars offer innovative ways of thinking about family. Hartrick, Lindsay, and Hills (1994), for example, offer the simile of family as a polyphonic novel. Here, the family is viewed as a composition of numerous, independent, and unmerged voices and consciousnesses; they argue that there is a diversity of experience and myriad of meaning within any family. Further, they say that, since family synthesis is an ongoing process, family can never be known in any final sense.

Rosenblatt (1994) likens the family to a river. In thinking of families this way, the timelessness and supra-individual nature of families is emphasized. This simile reflects the sense that the family reaches back and extends forward in time and is ever-changing. In addition, thinking of the family as a river allows consideration of those things that contribute to the river's replenishment: it draws on diverse sources such as genes, traditions, social patterns, identity, work efforts, members, and a wide variety of involvements.

In discussing new ways of viewing families, Fox and Luxton (1993) emphasize the interactional, functional, and emotional nature of families. Families here are relationships that mobilize resources especially for the sake of generational and daily reproduction. People, these authors claim, actively create their families. Emotional connection is central to families, a connection that ties people of different generations and households together for life.

Another perspective on family is offered by Gubrium and Holstein (1990):

To speak of a specific family — say the Martin family — is to describe a thing that is organized in a certain way, has an inside and outside. Yet, when we take the voices of those who speak for the Martin family into account, this thing loses its boundaries.
Could it be that when we listen carefully and let those concerned define the Martin family, that 'it' becomes many things, as potentially diverse as those who speak for it? (p. 7).

Gubrium and Holstein assert that family is a socially constructed entity that derives its meaning from the conditions and understandings of everyday life. They, like other family theorists such as Chubb (1990) and Maturana and Varela (1987), assert that the interactional process of meaning construction is central to family.

From these writings, a theoretical perspective on family for the purposes of this research can be construed. Family is socially constructed by a collection of individuals, each with his or her own voice. Family derives its meaning through the process of meaning construction enacted in relation to the conditions and understandings of everyday life, much of which centres around the mobilization of resources for generational and daily reproduction. Within families, multiple realities coexist. Thus family members' accounts of family life can be convergent or divergent. Social and cultural factors outside the family shape the multiple realities within it. The past, present, and future shape family life. Emotional connection is central to family.

Ecological perspectives on health promotion and family provide a forestructure for the purpose and questions of this study. The central aims of this research are to understand social processes in family life that contribute to family influence and to capture the social and cultural factors that impact on these processes. Symbolic interaction, a theory concerned with social processes, and feminist and critical perspectives that guide inquiry into social and cultural influences, are congruent with the aims of this research and are presented in the next sections.
Symbolic Interactionism

A theoretical perspective often used to guide research and practice in the family field is symbolic interactionism (Klein & White, 1996). Symbolic interactionism derived from nineteenth century theoretical discourse in American sociology (Klein & White, 1996; Strauss, 1977). Drawing on this theoretical tradition, George Herbert Mead (1934), a social psychologist and pragmatist, established a theoretical perspective on the interrelationship between mind, self, and society that delineated an ontological position and epistemological framework for what later was articulated as symbolic interactionism by Herbert Blumer (1969). As a social psychologist, Mead was interested in the effect the social group has on the experience of the individual (Mead, 1934). Mead’s theoretical contribution was to explain that minds and selves are social emergents, that language in the form of vocal gesture is the mechanism for their emergence, and that consciousness is a product of the interaction between person and environment (Mead, 1934). Thus, Mead theoretically linked mind, self, and society.

Blumer coined the term symbolic interactionism to characterize the theoretical perspectives of a diverse group of scholars: pragmatists including Mead, William James, John Dewey, Charles Pierce, and the sociologists, W.I. Thomas, Robert Park, Charles Cooley and Louis Wirth (Lindesmith, Strauss & Denzin, 1975). The assumptions of their work are summarized by Lindesmith, Strauss, and Denzin (1975):

1. Human societies are interactive — produced, shaped, and maintained by interacting individuals;

2. Persons are able to take on their own and others points of view;
3. The meaning of objects arises out of the behaviour directed towards those objects;
4. Persons self-consciously produce their social worlds or universes of discourse and meaning;
5. By taking on the perspective of others, persons act symbolically, thereby they manipulate; shape, and formulate representation of one another.

A central focus for symbolic interactionism is the acquisition and generation of meaning through social interaction processes (Klein & White, 1996). As a theoretical perspective on the relationship between the individual and the collective, symbolic interactionism is a useful perspective to guide research investigating the family influence on the individual. Grounded theory, a method derived from symbolic interactionism (Strauss, 1987), is the method used in this study and will be discussed in depth in Chapter Four.

Critical and Feminist Perspectives

Theoretical perspectives from health promotion, family, and symbolic interactionism reviewed in the previous section contribute to the orientation to health promotion and family that guides this research. The review of the empirical and theoretical literature in this dissertation points to economic and gender issues as two factors implicated in family influence on individual health-related decisions. The decision to include critical and feminist perspectives as theoretical forestructures is related to the trend in social science, mentioned earlier, that encourages scholars to be cognizant of the historical, social, economic, and political context within which phenomena occur, an approach that can bring into view the impact of economic and gender issues on family processes (Campbell & Bunting, 1991). In the next section, critical and feminist perspectives that guide this research are discussed.
Critical Theory and Research

Critical theory evolved in response to the concern that technical knowledge generated by positivist science contributed to oppression (Campbell & Bunting, 1991). In the early years of its development, critical scholars were associated with the Institute of Social Research in Frankfurt, Germany in 1923 (Campbell & Bunting, 1991; Held, 1980). Critical theory matured into four criticalist traditions: the emergent schools whose scholarship drew on Marx’s theories, the geneological writings of Foucault, post-structural deconstruction associated with Derrida, and post-modern views (Kincheloe & McLaren, 1994). Critical theorists were concerned with social analysis to benefit the oppressed, a decidedly political position with ethical undercurrents (Allen, 1990; Benhabib, 1992; Fraser, 1995; Held, 1980). This theoretical position is political and ethical in the sense that these theorists laid the theoretical foundations for raising questions that challenge society, culture, and the relationship between the individual, society, and nature to shed light on ideologies that sustain social injustice (Allen, 1987; Fraser, 1995; Held, 1980).

Some critical theorists view family as an abstraction that provides unique opportunities to explore questions about the relationship between the individual and society (Feuer, 1959; Held, 1980). Marx and Engels, the forefathers of critical theorists, explored family as an entity from the materialist conception of history (Feuer, 1959; Held, 1980). Critical theorists from the Frankfurt School, particularly Horkenheimer, Adorno, Fromm, Marcuse, and Reich, integrated the work of Marx and Freud to theorize about the relationship between family, the individual, and society. These expositions, particularly the writings of Horkenheimer and Adorno, detailed the ways in which capitalism reinforced the power of the
father in the family (Held, 1980), a position that resonates with feminist theories about family.

As a tool for social critique, critical theory aims to unmask the influence of ideologies on patterns of behaviour (Allen, 1985; Campbell & Bunting, 1991; Eakin, Robertson, Poland, Coburn & Edwards, 1996). Criticalists, as researchers or theorists, engage in a form of cultural or social criticism (Kincheloe & McLaren, 1994). Criticalists hold to these basic assumptions

1. Thought is mediated by power relations that are socially and historically constituted;
2. Facts cannot be isolated from the domain of values or removed from some form of ideological inscription;
3. The relationship between concept and object and between signifier and signified is not stable or fixed, but often mediated by relations of capitalist production and consumption;
4. Language is central to the formation of subjectivity (conscious and unconscious awareness);
5. Certain groups in society are privileged over other groups. Although the reason for privileging varies; the oppression that characterizes contemporary society is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable;
6. Oppression is expressed in a variety of ways, for example race, gender, class, and focusing on only one obscures the interconnections among them; and
7. Conventional research practices contribute to the reproduction of systems of oppression such as gender, class, and race. (Kinchele & McLaren, 1994, p.143)

Marshall (1988, pp. 216-217) offers a list of assumptions held by contemporary critical theorists that underscores the importance of complexity, subjectivity, class, the
relevance of everyday life, the contribution of economics to oppression, and the dialectical nature of social reality emphasized by Kincheloe and McLaren. Attending to these assumptions, the researcher has a theoretical perspective that guides inquiry toward distinguishing between patterns or regularities that are universal or inherently human and those that are a function of ideology (Allen, 1985). This process of critique, which involves uncovering misrepresentation, is viewed as the initial step in addressing social injustices (Allen, 1985; Kincheloe & McLaren, 1994). Critical theory is a theory of social rationality — an approach to addressing the basis on which communities and groups make decisions (Allen, 1990), a theoretical perspective that fits for a study seeking to explain the influence of a group such as family on individual decision making. As it is used in this study, critical social theory is a tool for critique contributing to the analysis and to the explanation of the findings.

Feminist Theory and Research

In theorizing, feminists make certain assumptions: that gender is the most salient variable in every society, that all societies are organized according to gendered division of labour, and that an important aspect of any society is its gender structure, that all societies have kept women in subordinate positions, that women are socialized to be seen and not heard, and that feminist theorizing is a first step toward social change that leads to equality for women (Belenky, Clinchy, Goldberger & Tarule, 1986; Chafetz, 1989; Coser, 1989; Mies, 1991). Research drawing on the assumptions of feminist theory has become part of an emancipatory project in which feminist researchers seek to use knowledge toward the correction of longstanding inequities (Mies, 1991). However, there are points of tension
between feminist theory and research. The two points of tension that are discussed here are the relationship between the women's movement and women's research and issues related to research methods (Mies, 1991).

With regard to the tension between the women’s movement and women’s research, feminists argue that traditional approaches to social science serve the interests of those in positions of control in society with the result that what is identified as problematic in social science is problematic for those in positions of control (Acker, Barry & Esseveld, 1983). The goal of social science guided by a feminist perspective is to provide women with an understanding of how their challenges in the everyday world are shaped by dominant social structures (Acker et al., 1983; Campbell & Bunting, 1991; Hall & Stevens, 1991). Feminist theorists holding these views see research as an instrument for social change that would benefit women (Mies, 1991).

The recent merging of feminism and science raises new questions: Because of the political nature of feminism, is feminist science not a contradiction in terms? Is there feminist methodology? Is there feminist method? Why should feminist values take precedence over others? Do women do science differently than men? What kinds of science are consistent with feminist critiques? How can politicized inquiry increase the objectivity of inquiry? (Fonow & Cook, 1991; Harding, 1987; Thompson, 1992; Tuana, 1989). Far from resolved, these questions are the focus of on-going reflection and debate (Olesen, 1994).

Addressing the question of whether there is a distinct feminist methodology, Harding (1987) argues that there is not. Rather, she argues that feminist theory points to methodological features that give direction for “applying the general structure of scientific theory to research on women and gender” (Harding, 1987, p.9). A number of feminist
scholars list the features of feminist inquiry including the following: women's experiences are valued, subjective data are legitimate, informants are experts on their own lives, women's lives and qualities are revealed when their voices are included in research, knowledge is relational and contextual, research should contribute to women's liberation by producing knowledge useful to women, methods used should not be oppressive, and the research should be critical and question dominant intellectual traditions while reflecting on its own development. (Acker et al., 1983; Belenky et al., 1986; Campbell & Bunting, 1991; Duffy, 1985; Hall & Stevens, 1991; Harding, 1987). Longino (1988) suggests that research from a feminist perspective is doing science as a feminist.

Family research from a feminist perspective derives from a reading of the family as the locus of domestic labour, the site of human reproduction and socialization, or as hegemonic ideology. In the past two decades, feminists have deconstructed the family, highlighting the oppression based on gender apparent in marital and family life (Blaisure & Allen, 1995; Flax, 1988; Fox & Luxton, 1993). Feminists argue that conventional formulations of the family reinforce ideologies of the dominant culture that obscure issues of gender and power, plurality, difference, and marginality (Baber & Allen, 1992; Felski, 1989; Fox, 1993; Gittens, 1993; Hartrick, 1994; Thorne & Yalom, 1992; Wilkinson, 1993). Further, although women in families have long been responsible for the health and well-being of family members (Fox & Luxton, 1993; Gittens, 1993; Mandell & Duffy, 1995; Thorne & Yalom, 1992) the particular household tasks essential to nurturing and caretaking have been devalued and ignored (Cott, 1977; Fox & Luxton, 1993; Mandell & Duffy, 1995). Moreover, women have carried out these responsibilities from a position of subordination (Cott, 1977).
Family research guided by feminist perspectives has done much to reveal oppressive family dynamics (Baber & Allen, 1992; Thorne & Yalom, 1992).

In this study, the position that I am taking is that this research will investigate the everyday experiences of women, men, and male and female children in families while recognizing that everyday experiences are inextricably connected to the larger political, social, and economic environment. Focusing on gendered experience in families has potential to expand awareness of gendered existence as it is socially constructed (Allen, Allman & Powers, 1991). A feminist perspective will permit analysis of issues of gender and power in the family as this relates to the health experience. This research has critical, not emancipatory, goals. Feminist theory guides the selection of the research question, the type of method used, the implementation of the research, the analysis, the interpretation of the findings, and the dissemination process.

Critical and feminist theories are each a "genre" of theories (Campbell & Bunting, 1991). While the adherents of these perspectives often disagree about philosophy and strategy, both envision a world in which equality, gained through social action, enables all persons to enjoy well-being and prosperity (Bent, 1993; Campbell & Bunting, 1991; Felski, 1989; Habermas, 1973). Critical theory is a reflective theory that produces knowledge about ideological factors that shape the social context (Allen, 1985; Campbell & Bunting, 1991). Feminist theory, like critical theory, depends on criticism to achieve its goals; however, it differs from critical theory in that it focuses on women and values, feelings as well as intellectual processes (Campbell & Bunting, 1991). These theoretical perspectives provide me with tools for designing research that values women and seeks to reveal interests that shape social situations and the related structures of power.
Personal Situatedness

In research such as this, in spite of every attempt to represent adequately the position of the participants, the researcher becomes part of the research. The researcher's own beliefs and values rooted in professional and personal experience are central to the research process. Here, I briefly describe aspects of my life that have shaped the beliefs and values that I bring to the research. Further, I acknowledge participants' opinions about my research topic since their opinions were inspiring, encouraging and enriching — thus they were an important source of my compelling interest in this topic.

As a white, middle-class, middle-aged, heterosexual mother of two adult children, in my marriage of twenty-seven years, I assumed a traditional female role taking primary responsibility for child care and home management. In tandem with this, another central identity in my adult life has been that of staff nurse, nurse educator, researcher, and leader in both the community and in nursing. I see myself as one who approaches life with openness and curiosity and a love of life and living.

I, like my extended family and my children, deeply value family. Because of my journey through marriage, homemaking, and raising children, my work with families in critical care settings, and my familiarity with family theory, I have a heightened curiosity about how families work. Family theories that I studied during my first nursing degree were incongruent with what I knew to be the experience of family life. In these theories, where were the passions, pain, and texture of everyday family life that I knew? In this research, one of my goals is to generate family theory that highlights the textured experience of everyday family life.
Another influence on this research is my commitment to heart health. Professionally, I have practised in and volunteered on behalf of cardiovascular nursing for much of my career. Personally, heart disease is a major threat in my family with all of my grandparents dying of either heart disease or stroke and my father disabled for twelve years as a result of a myocardial infarction. In my personal life, since my father's tragedy eighteen years ago, I have been committed to a heart-healthy lifestyle by running and/or cycling regularly, managing stress, and eating low fat, high fibre food. I hope that the maintenance of these patterns of living, in spite of the demands of the doctoral program, have potential to bring credibility to my research on the basis of the congruence between what I practice personally and what I represent professionally.

My values are bound to Judeo-Christian and feminist perspectives. Within the Judeo-Christian perspective, I hold liberal views that encourage working in partnership with the oppressed for social change, a belief consistent with the critical perspectives informing this research. The feminist perspective has sensitized me to issues of power operating throughout the research process and to the oppression of women, and supports my belief that knowledge gained through life experience is valuable. Therefore, I believe that social change can relieve oppression and that I should apply my time, energy, and skills to this pursuit. I believe that working in partnership with the oppressed is the best approach to achieving social change and that it is possible for an academic to work in partnership with non-academic people if due attention is paid to reducing power imbalances and respecting experiential knowledge.

Another aspect of my personal situatedness that influenced my work throughout the research process was participants' opinions about the importance of this research. Here, I share those opinions. In the midst of busy — sometimes excruciatingly busy — lives,
participants took time to speak honestly and openly with me. Participants told their stories with passion, anger, hostility, disappointment, discouragement, joy, pleasure, pain, and sometimes ennui. Their stories, however, are told with conviction that families and health are inextricably intertwined. One man eloquently stated, “When we are healthy as a family, it helps us as individuals, and when we’re healthy individually, it also helps us on a family level as well. So, they’re connected.” Further, the stories revealed a conviction that society, families, and health are connected. One woman reflected:

If you’re writing this paper on the family unit and health in the family unit, I would say that I wish more people would look at the family as a very integral part of health and I wish that the there were more government programmes offered to people who were just becoming parents instead of putting money somewhere else. Why couldn’t it be on educating people how to become parents? Because, I look out there in the school system and I see a lot of high-need children. How did they get that way? Where are their parents? Do their parents know how to help those children? A lot of times they don’t. They don’t have the education. They don’t know how to be parents. I mean, how do you teach somebody to be a parent if they haven’t had the upbringing that encourages that? But if there was something that would help young people prepare themselves for being parents, I think it would save the medical system a lot of money.

Commenting on families and health, another participant explained,

The health of the family determines the health of our society both physically as well as mentally and emotionally because if you have strong, stable families we’re going to have strong, healthy communities, but if the family unit is not healthy, physically, mentally, whatever, we’ll have a dysfunctional society and we’re seeing it already. So for us in order to have a healthy society, we’ve got to have healthy families — that’s where it’s got to start.

Participants want health care professionals to know just how very important the link between families and individual health is. In her enthusiasm for this topic, one woman closed the interview saying “I hope your study is absolutely successful.” By articulating their opinions on the link between families and heart health, participants made public their views,
thereby using this research study as a way to advocate for more attention to be paid to the link between families and heart health.

Summary

In this chapter, theoretical forestructures and personal situatedness of the research are discussed. Theoretical and personal forestructures indicate that my personal and professional interests converge, leading to a focus on family and its impact on heart health as a research interest. Theoretically, four perspectives frame this study: perspectives from health promotion, the family field, symbolic interactionism, and critical and feminist theoretical perspectives. Each perspective contributes in a slightly different way. Theoretical perspectives on nursing orient the study to a view of health as that which is constructed through the process of interaction between the person and environment. Further, the family is a primary environment for the construction of health. Theoretical perspectives on health promotion suggest that the individual experience of health is embedded in a social and cultural context within which the individual constructs meanings that underlie health-related decisions. Family is one of several contexts within which this occurs. Family is cast theoretically as an intimate social group characterized by formative spirit and complexities. Symbolic interactionism is well suited to the theoretical perspectives on family and health selected to guide this study since it is centrally concerned with the acquisition and generation of meaning through social interaction processes. Critical and feminist perspectives offer additional theoretical perspectives that consider the broad social context that underpins family life.
Theoretical perspectives on nursing, health promotion, and family and symbolic interactionism oriented me to the research purpose and questions. Symbolic interactionism contributes a theoretical perspective that guides data collection and analysis. Feminist theory guides the practice and process of this research and combines with critical theory to inform the data analysis and explanation of the findings. In the next chapter, the purpose, research questions, and methods are presented.
CHAPTER FOUR: METHODOLOGY

In this chapter, the methods of the research are explained. First the purpose and objectives of the study and a statement of the research questions are presented. Then, an overview of grounded theory, and critical and feminist approaches as applied to this study are discussed. This is followed by a discussion of specific research sites — the Campbell River District General Hospital Heart-Health Programme, the Vernon Heart Healthy Community Kitchens Programme, and the Nanaimo Healthy Hearts Programme. Then, I introduce the study families. Next, a detailed overview of how grounded theory, informed by critical and feminist perspectives, was used in this research is provided, including descriptions of the theoretical sampling process, data collection and analysis, coding, memoing, and data management. Finally, ethical considerations and the criteria for evaluating the scientific rigour of qualitative research are discussed.

Purpose and Objective

The purpose of this study was to explore family processes and health-related decisions in response to heart-health interventions. It objective was to generate theory about how family dynamics influence health-related decisions when one or more members participate in or are exposed to a heart-health intervention.
Research Questions

The following research questions were addressed.

1. From the perspective of participants, what aspects of heart-health programmes influence family processes?
2. How do family members perceive these aspects of a heart-health programme to influence family processes?
3. How do family members perceive the processes to influence individual health-related decisions in response to heart-health interventions?

Methods

Grounded theory is the method used in this research. However, to address issues of power and gender embedded within the socioeconomic context, this research uses a blended approach with feminist and critical approaches informing grounded theory. This section begins with an overview of grounded theory as method, then critical and feminist approaches to research are addressed.

Grounded Theory as Research Method

Grounded theory, a method derived from symbolic interactionism (Strauss, 1987), is a method well suited to family research because of its focus on social processes (Daly, 1992; Hayes, 1992). Grounded theory is a systematic, naturalistic, qualitative research method that does not usually involve numerical calculations, but rather analysis of textual data (Strauss & Corbin, 1990). As a research method it was developed by Anselm Strauss and Barney Glaser (Glaser, 1978; Glaser & Strauss, 1967) and further explicated by Strauss and Juliet Corbin
(Strauss & Corbin, 1990) and Glaser (1992). Grounded theory evolved from Strauss's background in symbolic interactionism and pragmatism and Glaser's academic preparation in the use of empirical methods to generate theory (Strauss & Corbin, 1990; Strauss & Corbin, 1994). It is a method of study that aims to discover underlying social forces that shape human interaction (Munhall & Boyd, 1993; Schatzman & Strauss, 1973). Grounded theory is therefore particularly relevant to this study which aims to examine family processes around issues of cardiovascular health.

Grounded theory applies inductive and deductive reasoning to the examination of a variety of data sources to generate and substantiate salient concepts, conceptual relationships, and evolving theory (Glaser & Strauss, 1967; Munhall & Boyd, 1993; Strauss & Corbin, 1994). Because family life is a social process, grounded theory is an appropriate research method with which to explore these research questions. Further, since grounded theory emphasizes change and the variability and complexity of life (Strauss & Corbin, 1990; Strauss & Corbin, 1994), this method is well suited to examining how everyday family processes shape health-related decisions (Hayes, 1992).

Grounded theory has evolved since it was first articulated by Glaser and Strauss in 1967 (Corbin & Strauss, 1990). Basic tenets of the method are presented in this section, and further elaborated in subsequent sections. In grounded theory, data collection and analysis are interrelated processes. This stands in contrast to other qualitative methods in which data are collected prior to the analysis (Corbin & Strauss, 1990). In grounded theory, data collection and analysis lead to the identification of concepts. The concept here is the basic unit of analysis. Concepts referring to incidents, events, and happenings are taken as indicators of phenomena and are given conceptual labels (Corbin & Strauss, 1990). Once a number of
concepts have been identified, similar ones are grouped into categories which become the "cornerstones" of the theory (Corbin & Strauss, 1990). Unlike most sampling processes in research, sampling here proceeds according to the unfolding theory, a process called theoretical sampling. That is, situations, people, or documents are sought that maximize the potential for conditions to vary relative to the phenomenon of interest. Constant comparative analysis is a primary strategy for grounded theory analysis (Corbin & Strauss, 1990; Glaser, 1992; Mullen & Reynolds, 1978). Using this strategy, concepts and hypotheses are generated and interrelated through core variables that are at once parsimonious and broad (Glaser, 1992; Mullen & Reynolds, 1978). Theoretical sensitivity is the "glue" that holds grounded theory together. Theoretical sensitivity refers to a personal quality of the researcher that is characterized by having insight, the ability to give meaning to the data, the capacity to understand it (Strauss & Corbin, 1990). Ultimately, a mid-range theory is developed in a specific content area (Corbin & Strauss, 1990; Glaser, 1992; Mullen & Reynolds, 1978). As Strauss and Corbin (1990) write, "to reach these ends requires maintaining a balance among the attributes of creativity, rigor, persistence, and above all theoretical sensitivity" (p. 58).

Critical and Feminist Approaches to the Research

It is increasingly recognized that the complexity of the problems that are relevant to a practice discipline such as nursing challenges researchers to develop unique qualitative research methods that blend approaches (Allen, 1985; Lowenberg, 1993; Thorne, 1991; Wuest, 1995). Health promotion scholars have also identified the need to reach beyond positivist and constructivist traditions in health promotion research (Eakin et al., 1996). This
research represents a grounded theory study, in the constructivist tradition, that is informed by feminist and critical theory, a blend that considers the broad social context.

**Critical Approach**

Critical theory calls for a critique and challenge of social reality as it is commonly understood (Thompson, 1987). Habermas offers a theoretical framework, Knowledge-Constitutive Interests, that was used to guide data analysis and the explanation of findings in this study. Habermas identifies three different kinds of interests: technical-cognitive interests which relate to an interest in control; practical interests which relate to meaning-construction within a normative order; and emancipatory or critical interests. Critical or emancipatory interests refer to distinguishing between theoretical statements that grasp social action as such in contrast to theoretical statements which express ideologically frozen relations of dependence that can, in principle, be transformed (Habermas, 1971). This framework brings into view the relationship between social and political norms and human experience (Meehan, 1995).

Basic to Habermas's Knowledge-Constitutive Interests are the dual strategies of reflection and dialogue, directed toward these three types of interest (Habermas, 1971). Reflection on and discussion about technical interests involves examining who has authority and how technical interests shape reality (Allen, 1987). Reflection on and discussion of practical interests involves determining by what standards the facts are constituted (Habermas, 1971). Critical interests involve reflecting on and discussing whether or not theoretical statements are an accurate reflection of social action or represent ideologically frozen relationships (Habermas, 1971). Posing such questions allows the researcher to
distinguish between patterns or regularities that are universal or inherently human and those that are a function of ideology (Allen, 1985). This framework was used to construct broad questions to guide the analysis (Appendix B). Habermas’ Knowledge-Constitutive Interests provides direction for making explicit assumptions and ideologies; the previously invisible becomes visible. In this way, new knowledge is generated that can be used to formulate alternate plans (Allen, 1985).

Feminist Approach

The feminist perspective is well served by qualitative methods since both value lived experience (Hall & Stevens, 1991; MacPherson, 1983). Within the qualitative paradigm there is a range of methods that drive nursing research (Thorne, 1991). Grounded theory is consistent with feminist epistemology in that both recognize multiple realities, seek to build theory from the perspective of participants, and seek to understand social structures at the micro- and macro- level (Wuest, 1995). Wuest (1995) points out that tension in using grounded theory from a feminist perspective arises from the potential imposition of feminist ideology on the analysis of the data. Wuest asserts that this can be handled using reflexivity throughout the research process. This study, drawing on a feminist perspective, focuses on science as practice and process. In this section, I provide an overview of the strategies used to ensure that the research question is equally as relevant to women and men, that women's experiences are accessible as theoretical and empirical resources, that the context is considered, that the research is useful to and is disseminated to women and men equally, that the research process is not oppressive, and that there is critical reflection on the scientific process.
One of the early issues to resolve in this study was the issue of relevance. As mentioned earlier, feminist critique of science indicated that scientific research has historically served the interests of those in positions of dominance and control. It has failed to serve the interests of women (Acker et al., 1983; Duffy, 1985) among other groups such as the poor and undervalued ethnic groups (McAdoo, 1993). I knew from personal experience as a mother and wife that family influence on individual health-related responses was a relevant area of concern for heart health. I discussed the relevancy issue with other women, seeking input from women who were concerned about heart health both personally and professionally. From these discussions, my sense that this was an important area of inquiry for women was validated by homemakers and those professionally involved in the Canadian heart-health initiative.

Then, I gave thought as to how to carry out the study so that it was not oppressive to those involved. Three areas of concern were identified as having potential for dynamics that could be oppressive: the relationship between me and the women paid to work on the study; the data collection process; and data analysis (Acker et al., 1983). In my relationship with the women working on the study, leadership characterized by encouraging consensual decision-making and valuing the work of contributors was used to reduce power inequities.

With regard to the data collection process, grounded theory methods provide direction for gathering rich, contextual data about women's experiences guiding the researcher to draw out key concepts, explanations, and interpretations (Acker et al., 1983; Glaser & Strauss, 1967). However, grounded theory was developed within a paradigm in which the interviewer receives but does not give information thus objectifying the interviewee (MacPherson, 1983). Moreover, the research relationship between the researcher and participants lacks personal
meaning (MacPherson, 1983). Oakley (1981) challenged this tradition and offered an alternative technique. Oakley established an interview model in which the interviewer is personally invested in the research relationship, arguing that this investment alters the relationship from one in which there is an observer and observed, thus establishing a non-hierarchical relationship. She suggests that such research relationships foster rapport and are therefore more effective in accessing participants’ experiences. While this technique may alter the relationship toward a less hierarchical one, whether or not it becomes a non-hierarchical relationship is arguable, since the researcher still assumes the power to define the research process (Acker et al., 1983). Furthermore, the researcher’s personal investment in the research relationship may make some participants uncomfortable since they may expect the dialogue to be one-way — interviewee to researcher (Acker et al., 1983).

Finch (1994) questions the ethics of fostering rapport if the purpose is to enhance the effectiveness of the interview. If the researcher uses this strategy, Finch sees potential for breach of trust if the researcher uses the data for his/her purposes without due consideration of the benefit to those who have been interviewed. Finch sides with Oakley in her position that the researcher should create a product that is *for* women rather than data for the use of the researcher. I suggest that reflexivity, discussed below, is an effective strategy for asking questions that relate to the ethics of interviewing. In this study, guided by the feminist commitment to a non-oppressive research process, I used Oakley’s strategies in an attempt to make data collection less hierarchical. Reflexivity is used to explore whose interests are served to ensure that the findings are for the women.

Strategies to reduce power differentials were also used in the analysis phase of the research. When using grounded theory as a feminist, reading and analyzing transcripts of
interviews and assigning the content to concepts and categories is only achieved from a position of authority on the text and therefore creates a hierarchical bind (Acker et al., 1983). Keller (1985) suggests that a feminist approach to research could replace this subject/object duality with dynamic objectivity. Dynamic objectivity, she says "... aims at a form of knowledge that grants to the world around us its independent integrity but does so in a way that remains cognizant of, indeed relies on, our connectivity with that world" (p.117). Reflexivity (see below) during the analysis was used to sensitize me to my role in the construction of the knowledge. Involving participants in the analysis and validating the theory with them were strategies for reducing power inequities since this measure involved participants in the knowledge construction process.

Reflexivity, mentioned previously, is the practice of reflecting upon, examining critically, and exploring analytically the nature of the research process (Anderson, 1981; Fonow & Cook, 1991; Porter, 1993). According to Wuest (1995), reflexivity reduces the potential of imposing feminist ideology on the emerging grounded theory. It was also used to sensitize me to my role in constructing the knowledge and to explore whose interests were served throughout the research process.

Using reflexivity, from the early stages of the research and throughout, I considered the meaning of the research question in light of theoretical and personal understandings. This allowed me to achieve some clarity about a research design that was congruent with my personal and professional values and my purposes in selecting the topic. Then, in the early stages of data collection, I spent time with selected family members in my family talking about family influence on individual heart-health decisions — an opportunity that allowed me to reflect on my own views on the topic within the context of discussion with them. These
conversations and my reflections on how my family experience has shaped my values were taped to facilitate recall. These tapes were not transcribed. The process of talking with family members and reflecting on those discussions sensitized me to similarities and differences in our perceptions. Then, during and following research sessions with families, I reflected on dynamics such as how I moved from the researcher role to the therapeutic role. These observations were captured in the field notes and became a resource for planning subsequent interviews with the families. As well, during data collection and analysis, I thought about matters such as who has voice within the family and what stance is taken on a family position when discrepant perspectives are expressed (Daly, 1992). It was necessary to reflect on who has voice in a family to raise my awareness of the issue of voice during data collection and analysis. I noted my reflections in field notes which were taped and transcribed following the family sessions. When selecting excerpts for the final report, I gave thought to the selection process relative to the issues of voice and discrepant views. Feminist perspectives guided this research throughout the research process, from identification of the research question through to dissemination of the research report.

Summary

Grounded theory, with its focus on social process, is well suited to research on family. Moreover, because it emphasizes the importance of theory to the development of a practice discipline, grounded theory is particularly suited to generating knowledge for practice (Mullen & Reynolds, 1978; Strauss & Corbin, 1990). Although grounded theory differs from empirical-analytic science in that its goal is understanding rather than control, both share an epistemological problem (Allen, 1985). Neither interpretive sciences nor empirical-analytical
sciences have inbuilt strategies for distinguishing between intentional patterns and patterns that are a function of ideology and misrepresentation (Allen 1985). Critical theory and feminism are similar in their concern for explicating hidden social and political factors that maintain the position of those in control (Bent, 1993; Campbell & Bunting, 1991; Felski, 1989; Habermas, 1973). Critical and feminist theory are epistemologically congruent with grounded theory in that all hold that knowledge is contextual and value-subjective, and that everyday experience is a source of knowledge. For Habermas, as for other critical theorists and for feminists, it is action on behalf of the oppressed that counts. The feminist perspective moves beyond critical theory, positing that it is as valuable to free individual women from oppression as it is to liberate groups of people (Bent, 1993). When augmented by critical and feminist perspectives, grounded theory generates knowledge for practice while valuing all participants and unmasking hidden ideological forces that shape experience.

Research Communities

Families invited to participate in this study were those in which at least one member attended one of the following heart-health programmes: the Campbell River District General Hospital Heart-Health Project, the Vernon Community Kitchens Programme, and the Nanaimo Healthy Hearts Community Development initiative. In addition, families living in British Columbia representing diversity with regard to geographic, ethnic, socioeconomic, and family form were invited to participate. Like all Canadians, members of these families are recipients of widely disseminated media health-health messages. Access to the worksite and community development programmes was facilitated by Ms Lynne Blair from the BC Ministry of Health and Co-Principal Investigator of the BC Heart-Health Demonstration
Projects. Heart and Stroke Foundation of BC and the Yukon personnel facilitated access to the Vernon Community Kitchens Programme and the word-of-mouth method was used to access families from the general population.

Campbell River District General Hospital Heart-Health Programme

Upon learning about this study, the Medical Health Officer for the Vancouver Upper Island District said that it would help him to plan future heart-health programmes in his community if he knew about family influence on heart-health (Dr. Brian Emerson, personal communication, May 8, 1995). He introduced the idea of this project to the planners of the Campbell River District General Hospital Heart-Health Programme (CRDGHHHP) who then agreed to approach participants about their families' willingness to participate in this study.

Campbell River District encompasses a small community on Vancouver Island with a population of 21,135 (PCensus-Canada, 1991). A relatively young community, 73% of those living in Campbell River are under age 45. There are 5,830 families in this district: 13% are single parent families; 1.2 children is the average per family; and the mean annual family income is $54,353, slightly higher than the Canadian average. The majority of wage earners work in the logging and manufacturing industries and in retail.

The CRDGHHHP was implemented between September 1993 and June 1994. Taking a multifactor approach, the project identified participants' cardiovascular risk profile, disseminated information about heart health and cardiovascular disease via lectures and educational displays placed in the hospital cafeteria, offered exercise programmes, and tested knowledge. About 130 individuals began the programme in September 1993 with about 100 completing it in June 1994. The coronary risk profile improved for 9% of participants. This is
apparently primarily attributable to changes in dietary intake and exercise patterns. Interestingly, 5% of participants had blood pressure recordings that improved over the nine-month period. As well, participants claimed to have learned about heart health from the project (Linda Nagle, personal communication, August 28, 1995). The 9% improvement in coronary risk profile is less than the 16% reduction in risk for coronary heart disease obtained in the outcome evaluation of the Stanford Five City Project. The Stanford Five City Project outcome evaluation demonstrated a 4% reduction in blood pressure levels, similar to the 5% obtained in this worksite programme (Farquhar & al., 1990).

The influence of the Canadian Heart-Health Initiative was evident in the evolution of this project. In the fall of 1992, the co-ordinator of the Upper Island Heart-Health demonstration project sent letters to community members inviting attendance at a one-day workshop on heart health. The workshop brought together people from the community, sparking interest in heart health in venues as diverse as hospitals, fitness facilities, school boards, and home care. One participant attended because of her concern about the effects of shift work on health, particularly heart health. Prior to attending the workshop she had read a study that linked shift work to cardiovascular disease. In this study Knutsson (1989) measured the incidence of coronary heart disease in 504 male day- and shift- workers from 1968 to 1983. He determined that shift work does increase risk for coronary heart disease and that there is a dose-response relationship between years of shift work and presence of the disease. As the day-long workshop unfolded, this woman, a recreation professional, together with a nurse, devised an intervention for heart health that targeted shift workers in Campbell River. A proposal was submitted and funding was obtained from the Upper Vancouver Island Heart-Health Demonstration Project. The administrators of Campbell River District General
Hospital opened their doors to the project. Three families from this programme participated in the study.

**Vernon Heart Healthy Community Kitchens Project**

The Vernon Heart Healthy Community Kitchens Project is a joint initiative between the North Okanagan Health Unit, the Vernon unit of the Heart and Stroke Foundation of BC and the Yukon, the Social Planning Council of North Okanagan, the Ministry of Social Services, local churches, and Neighbour Link Volunteer Services.

According to the 1989 census, the average income in Vernon was $32,242. This is 14% lower than the provincial average, while the average income for single women was $10,948. At this time, 16.6% of families were headed by single women (North Okanagan Health Unit, 1995). Standard morbidity rate for heart disease in 1990 for males and females was in line with the provincial average, while 1990 statistics on cerebrovascular disease indicate men and women in this community are at slightly lower risk than the provincial average. These figures suggest that heart disease and stroke are the major causes of death for both adult males and females in Vernon (North Okanagan Health Unit, 1995).

In support of community efforts to reduce the incidence of heart disease in Vernon, the Heart and Stroke Foundation of BC and the Yukon funded the Vernon Heart Healthy Community Kitchens Project as part of its “community grants” programme. Personnel at BCYHSF connected me to the nutritionist responsible for the Community Kitchens project. It was communicated to them that I required assistance with finding families for this study. The objectives of the project are to encourage persons of limited income to develop healthful lifestyles and to improve their access to low-cost nutritious meals. With an emphasis on self-
help and mutual aid, the programme is designed to provide a context within which participants become aware of barriers to healthful living and discover strategies for overcoming them. Formal evaluation of the Kamloops Food Share Project demonstrated that benefits of Community Kitchens include skill development, enhanced self-esteem, food security, and social support among participants. The Vernon Community Kitchens Project promotes heart health and works to prevent heart disease by addressing issues that place low-income persons at risk for heart disease: poor nutrition, barriers to food security, and social isolation. Local statistics indicate that this community is at high risk for heart disease. Five families were accessed for this study from this programme.

Nanaimo Healthy Hearts Programme

Another community received funding from the B.C. Heart-Health Demonstration Project to implement a community-based programme for heart health: the Nanaimo Healthy Hearts Programme. Several community partners, including the Central Island Health Unit and the Nanaimo, B.C. Social Planning Advisory Group on Poverty, came together to design a programme aimed at increasing public awareness of heart health and citizen participation in heart-health initiatives. Nine sub-projects emerged including a Community Garden, School Gardens and a Planned Parenthood project — the outcome of the latter was a pamphlet on smoking for expectant teens, a pre-school initiative produced a heart-health cookbook. All projects were completed when this study began. During this community-based heart-health initiative, citizens identified the need to enhance neighbourhood cohesion. The Healthy Neighbourhood Initiative was created in response to this perceived need. Two families for this study were accessed from this community.
Nanaimo is a city on Vancouver Island with a population of 60,065 (PCensus-Canada, 1991). According to this census, 65% of those living in Nanaimo are under age 45 with the average income for males working full time $40,186. For full-time working women the figure is at $26,258. Men’s jobs are primarily in construction trades, sales, and service, whereas women are employed primarily in sales, service, health care, and management. In this city, there are 17,060 families averaging one child per family. The average annual family income is $47,434. Fourteen percent of families are lone-parent, 12% female-headed and 2% male-headed. Three families were accessed for the study from this city.

Grounded Theory: A Systematic Approach

Grounded theory is a qualitative research method that uses a systematic set of procedures to generate an inductively-derived grounded theory about phenomena (Strauss & Corbin, 1990). In this section, this systematic process is delineated.

Settings and Approach

The study took place following the implementation of the above mentioned heart-health programmes. In the Campbell River District General Hospital community, families were recruited one year following participation in the worksite programme. Since the programme was planned and implemented by recreation professionals from the community, access to potential subjects for this study occurred entirely outside the hospital. Guided interviews and participant observation generally took place in the participants' homes. Observations of the neighbourhoods and communities in which the families resided were made on the way to and returning from family visits and while visiting the community, and
immediately dictated as fieldnotes. The research sessions and fieldnotes from participant observations were audiotaped and the taped conversations were transcribed soon after they were complete. Magazine and newspaper articles, popular books referred to by participants, flyers and newsletters generally available to the public, notes on videotapes viewed, and printouts from relevant internet sources were gathered as part of the data and filed according to type of data source.

In the participating communities, an Information Letter (Appendix C) was distributed to potential participants by the community contact person. In this letter, the purpose of the study was outlined in lay terms, expectations of participants were delineated, and an invitation to participate was extended with instructions for contacting me made explicit. At the time of the first meeting, the Consent Form (Appendix D) was given to potential participants, questions arising were answered, and they were assured that non-participation in the study would in no way harm their status at school or work or interfere with their future participation in heart-health programmes. No potential participants refused to participate in the study. Second meetings and participant observation activities were booked by telephone. A second or third contact with participants living in remote communities was made by telephone to clarify data or to gather additional information about emerging categories.

Families were usually visited in their homes. During the home visits, observations and unstructured interviews took place. On several occasions, the researcher/participant interactions extended to pertinent family activities such as a birthday party, dinner with extended family, a concert, and a walk in the woods. Participant observation occurred in the worksite of two participants. Participant observation refers to occasions during which the researcher is a participant in the social scene while making observations relevant to the
research (Hutchison, 1993; Spradley, 1979). Collecting data in a variety of settings and under various conditions added considerable depth and richness. One woman, who did not reveal her smoking habit in front of her daughter at home, later talked about it during my visit to her workplace. Two participants met with me in my office, one met with me in a coffee shop, and one participant hosted me in his office. While most participants were comfortable having me visit their homes, a few participants chose to meet elsewhere: two felt it was more convenient to meet at their workplaces given busy lives and two seemed uncomfortable with the idea of me visiting their homes. Informal contacts by telephone or during face-to-face meetings with experts in health promotion, health education, and community health were made to discuss emerging themes providing input into the analysis during.

**Theoretical Sampling**

Theoretical sampling is a term used in grounded theory that refers to the process of concurrent collecting, coding, and analyzing of the data to determine a subsequent sampling plan (Glaser, 1978; Glaser, 1992). In a process referred to by Strauss and Corbin (1990) as open sampling, I began data collection by meeting with several families from the Campbell River site. Open sampling is defined as sampling that admits persons, places, situations to the study that provide the best opportunity to gather the "most relevant data about the phenomenon under investigation" (p. 181). In the case of this study, it occurred in conjunction with open coding, the process of naming and categorizing phenomena (Glaser, 1992; Strauss & Corbin, 1990). Then, socioeconomic and lifestyle diversity were sought to enrich the data. For example, the first three families who entered the study included parents who were older than 45, white, and middle class; thus, for subsequent research sessions
variation in age, ethnicity, physical ability, sexual orientation, family type, and income was sought. As well, in the first three families, members agreed on lifestyle issues, so an effort was made to include families in which members did not agree on this. As key concepts and categories were identified and connections between categories made, theoretical sampling turned to a focus on maximizing conditions, contexts, consequences, and actions/interactions that validated and enriched the connections made earlier. In this study, sites were accessed that were considerably different from other situations allowing for maximal variation in the data. Maximal variation refers to a wide range of conditions within which the phenomena occur, a number of actions and interactions that characterize it, and a range of consequences (Strauss & Corbin, 1990). Maximal variation was partially achieved by including families from a community kitchens programme and families living in a remote village since these sites were considerably different from other sites.

During early open coding, it emerged that heart-health programmes are only one kind of heart-health message; participants spoke of the barrage of heart-health media messages they are exposed to. Thus, to enhance diversity in my study, I accessed families from the general population with members who are exposed to media heart-health messages. Messages about heart health are widely disseminated to Canadians by television, radio, newspapers, magazines, videos, and books. Through my professional and personal network, I was able to carry out a theoretical sampling process that allowed for rich variation in the data. Contact with thirteen families was facilitated by three nurses, a social worker, a nutritionist, and a senior partner in an urban law firm. Upon hearing about the study, four families from the general population spontaneously volunteered to participate out of an interest in heart health and families. These seventeen families represented diversity in regard to geographic location,
socioeconomic status, ethnic origin, and family type and developmental stage. These families augmented the diversity represented by the eleven families accessed through the heart-health programmes.

As the process of data collection and analysis unfolded, other sources of data were consulted including experts, community representatives, government documents, government personnel, and newspapers — sources that were instrumental in understanding the core phenomena (Charmaz, 1990; Duffy, 1984). This technique, known as discriminant sampling, maximizes opportunities for the story line to be verified (Strauss & Corbin, 1990). The story line is the conceptualization of the core category (Strauss & Corbin, 1990). Thus, theoretical sampling revealed conditions that influenced experience, strategies for dealing with experience, and consequences of the experience and allowed for verification of the story line. The families came into the study as a result of this theoretical sampling process.

Description of Families

Twenty-eight families participated in this study comprised of 86 individuals, 42 adults and 44 children. Ages of family members in study families ranged from 1 1/2 years to 81 years of age. Children represented both sexes equally; however, adult female participants outnumbered males two to one. Considerable geographic diversity was evident as participant families were located in eight distinct communities in metropolitan, urban, suburban, and rural settings throughout British Columbia, including metropolitan Vancouver, Vancouver Island, and the interior and central parts of British Columbia. Socioeconomic diversity was also apparent with nine families reporting an annual family income of $30,000 or less, eleven families with an annual family income less than $76,000, and six families reporting annual
family incomes of over $76,000 and less than $200,000. Two families reported a family income of over $200,000 per year. Occupations of the adult family members included those currently unemployed, blue and white collar workers, homemakers, semi-professionals, professionals, and the retired. Educational levels ranged from the never-educated to professional education. While the majority of participants (65 of the 86) identified with the dominant English Canadian culture of British Columbia, 21 participants claimed links to one of the following ethnic minorities: East Indian, French Canadian, African American, Asian, Iranian, German Canadian, or Canadian First Nations. Twenty-one participants identified specifically with a religious affiliation, Jewish, Mormon, Christian, or Roman Catholic. Although all interviews were conducted in English, other languages spoken by participants included French, Persian, Chinese, Punjabi, and German. In the Punjabi-speaking family, the elderly mother spoke no English and in this case comments directed to her from me and her responses were translated by her middle-aged daughter.

Data Collection

Each family participated in one or two two-hour research sessions, usually in their homes. In some cases, all family members living in the home participated in the research session whereas in other cases some members opted not to participate or were not available. During the research sessions, interviewing was augmented by participant observation to ensure that rich contextual data were systematically gathered (Spradley, 1979). Questions were developed prior to the interviews to ensure that the data collected were relevant to the research questions (Appendices B and F). These worked well to guide the interviews in that relevant detail was accessed as well as rich descriptions of experience. As mentioned in the
Procedures section, research sessions and participant observations were taped and transcribed.

Participant observation took place during each data collection period, such as visits to participants' homes for the occasional family evening, meal and/or outing. I attended one community kitchens planning session. Field notes from participant observations were recorded immediately upon leaving the meeting with families and were transcribed within a reasonable time period (about three weeks) following the interviews. A camera was used to photograph several families. Photographs were used for recall, reflection, and as a focus for discussion with participants to enrich the data about the congruence between the my observations and the participants' experiences. Photographs were taken when the purpose of taking the photograph was clear and participants consented to having the picture taken (Highley, 1989). Some families, upon being asked, donated one or more family photographs to the study. Demographic data were collected from each family to facilitate a description of the sample (Appendix E).

In addition to local communities that were familiar to me, I travelled to one village, one town, and two cities previously unknown to me to collect data. When visiting new locations, I made a point of staying several days to gather data about community life, walking or driving through them on my way to visit families, making observations and taking photographs on my way. Once, I toured a town by bicycle and attended a play and a concert in the park. In towns and cities unfamiliar to me, I visited coffee shops, stores, restaurants, and local places of interest to get a feel for life in the town (Geertz, 1973). Data relevant to the research questions were documented in fieldnotes. During the research sessions with families, reflections on my observations of town or city life facilitated the formulation of
several lines of questioning that in some cases uncovered powerful data, such as the realization that access to recreation facilities was problematic in rural communities.

Data collection in families presents specific challenges. One has to ensure that one member does not speak for the entire family (Daly, 1992). Specific strategies were used to ensure that all family members' voices were represented in the data. These strategies included stating at the outset that I was interested in hearing from all family members, drawing out quiet participants by cueing into and probing areas of interest or concern for those members, and allowing each family member to respond in turn. School-aged children were asked to draw a picture of their families or of a favourite activity and to describe the picture (Bossert & Martinson, 1996). In the case of children under six, special attention was paid to documenting behaviour.

Sources of data, including family situations, non-technical data, and expert opinion were sought until it was determined that there was theoretical saturation — that is, until there were enough data to support the categories (Glaser, 1978; Glaser & Strauss, 1967). Theoretical saturation is reached when no new or relevant data are gathered, when the category descriptions are dense, and when the relationships between categories are well established and validated (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Formal data collection began in August 1995 and was concluded in July 1996.

Data Analysis

Data analysis was concurrent with data collection. I began processing and analyzing the data during conversations and participant observations. Once transcripts of the research sessions and fieldnotes were received from the transcriptionist, they were read to get an
I then read through the transcripts and fieldnotes, examined photographs, and perused other relevant data sources, such as pamphlets, and made notes in the margins of the transcripts and in memos. Theoretical notes and memos that built on the emerging theory were made immediately following each interview and data analysis session. Theoretical memos were kept in hard copy form in a file ‘Data Analysis’ as well as in the NUD*IST (Non-numerical, Unstructured, Data Indexing, Searching and Theorizing) files named according to categories or notes attached to computer-generated nodes which represented codes (Richards & Richards, 1995). Hard copies of the notes created in NUD*IST were kept in the data analysis file to facilitate thoroughness in using all analytical memos during the process of theory building and analysis.

Coding

Coding is the process of analyzing the data (Strauss & Corbin, 1990), the link between the data and the theory (Glaser, 1978) and the beginning of organizing the data into topics and files (Patton, 1990). Coding is substantive and theoretical. Substantive coding conceptualizes the empirical substance and theoretical coding conceptualizes how the substantive codes relate to each other thus the fractured story is developed into a theory (Glaser, 1978).

A grounded theory analysis begins with open coding — that is, coding the data in every possible way (Glaser, 1978; Strauss & Corbin, 1990). The goal of open coding is to generate categories and their properties that are relevant for integration into a theory (Glaser, 1978). During the coding process, with each new submission (a photograph for example), I began by examining or reading it to get an overall sense of the data. Then, the formal coding
process began with open coding, naming, and categorizing content. In grounded theory, data can be analyzed in various ways. The researcher can analyze data in small units such as line-by-line analysis or larger units such as entire documents (Glaser, 1978). I decided to examine what I perceived to be thought units of participants. I reasoned that analyzing the data in this way had potential to preserve the voice of the participants during data analysis. When examining the data, I asked myself these questions: What does this datum represent? And, What is going on here? (Glaser, 1978). Initially, I became familiar with the problem area by talking with the first three families enrolled in the study and coding these four early transcripts by hand, not computer. Open coding revealed concepts and categories that were the basis of selection of subsequent families. Open coding led me to decide that it was important to define health and family from participants’ perspectives.

Constant comparative analysis was used to construct the codes. Constant comparative analysis involved comparing data units to each other and data units to emerging concepts (Glaser, 1978). Participants’ words as they appeared in the text of the transcripts were used to name the codes whenever possible. I involved participants in deciding on the names for the concepts. Open coding yielded a plethora of codes which were reduced through constant comparative analysis to more meaningful, dense, and rich codes. That is, by constantly comparing the data, some codes were subsumed by others or new codes were identified that captured the essence of one or more other codes. For example, participants referred to times when the family was working well as a time that was “comfortable” which became the category “family climate of comfort.” Throughout coding, memos and diagrams were made to keep track of the rationale for, and process of, the evolving coding process. For some concepts, specifically those of a descriptive nature, coding did not progress beyond open
coding, for example, family definition and heart-health messages. In this case, the intent was to identify themes. If the researcher's intention is to pull out themes, coding ends before the concepts are developed analytically using axial coding (Chenitz & Swanson, 1986; Strauss & Corbin, 1990).

As open coding progressed, axial coding began. In axial coding, the data are reconstructed by asking questions of the data such as: What are the conditions under which this phenomenon occurs? What are the consequences of action? What is the context within which the phenomenon occurs?, and How does this relate to the notion of family? (Strauss & Corbin, 1990). By asking questions of the data, the researcher is looking for conditions, context, action/interactional strategies, and consequences that relate to the phenomena of interest (Glaser, 1978; Strauss & Corbin, 1990). According to Glaser (1978) this is theoretical coding — that is, the theory is constructed from the data. Hypotheses are generated and tested through further data collection and analysis. In grounded theory this involves hypothetically relating subcategories to a category and verifying the hypothetical statement against actual data (Strauss & Corbin, 1990). Relational or variational sampling occurs along with axial coding to maximize differences in the data (Strauss & Corbin, 1990).

Axial coding is the basis for selective coding, the process of selecting a core category. In other words, it produces a category to which all other categories relate. One strategy used in selective coding is to describe conceptually how participants resolved their main concern (Glaser, 1978; Glaser, 1992). Glaser (1992) points out that the basic social process (BSP) does not necessarily involve rate of movement, direction, differential interpretations, and consequences and will only involve these characteristics if in fact they are present in the data. The core category, or BSP, has integration, density, saturation, completeness, and a
delimiting focus (Glaser, 1978; Glaser, 1992). It accounts for as much variation in the pattern of behaviour with as few concepts as possible thus maximizing parsimony and scope (Glaser, 1978).

As data analysis progressed, I consulted with several participants about my analysis, seeking validation for the conceptualization of key concepts and categories and the relationship between them. As well, I worked with some participants to decide on names for key concepts and categories. The BSP was validated with several participants. Thus, an interactive, reflective, inductive/deductive process between participants and me was characteristic of the unfolding data collection and analysis process.

**Memoing**

Throughout the analysis, memos were kept to document my thought processes. Memos are written records of analysis related to the formulation of the theory and include code notes, theoretical notes, operational notes, and reflective thoughts (Schatzman & Strauss, 1973; Strauss & Corbin, 1990). Diagrams were generated to capture visually the relationships between categories. Memos and diagrams enabled others to follow my decision-trail as the analysis unfolded, and facilitated me in revisiting earlier interpretations to get a sense of my developing thinking.

**Data Management**

As mentioned previously, taped interviews and fieldnotes were typed by a transcriptionist using computer software. Hard copies and word processing files on disks were prepared from the transcripts. Data were entered from the word processing disks into
NUD*IST, a qualitative data analysis system (Richards & Richards, 1995). I read all hard copies to get a sense of what people were telling me. Hand analysis of the hard copies of the first twelve research sessions was completed augmented by analysis using NUD*IST. Then, hand analysis was abandoned since I felt confident that NUD*IST was a dependable approach to data analysis. Eventually, data from the transcriptions of all research sessions and fieldnotes were analyzed using NUD*IST. I discovered that the computer compared well with hand analysis and, as the data grew, computer analysis was an efficient way to manage the volume. NUD*IST allowed for a dense and complex analysis.

All transcripts of interviews and fieldnotes were coded using NUD*IST. In an effort to minimize fragmentation of the data, data were coded according to meaningful groupings or thought units rather than line-by-line coding. For example, every effort was made to keep topical responses intact. NUD*IST facilitated this process because thought units could be coded in a variety of ways with some thought units placed in up to five different categories or (to use NUD*IST terminology) nodes. Initial codes were named using the words of participants as code names. In this way, NUD*IST assisted with keeping the “in vivo” expressions of participants intact while allowing for a dense analysis and ease with retrieval. Approximately 400 hierarchically-ordered nodes were created using NUD*IST. Throughout data analysis, I used both hard copies of the transcripts and NUD*IST to ensure that my analysis reflected concepts and categories identified during coding the hard copy.

As open coding progressed, the hierarchical system developed. That is, some codes were subsumed under other codes to create higher and lower level ordering of the data. For example, one high-level concept identified was health-giving family processes. Within this category, there were 24 subcategories, five of which had their own subcategories. Frequently,
I printed out the coding structure to examine the codes to facilitate making decisions about merging categories and to envision the relationships between categories. As the categories began to take shape, some categories were subsumed by others or one or more category became a new category. Further, some categories became subcategories of a new category. Data pieces remained intact as codes were reordered and merged, a process facilitated by NUD*IST functions. Notes were kept regarding the logic of reordering or recoding the data pieces in NUD*IST. Finally, hard copies of all the data that related to specific categories were generated, allowing me to hand code the data again with marginal notations linking substantive and theoretical categories. This facilitated axial coding and the selection of a core category. I selected excerpts in the final report from these hard copies.

Ethical Considerations

The study was reviewed by the University of British Columbia Behavioural Sciences Screening Committee for Research Involving Human Subjects with approval received June 19, 1995 # B95-0243. In this section, I detail the steps that were taken to meet ethical standards; the process of accessing participants is explained; how data were managed and stored to protect confidentiality is described; and informed consent is considered.

The Campbell River District General Hospital maintained distance from the study by requesting that the Heart-Health Programme Co-ordinator, who is not an employee of the hospital but who has the list of participants, act as the contact between me and potential participants. An introductory synopsis of the proposed study was sent to this woman. Once she agreed to be involved and ethical approval was received, copies of the Information Letter were sent to her, and she kindly addressed and distributed letters to potential participants.
In Nanaimo, a co-ordinator of the Nanaimo Healthy Hearts Programme provided me with a list of names of community leaders to whom I could send letters requesting participants. Additionally, she placed a notice about the study in a local community newsletter. In Vernon, a nutritionist with the North Okanagan Health Unit who was assigned to work with the Vernon Community Kitchens Project received a synopsis of the study and distributed letters to potential participants.

In other communities, contact persons from my professional and personal network distributed letters to potential participants who then contacted me. In three cases, participants upon hearing about the study from others, expressed interest to me directly.

Participants were contacted and an appointment for an initial research session was booked. When I arrived at the home of participants, I provided family members with the information letter following which I explained the purpose, procedures, and duration of the study and asked if there were any questions. Signed consent forms were obtained and a copy was given to participants prior to the interview. Consent forms were kept in a locked filing cabinet in my home office in a binder with the list of names, addresses, and telephone numbers of participants separate from the data.

To ensure confidentiality, families and individuals were assigned code numbers for identification on all tape recordings, transcripts, and written materials. No names or identifying information appear on any of the data. Participants were assured that fictitious or no names would be used throughout this final report and in future presentations. The tapes, typed transcripts, and PC disks are kept in a locked filing cabinet and will be erased three years after completion of the study. Only two committee members and the research assistant had access to data stored either in filing cabinets, on disks, or on the hard drive of my
computer. Only I have access to identifying information. Care was taken to ensure that small communities were not identifiable to protect the privacy of participants from those communities.

Informed Consent

Informed consent is a pivotal aspect of research protocols (Richards & Richards, 1991). Typically, informed consent involves laying out the title of the research, purpose, and explanation; identifying the risks and benefits; providing opportunities for participants to ask questions; and informing the participants that they are free to withdraw from the study at any time (Field & Morse, 1985). Grounded in the principle of autonomy (right to self-determination) for first party consent and non-maleficence (do no harm) for second party consent (Davis, 1989), informed consent is problematic because little is known about factors limiting autonomy and interactional processes that may contribute to harm (Davis, 1989).

Qualitative research, and particularly qualitative family research conducted by a nurse, is especially problematic with regards to informed consent (Larossa, Bennett & Gelles, 1981). The process-oriented quality of qualitative research (Munhall, 1988), the blurring of roles of nurse/researcher (Fowler, 1988; Robinson & Thorne, 1988), the intimacy and pervasiveness of family life, the setting within which family research occurs (Larossa et al., 1981), and the inclusion of young children (Davis, 1989) are factors that contribute to ethical dilemmas in qualitative family research. Some researchers argue that informed consent is impossible in qualitative research (Ramos, 1989; Robinson & Reis, 1989). Thus, an expanded view of informed consent is called for (Davis, 1989; Larossa, Bennett & Gelles, 1981; Munhall, 1988; Ramos, 1989; Robinson & Thorne, 1988), one that takes into account
the potentially problematic aspects of qualitative family research that guided this research. The following paragraph outlines strategies that were used to support the participant's right to know and to ensure safety.

First, qualitative family research requires a kind of consent in which emergent difficulties are discussed openly. This is a process referred to as ongoing consensual decision-making (Munhall, 1988; Ramos, 1989; Robinson & Thorne, 1988). Family research is most often conducted in participants' homes allowing the researcher to conduct the research in an environment that encourages friendliness, trust, self-disclosure, and opportunities for serendipitous data collection (Larossa, Bennett & Gelles, 1981). Because of the pervasiveness and intimacy of family life, the researcher cannot know or explain at the outset who or what will be included in the research (Larossa, Bennett & Gelles, 1981). Therefore, I encouraged participants to draw their own boundaries of privacy by emphasizing and reiterating participants' prerogative to withdraw from the study or delimit discussion at any time (Daly, 1992; Larossa et al., 1981).

With regard to the informed consent process with children, following a verbal explanation of the study by me or one or both parents, school-age children were asked if they had any questions and were invited to sign the consent form. This provided an opportunity for children to become involved in the informed consent process autonomously.

Scientific Rigour of Qualitative Research

At this time, there is an unresolved tension around issues of credibility of qualitative research within the research community (Patton, 1990). To ease these tensions and to enrich
the debate, a number of scholars have developed criteria for testing the credibility of qualitative research (Guba & Lincoln, 1989; Hall & Stevens, 1991; Sandelowski, 1986).

Criteria identified by Guba and Lincoln (1989) are particularly relevant for this study. Grounded theorists believe that the canons of good science should be modified to fit qualitative research (Strauss & Corbin, 1990). Guba and Lincoln would like to redefine the usual scientific standards to fit the realities of qualitative research (Strauss & Corbin, 1990; Guba & Lincoln, 1989). Thus, their criteria may be used to judge the adequacy of a grounded theory approach to research. Guba and Lincoln identify approaches to evaluating the quality of goodness of qualitative research that are used in this study: trustworthiness and authenticity. Hall and Stevens (1991) identify standards for evaluating the adequacy of feminist research that augment Guba and Lincoln’s criteria. Hall and Steven’s (1991) techniques including rapport, coherence, complexity, consensus, honesty and mutuality, and naming augmented Guba and Lincoln’s criteria to enhance the scientific rigour of this study. The use of these criteria are addressed in the next section.

Adequacy of the Research

According to Guba and Lincoln’s (1989) schema, trustworthiness parallels traditional notions of internal and external validity, reliability, and objectivity. Trustworthiness has several dimensions: credibility, transferability, dependability, and confirmability. Credibility parallels the quantitative notion of internal validity and refers to the synchronicity between the constructed realities of respondents and the reconstructions attributed to them. Techniques for increasing credibility include negative case analysis, progressive subjectivity (the process of monitoring the researcher's own developing construction), and member-
checks (the process of testing hypotheses, data, preliminary categories and interpretations against those from whom the original constructions were collected). Negative cases were successfully included in the study and enriched the data considerably — for example, families in which the adults did not agree on lifestyle choices. Progressive subjectivity and member-checks occurred throughout the study; reflexivity occurred throughout and evolving data analysis was shared with selected participants, friends, doctoral colleagues, and committee members.

Qualitative family research presents unique challenges in the realm of credibility. Threats to validity in family research arise from the interaction between the researcher and the research project. Because of the sensitive and intimate nature of family research, the researcher may mistake her researcher role for a therapeutic role (Daly, 1992; Gilliss, 1991; Moriarity, 1990). As well, because the researcher is also a member of a family, the researcher may unknowingly infuse her own family beliefs into the research situation, weakening the credibility of the study (Daly, 1992). Or as a member of a family, for example, the researcher may focus on or overlook aspects of the family life of participants that are personally disturbing. As a family counsellor or practitioner, the researcher may bring her professional theoretical perspective to bear on the data collection and analysis process. Thus, the researcher becomes an integral part of what is researched. Reflexivity, described earlier, was a strategy used for raising the researcher’s consciousness about her own family dynamics. Reflexivity allowed me to become clear about my pre-understanding of the phenomena and then throughout the research process to track the transition from these pre-conceptions to what I believed to be a new interpretation.
Transferability is parallel to the quantitative notion of external validity or generalizability and reflects the degree to which conditions in the study context and the receiving context match or overlap. The technique for establishing the degree of transferability is thick description. The researcher provides a thorough description of the study context to facilitate transferability judgements on the part of others who may wish to apply the study findings to their own contexts. I introduced excerpts from the data that appeared in the final report with descriptive information about the speaker(s) and family, and rather lengthy excerpts were selected to provide the reader with detail. Detailed notes were taken on the families and communities, and used with discretion in the final report to protect the identity of participants.

Dependability parallels the quantitative criterion of reliability and refers to the tracking of changes and shifts in the maturing interpretation. Dependability is ensured by carefully documenting the analysis process in a manner that is easily retrievable. Dependability was best achieved using hand-written notes which allowed me to draw pictorial representations of the relationships between categories. I found it more difficult to use NUD*IST to keep and track the evolution of my thinking. However, NUD*IST provided an additional way to track the coding process and memos embedded in the programme for retrieval and examination.

Confirmability is parallel to the conventional notion of objectivity. It is concerned with assuring that the data, interpretations, and outcomes are rooted in contexts and persons. Data are managed and the on-going analysis is documented so that the interpretation can be tracked to sources in the data. Further, the rationale behind assembling the interpretations is explicated. Selected participants were actively involved in identifying key concepts,
categories, and relationships as the analysis progressed to achieve what Keller (1985) refers to as dynamic objectivity. Involving participants in the analysis kept the analysis grounded in their interpretations. The logic of the interpretations was discussed with dissertation committee members and colleagues.

Another criterion identified by Guba and Lincoln (1989) as important for evaluating qualitative research is the authenticity criterion which refers to fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity. Fairness refers to the extent to which different constructions, and their underlying value structures, are solicited and honoured within the research. An issue here that relates to the feminist perspective informing this study is how male (adults’ and boys’) perspectives would be adequately represented in the context of a feminist methodology. To deal with this potential issue, I actively sought a sample of families that included male members and made sure that the voices of males were well represented in the text and in the analysis. Ontological authenticity refers to the extent to which individual respondents' own constructions are expanded as a result of participating in the research. Techniques for demonstrating ontological authenticity included documenting testimonies of participants and identifying participant responses that demonstrated a growing awareness of central issues.

Educative authenticity represents the extent to which individual participants' understanding of and appreciation for the views of others are enhanced. A number of times, family members expressed surprise at the responses of others in their family. In one case, a mother, intrigued by her daughter’s level of knowledge about health, requested a transcript of her daughter’s responses to the question, “How do you stay healthy?” In one family, the interview provided an opportunity for two teenage daughters to express their views on how
family meals were handled in the family, views that had not been expressed previously. To achieve educative authenticity, a short document delineating the findings was distributed to all participants.

Catalytic authenticity refers to the extent to which action is stimulated or facilitated by the research process. Catalytic validity was facilitated by the connection of this study to the larger BCHHDP and to the Heart and Stroke Foundation of Canada (HSFC) and the Heart and Stroke Foundation of British Columbia and the Yukon (HSFCBCY). These connections gave the research visibility in a larger heart-health community. I shared results of the study with the Director of Health Promotion for the BC Ministry of Health, and have reviewed a number of policy-related documents — specifically, position statements on Children and Cardiovascular Health and Food Access prepared by the HSFBCY and the BC Heart-Health Coalition respectively, and a position paper on Women and Heart Health released by the HSFC. Further, I have shared my results on a one-to-one basis with leaders in the heart-health movement — for example, heart-health champions in the Yukon and the chief executive officer of the HSFC. Another strategy to achieve catalytic validity was to distribute an executive summary of the findings to all who assisted with access to participants.

Tactical authenticity refers to participants' ability to act based on findings from the study. Tactical authenticity occurred in at least one family and is highlighted in the findings. Because of the interview, one woman was empowered to resume skiing, a hobby she had given up because of family constraints.

Another strategy that contributes to auditability by allowing for a systematic analysis of the rationale behind the study is delineating my location relative to the study. Heidegger notes that, for one to know anything, there must be some preunderstanding of what is
knowable (Addison, 1989; Heidegger, 1962). He posits that one's anticipation and foreknowledge guide one in the understanding of phenomena under consideration (Guignon, 1983; Heidegger, 1962; Kockelmans, 1985). Heidegger argues that clarifying presuppositions inherent in the interpretive situation is essential if one is to justify one's interpretation (Heidegger, 1962). Talking formally with my own family members to identify our conjoint perspective of family influence on individual health-related decisions was a strategy that I used to raise my awareness about my personal situatedness.

Hall & Stevens (1991) suggest that fidelity and authenticity strengthen adequacy of the inquiry. Rapport, coherence, complexity, consensus, honesty and mutuality, and naming were strategies derived from Hall and Stevens’ criteria and were applied in this study.

Central to a feminist perspective on research is an approach that values engagement with, rather than detachment from, the persons and processes to be understood. Rapport has to do with how well participants’ reality has been accessed. This can be evaluated in a number of ways: depth and specificity of information shared, verbal and non-verbal indications of participants’ comfort, willingness to be involved over a prolonged period, and their inclination to recruit others. The specificity of the data, impassioned responses, and openness of participants to second interviews or participant observation were evidence to me that a comfortable rapport was established. Further, several participants referred other families to the study.

Coherence is a characteristic of the research that indicates a unity in the research account. Coherence is recognised by the congruence between the whole and parts, and by the plausibility and comparability of data and the products of analysis. Coherence can be checked throughout the research process by reflecting on and discussing with colleagues questions
pertaining to the faithfulness of the analysis to the raw data. Hall and Stevens (1991) suggest a line of questioning for reflection to guide checks of coherence (Appendix B). In this study, checks for coherence were made and documented throughout the research guided by the suggested questions. Further, in sharing my evolving analysis widely, others had an opportunity to provide feedback related to coherence.

Concern for the complexity of reality is essential in feminist inquiry. Contextuality, exceptions, and indeterminants can only be achieved by capturing the complexity of everyday experience. Complexity was achieved in this study by locating the analysis in the participants' everyday lives; by defining words from the perspective of participants that were key to the lexicon of the research questions, health and family; by exploring the broader socio-political and economic structures; and by reflecting on the historical context of this substantive area. Concern for complexity was evident in resisting oversimplification of the relationships between or among the categories of the data by avoidance of forcing dimensions (Glaser, 1992).

Consensus is a key verificatory element in feminist research. Hall & Stevens recommend a line of questioning to meet this criterion that can be used throughout the research process; this line of questioning was used (Appendix E). As well, strategies in this research that were used to meet the criterion of consensus included careful documentation of non-verbal behaviours during interviews and participant observations.

A feminist approach to research values honesty. Strategies for enhancing the adequacy of the research, as well as ethical considerations, do much to strengthen the honesty of the research. Strategies that encourage mutuality enhance the honesty of the study. When egalitarian co-operation is evident in the researcher-participant relationships, participants are
seen as peers rather than objects of the study. One strategy for equalizing power relations between the researcher and participant is for the researcher to engage participants in exchange and dialogue as opposed to asking questions that extract data. This was a key strategy used throughout. Conscious monitoring and documentation of reflections about power dynamics was used to provide information useful for ensuring mutuality.

Another criterion for achieving adequacy is **naming**. Naming involves ensuring that the concepts identified as central reflect the words used by participants in the study. In selecting a name for a category, I started with participants’ exact words. Through consultation with select participants, I worked with these words until it was determined that their words adequately captured the meaning of the category. In most cases, participants guided the naming of this study’s theoretical concepts, providing another opportunity to highlight participants’ voices.

Above are criteria and related strategies by which I sought to achieve adequacy of this study and by which it can be judged by others. By engaging you, the reader, in an interactive process that includes contextualizing the findings, tracking the interactions among the researcher, participants, and the intent of the study, I have attempted to create a context within which the truth claims of the researcher can be systematically assessed (Altheide & Johnson, 1994).

**NUD*IST: Its Contribution to Adequacy**

New to using a computer analysis programme for analysis of qualitative data, I approached its use tentatively. Richards and Richards (1994b) point out that, although qualitative data are less amenable to tidy processing methods offered by computers, software
programmes are efficient for qualitative data management. NUD*IST operations can be categorized under three headings: the document system, a hierarchical indexing system, and an analysis system (Richards & Richards, 1991). The document system processes and maintains the on-line and off-line textual data. The indexing system includes a data-base for indexing data, and facilities to create, modify, and inspect that data-base. The analysis system is a set of facilities for manipulating the indexing database and is designed to help the researcher define and explore research ideas, find text relevant to complex ideas, pursue wild hunches and formulate and test hypotheses (Richards & Richards, 1991).

Because of my tentativeness about the usefulness of NUD*IST, I coded initial interviews by hand and computer to validate the effectiveness of the computer for data analysis. The combination of hand analysis and computer analysis was found to be effective for early coding. Hand analysis involves generating notes in the margins on the hard copy of the transcript. Hand analysis allowed me to go back easily to notes in the margins of the transcript while new codes were identified. This iterative process allowed for a level of immersion in and familiarity with the data that created a strong foundation for data analysis as it progressed. I kept detailed memos in a file in a filing cabinet as the analysis progressed as well as memos in NUD*IST. As more data came into the study, NUD*IST became increasingly valuable, as I will explain.

More data meant more data to manage. For example, as a new strong or salient category was identified, I was able to investigate all documents for key words using NUD*IST so that all documents were investigated for as minute a detail as one word — the term BUSY, for example. This word was used frequently in families with young children, families that entered after the transcripts of the research sessions with four families had been.
coded. Using NUD*IST I was able to go back and search data from the first four families for this key word. The search function in NUD*IST is time and labour efficient in that all documents can be searched upon command sequentially for such a word as BUSY. In addition, this search function allowed me to readily search for a word that I recalled was in a descriptive quote but I could not readily find in the transcripts. For example, to find the quote from the man who referred to himself as a “fryer”, I was able to search all documents (or only one if I remembered who exactly had used the term) and pinpoint the exact statement. On several occasions, I was most thankful for this function because I was easily able to retrieve what I believed to be the most descriptive quotes pertaining to a category. Another capability of NUD*IST that I believe contributed to the adequacy of the research was the capability of coding various segments of the transcripts in a number of ways. To explain, the word BUSY may well have been embedded in a segment that was representative of other categories or codes. Using NUD*IST, I could code the segment of the transcript for BUSY but also for other codes, for example, health-depleting family processes. Thus, I was able to keep long segments of the interviews intact while coding those words in more than one way. This allowed for minimal fracturing of the data, a strategy that gave prominence to women’s and men’s voices rather than my voice (Belenky et al., 1986). Furthermore, the programme generates a report of the search that contains segments of the transcripts containing these words that allowed me the luxury of reading the quotes surrounding the key word so that I could compare and contrast the use of that word and think about the meaning of these quotes relative to categories of the developing theory. The hierarchical coding properties of NUD*IST facilitated the identification of relationships between categories. The limitation that I discovered in using this programme was the inability to memo using diagrams. I was
thankful that I had created diagrams of relationships between categories in the hand coding stage of data analysis as these diagrams were invaluable to return to as the theory developed. Nonetheless, as I discovered its capacities for searching and managing data and for generating reports, I was convinced that using NUD*IST enhanced the thoroughness and efficiency of my hand analysis.

Summary

Chapter Four is the bridge between the preceding background and theoretical and personal forestructure of the study and the report and discussion of the findings. Here, the purpose of the research and the research question were introduced. An overview of grounded theory and critical and feminist approaches to research were provided and then the research process was presented in detail. The research communities and families were described, strategies for data collection and analysis were explicated and ethical considerations were highlighted. Criteria for evaluating the scientific rigour of qualitative research were presented and their use in this study delineated. Reflections of the contribution of NUD*IST to the adequacy of the research were included. Findings are presented in Chapters Five, Six, and Seven.
CHAPTER FIVE

HEART-HEALTH MESSAGES: RECIPIENTS’ VIEWS

In the 1980s, various initiatives were undertaken to reduce heart disease in Canada with a primary focus on dietary fat intake reduction, exercise, and smoking cessation — a risk factor reduction approach. Messages to Canadians to change their lifestyles to reduce the risk of heart disease are disseminated in various ways: through community-based programmes, worksite programmes, school programmes, media campaigns, and public service advertisements. This study is embedded in the social context of these community-level and population-level public health initiatives and popular media coverage of heart-health information, looking at what happens in families to influence individual behaviour change. Its findings are presented in three chapters.

Chapter Five provides an overview of patterns evident in the data relative to participants’ reception of such messages. This chapter explicates participants’ perceptions of receiving heart-health messages. The more central question of family influence on individual health experience is addressed in the next two chapters. In Chapter Six, an interpretation of participants’ definitions of family and health is offered as a background to the main question about family influence. Then, Chapter Seven builds on the definitions and links presented in Chapter Six and presents a grounded theory of family influence.

Heart-Health Messages: Settings and Channels

Heart-health messages come to Canadians through various communication channels: heart-health initiatives such as worksite, school, and hospital programmes, heart-health community development initiatives, Heart and Stroke Foundation of Canada and American
Heart Association publications, the media (television, radio, newspapers, and magazines), and lay publications. In this study, participants said that heart-health messages are “everywhere.” They note that the most commonly received heart-health messages are disseminated through media sources, such as television and newspapers, and lay publications on health, such as “Fit or Fat” by Covert Bailey (who also performs on television), from doctors’ offices, and from exercise videotapes. In addition to the sources mentioned by participants, such messages can be found in federal publications inserted into widely read Canadian magazines, on radio talk shows, in handouts from community health centres, in hospital newsletters, and even greeting cards! One greeting card message reads, on the front, “Eat a healthy diet, exercise regularly, get plenty of rest” and on the inside “I have big plans for your body.” This captures salient aspects of common heart-health messages — lowering fat in the diet and exercising have socially desirable effects. Heart-health messages are indeed everywhere.

Recipients Speak Out

In this study, participants of all ages were asked “Where do you receive your information about heart-health?” For those who participated in heart-health programmes, I probed those aspects of the programme that influenced their choices and affected family processes. The participants reported that heart-health messages ranged from useful, to confusing, potentially harmful, inadequate, and divergent from their views on health.
Useful Messages

One woman who participated in a worksite heart-health initiative tells how the programme influenced her cooking patterns:

Researcher: So, before the tape went on, you were telling me that you made some changes in your cooking and received information about diet from the programme.

Woman: Yeah, just sort of low-fat type, non-stick pans and just different things than we did before.

Researcher: Did you, did those become lasting changes?

Woman: Um, yes, they have . . .

The programme provided her with information and strategies to support lasting dietary change. It appears in the following excerpt that her husband also changed his cooking habits.

Researcher: [Turning to the woman’s husband] Did you learn something about healthful eating from your wife attending the programme?

Man: Yeah, I cut back pretty good on the grease portion. [laughs]

Researcher: Oh?

Woman: He was a real fryer [meaning he frequently cooked fried foods].

In this family, the strategies adopted by the woman were disseminated to her husband. In another family, the same programme had no effect on individual members. When asked “What aspects of the programme exerted an influence?” The woman replies “It didn't influence anything. It did nothing actually.” This suggests variability in the usefulness of heart-health messages to recipients.

A number of participants attended a community kitchens programme. This programme combined health education with skill development, resource provision, rewards, and social support. Although this community kitchens programme did not target women
specifically, participants in this study from the programme were all women living in poverty.

Fieldnotes from an observation day describe this combined approach in practice:

At the beginning of the session, a woman did an exercise session. Apparently the women wanted some exercises for stress incontinence and information on heart rate during exercise. An exercise specialist took the group through a demonstration of pelvic floor exercises. She talked about heart-rate levels recommended for cardiovascular fitness. She then took the women through a series of chair exercises and demonstrated how these exercises increased their heart rate. Everyone seemed quite engaged with the children playing quietly or sitting on their mother’s laps while the chair exercises were in progress. Then the women broke into community kitchen groups to plan menus using bargains from local grocery stores to guide planning. One of the women whom I interviewed a couple of days ago was there planning menus with a woman who was known to be mentally challenged and another woman who has in the past lived with physical abuse and currently lives with the threat of emotional abuse. This woman is obviously reaching out in terms of being supportive to others and I just was really struck by her strength. Watching the women work together, I had the sense of being in a caring community — the women caring for each other and the leaders caring for the women by providing resources, materials, organization, and positive regard. The leaders suggested that the women look for recipes for hearty soups and casserole dishes with meat or fish as well as vegetarian, a plan that related to the bargains available that week in the grocery store. There were various cookbooks and recipes available, many heart healthy. The woman worked in groups to decide on the recipes for the next day’s cooking session. One of the leaders does the shopping in preparation for their cooking day. The meals they cook provide dinners for the family for a week for a charge of $7.00. There was also a sheet for a barter system — an exchange of clothes and services.

Educating for risk reduction was a goal of this programme in combination with meeting the perceived health information needs of the women, such as developing skills for meal preparation. In addition, relieving the stress of poverty and social isolation were foundational elements of the programme.

Participants report that the community kitchens programme was a very positive experience for them in terms of health-related benefits. One woman spoke of how her health-related patterns changed after she attended the community kitchens programme: she learned
to cook less starchy food, learned to use flyers to reduce food costs, learned how to shop for bargains and choose low-fat, preservative-free meat. During my visit to her home, the woman told me that she hoped to join a hiking club in town as a way to increase her activity level. When I spoke with her several months after the initial interview, she mentioned that she had indeed joined the hiking club and was hiking regularly. The women who participated in this programme speak about the benefits of the programme to their lives: access to healthful food for their families, meal preparation and budgeting skills, ideas for active living, and enhanced social networks.

Like others, one woman reports using media messages and Heart and Stroke Foundation of Canada Publications to access health information. She recently found that a Heart and Stroke Foundation publication contributed to her knowledge about nutrition. To the question, "Where do you get information about heart health?" this woman responds:

Well, I read the local paper and the Vancouver Sun and do get health information. Sometimes, once in a while, I'll clip a recipe. Speaking of heart health, I just came across something recently put out by the Heart and Stroke Foundation — Canada’s Food Guide. I kept it on my counter for ages to sit down and read. It was on balanced diets and I was really surprised to learn how much food and items in different categories that one was supposed to consume daily for a balanced diet. I purposely kept it aside to inform myself about nutrition.

While she points to the usefulness of health messages, she speaks of the downside in the following passage:

There are so many [messages] ... the whole heart-health thing you know, it’s just one of many, just one of too many, so the most we can cope with is trying to maintain without going in any specified direction.

According to this woman, she is bombarded with health messages. Resolving heart-health messages within the flood of health messages taxes her family’s capacity for change.
Confusing Messages

Heart-health messages are not always perceived to be useful, often they are perceived as confusing. Confusion occurs when messages conflict or when dissonance arises with respect to the messages. One man in his seventies echoes the response of others when he speaks of his reaction to one controversy:

I had gone to margarine and have gone back to butter because of the controversy on TV. They don’t seem to be sure about what’s right and what’s wrong.

Perusal of lay publications echoes his perception. Sondra Gottlieb, a prominent Canadian in the foreign affairs field, writing in the Globe and Mail, Nov 11, 1995, dramatically describes how she perceives media health messages:

In the eighties, the new morality took root (stay fit, stay slim, and live forever) and for me gave out a far more confusing message, filled with conflicting sermons. I go so far as to read the New York Times and the Wall Street Journal so I’ll be two days ahead of Canadians with the latest medical intelligence. I analyze the most recent reports about possible scientific breakthroughs. Trembling with fear and confusion, I try to sort out what is “in”, “out”, “can’t make up our minds”, and “this better not be true”.

Sorting out what messages to believe by accessing up-to-date information is a daunting task for Ms. Gottlieb. Some of the respondents in this study report that, when they were confused about what messages to believe, they waited until the controversy resolved. One middle-aged couple tell how they handled the margarine controversy:

Researcher: Where do you get your information about heart health?

Woman: Well, from my nursing background mainly.

Man: You’ve also got the Heart Cook Book. And some of that stuff comes from the press, just, you know, stuff that you read in the paper . . . . Remember
there was this fuss about margarine awhile ago about some kind of stuff in the margarine? Yeah, that margarine wasn't necessarily better because it has, I can't remember what the stuff was . . .

Woman: Oh yeah, yeah,

Man: Although Becel didn't have any of this but that did make us sort of sit and look up about what was in margarine . . .

Woman: Yeah. I took my cue there from the Canadian Heart Foundation. I phoned them. I have their dietary number.

Researcher: When you heard about the controversy about margarine, then what happened in the family?

Man: We just sort of waited until the dust settled . . . within a short period of time it became clear what was in what and so we could just react when we found out.

Researcher: Did that happen?

Woman: Yes.

These partners report that they handled the heart-health/margarine controversy by waiting for the issue to be resolved in the press by what they perceived to be “bona fide” Canadian experts on heart health, then they took action based on this input.

According to participants, sorting through and resolving conflicting messages is only part of the challenge. Confusion arises as well when one is challenged to resolve dissonance between public heart-health messages and the heart-health experience of others in one’s social circle. In the following excerpt, one man speaks of meeting others who closely followed prescriptions for heart health yet still suffered serious heart problems. Speaking for himself and his wife, he said, “Our philosophy is to eat everything and eat it in moderation, I think because I have met people that lived like monks and still had heart problems.” For this man, eating moderately is his way of managing dissonance arising from what he hears about
heart health and what he observes. Participants identified various strategies for dealing with confusion about heart-health messages: indecision, accessing up-to-date information, seeking moderation, and waiting for resolution of the issue to be made public.

Conflicting heart-health messages were mentioned by some participants as a justification for their inattention to heart-health messages. One man in his thirties, whose lifestyle defies heart-health messages, colourfully describes how media controversies work so that he can justify his chosen patterns:

Man: I don't really read a lot about healthy eating. I just don't find it interesting. Most of the feedback as far as my eating goes is from friends or, people close to me [like family], who are over to my apartment. They look in my fridge and go “Oh my God, [laughter] where's the food, you have things to put on food but you have no food [laughter].

Researcher: Ketchup, HP sauce, Dijon mustard . . .

Man: Yeah. “Have a touch of Dijon.” Or, they'll open up the freezer and see all this frozen food. It’s like, “Geez, don't you have any fresh fruit or fresh vegetables?” So most of the feedback is immediate in that area, if anyone was to go roaming through my refrigerator. But, no I don't really read it. If there happens to be some piece on TV, then, you know, I might listen to it as opposed to channel surfing or whatever, but no I don't really concern myself over it. I suppose I have this attitude that, well, something one day is good for you and then the next day it turns out that you're better off with what you were eating beforehand. So I suppose I take a certain amount of good eating and when I hear these stories ... one of those things that was supposed to be really good or better and it turns out it was worse so of course I love stories like that because it just reinforces that it’s better to do nothing which is exactly what I do [laughs].

Messages for heart health may be either useful or, or for people like this man, confusing and frustrating. The frustration and confusion for him justify resistance to the heart-health movement.

Other Complaints

Participants also speak of ways in which heart-health messages contribute to reduced health status, fall short of their expectations, or diverge from their definitions of health.
Participants stories included examples of how heart-health messages contribute to reduced health status. One participant tells how she integrates health messages about diet and exercise into everyday life in this excerpt:

I went for years and years and years without ever having a potato chip. I never used to have cheese in the house because if it was there I would never, it just wouldn't last so I just knew better than to even buy it. Since we've been together [she is recently married] I buy it [cheese] and I love it of course and I try to find some moderation because when I did deprive myself of those things, every once in a while I would completely pig out. I don't think that that's very good for your body. A year or so ago I was really running a lot and I think that was really stressful for my body so I don't really have a happy medium yet.

After trial and error, this woman tells how lowering fat in her diet and exercising interfered with her overall physical health: strict adherence to low fat food led her to periods of overindulgence and too much running was physically stressful. Another woman recalls implementing a walking programme in response to a worksite heart-health programme only to experience chest pain while ascending a hill near her home. When we talked, this 65-year-old woman did not understand that the chest pains she experienced could be a symptom of heart disease. This woman’s health was also strained as a result of action taken in response to the heart-health programme.

Heart-health messages were perceived by some to fall short of their expectations. One woman who participated in a worksite programme tells how the programme disappointed her:

Researcher: When you went to the programme, what were you expecting?

Woman: I was expecting to be tested for risk factors. They did test ... just verbally, your life style, what you eat and what do you do and do you smoke how much alcohol do you drink or do you have drinks or your past. I guess they fed all this into a computer and the computer describes it as your risk factor and then we got a print out and you are at this level of risk factors, this level and it would help if you did some exercise and changed your diet or so on and that was it, so I wasn't impressed.
During the interview, it was clear that this woman takes considerable pride in her commitment to healthful living — she regularly and thoughtfully prepares nutritious meals and she has a long-standing commitment to active life. She appeared energetic, capable, physically strong and attractive and looked much younger than her stated years. She recalls:

Researcher: They [those implementing the heart-health assessment] thought you should have more exercise?

Woman: Yes, but I didn't like it [the lifestyle assessment].

Researcher: I can imagine you get a fair bit just of exercise gardening [gazing over the extensive garden that the woman maintains herself].

Woman: Well I do.

Researcher: And working. [The woman works as a staff nurse on a busy unit as well as taking full responsibility for maintaining the family home and garden].

Woman: Yes, but actually going out and jogging and all these things I don't like it [jogging]. I don't think I'm fat either [spoken defensively as if it was suggested that she were overweight] . . . Even though they gave me my personal profile, I actually have not changed anything since I went to it [the programme].

Risk factor assessment conducted during a worksite programme did not convince this woman of its worth.

For others, heart-health messages omitted essential areas of concern. As I was leaving the research session with one woman, she raised a health concern. The following is an excerpt from my field notes:

M. pointed out that because she and her children live below the Cambie Street Bridge, carbon monoxide builds up from the cars on the bridge and the fumes come into their home. She said that she had to keep her windows on the bridge side closed and there are no windows on the other side of the apartment. The
fumes are very heavy at times. She said that she would like more information about the health effects of carbon monoxide pollution.

Carbon monoxide pollution was perceived as a potential threat to health by this woman, a threat about which she perceived her knowledge to be inadequate. For others, usual health messages did not acknowledge essential elements of health. A woman in her thirties living in city housing with three dependent children points to the link between health and income:

I think health with a family really depends on the income. You know, there's a lot of mothers out there that I've known that are great mothers but they're on welfare and they're paying seven hundred for rent and they're left, you know, with three hundred dollars for the rest of the month and they are going to have macaroni everyday and they're not eating right. Or luckily, their medication is paid for if they get sick. And then I think the same thing with stress and depression comes out of stress if you can't send your kid to a birthday party because you don't have a present and I think that’s health too. Just mentally, there's a lot with health because if you're not mentally well you get sick and I think the finances [play a big part here].

For this woman, health is more complex, it includes multiple kinds of stress, and depends on many factors, including income.

Heart-health messages which are easily accessible by the public may disseminate useful information and strategies for effecting change, but they may also be confusing, potentially harmful, fall short of expectations, and diverge from their views on health. Participants identified various strategies for dealing with confusion about heart-health messages: accessing up-to-date information, seeking moderation, indecision, and waiting for resolution of the issue to be made public. One woman provides an explanation for why heart-health messages are lacking in usefulness:

[There is] discrepancy between the images and the vision that people have about the messages they're getting and the reality of it exists and that discrepancy, that gap and how to get from an idea where they like to go and where they are right now.
While heart-health messages are perceived to be valuable for many, discrepancies between what is communicated and recipients' perceived lived reality creates difficulties.

Heart-Health Messages: Media and Popular Press Presentations

Participants emphasize the ubiquitous nature of heart-health messages. Hence a review of publicly accessible materials, newspapers, magazines, and diverse professional and lay publications was undertaken to add texture to the participants' assertions. Written materials that are easily accessible to Canadians include tools to, and strategies for, assisting with changing lifestyle behaviours to reduce the risk of heart disease.

The Heart and Stroke Foundation of Canada (HSFC) offers a tool to assist readers with healthful eating. In a flyer entitled "Take the Heart Smart Fat Quiz" readers are encouraged to take a quiz designed to assist them with identifying sources of fat in their diet. The flyer includes information about comprehensive strategies for healthful eating. Canadian Living and Chatelaine, magazines widely read by Canadians, offer heart-health recipes and strategies for healthful eating, strategies for smoking cessation, and ideas for adopting and maintaining an exercise regimen. I reviewed a number of issues of Canadian Living Magazine from 1988-1996 that were available in the local public library and in the homes of friends and family. From this review, articles pertaining to heart health are evident with an emphasis on women and heart health in recent years. For example, an article which appeared in the Canadian Living Magazine in September, 1995 was entitled "The lady killer: For every woman killed by breast cancer, eight die of heart disease or stroke." The author writes:

Many of the risk factors of heart disease apply both to men and women — family history, age, physical inactivity, high blood pressure, smoking, diabetes, obesity, and high cholesterol. In reviewing your risk factors, recognize that a fatalistic attitude
could prove fatal. There is no question that exercise, limiting your fat intake and not smoking cuts your risk of heart disease.

Newspapers were found to feature articles that relate to heart health using such titles as “One man’s struggle to be half the guy he once was” (Vancouver Sun, October 12, 1994) and “Eschewing the fat: A problem for the 90s family” (Globe and Mail, March 18, 1995). Both articles recommend reducing fat in the diet, citing statistics, medical studies, and government declarations in support of their position.

A hospital newsletter also addresses the risk factor issue. In an article entitled “Women and wellness” Dr. Don Ardell, Director of a Wellness Centre in Florida, tackles the smoking and weight issue. He writes “you can, if you need to, LOSE [his caps] pounds with cardiovascular exercise and strength-adding/bone-density building weight training. These activities will speed up your metabolism, thereby defeating biological programming that otherwise adds fat during the middle years.” He concludes, “If you are female and worried about the horrible choice between smoking and weight gain choose neither. Select wellness.”

In summary, heart-health related messages are widely disseminated through diverse channels and are used for disseminating new information and/or strategies for change. Participants perceived these messages in a variety of ways: useful, confusing, potentially harmful, inadequate, or divergent from their views on health. Strategies for dealing with confusion about heart-health messages included indecision, accessing up-to-date information, seeking moderation, and waiting for resolution of the issue to be made public. The gap between participants’ perceptions of everyday life, including the family context, and the messages may be central to the perceived downside of heart-health messages.
Discussion

Heart disease is the leading cause of death in North America (Heart and Stroke Foundation of Canada, 1993). Because of the high social and personal costs of this condition, research dollars have supported research aimed at developing an extensive and body of knowledge about risk factors for heart disease to support preventive approaches (Evans, Barer & Marmor, 1994; Stamler, 1978). At mid-century, numerous extensive epidemiological studies such as the Framingham study (Center, 1966) and the Seven Country Study (Keys, 1980), showed that risk for heart disease increased with high fat intake, sedentary lifestyle, high blood pressure, and smoking (Evans et al., 1994; Stamler, 1978; Winkleby, 1994).

International, intra-national, and extensive animal-experimental work were confirmatory and provided powerful evidence, particularly of the link between diet and heart disease (Evans et al., 1994; Stamler, 1978). Interventions directed at modifying risk factors for cardiovascular disease began using a medical model with a focus on identification and treatment of high risk individuals (Winkleby, 1994).

Primary prevention was the next extension of this approach. Public health models were employed in the 1970s and 1980s to develop community-based risk-reduction with some success as evidenced by risk factor changes (Green & Higgins, 1995; Green & Richard, 1993; Winkleby, 1994). In the 1990s, in response to research identifying social and economic conditions as central determinants of heart health (Evans et al., 1994), the current trend in cardiovascular disease prevention combines approaches that address social and economic factors such as public policy initiatives and community development with more traditional health education approaches to risk reduction (Green et al., 1994; Leupker et al., 1994). Risk factor reduction remains an organizing perspective in evolving approaches to cardiovascular
disease prevention — from medical intervention to community-based public health to health promotion initiatives that address cardiovascular risk factors and related social, economic, and environmental factors (Green & Higgins, 1995). Risk for heart disease is related to diet, sedentary lifestyle, and smoking, a message widely disseminated by the media and health promotion initiatives. Participants’ accounts of receiving such heart-health messages reveal tension between these messages and the perceived lived reality of participants’ everyday lives.

The findings of this study reflect those reported in a study by Lupton and Chapman (1995). Lupton and Chapman investigated media coverage of the diet and cholesterol controversies and the responses of members of the lay public to them, using 12 focus group discussions with 49 adults. Participants in the Lupton and Chapman study expressed concern about diet; however, they also expressed a high degree of cynicism about how the media covered controversies about diet. Further, they expressed discouragement with health promotion advice on diet and cholesterol control.

Like some of the participants in my study, some in the Lupton and Chapman study drew on the knowledge claims of medical and epidemiological researchers to construct their understandings of the issues. Lupton and Chapman found that the participants in their study were critical of professionals for disseminating conflicting messages and critical of the news media’s propensity to use conflict about health issues to attract audiences. Participants in the Lupton and Chapman study coped with the confusion about conflicting messages by holding to the adage ‘everything in moderation’. Another strategy they used to deal with confusing messages was to observe family and friends, a strategy evident in the present study. Lupton and Chapman (1995) concluded that recipients of health messages must negotiate the
meaning that they will accept when health messages are challenged by news reports of dissenting opinion or by personal experiences. Lupton and Chapman's (1995) participants underscore the importance of medical expertise in translating technical knowledge into meaning for personal risk. In light of the discussion of Lupton and Chapman's interpretations, the findings of the present study illustrate how heart-health messages can be disseminated to relieve or exaggerate some of this informational confusion.

In conclusion, findings presented in this chapter capture patterns in the data that relate to participants' perceptions of the impact of heart-health messages supplemented by examples of how heart-health messages are portrayed in the media and popular press. Heart-health messages, it was determined in this study, generally target the individual not the family, yet the family is a context within which effective diffusion of health messages can occur. Although heart-health messages are perceived by participants as useful, they were also portrayed as confusing, potentially harmful to health, inadequate, and divergent from their views on health. When heart-health messages fall short, participants' accounts suggest that the messages fail to address the realities of their everyday lives, that they sometimes conflict with other health-related messages, or that they may even defy common sense. Health promotion initiatives that relieve confusion by providing recipients access to dependable information as well as initiatives such as the community kitchens programme that address health-related issues of everyday life have potential to reduce or relieve discomfort with heart-health messages.

In the next chapter, definitions of family and health and the link between family and health are developed to begin to understand how family, conceptualized as local and contingent, exerts an influence on individual health.
CHAPTER SIX:

HEALTH AND FAMILY DEFINITIONS: VIEWS FROM THE GROUND

Health and family are powerful terms that not only touch the heart of our daily lives but their definitions are central to the determination of policies and practices that govern our daily lives (Fox & Luxton, 1993; Rootman & Raeburn, 1994). Family was understood by some participants in ways that I had not anticipated; for example, one woman in her sixties spoke vividly of the influence of her deceased mother on her current health patterns. Furthermore, early in the research process, it was apparent that participants were making complex links between family and health that turned on a unique view of health. I therefore decided that a comprehensive analysis of health and family was necessary to more fully understand the everyday family influence on the health of the individual. Participants’ definitions of the terms “health” and “family” open this chapter to fully ground the main concepts of the research in participants’ understandings of these key terms.

Participants offer rich, lively, and complex definitions of “health” and “family” and identify key links between the two. These excerpts represent the words of participants who differ in age, socioeconomic circumstances, geographic settings, family types, sexual orientation, and cultural groups. In this chapter, “health” is defined first, followed by “family”. The section concludes by describing how family operates as the interface between the individual and society.
Participants Define Health

Participants’ definitions of health are diverse. They range from short or simple statements to complex and sophisticated theories. Participants from age 7-81 contribute to the definitions of health offered in this section.

An example of a short but powerful statement about health came from a middle-aged woman, “This sounds very cliché but being healthy is … if you don’t have your health obviously you don’t have anything.” Another female participant, a financially strained, married mother of three elaborates:

You need your health to have your energy to raise your family and everyone wants to raise healthy, happy kids, you know, for the future. And they want them not to be insecure and have high self-esteem.

This woman, like others, perceived that what she is able to do for her children now will have future benefits for their health. This view of health as an energized and dynamic state that operates over time is evident the words of another. A woman who recently immigrated to Canada from Iranian. She said:

When I feel healthy I feel like I can do things. I can stay healthy for me and my child, I want to be able to achieve — she’s going through a lot of things, her teenage years, and school. I just want to be strong … I don’t want to have depression ever again or be kind of tired. I want to stay healthy, take care of myself, do my hair and the make-up, go out with my friends and you know drive carefully.

For this woman, health is a state in which she experiences a sense of vitality, one that motivates her to self-care. Staying healthy is important to her so that she can provide care for her daughter as she grows up.
The men in this study also speak of health in terms of energy. When asked what health meant to him, a professional in his thirties, recently married, responds, “For me it means healthy as far as mental attitude and physically feeling well, having an energy level to get through your day and to me it’s a lifestyle.” He, like others, speaks of the multidimensional nature of health, acknowledges that health is related to having energy, and points to the lifestyle dimension of health. Children also view health as related to energy. When asked what it felt like to be healthy, one teenage boy replies simply, “I have more energy.”

For some participants, energy flow, balance and moderation in lifestyle choices, and interpersonal connection are central to healthful living. One married, middle-class couple with two young children offer their theory about health that reflects these ideas. They say:

Man: [laughs] Mmm … I think we have both done a lot of individual thinking in defining what health means and we’ve certainly talked between us about health and everything from diet to exercise to having fun and I think for me personally, my beliefs about health revolve around balance, moderation, and keeping things shaken up.

Woman: Shaken up. [laughs]

Man: Not getting settled into anything, any particular rock or place or belief system. So, I believe in loosening and lightening up. Ill health happens as a result of becoming rigidified. All this energy becomes rigidified.

Researcher: So when you say “balance” what does that mean?

Man: Balance is a balanced diet and that includes everything from a wide variety of vegetables to not excluding sugar and potato chips so there’s a balance. But, also moderation by not having too much of any of those things.

Woman: One thing I would add to the definition of health is again similar to B.’s. I believe in it not being just a physical thing; I really believe in emotional health, physical health, and spiritual health . . . spirit in the old sense of caring for other people.
Like others, these partners view health as a multidimensional state that encompasses the physical, emotional, and spiritual. Energy is not a by-product of health but, rather freeing energy is health-giving. His wife notes that interpersonal connection is healthful. The partners have given considerable thought to the meaning of health. Their notion of the relationship between energy flow and health is one that guides food choices, activity choices, patterns of relating, and assessment of their belief systems.

Health is described as a state experienced in terms of levels. One male participant explains: “I guess that what I mean by the levels of health is, you can have people who are in tip-top shape, in perfect health but are not really alive.” Another man, a member of the homosexual community, observes:

I know people who have such low self-esteem that they have allowed themselves to become infected with HIV and yet they are people visually who would be seen by society and treated by society as very healthy people. People who compensate for such low images of themselves that they’re in the gym four or five days a week so they see themselves as healthy but some of them I have come to know better and I realize that they are very unhappy or very shy socially, they feel inadequate.

In these excerpts, two men allude to the multidimensional nature of health and comment on the complexities of health: an appearance of physical health may mask problems in other dimensions. A single professional man in his early thirties reflects on these same issues:

If I were to say I feel healthy, I guess I am primarily thinking of physical health; no colds, no chronic illnesses, no pain, nothing to worry myself over as far as my body is concerned but I think, upon closer examination, I would include my emotional well being and my psychological well being in my overall notion of being healthy. So, to have two but not all three, I would consider myself to be unhealthy in some way.

This man would consider himself unhealthy if he has difficulties in one of the three dimensions that are important to him.
Other participants identify hierarchies within these dimensions. One young, single mother living on social assistance clearly states that, for her, mental health is foundational. In response to the question “How do you define health?” she replies: “Right now? This week? This month? Mental health, I mean, major priority.” A professional man in his early sixties refers to levels of health and to health as a state that is related to the passage of time. Further, this man points to the notion that health is experienced in a socioeconomic context:

Man: But personally I feel healthy if my back isn’t sore or if things don’t hurt or my throat is not sore. To me personally, on any given day, whether I feel healthy that day or not is an absence of complaints. But, what does health count as a year? What is a healthy year? Or, what is a healthy decade? Then, we get into that more holistic definition of health. Yeah. Because, you know the background thing, of course, that stuff for me. We're comfortable, we have a nice home, we're adequate in money and live with it well and we're not living in fear and this sort of thing. So that background is okay and so that you can sit around and worry about whether or not you've got a sore throat. If you lived in Sarajevo, you really wouldn't give a damn if you had a sore throat or not.

Researcher: So if you had a healthy year what would that have been like?

Man: I guess free from relatively, well number one, good physical health, free from sort of major worries, free from family worries, that there weren't a lot of things pressing down and adequate rest so that I didn't get tired.

Unlike the young woman who identifies mental health as the most salient dimension of health for her, this man evaluates his state of health by noting his physical state. However, his physical state is closely related to the background context within which his life unfolds over time. Therein he experiences health in its fullness. Further, he alludes to the temporal dimension of health by noting that stress and fatigue accumulate over time with an overall effect on his vitality.

Other participants offer thoughtful and poignant personal theories of health that seemed to come from challenging life experience. In response to the question “What is your
personal definition of health?” one man, who had been through many difficult years of
finding a place of comfort for himself in life, replies:

Always for me it seems to come from an emotional basis, a balance between
the mental, spiritual, and physical. And, growth, intellectual growth, that’s the
first thing that comes to mind. When you talk about health I think that so
many of the actions that we take come from a deeper sense of how we look at
ourselves. It’s a balance between spiritual and emotional and physical health. I
don’t think I’m there yet. I have a long way to go. But, I’m experiencing a
sense of health that I have never had in my life in one area and that seems to
be spilling over to the other areas. I’m not the picture of health but it certainly
is relative to where I have been.

This man’s definition includes commonly held views of health, that health is a
multidimensional. For him, unlike those who take a hierarchical view of the dimensions,
balancing these dimensions is an important aspect of health. Further, he points out that the
actions we take come from how we look at ourselves, making the link between agency and
self-perception. The accounts bring to view the notion that self-care, self-esteem, and
positive self-perception relate to health. One woman, echoing the words of others,
underscores this by saying, “Quality mental health is understanding oneself and being able to
communicate that to other people.” For her, self-perception is the first step to mental health.
She points out that agency with regard to interpersonal communication is involved — one
has to be able to communicate self-perception to others. This woman links the notion of self-
perception and agency. Yet another, a single parent with two school-aged children living on
a meagre income, describes her transition to more healthful living in the following passage:

I was living like a really unfulfilling life, drinking, doing a lot of drugs, doing
a lot of coke, really negative, negative life and had these two beautiful babies
and trying to do this single parent thing and falling into this really seedy
lifestyle and feeling really empty and being promiscuous. It was a dark period
in my life and, you know, you can only fill your life with so much darkness
and then you’ve got to wake up. You crave for lightness in your life. Then my
priorities started to change. And I stopped drinking all the time and stopped
doing drugs completely, stopped smoking and went and bought myself a bicycle. I started to create a nicer home, started to be a better mother . . . So things like that changed in my life. I had more power when I changed my priorities. More insight because I saw beyond myself. I wasn’t as self-involved. I need to have harmony and I need to have balance. That’s suddenly become more clear.

Harmony, balance, and understanding oneself are essential to healthful living according to these thoughtful participants. Further, taking appropriate action based on these insights is perceived to be foundational to health. Analysis of these accounts suggest that at the core of health is agency arising from sense of self-esteem and positive self-perception. One man said “Many times you’ll resist healthful changes when you have a belief that you’re not worthy . . .” Thus, for the purpose of this study, health agency is the capacity to take action on behalf of one’s best interest that arises from a sense of self-worth. (See Appendix G for definitions of health agency and self-worth.)

Not all participants found it easy to speak of health however. One woman, who works full-time and is married with three children under age six, made the following response when asked, “What is it like to feel healthy?”:

I’ve never thought of “I feel healthy.” It’s either you feel tired or you don’t feel tired. I’ve never said, “Oh I feel healthy today,” I wouldn’t even know where to start with that one.

Perhaps, for her, reflecting on health is a luxury she can’t afford. A single mother coping with the aftermath of breast cancer treatment and living meagrely with two early teens, views health in the following way:

Gee, I just can’t answer that. Isn’t that amazing? I don’t know. I’m not grasping what health is, being healthy? [pause] Being fit? Is there more?

While most participants openly discussed their views on health, not all found it an easy term to define. Some participants offered well thought-through definitions of, or
personal theories about health. Health emerged as an energized, balanced or hierarchically-ordered, dynamic, multidimensional state that is related to lifestyle. The dimensions of health include the physical, emotional, mental, and spiritual. At the core of health is the capacity to take action on behalf of one's best interest that arises from a sense of self-worth. Health agency is the term selected to refer to this process. (See Appendix G). In the next section, participants' views on family are presented.

Participants Define Family

Participants speak of family as a collection of those connected by blood relation, legal bond or life circumstances, and/or those who share daily life, obligations, life history, similar interests, and/or caring, love, and mutual commitment. When asked, "Who do you consider family?" a married couple, both over 50 and in their second marriage, offered a description that echoed that of others. Family, for them, includes those related biologically, legally, and through friendship therein incorporating all those with whom a specific kind of emotional bond has been established. In this quote, you will notice that the death of a key family figure, the grandfather, lead these partners to identify another in their social circle to fill assume the role of grandfather.

Woman: Oh, it's my biological family, and my husband's children and his sister and his sister-in-law. We adopted a grandfather because my dad just died and my husband's father died long ago. We adopted my husband's first wife's uncle as a grandfather for our daughter and I consider him family. And my pals from my single days... the bunch of women are coming over tomorrow for lunch... they’re my family too. We’re very close, we look after each other psychologically and physically they look after me. S., my daughter, says "I have two mothers, a birth mother and my real mother."

Researcher: What does the grandpa do that makes him family?

Woman: I care about him and he cares about us... and he has wisdom and age.
Man: We did this for the child to see an extended family. Our parents were dead and there was not much vertical family, lots of lateral extended family but not much vertical family and so that basically was the idea of enrolling grandpa.

Woman: We looked around really hard and it didn’t matter to us how he was involved biologically.

Researcher [To the man]: Who do you consider family?

Man: My immediate family, of course. My wife and child, my kids from my first marriage, my sister, her husband, my sister-in-law and her kids, my late brother's widow, my wife's grandma, sister and brother and our adopted grandpa, cousins that I rarely see but one has become a close friend of my wife’s, although I haven't actually laid eyes on her for twenty-five years... but she’s a teacher she shows such an interest in our daughter.

Woman: But she has become a close friend of mine, we’ve talked on the phone but not met. She’s taken a great interest in our daughter.

Man: So, she is family. And then I have cousins around here and an aunt who I rarely see and I guess I would be hard pressed to say if they are family or not.

Family for this couple is richly varied and extensive. It includes those related by blood or legal marital bond, long-time friends, and a loosely-related uncle who they adopted as grandfather. The grandfather they adopted is not related biologically but connected through love and caring. As well, he brings wisdom and age to the family unit. From the man’s description above, the way he thinks about who is in his family has changed with the passage of time. For this couple, as for others, there is some uncertainty as to who counts as family. Uncertainly about who is family is evident in the words of a nine-year-old boy. When asked “Who is part of your family” he replies:

Boy: Everybody in Nova Scotia that's in my family and my mom and my brother and my cousin and my other brother but my other brother is actually not really my brother but he is my brother but we just have different moms and dads.
Researcher: So he’s your step brother and so that’s all your family, your mom and your dad —

Boy: Well, my dad’s not really family . . . well he is our family. I go to his place every weekend and some Wednesdays.

This boy is not certain whether or not his father counts as family. In addition to uncertainty about who counts as family, some participants do not agree with other family members on who counts as family. The following is a quote from the research session with a white middle-class family of six. The mother begins with her description, the father follows with a slightly different description, an eight-year-old son pipes in with his view, and the 16-year-old daughter closes with her definition:

Woman: Well, my children and my husband are my family. We’re quite close to our extended family but I really feel that it’s my children and my husband that we’re family.

Man: Well, J.[his wife] and the children in the first instance. We’re very close to J.’s family and to my father and to a lesser extent the rest of my family but this will be the main family in my life.

School-aged son: Well, like my grandpa on my dad’s side and then my mom’s sisters and her mom and dad and then the people in this house.

Woman: Phew this is a good week!

Teenage daughter: I think of everybody as my family here and like grandpa, grandma, uncles and cousins and in a way friends that I’ve had for a long time because I have had most of my friends since grade three . . . about four friends.

The woman and her husband are similar in their views of who is family for them, family is primarily those who comprise the household. The man tentatively extends his definition to encompass select kin. The daughter, like the woman in the first excerpt, includes long-time friends as family. These family members, like other participants, do not share the same perception of who is family.
I tried to understand more about what it means when family is not defined as those who share a household. One man, a young, professional, married man without children, articulates this. Here, he speaks of connection as the bond that holds kin together when the family unit breaks up because of divorce:

Man: I think that if a family breaks up I don’t give up on that family. I’m from divorced parents but I still feel a sense of family connection with my father and my mother even though they haven’t been married for twenty-eight years there’s still a family amongst myself and my two brothers and my father and mother so I still feel connected in some way.

Researcher: What do you mean by connected?

Man: That we're still a family like I still describe myself, my two brothers and my father and mother as a family even though my father and mother don't live together anymore.

Researcher: So you're connected as a family

Man: Em, em. And through the kids, my parents get along but they don't really have anything to do with each other. But even within the breakup of a family, that kind of family respect that I believe in didn't leave.

Researcher: What do you attribute that to?

Man: Reasonableness. I think that both my mum and dad realized that because there were three kids involved everything had to be reasonable in the breakup that it was reasonable that my mum keep the kids, that it was reasonable that dad was still involved. Two of us, actually all three of us, went to live with my dad afterwards when I was at university. Both parents are very close with their families. P. [his wife] and I have talked about this before it amazes me how broken up some families are.

Researcher: Broken up meaning

Man: Well like my driver at work, he hasn't talked to his brother in like nineteen years, he lives in the same city, I can't imagine that. It’s just so sad if you can't count on your family, it’s your people, who can you count on?
In addition to biological relation, this man attributes specific interpersonal qualities—respect, fair treatment, and dependability—as those that are meaningful to him in his construction of who is family.

Like the teenage girl and woman quoted earlier, another participant includes friends among those he considers family. Further, he speaks to the downside of defining family only as those who are related by blood or by co-habitation. This homosexual father who lives with his teenage son speaks of two kinds of family in a way that captures some of what other participants allude to. When asked who he considers family, this man replies:

Man: Oh that's very interesting, that is a very interesting topic because I've come full circle on that issue in that the degree by which you allow yourself to think that you are a different sense of family. In terms of, I think we are always family in terms of our own [kin]. When you say family I really resent my ex-wife telling my children we're no longer family and dad's home and my home and we're not a family and from children's point of view, from the couple's point of view as adults no, we're not a family, um, but with the children's point of view I think that saying that to a child is very wrong because then there's a sense of them leaving their accessible love. So many times when those conflicts come out men tend to retreat from that. I know a lot of men who have lost contact with their children both who are divorced. It just seems that it's easier when there's conflict to retreat but I don't know if I'm on track with your question.

Here, he raises the possibility of thinking about family in a different way. He explains that his former wife holds to the sense of family as those who share a household and this definition he perceives is a potential barrier to children's access to his love. Herein, he raises the issue of family as an abstraction that has to do with emotional connection. He goes on:

Researcher: Well, who would you consider in your family right now for yourself?

Man: Yeah my three children and my brothers and their wives—that's one sense of family. But I also have the sense of another [family], of people that I have a sense of tribal family [with] and these are other men and women that I
have a sense of family with as well. A true sense of feeling love and a sense of caring.

Researcher: And how many people would that be, just a rough estimate.

Man: [laughing] I'm laughing at that. No I've had a very unusual experience because I've got from a place in my life, of being cut off from people to a place of feeling very loved by very many and its really a nice feeling.

Researcher: It must be.

Man: What it has allowed me [to do] was to know who I am. Its not a gender-specific item, its not an orientation-specific item, this whole concept of "I need to more of who I am as a person" not necessarily "who I am sexually." I think that whole issue allowed me to just be more. Yet how many would you say that is? [referring to his tribal family] One, two, three, four, at least comes to mind.

Researcher: Is that adults and children or mostly adults?

Man: Oh isn't that interesting, well I'm not including one or two children in there too, yeah.

Researcher: So it is a kind of extended family

Man: Yeah.

Researcher: ... not related by blood. But rather by connected in some other way.

Man: By experience. And I feel very grateful for that because I had just a sense of isolation.

Like the family who adopted a grandfather, this man turns to others to build a family that meets his needs for a sense of family. His friends, through their love and caring, and through shared experience, have broken his isolation and contributed in some way to his sense of self. He speaks of family in two ways. In the first sense of family, he includes children, siblings, and their wives — people who are kin but not necessarily those who live with him. In addition, he speaks of tribal family which is a sense of family that he experiences with friends with whom he has a feeling of love and caring. Family, for him as for other participants,
includes kin who live in the same household as well as kin and friends who do not. Family, for him as for others, is an abstraction that is an interpersonal experience of connection that breaks the feeling of isolation and contributes to a sense that he is loved and valued, a sense of self-worth.

One participant captures the sense of family as an interpersonal connection that contributes to a sense of connection and self-worth:

Man: [A comfortable feeling in family] isn't easy because we're all diverse beings, you know, we've all got different comfort levels in all kinds of different areas and I think that the families that seem to be together and have that nice glow to them as a family somehow found that style that works for them and you can almost pick them out.

Researcher: What is it that you're picking out, just to work on that term, glow, are there other terms, other words?

Man: I just see it in the way that they tend to relate to each other in everyday situations . . . . There's a respect, there's a preference, it looks like there's a care for what the other person really thinks or feels rather than how it affects you and sometimes you meet families that are like that, you get that feeling from them that they really have a lot of respect and care for the other, the other members of that family.

Researcher: What does that respect do for each person?

Man: They feel good about themselves, you know it creates an atmosphere where they can feel good about themselves and almost everything starts from the heart. The more that you believe that you're okay, the more you're going to let other people know that they're okay. And without believing you're okay, you're going to let others know they're not okay and so they're not going to feel like they're okay and it creates a big [societal] decay. It starts from that.

According to this man, families in which respect and care for other members is expressed in everyday actions create an environment in which members feel good about themselves. For him, this translates into individual expressions outside the family that benefit society.
Family is characterized by participants as an individually identified group — those connected by blood relation, legal bond or life circumstances and who may or may not share a home, obligations, life experience, and love, and caring — a dynamic group and one that changes over time. Some participants expressed uncertainty about who was considered family and in some families not all members had the same perception of who was part of the family. Family is constructed by participants as kin and/or, housemates, and/or an abstraction that relates to emotional connection characterized by respect, love, and caring that contributes to a sense of self-worth. In the next section, participants’ accounts of the link between family and health are presented. (See Appendix G.)

Participants Connect Health and Family

Family, it is concluded, is constructed by participants as kin and/or housemates and/or an abstraction that relates to emotional connection and valuing that contributes to a sense of self-worth. Health, as described by participants, emerges as an energized, balanced or hierarchically-ordered, dynamic, state with multiple dimensions at the core of which is agency arising from a sense of self-worth. Several participants emphasized the link between family and individual health.

One middle-aged woman with severe fibromyalgia reports on how the link between family and health operates in her life:

When the family is working I have better health. Definitely. My fibromyalgia is a bellwether of whether there’s healthy communications and healthy family working or not because I am definitely much tireder when it’s not working or when we are not communicating. I know my daughter is also affected because she doesn’t sleep well when we’re not communicating well or when the family is not healthy.
Family functioning and communication patterns appear to contribute to the physical health of this woman and her daughter.

Evidence that family influences emotional, mental, spiritual, and social health was expressed by other participants. When asked for her thoughts on the link between families and health, one female participant, recently divorced, on social assistance, and raising four children under six offers a moving example of how her poor marital relationship had a severely negative affect on her mental health. This woman recalls that eighteen months before the interview she was almost incapable of carrying out the most basic tasks because of a depression which she attributes to the presence of her abusive husband. She remembers what it was like for her before her husband left the family, “He was so abusive, I was so depressed I could hardly get off the couch to get a meal for the family.” Now that she is separated from her husband she is no longer depressed. Rather, she reports that she has a very active life, caring fully for her children, advancing her education, working out several times a week, and participating in the community kitchens programme.

In another family, a number of family members have recently experienced compromised health. Family members who participated in the family interview included the mother (a woman in her mid-thirties) and two daughters (one 11 and one 14). The 14 year-old was frail, thin, and bent over. She has with a negative attitude about almost everything but animals, her mother, and her siblings. One year earlier, she was treated for pneumonia which left her with what she believed was a chronic fatigue situation. At the time of the interview, she is in treatment for depression. She reports that she performing poorly in school both academically and socially. Not only does this teenager have health problems but other
members of the family struggle with physical and emotional difficulties, particularly the mother.

The family described below is living comfortably in a rural town because of the husband/father’s work in a resource-based industry, a job which takes him away from home often. The woman was married at eighteen and had four children in rapid succession. During the interview the woman reveals that she is in an unhappy marriage and suffers from a prolonged depression which is beginning to lift. She reports that she feels trapped — while she is financially comfortable, she is isolated and overwhelmed. She attributes this to living far from friends and family and having to cope with her children on her own most of the time.

The following is an excerpt taken from an interview with this woman and her two teenage daughters. During the interview, the two younger children play raucously in the background. The husband/father was out of town. Here, the mother describes the various physical ailments family members have experienced.

Researcher: I’m interested in how people stay healthy, maybe to start the interview we can brainstorm ways that you stay healthy in the family.

T. [14 year-old daughter]: I don’t, I’ve missed too much school.

Woman: Well, she has. Actually our whole family has been sick more this year than EVER. I don’t know if it’s all these new viruses or living here.

T.: It’s called sick of living here.

Woman: T. had pneumonia this spring and she’s never, ever had anything like that, and my little guy had to have his tonsils out, and I’ve got allergies now from where I don’t know and G. my third one has asthma, not bad, but enough that she went on medication. And I may have to have my gallbladder out . . . which is shocking . . .
The fourteen-year-old daughter makes the link between illness in the family and their
geographic location and living situation. Later in the interview, the woman talks about her
prolonged depression and how her emotions have affected her daughter.

Researcher: [Later in the interview] We don’t know much about the link
between families and health. What is your view?

Woman: Well I can say for myself, I have mainly suffered from depression. I started having kids when I was 19, four kids all through the ‘80s. I was just having kids on my own basically since my husband was out in the bush and I think my being stressed especially for my oldest T. [the fourteen-year-old daughter]. It was hard on her in the early years and you know I sort of blame myself sometimes for the problems she has now ... well... you see... my brother died two weeks before I had her and I think what happened with me not being in a really great relationship [her marriage] at the time, we’re still together but I took everything and put it into her, I spoiled her ... there was a lot of anxiety and grieving that really affected her. I haven’t had any real problems with her. It’s just the emotional roller coaster living with her sometimes but we’ll get through it won’t we T.

T. : I want to move out of here and we can get through it on the phone.

Researcher: And how does this affect the other children?

S. [11 year-old-daughter speaking to T.]: You get all the attention when you’re sick.

Later in the interview, the two oldest daughters express how they perceive their father’s role
in the family and the eldest daughter describes how she is verbally abused by him. Both girls
dislike, mistrust, and feel neglected by him. Several times during my visit to their home, they urged their mother to leave him.

Researcher: [Later in the interview.] So how does Dad fit into this?

T.: Dad doesn’t ... he doesn’t even want us.

Woman: It’s been a real issue in this family. It’s hard for him because basically he’s not here. But, he doesn’t take an active part in being a parent. He’s never really been there. When the kids were born ... The whole process ... It’s been really hard. I don’t want to say too much in front of these guys.
T.: [Referring to her father.] I hate you, I hate you, I hate you . . .

T.: [Later in the interview — to her mother.] I really think we should just leave, you want to leave and we want to leave.

Woman: [Later in the interview.] I worry about what their relationship is with their dad. That’s one of my big concerns. How many kids can sit there and say ‘leave dad’. They love him. He’s not mean to them.

S.: Yeah, right . . . [cynical tone]

T.: He comes up to me and he goes, you’re so ugly, you’re such a loser, and, you know, what is that doing to my self-esteem, why should I respect him? He doesn’t respect me.

In this family, some members perceive that the father/husband treats them as he sees fit, not as they would like to be treated. Several family members report difficulties physically, mentally, emotionally, and/or socially — particularly the mother and her 14-year-old daughter. This family exists as a structural unit but the sense of family as caring and respectful is disrupted for at least two of the four children when their father comes home. Breaking up the family as a structural unit is perceived as the most tenable solution by two of the children. This family exemplifies the interactive relationship between family health and individual health. Family dynamics do not support the health of members, especially the 14-year-old daughter, whose compromised health has a negative influence on family dynamics. The daughter has difficulty convincing her father of her self-worth and she experiences compromised health. This reinforces what others say about interpersonal relationships, individual sense of self-worth, and health.

Professionals with two children under seven, have given considerable thought to family dynamics that support individual health. For them, interacting with their children in a respectful and egalitarian family relationship fosters open expression within the family which
strengthens individuals. They believe that this keeps energy flowing which is essential to health.

Woman: If we are able to treat each other with respect then the kids can feel more confident to say what they have to say and they have more a sense that their experience is valid.

Man: Break that hierarchy of powerlessness that we’ve all been indoctrinated in and make them feel that they have some sense of strength and power too.

Woman: Talking in the family is another way of keeping that energy flowing and if that energy is allowed to flow it promotes an open flow for every individual, that’s what creates a healthy individual.

In contrast to the previous family, both parents have given thought to what family dynamics can contribute to the health of family members. The principle that they live by is that treating their children with respect, listening to them, validating their children’s experience, and talking openly are family dynamics that contribute to individual health. They reinforce what others say about the centrality of self-worth and open communication to the health experience.

Several families point to the impact of the ill health of one member on the family. An example of how an individual family member’s physical health affects family dynamics to the detriment of the health of others and the functioning of the family is apparent in the following excerpt. One woman, who lived for many years on a low income as a single parent with two boys, recalls what it was like for her when there was illness in her family:

Woman: When my son was young I used to spend many, many nights in the hospital. I remember many a day leaving there crying because I didn’t know where I was going to get the money. I worked the night shift as a waitress. They said, “OK, now you can go to the hospital.” But I had to find someone to look after my other boy, find bus fare to get to the hospital. Then, you’re all stressed out because you have to come up with money for the bus and medications, take time off work, then getting sick myself because I worry so much about them, then you’re up all night with a sick kid but you still have to
go to work so then you get run down and everything comes to a screaming halt.

Researcher: What do you mean everything comes to a “screaming halt” when mom gets run down?

Woman: Because then the dishes pile up and the laundry piles up and you don’t want to cook for your kids. When mom is sick and you’re throwing up and you’ve got to cook and clean and make sure they have clothes to go to school the next day, go out to the store and buy lunches and make their lunches, make sure their homework is done. Just everyday being a mom is really busy. There’s a million little jobs. And so when mom gets sick. We can’t get sick. We have to crawl on our hands and knees and throw stuff in the dryer. We can’t stop because if you stop . . . [children interrupt]

This woman points to a vicious cycle: a family member is ill, the illness is stressful for the primary caregiver (in this case the mother), the stress negatively affects the health of the primary caregiver who has difficulty seeing to the everyday needs of all family members. The functioning of the family unit is thereby compromised.

Participants’ accounts suggest that there is a link between respect and caring in the family and the self-worth that supports health. Open communication in the family fosters self-worth. On the other hand, disrupted communication characterized by devaluing or abuse contributes to compromised health. Further, when one member experiences disruptions to his or her health, smooth family functioning is affected. The link between families and individual health takes shape as an interactive process that plays a role in the individual health experience.

Participants Connect Individual, Family, and Society

Participants emphasize the link between individual, family, health, and society. One couple, parents of two school-age children who live on a modest income in a small city, seem
to use the interview as a way of taking a political stand on the role of family in society. Their view is that the government should institute policies that strengthen and support the family unit.

Researcher: Do you have any thoughts or reflections before we finish today?

Man: We really feel that the family unit is the core of our society.

Woman: Yes.

Man: The health of the family determines the health of our society both physically as well as mentally, emotionally because if you have strong, stable families, we're going to have strong healthy communities, but if the family unit is not healthy, physically, mentally, emotionally whatever, and we have a lot of dysfunctional families, we'll have a dysfunctional society and we're seeing it already and so for us in order to have a healthy society, we've got to have healthy families. That's where it's got to start.

Researcher: Do you see this more than just parenting or being a couple?

Man: There's a lot of single mothers out there that are wonderful single mothers but as a family you still need to have a father and a mother because a lot of what children model is what they see at home and you can be the best mother in the world but if you have a son at a certain point he needs to have a male role model. It might be a teacher or whatever and that helps but it's not the same as having a father to model. So, I think that it's very important to teach people how to stay together and also how to work together in their marriage so that it will work out.

Woman: And can I add one more thing? This is probably really radical. I also feel that the government should not put money into day care, they should put money into having one of the parents stay home because nobody is going to love that child as much as a parent. Nobody is going to give that child as much care as a parent and even if the government put the money into paying a grandparent that's still better than an insensitive day care worker who has fifteen other kids to look after. I feel so strongly about this. It's very frustrating for me when I see on the TV these people that say, "we need more money for day cares." No, we don't, we need more money to acknowledge or support at-home parenting.

Man: Yeah, if we can use that money to help a parent stay at home that would be money better spent.
This man uses the term health to refer to families, communities, and society. For him strong families are foundational for a healthy society. He is not alone in his views. Here, an excerpt included earlier is expanded to illustrate this view from the perspective of another participant:

Researcher: What does that respect [in a family] do for a person?

Man: They feel good about themselves, you know it creates an atmosphere where they can feel good about themselves and almost everything starts from the heart. The more that you believe that you're okay, the more you're going to let other people know that they're okay. And without believing you're okay, you're going to let others know they're not okay and so they're not going to feel like they're okay and it creates a big decay. It starts from that.

This participant theorizes that feeling good about oneself enables one to be compassionate to others. He also believes that an absence of feeling for others contributes to moral decay.

Researcher: Decay of?

Man: Decay of morals, decay of, philanthropic belief that you should help other people that you should make things good for other people. It all comes from that, believing that you're okay . . . I think that if you look at communities where the crime level is very high, where poor health, where drug use is very high, you'll find it comes back to that, that basic how were people made to feel when they were new people in families.

Researcher: So you're making a link between families and society and health.

Man: Oh yeah, very much so. I think that the individual family unit has a huge effect on the way the whole society is. If a family can't survive and prosper as a family, I can't imagine how a community can. All those lessons that you take to the community are in a sense lessons you learned first right here, you know, in your homes. If there's no respect for people's well being at home you can never take it out into the wider society.

Reiterating the view of the man highlighted earlier, this one identifies the family unit as the basic social unit of society and for him, how individuals are treated in families as children determines how these children will function in society. According to many participants,
family is central to individual health and to the capacity of individual members to contribute to society.

Discussion

In this chapter, health and family are defined from the perspective of participants. Early data analysis revealed that participants’ definitions of these concepts and the links between them had potential to shed new light on their meaning of these concepts. Thus, to gain a better understanding of family influence on individual health, it was decided that defining family and health from the perspective of participants would strengthen the analysis. Here, I compare participants’ conceptualizations of family and health with those in the scholarly literature.

Health

Definitions of health abound. They are derived from medicine, nursing, psychology, anthropology, sociology, politics, holism, and lay perspectives (Rootman & Raeburn, 1994). Lay perspectives on health are diverse, ranging from popular Western definitions that reflect the medical perspective — health as the absence of disease — to a perspective evident in many non-Western cultures — health as living in harmony with nature (Calnan, 1987; Spector, 1985). Despite this diversity, participants’ definitions of health reflect ideas expressed in the World Health Organization’s 1947 definition of health. Here, health is defined as a state of complete physical, mental, and social well-being, not merely the absence of disease and infirmity (Rootman & Raeburn, 1994). Participants’ definitions of health are consistent with the Ottawa Charter definition of health that expands on the 1947 WHO definition, “Health is . . . a resource for everyday living, not the objective of living” (Ottawa
Charter for Health Promotion, 1986, p. 426). Participants’ words add texture to these definitions by defining health as an energized and valued state, with a temporal dimension, a spiritual dimension, and complexity with regard to its multidimensional nature. Participants suggest that at the core of health is self-worth.

A systematic review of 112 qualitative studies that was conducted to develop theory regarding an individual’s experience of health and disease was revealing (Jensen & Allen, 1994). Themes identified resonate with those evident in this study. Studies reviewed in this systematic review used grounded theory, phenomenology, and ethnography, and involved informants with disease or chronic illness as well as those who considered themselves to be “healthy”. In this systematic review, participants ranged in age from early adulthood to the very old, a similar age range to those identified in this present study. In this present study, however, the age range of participants contributing to the health definition is considerably broader, 7 to 81. In the systematic review, the authors identified the following themes to describe the lived experience of health and disease: abiding vitality, transitional harmony, rhythmical connectedness, unfolding fulfilment, and active optimism. Abiding vitality — the idea that when one is healthy there is sparkle and animation — is similar to the notion in this study of health as an energized state. Transitional harmony refers to the idea that when healthy one has a sense of harmony and balance, a notion appearing in participants’ definitions of health in this study. Some participants in this study would agree that health is experienced when all dimensions are balanced, whereas others suggest that health in one specific dimension is a necessary condition for health in the other dimensions. Rhythmical connectedness refers to the idea that, when healthy, one experiences wholeness and an accompanying attachment to the world and that these social connections provide a positive
sense of personal contribution or effectiveness, as well as positive identity. Converging on several aspects of participant’s definitions of health, this theme reflects participants’ views that emotional connection is part of health and that self-worth that is fostered in the family context is related to this.

While participants’ definitions of health reflect those evident in the systematic review, defining health in the context of a discussion about families and heart-health perhaps highlights certain aspects of health. For example, their definitions of health brought to light the complexities of the multidimensional nature of health. Sometimes one dimension, such as physical or mental health, appears to dominate while at other times there is a need for balance between all dimensions. Why this is so is not clear and would be a good question for future inquiry.

Participants’ health definitions apparent in this study are consistent with the scholarly literature. However, comparing their definitions of health with others raises at least three concerns: under what circumstances does one dimension of health take priority attention; whether self-worth will emerge as central to health in other study contexts; and how family fosters self-worth in a way that supports health?

**Family**

Common definitions of “family” derive from scholarly work in sociology, anthropology, and family studies. Historically, family has been defined in terms of structure and function (Fox & Luxton, 1993; Gilliss, Highley, Roberts & Martinson, 1989). Understanding “family” is increasingly challenging as the diversity of family types and patterns of living change (Fox & Luxton, 1993; Klein & White, 1996; Levin, 1993). Scholars
suggest that family can be conceptualized as a concrete group, a social institution, a
construction linked to the ideology of motherhood, a set of social ties, or a way of describing
our social relationships (Fox & Luxton, 1993; Gubrium & Holstein, 1990; Holstein &
Gubrium, 1994; Klein & White, 1996). Participants, who represented considerable diversity,
defined family as kin and/or housemates and/or an abstraction that relates to emotional
connection characterized by respect, love, and caring that contributes to a sense of self-worth.
Thus, the scholarly literature and participants’ definitions are similar.

Fox and Luxton (1993), Canadian sociologists, reflecting on the conceptualization of
family, conclude that too much emphasis has been placed on the family as a social unit that
meets the daily needs of adults and children. They suggest that the emotional connection that
ties people together across generations and between households is missing from definitions of
family. Participants refer to this emotional connection as a “sense of family”. Like this
study’s participants, Gubrium and Buckholdt (1982) speak of the term family to convey the
idea of a set of relationships that are characterized as trusting and giving. Beutler, Burr,
Butler, Bahr, and Herrin (1989), family scientists, speak of family members as those who
care about one another as whole persons. Participants point out that individual health affects
family health, a link demonstrated elsewhere (Hayes, 1992).

Participants note that individual health, family, and society are interconnected. There
is a need for research investigating the link between family dynamics, their interaction with
social networks, and health and illness responses (Cardwell, 1993; Kenneth, 1989).
Wilkinson (1993) identifies the need for research that investigates non-dominant social or
ethnic groups and the forces that sustain them in an era of continuous change and economic
stress.
Participants contribute to an understanding of health and family by offering definitions of these terms that bring into focus the following themes: self-worth is at the core of health; family in the "sense of family" is important to health; and individual health, family, and society are interconnected. In the next chapter, a grounded theory is presented that builds on these definitions and links.
CHAPTER SEVEN

FAMILY INFLUENCE ON INDIVIDUAL HEALTH-RELATED DECISIONS:

TELLING THE STORY

In Chapter Five, participants speak of the impact of heart-health messages from their view as recipients. Heart-health messages were perceived by them as useful, but also problematic. When perceived to be inadequate, these messages were inconsistent, confusing or incongruent with the lived reality of recipients’ daily lives. Chapters Six and Seven explore the lived reality of responding to heart-health messages with a specific focus on family influences. Chapter Six opens with participants’ definitions of health and family. Participants’ definitions of health are congruent with but augment the WHO (1947) and Ottawa Charter for Health Promotion (Ottawa Charter for Health Promotion, 1986, p. 426) definitions of health. Participants emphasize the centrality of self-worth to health and health agency and identify family as an important context for health. (See Appendix G).

Participants’ accounts suggest that there is a link between respect, caring, and communication in the family and the self-worth that contributes to health. Further, participants articulate a link between individual health, family, and society. Now in Chapter Seven, these ideas are more fully developed. The chapter opens with a description of family climate and its two dimensions, stress or comfort, family factors that affect the individual health experience. Then, two family strategies, talking and modelling, are presented. Conclusions are drawn as to how these concepts are linked to participants’ reflections on health and health agency as it pertains to the experience of constructing health-related decisions to support heart health.

(See Appendix G for ‘Definitions of key terms’.)
Family Climate: An Overview

Participants’ stories and my observations left me with the sense that there was an ambience in the family constitutive of individual health. During research sessions, a line of questioning on “What is family health?” allowed me to develop this concept. Data were analyzed at the family level. Responses seemed to fit into two categories which I eventually called family health-giving processes and family health-depleting processes. However, some characteristics could be placed under family health-giving processes or under family health-depleting processes depending on the context. Togetherness is an example of such an item. Togetherness was described as health giving, but for women in particular, too much togetherness could be health-depleting. I identified another category of concepts that were contextually dependent and called it contextually-dependent family health processes. An entry dated April 17, 1996 in my theoretical memos is revealing: “Respect, trust, and caring (and maybe togetherness) seem to cluster frequently. All appear to operate to reduce or limit individual stress.” This new category raised new questions. How did this thing I had named family ambience operate? What should it be called? How could its complexities be captured? A family visit toward the end of the study helped me name the idea. During this family visit, I explored these questions in an interchange in which we were discussing how the family resolved conflict. The body language and words of the two teenagers suggested that problem-solving was experienced differently for the son and daughter. Now, I began to think of family ambience as something that was experienced differently by different members of the family. This insight combined with the awareness that perceived family ambience relates to context lead me to develop a metaphor — family ambience is like the weather, ever-present, changing, and perceived variously. I selected the term family climate as the theoretical code
since it metaphorically captured the meaning that participants’ input suggested to me.

Selected participants validated the appropriateness of the term.

Now, I had to name the three conditions of family climate that were identified. Close examination of participants’ words revealed that frequently “comfort” and “stress” were terms used to describe the feeling in their families. In-depth discussions with some participants about what these conditions should be named lead to the selection of family comfort and family stress as theoretical codes for family health-giving and family health-depleting processes. Next was the task of naming the working category “contextually-dependent health processes.” Re-examination of the data revealed that family climates of comfort and stress had qualities that were interpersonal, for example respect, and those that were contextual, for example, time and money. Then, relational and contextual became two elements of family stress and comfort. As I re-examined the data, I felt that something was missing in my analysis. In the data, there was a particular kind of stress that involved abuse that was extremely detrimental to individual health — the term perpetrated stress was coined as another element of family stress. In the first section of this chapter, family climate, family comfort, family stress, and perpetrated stress and their related elements are developed.

Family climate is a family ambience that is one of stress or comfort. Family climate is palpable family ambience, a “glow” characterized by such qualities as trust, respect, and caring or “chaos” characterized by such factors as time pressures or unpredictability. Family climates of stress or comfort are fluid conditions, not binary opposites, experienced in disparate ways by family members. One family exemplified this. This family included middle-aged parents who immigrated to Canada from India twenty years ago, the woman’s 81
year-old mother, two teenagers, and an 8-year-old boy. The responses of the teenage son and teenage daughter differed. Turning to my field notes:

What struck me was that family dynamics are not experienced in the same way for all family members. When asked the family how they solved problems, the son replied "we talk about it" and his teenage sister, who was older, contradicted him saying "We don't [solve problems]." Throughout the interview the daughter's body language communicated tension and a certain amount of withdrawal from the family unit. Her teenage brother, on the other hand, was very relaxed and forthcoming. So, the two teenagers, although they're part of the same family, appear to have somewhat different perceptions. I wonder if this is due to gender, personality, or formative experiences.

In another family, the parents took the position that they value open and egalitarian communications in their family; however, this style was not apparent in their communications with their 7-year-old son. Interactions with him in my presence did not foster openness. The child's parents, seemingly in his best interests, frequently corrected responses or spoke on his behalf. Eventually the child withdrew from the conversation. When the interactions with him began during the research session, he was standing on a huge leather chair, the back of which was facing us. As the conversation progressed, his comments were repeatedly corrected or interrupted by his parents. Ever so slowly, he slid down until eventually he was in a crouching position on the chair — silent with eyes peering at us over the headrest. The open interplay of exchanges between the husband and wife was not apparent in their interactions with their son. I wondered if his experience of open communication in the family was different from that of his parents.

Contextual comfort operates similarly. Its effects contribute to individual health but this may not be the same for all family members. While I was visiting one particularly oppressed woman, her former husband came to the door. He was well dressed and healthy
looking. Stirred by this image, I reflected on marriage breakdown and women’s poverty. Are some women left in poverty while their former husbands and the fathers of their children are financially comfortable? I spoke with the women in the study who were single mothers living on social assistance and they confirmed that this was the case. Most female, single parents in this study received no, or minimal and/or unpredictable financial support from their children’s father. One participant claimed that she had never received financial support for her 7-year-old child from the child’s father. She pointed out that because the child’s father was abusive, she stays away from him and she will not reveal to him where she and her child live out of a concern for their safety. According to this woman, she knows from friends and family that he is currently living in comfortable financial circumstances with a new family. In another situation, a woman was left with four preschool children by her abusive husband. She claimed that she was awarded support but is unable to collect it from him. When she presses him for support, he takes punitive action on the children, “breaking their hearts” by dismissing or ignoring them. This she finds is distressing for her. When asked about the children’s father’s current life, she replied that he lives alone on the same income that she and her four children live on. Another single mother of school-aged boys who has supported her family on social assistance for many years told me that she has not received child support for the boys from their father for a number of years. She lacks the funds and energy to take legal action so their situation is unlikely to change. The boys’ father is employed and living with a new partner and their child. This sample included only one single father, inadequate for effectively comparing and contrasting the adult male and female experience during family breakdown. The issue of financial well-being was not raised by this single father.
Thus, family climate was found to have two dimensions, stress and comfort. Under certain conditions, family stress was described as perpetrated stress. Family climate appeared to be experienced variously by family members.

**Family Climate of Comfort**

Family comfort has two facets: relational and contextual comfort. In this section I will describe how relational comfort contributes to a sense of self-worth that contributes to an overall sense of health and inspires individuals to make healthful lifestyle choices. I will also explain how contextual comfort is related to adequate resources of time, money, information, and access to community services. Relational and contextual comfort work in concert to influence individual health experience.

Characteristics of relational comfort identified by participants include respect, caring, trust, intimacy, empathy, unconditional love, support, connection, emotional security, acceptance, togetherness, autonomy, predictability, and flexibility. The sense of family that is introduced in Chapter Six has similar characteristics. Relational comfort and its effect on individual health is described in the insightful comments made by parents of two school-aged children. Here, the non-linear quality of the family/health link is evident; family relational comfort bolsters members' health which in turn enhances individual sense of self-worth, a motivating factor for healthful living.

Researcher: When your family is healthy, what is going on?

Woman: It's not so much just the physical, it's the emotional, the spiritual as well as the physical, there's so much more involved in family health than just whether you're not sick.
Pardon? [to husband].
Man: I said there's more to it than just not being sick. I think that in our family that we have to focus on all of those areas [referring to his wife's comments on the emotional and spiritual aspects of family life]. We try to eat well and do all those things that are important but I think that we're always working on trying to be closer as a family and doing things together and yeah, it's more than just the physical thing. And when we're healthy as a family, it helps us as individuals and then when we're healthy individually it also helps us on a family level as well, so they're connected.

Researcher: What does it mean in your family to have this feeling of closeness?

Man: Okay, I think that for me, this idea of closeness, the idea that you're not alone in the world, that in itself is very reassuring and fortifying. I think that the stronger the family unit is, you know, the more support that you have. The more love that you have from your family, it just feels like you have more support against whatever is assaulting you, whether it's things that are pulling down your health, whether it's stresses from work, or whatever. It's just the idea that you have the love of your family and the closeness of your family, the support of your family, that just fortifies you more and even if it's... Well, I know that it's something that affects you on a physical level because your immune system, I'm sure, is stronger when you're more at ease and you have this sense of love around you, just that mental, emotional peace that you have when you know that that's behind you also contributes to your health. It's really an important part about health is just that family closeness.

Researcher: [To woman] Do you want to take a run at this question from your viewpoint?

Woman: Well he said it beautifully. I mean that's why I wanted him to go first. He did say it beautifully. I just want to add unconditional love. When you have your family, there's an element of unconditional love so no matter what you do, no matter who you are, you know that they will love you and they'll be there for you and I mean there's something really, I mean you feel that warm and fuzzy feeling and that's got to be healing. [Laughs] It's got to be so.

For this couple, the love, togetherness, support, and closeness of family life are perceived to be fortifying and instill in members a sense of closeness that strengthens mental, emotional, and physical health. In the following excerpt, the same partners point out that being at ease with oneself and feeling a sense of self-worth and unconditional love contribute to an individual's capacity for changing lifestyle patterns to more healthful ones.
Researcher: What I'm trying to understand more about is how this relates to a family member's capacity to change to more healthful behaviours.

Man: Of the changes that I've made in my own life a lot of that happens when you reach a point in your life when you're more at ease with yourself and who you are. Many times you'll resist healthful changes when you have a belief that you're not worthy . . .

Woman: You can get healthy because your family wants you to be healthy. It's not as though the family is going to pull you all the way, you know, but at least they can pull you in the right direction and get you kind of started on your journey.

The man emphasizes again the salience of self-worth to health agency and adds that being at ease with oneself is a key to change toward healthful living. The woman tells how her family's concern for her health inspires her to live healthfully.

Reiterating and expanding a quote previously used illustrates how participants perceive the link between family climate of comfort and self-worth:

Man: With any family I guess you establish your own style . . . families that seem to be together and have that nice glow to them as a family . . .

Researcher: What do you mean by glow?

Man: There's a respect, there's a preference. It looks like there's a care for what the other person really thinks or feels rather than how it affects you . . . .

Researcher: What does that respect do for each person?

Man: They feel good about themselves, you know it creates an atmosphere where they can feel good about themselves and almost everything starts from the heart. You know it's like P. [his wife] was saying about building that security into children which we believe it helps if there's a parent around all the time when they're really in those young years because then they start to have a good feeling about themselves and everything comes from that.

Researcher: Everything meaning?

Woman: I think your self confidence in as far as thinking, "Well I can do this, I can do that" instead of always having doubts whether or not, "Oh should I or shouldn't I." But, "I can try it" and accepting you know, strengths, weaknesses.
I mean, it all sounds very, very rosy but you have to go through the roller coaster to get there, but, just to know that the roller coaster is okay.

For this couple, as for others in the study, a family climate of comfort is characterized by respect, caring, and empathy which enhances family members' sense of self-worth, therein contributing to the individual’s capacity to take a proactive approach to life. The man, like other participants, hints at the relationship between relational and contextual comfort pointing out that adequate time for parenting is a contextual factor that contributes to a supportive family dynamics.

Contextual comfort depends on adequate resources of money, information, time, and access to community services. For example, access to money allows family members to purchase healthful food and access recreational facilities. Relational and contextual comfort act in concert to exert a combined effect. In this study, the interplay between relational and contextual comfort was evident in families from the low-end of the income scale to the middle- and high-end.

Several families at the lower end of the income scale seemed to experience a sense of relational comfort at home which contributed to contextual comfort. In these families, respect, caring, and support among family members fostered healthful choices in spite of financial constraints. The experience of one married woman captures this. For her, family relations are centrally guided by the Christian principles of equality, love and respect. She explains:

Woman: God created us equal, God created Eve out of Adam's side; Eve wasn't created from his behind or his head or anything else but his side. God meant for us to be by his side. The Bible simply says that we are created equally. So, no, neither man or woman is thought of as less equal in God's
eyes... it's totally done out of humility, not out of lording it over. We work through things.

Researcher: Humility about what?

Woman: Not being haughty, not being boastful, not being argumentative, not causing dissension on both our parts. That doesn't mean that we don't have, we don't have our disagreements but it's been in our disagreements if we have boundaries for respecting one another as far as no yelling, absolutely no name calling, no cutting each other down and all of these things we have been taught by the church. The churches that we have been to have given us the tools on how to end a disagreement, to get to the bottom of things, and when we couldn't, they're there for us. We could call them up any time we go in and sit down and say our piece and they would help us through things. So, communication is done out of humility and it's out of total love for each other.

Communication in the family for this woman means working things out in an egalitarian and respectful manner which is driven by love for each other, not merely self-interest, a situation in which there is relational comfort. Counseling services available at their church are a community resource used by this family to resolve differences. In the following excerpt, the same woman tells of the interactive effect of finances and her faith on her family's health.

Researcher: When this family feels healthy, what's going on?

Woman: Oh, I think it has a lot to do also with finances. I think money has a lot to do with it simply because I think society is preaching at you. If I did not have a grasp on God's plan for my life, if I take that away, and were to think of it in not that perspective I would really be suffering from an incredible low self esteem simply because money is not coming in and there's no hope in the future of money coming in and you're doing the best you can do to raise your kids.

Researcher: Is that your experience right now where you're feeling that you don't have much coming in financially?

Woman: For myself, no. But even when we didn't have a lot coming in, because I had a grasp on God's plan for my life, and that it was God's will that I be content when we had little, be content when we have much. It's been a tremendous lesson to learn simply because I had that peace. God never, ever has he ever failed us in all the struggles that we've been in. So from my standpoint, that's my idea of family. Our family, spiritually healthy, is first and
foremost which just permeates into all other areas of our lives. It’s just, you feel good about who you are in Christ, you feel good about eating properly and then in turn you're doing that responsibly, as a responsibility unto God. But then, you get the bonus points because you're feeling good because you're eating better and because you're exercising more.

A shared sense of spiritual health between this woman and her husband is essential to family health. This, in turn, affects all other aspects of healthful living. This woman’s comments point to a health-related web of interaction: access to community services, family health, individual health, and individual health-related decisions — specifically nutrition and exercise.

In high income families, members supported each other’s health pursuits by providing ideas, inspiration and companionship. This pattern is evident in an excerpt from an interview with a newly married, well-paid professional couple living in a metropolis.

Researcher: What is the influence you have on each other’s health choices?

Man: I certainly feed off J.’s energy to run. That motivates me to get out there and run.

Woman: Yeah, when we make the commitment, it’s a lot easier to run with somebody else. I know this may sound funny, but I also like his [referring to husband] influence on me health-wise . . . .

In this interchange, the respect and admiration this couple has for each other is apparent as is their openness to each other’s ideas and suggestions.

Researcher: And what about eating habits and food preparation?

Man: I think J. [his wife] is a healthier eater than I am. There’s no doubt about it. But I think we both try, I think we’re both conscious of it.

J.: We're both very well educated in what is good to eat. Just yesterday I said to V. “I heard this interview on the radio that you know cancer strikes one in three in the population and that fresh fruits and vegetables are something that you could eat to reduce the chance that you'll be one of those one in three.”
And we just don't have a good enough routine in that way. We're not home after work together, we don't really make the time to go and do a proper grocery shop. So we're still working on that because we think that eating properly is very important. Last fall, during the wedding celebrations, we both sort of fell off that proper eating track.

Relational comfort contributes to this couple's capacity to work out and implement healthful choices. With regard to resources, information and money are readily available to this couple but time is perceived to be limited. Like many other participants in the study, the relational and contextual elements of family life create a comfortable family atmosphere that contributes to the health and the health choices of family members. Nonetheless, there may be elements of family stress for the family to consider.

Family Climate of Stress

As mentioned earlier, family stress can be relational, contextual, or perpetrated. Relational stress is related to patterns of interaction in which disrespect, silencing, dismissing, disagreement, and disconnection are present. Contextual stress is related to lack of time, money, information, and/or barriers to adequate services or facilities. Relational and contextual stress work in concert to influence individual lifestyle choices. Perpetrated stress is stress induced in one or more family members by another. Perpetrated stress has characteristics of both contextual and relational stress. Emotional and/or physical abuse, neglect, withholding of family resources, and/or violence provoked by a specific family member or members in a position of authority were features of perpetrated stress. Perpetrated stress has serious implications for the health of family members. Relational, contextual, and perpetrated stress may create a family climate that undermines individual health.
A particularly vivid example of family stress is evident in the following excerpt. In this family, both parents work full time while raising three children under eight. The dialogue took place between me and the mother and the father in the presence of two of their three children. The parents are concerned about their chronic inability to create healthful meals for the family. The woman describes a family situation which is chaotic and one in which members experience considerable interpersonal tension. This excerpt demonstrates how time pressures stimulate interpersonal tension which is left unresolved. This family seems caught in a vicious cycle of time pressures and interpersonal tension that leave the mother feeling tired and hopeless.

Research: What does it feel like when you're working well as a family?

Woman: Well? [laughs]

Man: You mean when they are going to bed and stuff like that?

Researcher: ... when things click along.

Woman: You see, that doesn't happen very often around here. There's never a day when there's no major crisis. Like this morning [One week before Christmas] we're trying to all get out to church together and D. [7-year-old son] decides that R. is wearing his T-shirt. I mean this is at 9:30 this morning. We're still trying to hurry around to get ready, get everybody fed, out to church, and finally I just left J. [her husband] and D. fighting and I took R. and we went to church by ourselves and nobody else went today. There's not EVER a day when there's not some aggravation or crisis going on. I mean, we've got three kids. If there's just two of them it's usually okay but with three of them together it's chaos.

Here the woman describes a family and personal situation characterized by chaos, disagreement, lack of co-operation, disconnection, and time pressures. Later, the interviewer asks the woman about her health. The following excerpt repeats a previous quote, expanding it for clarification of emphasis to demonstrate the context of a climate of stress:
Researcher [to the woman]: So when you're feeling healthy, what does that feel like for you?

Woman: I've never thought of I feel healthy. I've never thought of it using that term. It's either you feel tired or you don't feel tired. You know, I've never said "Oh I feel healthy today." I wouldn't even know where to start with that one.

Researcher: So, that isn't a way you think?

Woman: Oh no, probably it's more. I mean these last few years I've been working — it's a year in October I went back to work, and I've just been so tired. I mean I've gone to the doctor to make sure that there is nothing wrong, check the blood and all this and she just kind of looked at me and says, "Well you're working and you have three kids, what do you expect?" And, of course, she asked "Are you depressed? Because that can cause fatigue." No, I don't think so. I would never say I feel healthy.

Contextual and relational stress disturb family life, a pattern noticeable in other families in which parents worked full time while caring for dependent family members.

Another family story reveals how living in poverty limits access to health-related resources and how this contributes to relational stress in the family. This family lives in well-maintained city housing in a neighbourhood of a major city known for its many social problems. In the following excerpt, the mother and one of her sons talk about their inability to access organized sport because of financial constraints. The mother believes that organized sport would challenge the boys to reach their potential, contribute to their physical fitness, and use up excess physical energy. Lack of access to sport is perceived as having health consequences, current and potential, for the family: because the boys do not get enough exercise they are overactive which is a strain on their mother. The mother believes that participation in organized sport has potential to protect her sons from becoming involved in delinquent activities during their teen years. In the excerpt, the woman and her son not only
speak of these problems but also demonstrate their awareness of how social issues impact their lives.

Woman: One of the things I find incredibly frustrating as a single parent who lives on a low income is that my children are not entitled to any kind of sports. I can't put them in hockey. I can't put them in karate. All these things are really expensive and to me all these things are totally about health.

Researcher: Right

Woman: You know what I mean? It's about not just the physical health but their emotional well-being because I mean I really believe that kids who are involved in sports quite actively when they become teenagers will stay involved in sports, and be less like to get into trouble in other areas, maybe less likely to get into drugs and delinquent behaviours. Even at a young age, they're nine, and I can't, I really, truly can't, afford to keep them in anything. I can put them in baseball in the summer at the community centre.

V. [9-year-old]: Or soccer.

Woman: Yeah, but there's just not enough money. You know, what I mean? And I don't know why.

V: I'm good at soccer.

Woman: They're great at soccer [referring to boys]. Yeah, I don't know why in the school system it's just not available. It's not part of the programme. Even at school it's not available. It's ridiculous and I think it limits children that you know otherwise would be great at it. Like they are the most active, physically active, children who need to wear off all that energy and when they don't, they drive me insane.

Here, the mother makes the link between access to sports programmes and mental health. In the following segment, the interview takes an interesting twist, the 9-year-old implores his mother to sign him up for hockey, then explores my family experience.

Researcher: V. can you talk about that a little bit about how you feel about playing soccer?
V: Well, I like playing it because my friends like playing it and, I like joining it, it's like, healthy . . .

Researcher: So do you play in a team V.?

V: No, I just play soccer at school. I never play hockey. I want to sign up for it. It's not that much really.

Researcher: Oh yeah?

V: Do you have kids?

Researcher: Yeah they're all grown up though.

V: Oh. When your kids were little, did they get to sign up for hockey and stuff like that?

Researcher: Let's see, my daughter didn't play hockey, she played baseball and she went to ballet and my son played soccer and rugby.

His question to me evidences the capacity of children to question their social situations relative to others. The interview continues:

Woman: Yeah. My best friend, her son is in hockey and her daughter is in gymnastics which is, like, over a thousand dollars a year to play hockey and he's nine years old. Those kinds of things just seem so, they seem so much about health that I don't understand why you have to be of a particular social class to be able to have those privileges: skiing, hockey . . .

V: I could draw a picture of me playing hockey.

Woman: Every year they ask what sport they can do such as hockey. I want to put them in gymnastics because, like I said, he's just phenomenal. Say I could afford to, maybe he would be a phenomenal gymnast, maybe he'd be a Canadian competitive gymnast.

V: I could do flips.

Woman: He's extremely flexible but I can't afford to. So it's like who would ever know? That's where the social, financial status thing comes into play. Where you say to yourself, "Is this right?" because all children should be considered equal. All children should have the same opportunity.
Social injustice is perceived by this woman to be a limiting factor for the health of her boys. Here, the woman is passionate about the injustice that she lives with because of social barriers to sport that her sons’ participation. The admiration she has for her son’s abilities fuels her emotion.

Another example of how social conditions determine availability of recreational services was evident in a rural community. As I spoke with families and community leaders in a single-industry town, it was reported that the town’s main company financially supports the local hockey arena in this small municipality of 2,500. To demonstrate this, I present data from three families who live in this town. When asked about the arena, one woman and her daughter give their views about its usefulness:

J. [14-year-old daughter]: Well it’s so boring here, there's nothing to do.

Woman: Well, that's another thing I worry about for my kids is that there is nothing here.

Researcher: What about the arena?

J: Oh the arena [spoken very sarcastically].

Woman: Well yeah, even the arena. They have public skating on Friday nights from what, five to seven? I don't know a couple of hours.

J: I don't know. I've never been.

Woman: On Friday nights and then they have it for a couple of hours on Sunday. It’s just not enough.

In contrast, here I recount a visit to another family with boys aged 11 and 16. The 16 year-old was a bit late for the interview because of hockey practice. These were the opening words of our interview:

Researcher: To start off I just wanted to get a picture of health and how you and your family stay healthy.
Woman [aged 42]: The boys stay healthy by playing hockey but I don't do anything [laughter] I just work. My husband has joined the gym, G. [16-year-old boy] joined the gym and plays hockey and they try to eat healthy but other than that.

During the interview the woman explained that in the winter, much of the family activity is centred around the boys' involvement with hockey. In a third family I visited, upon settling into the living room, I noticed many medals on the wall. I was told that they had been won by their teenaged son for speedskating. The son currently played hockey. The teenaged daughter had previously figure skated but is currently not involved in a sport activity. While in the first family, the children were at a loss for meaningful activities in the town, in the second and third family, hockey and speedskating provide a current focus for sport involvement.

Availability of recreation services is a contextual factor related to community economics. Families in this town differ from families in towns with a wider range of recreational services in the services that are available to them. Limited access to recreation facilities is a potential and contextual element of stress not only for families living in poverty but also for families in remote communities.

A different kind of family stress was evident in the stories of some participants — perpetrated stress. Perpetrated stress includes acts of emotional and/or physical abuse, neglect, withholding of family resources, and/or violence on the part of one family member who is usually in a dominant position. As mentioned previously, perpetrated stress seems to have characteristics of both contextual and relational stress and often has dire consequences for the health of family members. Some participants described situations which were clearly emotionally and physically threatening, an environment of perpetrated stress. For example,
one young single mother living in poverty and coping with a chronic illness described such a circumstance. She and her daughter fled from her male partner out of concern for their lives.

Woman: [Commenting on their move away from the threatening situation] But actually it's done her and myself a lot of good. So emotionally I've been doing better and my physical health is getting better too. I'm healthier. She doesn't have to be around me and the abusive boyfriend that I have yelling at me and his friends yelling at me. [To Daughter] Remember T. [former partner] yelling at me?

Daughter: [7 years old] And remember when you and B. were going to ... and you had a knife? Remember when we were at the house? Remember I was scared, I was going to JUMP [spoken very emotionally]?

Woman: I don't know. You see there was so much stress there that I don't remember. He was beating me and I was trying to scare him to get away from him sometimes, I don't think I ever pulled a knife out on him but maybe I did. I don't know. I can't remember, but I had a lot of stress living in that situation.

The above excerpt describes a household situation that the woman and her daughter fled — a situation in which the woman's live-in boyfriend was the perpetrator of stress in their lives.

Woman: ... I just walked out. Yeah ... it affected me. If I'm emotionally down my health goes right out the window sometimes.

Researcher: Yes, that's what I'm trying to understand more about what happens ...

Woman: It's stress. Stress causes my health to get worse ...

Here, this woman makes the link between perpetrated stress and health status. She elaborates:

Woman: Yeah, for example, once I was getting better and I had a family member visit me and there was one swear word after another and it was really stressful because I really care about these different people in my life, the stress that they go through and that they want me to go through with them. It's too much, the stealing from me and stuff like that, and me trying to figure out, "Why is this happening?", "What's going on with you?", and "What can I do to make your day a pleasant one?" without it being unpleasant for myself. That's just too stressful for me. [Now, she speaks as though she is instructing this person] "If I set the rules, try not to swear ... but try not to swear all the
time in front of my daughter and encourage her to do things that I said not to”, and just basic respect.

Researcher: Yeah.

Woman: Then it’s a lot more smooth for me and my health doesn't get affected by it. That's just a fact. That's what I've experienced. Because, when this person was visiting me, stress. Like this person was very stressful. Things that they were doing were very stressful, to me they were harmful things. I’m embarrassed about that because it’s my family, my mother. But my daughter gets really affected by that too so that's why, that's what I mean when I say I avoid that kind of stuff and I, I just go with, I just have people visit me who I know are going to be respectable, honorable.

According to this woman, she has learned that disrespectful behaviour causes her stress which makes her ill. Out of concern for her health, she now only surrounds herself with people who are respectful and trustworthy. In the following passage, this woman describes how her ill health has affected her capacity to care for her daughter.

Woman: Yeah, well I mean I still go the hospital but it’s not for a month anymore.

Researcher: Oh ?

Woman: But nothing like it was before, I was in the hospital so much before.

Researcher: Before your daughter was born?

Woman: Before she was born I was in the hospital a lot but after she was born I was always in the hospital. When I was working, I was so tired out because I was working too at the time and I was cutting metal and stuff and I had a nice job, it was fun. This one particular job was really hard on me. It was strenuous. I worked and I couldn't spend time with her and when I was able to see her I was really sick and I was barely walking around the house, very weak and resting like walking around in spurts. I would end up in the hospital very often and for a month at a time and she would be babysat. Even since the time she was just a newborn baby and that wasn't very good for her at that age. Now I have support [from the community kitchens] so I'm able to sort of give her what she needs [referring to the healthful foods prepared each week] without having to work so hard at that. So I can spend more time looking after me because I am a big job [laughs].
Here, this participant tells how her health condition involves long periods of hospitalization during which her daughter is placed in the care of others. As well, she points out that the combination of ill health and working at a physically demanding job interfered with her capacity to care for her daughter. In these excerpts, the woman describes the circular relationship between families and health; perpetrated stress contributes to her ill health and when she is ill she cannot provide her daughter with basic needs such as healthful food. This account describes the kind of family stress apparent in the accounts of two other families: a woman who tells of a depression that lifts when her abusive husband moves out and a fourteen-year-old girl and her mother who perceive their family situation to be harmful to their health and attributing this to how the father/husband interacts with them. In all three cases, the women acknowledge that the support they have received from community services has contributed to their compromised physical and/or emotional health. Thus, the link between individual, family, and community health is once again demonstrated.

Some of the words participants used to describe a climate of family stress are chaotic, disagreeable, disrespectful, dismissive, demeaning, silencing, disconnected, unsupportive, inflexible, authoritarian, deceptive, abusive, and violent. In this climate there can be contextual stress, which is related to inadequate resources of time, money, information, and to barriers to adequate services or facilities, arising from social injustice. In a family climate of stress, participants report experiencing a reduced sense of self-worth, a lack of control and, in some cases, depression and hopelessness. This may lead to a perceived inability to make healthful decisions. Some family members are the target of stress perpetrated by another family member, a type of family stress that seems particularly harmful to health. Relational,
contextual, and perpetrated stress create a family climate that undermines individual health. Conversely, compromised individual health contributes to a family climate of stress.

Family climate is palpable family ambience, a cluster of family characteristics that create a family feeling that influences individual health. Family climate, either comfort or stress, is basic to the health of individual family members. Communication, respect among and between family members, and access to resources contribute to individual health. In contrast, abuse, disrespect, poverty, and neglect are deleterious to individual health. Such aspects of family life as respect and trust contribute to a family climate of comfort. In contrast, facets of family life such as disrespect and abuse create a family climate of stress. Family climate of comfort or stress is centrally determined by relational processes and contextual factors. Relational processes are felt interpersonal family dynamics. Contextual factors are circumstantial determinants related to the community within which the family lives. Relational factors contribute to the impact of contextual factors on the health of individual members. Family climate sets a tone within which family processes are enacted. Two family processes that are influential in individual health related decisions are talking and modelling — processes described in the next section.

Family Processes Influential in Health-Related Decisions

Participants’ stories were full of comments about how talking contributed to individual health-related decisions. In a theoretical memo dated February 13, 1996, I noted,

When one member decides to adopt new health behaviours the family is challenged to think about this notion of how to live together in such a way that individual and family needs continue to be met. This happens through discussion, dialogue, problem-solving, often around the use of family resources of time, money, and energy. Teasing, putdowns, sarcasm, fighting, planning,
reminders about family roles and responsibilities and review of family-of-origin occur.

Talking seemed to capture the essence of the family strategy reflected in participants’ words and was therefore identified as the term to describe this theoretical code. Several types of such talking were noted — productive, unproductive, and dismissive talking. The term “productive” was an “in vivo” code used by one participant, whereas, unproductive and dismissive were terms that I selected for their descriptive qualities.

Modelling was more difficult to isolate and name as a theoretical code. From the opening sentences of the first family interview, the influence of family members’ behaviours and attitudes on individual health-related decisions was apparent. Particularly surprising to me was how frequently and vividly participants older than 60 reported family-of-origin influences on their current choices. As well, participants in their 30s and 40s cited the influence of grandmothers, uncles, and the family-of-origin setting on health patterns. For months, I struggled to name this code moving from family-of-origin, which lacked an action component, to action terms including guiding, leading, parenting, modelling (theoretical memo dated June 18, 1996). Other terms that appeared in the theoretical memos included teaching, watching, genetics, and family history.

Modelling and teaching were the terms that most commonly appeared in the theoretical memos. Modelling was also evident in participants’ words as “role model” or “model”. One of the drawbacks that was apparent to me was that, in common usage, the term encompasses observed behaviour whereas the concept as I was interpreting had another dimension, that of appraising others’ attitudes as well as behaviours. Finally, I decided that “modelling” was the best term but it would have to be defined to include observing
behaviours, appraising attitudes, and displaying behaviours. Modelling is the display of health-related behaviours and attitudes that runs through family life linking the past to the present. There did not appear to be distinct categories of modelling. Talking and modelling are family processes that inspire and give individuals a rationale for making health decisions. In this section, these family processes are discussed.

Talking

Talking is a central family process affecting individual health and lifestyle decisions for heart health. It is an interpersonal process that encompasses “talking it over”, “talking about it”, “discussing”, engaging in “dialogue”, “thinking it through”, “working it out”, “planning”, “setting goals”, “organizing”, “identifying issues”, “coercion”, “fighting”, and “battling”. Talking influences individual health in that it affects family members’ sense of self-worth, the perception of their capacity to maintain it in light of competing interests in the family and community. Talking is foundational to the capacity to take action to meet perceived health needs. Three kinds of talking were evident in the data — productive talking, unproductive talking and dismissive talking. Productive talking occurs as four types of talking: thinking as a family, expressing health values, corroborative talking, and problem-solving. Productive talking occurs in a family climate of comfort, although there may be times that characteristics of family stress are experienced throughout the process, especially when emotional investment is high. Productive talking moves individuals toward desired health goals. Unproductive talking is talking that is intended to focus on health issues but strays to unresolved differences among family members. It is a kind of talking that undermines individual sense of self-worth and stalls movement toward healthful choices and
often occurs in a family climate of stress. Dismissive talking is family dialogue in which one member dismisses the health interest of another family member. Dismissive talking may silence family members, lead to action or inaction, or to the escalation of family tension and can occur in a family climate of stress or comfort.

**Productive talking**

Productive talking focuses on the individual's health concern and related implications for other family members. Several types of productive talking are identified: thinking as a family, expressing health values, corroborative talking, and problem-solving. Various facets of family comfort — for example, respect, trust, togetherness, and available resources — catalyze talking so that it is productive in terms of inspiring members to change and provides a rationale for change. Family members' emotional investments differ with the type of talking. Thinking as a family requires a low emotional investment whereas problem-solving requires a focused and intense effort. Talking throughout a lengthy marriage can lead to a comfortable familiarity, a relational place where talking about familiar health issues may no longer be necessary.

Thinking as a family is apparent in the following excerpt. Here, a young woman refers to thinking as a family as a process whereby awareness of a health issue or concern is raised and implications for family members are discussed. The following is an interchange between the researcher, a middle-aged woman, and her teenage daughter who are members of a high income family:

Researcher: As a family can you remember the last time you tried to change your health behaviours and what happened in the family around that?
Woman: I think over the last five or eight years we've eaten far less red meat, mainly pastas.

Daughter: My Dad was in a weight loss programme at work and we looked at the books and got thinking that it would be a good thing for us all to eat healthier. We have salads basically every night.

In this family, thinking as a family involved reading and talking about change. By thinking the situation over, the family came up with a rationale for change — change would be better for them.

This notion of thinking as a family was evident in other interviews. One participant, a married man in his thirties, sheds some light on how thinking as a family works. According to him, talking stimulates thinking about health-related issues and concerns so that appropriate action can be taken.

Man: [Referring to how an individual formulates health-related decisions] You don’t really make decisions, you just do things in a certain way and it’s trying to figure out why you do them and until you talk about it, you don’t really think about it.

In this family, talking provides members with an opportunity to bring to their awareness of health concerns and issues as a first step to developing a rationale for change. A family environment characterized by respect, trust, concern, and togetherness is evident in families that refer to their use of thinking as a family to discuss health-related issues.

Expressing health values is another type of family talking that contributed to the construction of healthful decisions. One 47-year-old female legal secretary, a smoker since the age of 15, emphasized how talking about others’ smoking habits with her partner motivated her to quit. Her partner, a health professional, has strong views about smoking and health that he discusses openly and frequently with her. Building a trusting, respectful relationship with him motivated her to quit her thirty-year tobacco addiction.
Woman: [Referring to talking with her partner about smoking] We talk freely about other people smoking and I've found out that he has little patience with people that he feels haven't the ability to quit.

Researcher: I would think that trying to hide your smoking habit must have been really hard on you.

Woman: Oh, absolutely. Because that's one of the things that I've always prided myself on, I'm honest. I do not have a lot to hide from people. In a relationship, I want it to be open. I would be hurt if there was some major thing in his life that he felt he had to hide from me because I was being non-accepting or it just wasn't socially acceptable. So, I felt like I was a liar by omission . . . . So when he'd say, "Oh, I told this patient that you quit and if you can quit anyone can." I thought oh my God. I just feel like dying, just like dying. I mean there are some things that are mysteries that maybe add to relationships but deceit is not one of them. I don't like living that kind of life. Yeah, I feel much better about that absolutely, absolutely.

Establishing a family climate characterized by respect and trust inspired this woman to quit smoking.

Elements of a family climate of comfort contribute to another kind of talking that positively influences lifestyle choices: corroborative talking. Corroborative talking occurs when family members support each other by strategizing new health behaviours together. One woman in her thirties speaks of how concern for her mother's high cholesterol led to their collaboration in working out low-fat foods preparation, which in turn inspired her to shop for low-fat food items.

My mother and I talked about going on a low-fat diet, and then I said, "Why don't we do it together and we can correspond back and forth?" She's in Palm Springs six months of the year so we write anyways. I decided I was going to try and go as low fat as possible and really focus on low-fat meals so when I went into the store and I saw low-fat label I did purchase a low-fat chocolate-chip cookie mix.

Concern for other family members underpins another kind of talking: problem-solving. Problem-solving is the key process used to accommodate members' needs within the
family unit. One man, the father of two school-aged children, tells how he discusses his plans to work out with his wife so as not to disrupt the family unit:

As far as lifestyle things go, often-times we talk about it so, for example, exercise: I try to work out three times a week but I have to be pretty flexible because with my work and with family time I have to be careful in that I don’t allow my work-out time to infringe on my family time so often times I will discuss with K. [his wife], “Well I’ve got to go work out are we doing anything at that time?”

Talking over the implementation of his decision to exercise leads this man to devise a plan that was comfortable for others in his family. Talking that is problem-solving also occurs between parents and children. A mother and father recall how their young daughter went about advocating for her dietary wishes within the family unit.

Mother: B. [the daughter] at one point called a family meeting and said she was a vegetarian. We never even had family meetings so I don’t know where she got the idea.

Father: And we said, okay. What she said was, “I don’t like chicken don’t put it on my plate.”

Mother: And we do try to accommodate their wants within their diet.

The family climate is such that the child feels comfortable expressing her unique wishes and the parents hear her concerns and do their part to adjust family patterns in response. In this excerpt, talking was the process by which the child advocated for a change in her diet. Her parents respect her wishes and accommodate her request.

Productive talking that facilitates individual health-related decisions ranges from low emotional investment to intense interchange, including full-blown fighting and coercion. Low emotional involvement occurs when family members share information accessed from lay publications, media messages, or health information from heart-health programmes. Emotional investment escalates as more intrusive changes in usual family patterns are
propagated by new information. The following interchanges between me, a man and a woman demonstrates how exploring health-related decisions can raise the emotional stakes in a family. One couple in their mid-thirties with two young children tell how they worked through the woman's desire to resume an interest in skiing. During my first interview with the family, it became clear that this woman was placing other family members' needs ahead of her own. Upon realizing this, she declared that she would like to take up skiing again. The second interview opens with the woman and her husband telling me how her decision to ski unfolded.

Researcher: When I called, S. [her husband] was saying that you were going skiing this weekend. I remembered from our last interview that that was something that you were thinking that you wanted to do but that you hadn't really organized it. I wondered if you could talk about how, in the last few months, you were able to arrange this.

Woman: Well, we organized it and it didn't actually manifest. [Her husband was sick the morning they were to leave.] It's kind of neat. That's kind of the place where our differences bridge. Even though it didn't happen, just getting that thinking happening again and getting all those support things in place to pull off skiing for a day... it gets easier everytime we do it. I know when I ski a lot, it's like camping, your gear is all in one pile and ready to go and it's not a big deal to throw it in the car and head off for a weekend. But to get it all organized for the first camping trip of the summer is a big deal. So skiing is much the same for me and it all seemed so reasonable that "Wow! Okay. I can start skiing going in my life again." I don't have to, even though he doesn't [ski], I don't have to give that up even though I have two kids and, so I'm hopeful for my career [laughs].

Energized by her capacity to negotiate time for skiing this woman perceives that she may be able to work out a way that she can integrate career with family life. She is not only inspired to take up skiing but her success in negotiating a way to have her needs met inspires her to have hope for her career. In the following segment, the couple describes family problem-solving:
Researcher: When the topic comes up or somebody decides to make the change as you did with getting back to skiing, what terms would you use to describe that?

Man: Fighting. [laughter]

Woman: You mean when the idea first comes up?

Researcher: Yes, when you get the idea.

Woman: Coming to life . . . and then between the idea and the fruition, is that the place that you're talking about? Just that one commitment means it will happen. The intention is there. When I said to S. [her husband], “These friends have called and asked us to go skiing and I know you don't like skiing a lot.” It seemed like, from what I know of problem-solving, actually a resolution-type concept where I put out clearly what I want and what's important to me, knowing that it's not where he'd choose to spend a whole day and all that effort to get organized. But, I remember saying, “We've been invited, it's important, I really want to go, I want to start doing this again, I want my kids to start skiing and having a hobby and, you know, how can we make this work for you?” [To her husband] Remember?

For this woman, clearly communicating what she wants is essential for effective family problem-solving. This interchange continues:

Woman: And then you said, “Okay, I know it's important, I'm willing to go along with it, it's important and I know how much you like it and I don't want to ski but I'll go along to support you and help out and find a way to have fun too.”

Man: For me, it was a little different, because I actually didn't say, “Okay, but I don't want to ski.” But, I initially said, “All right I'll go along and I'll ski.” It was only half-way through the process that I finally said, “No, I don't want to ski.” So, I put out where I had to be with it.

Her husband reflects that throughout their discussions, he realized that it was important for him to be clear about his needs as well. The same interchange continues:

Woman: Oh that's right, I forgot that.

Man: There would be maybe a couple of different possible processes going on. One would be a more effective and healthy process, and the other would be less productive and less healthy process. The more effective and healthy the
process is for me, the more dynamic and engaging is the dialogue. I think I used the word dialogue rather than discussion.

Researcher: Okay

Man: Because it's a back and forth kind of thing and it's not always nice, there can be elements to it that are. That's why I use the word pleasant before, there can be elements that are disagreements or, or anger or different things.

Woman: Coercion

Man: Coercion. But it's like I keep and you keep bringing forward our different perspectives and ideas and feelings then the process moves along. So, first of all I said, "I'll go skiing." But then as we talked and we began to prepare, I realized that I didn't really want to go. So I'm not going to ski but I will go up and look after the kids. That would be my role. So that grew out of the dialogue.

The partners point out that the process of negotiating a reasonable solution is not always pleasant and involved emotional tension. The woman perceives it as process of resolving differences.

Woman: And that's why I call it too more of a conflict resolution, you meaning conflict as being different, okay, I want this, you don't want that, we have differences, how can we?

For the man, the process of resolving conflict took on a rich meaning — it is an opportunity to deepen their relationship.

Man: It's a deepening and an expanding kind of role. Now that's healthy. The other part of it would be just to say all right and just go along with it. Like if I say, "All right, I'll go skiing", and not talk about it, then there's no deepening in the relationship and nothing much can grow or change. I'll just go along.

In this spirited interchange, the woman and her husband explain how, through a problem-solving process, they explored the rationale for, and were inspired to try, new patterns. They do not recall an easy or smooth process but rather one involving a range of intense emotions: self-revelation, risk-taking, coercion, anger, fighting, and disagreements.
Both the husband and wife gained health benefits from this interchange. Their senses of self-worth are bolstered by a deepening of their relationship and their capacity to resolve competing interests in the family. Although qualities of family comfort appeared to predominate in this family, the partners report experiencing stressful family interactions.

In another family in which the man and woman were not as well educated, productive talking was evident although it was not described in the detail apparent in the previous excerpt. Recall the couple who changed eating habits as a result of the woman’s participation in a heart-health programme. The husband cooks and in the following excerpt he tells how he came to accommodate her desire to reduce the fat in their diet. An excerpt previously included is expanded here to illustrate the point:

Researcher: [Turning to the woman’s husband] Did you learn something about healthful eating from your wife attending the programme?

Man: Yeah, I cut back pretty good on the grease portion. [laughs]

Researcher: Oh yeah?

R: When you took the programme you came home and what happened so that your husband changed his cooking?

Man: Well, it was a shock for awhile anyway [laughter]. I don't mind now. She cuts back on all that other stuff, bacon, grease, it's like frying mushrooms in the grease you know. I don't mind at all actually, I still like the grease, but it's getting better.

Researcher: What was a shock?

Man: Actually the kids kind of like it, eh? Because the kids used to figure when I was cooking, like ever since she was working I was cooking you see and the kids they always see the grease. And they would say . . . [trails off and makes a face]. Yeah, yeah, the kids kind of straightened me out.

Researcher: [to the woman] What do you remember about this?
Woman: I can't actually remember how I introduced this to the family. I just kind of did it.

In this family, the father attributed his ability to change to his children (late teenagers) who convinced him that it would be to his benefit to do so. He speaks of going through a period that he described was a "shock" but eventually changed because of what his children said to him.

In discussion with a couple in their sixties, it is apparent that talking throughout a lengthy marriage can lead to a comfortable familiarity, a relational place where talking is no longer necessary. This couple, married for almost three decades, say that they no longer need to discuss certain matters since they know and respect each other's preferences.

Researcher: [After some discussion about healthful eating] How do you make that decision about what goes in the basket at the grocery store?

Man: We know that beforehand, what we buy.

Researcher: You have a list?

Man: She has a list. [referring to his wife]

Researcher: So do you sit down and talk about it before you go?

Woman: No.

Man: I know what she buys and she knows what I want.

Researcher: So your wife knows what you like?

Man: Absolutely.

Woman: Well, we should after twenty-seven years. And I don't ask G. really what he wants or what he'd like to eat. I cook what I feel like having. Like it's no — meals are no problem, I just cook what I feel like having.

Man: She knows the veggies I like and usually it's the same type of veggie that she likes and also in meat.
Researcher: Is that something you decided together? How did you come to that particular decision?

Man: It evolved.

Woman: I would say it evolved.

These partners describe how over time they have come to know each others' preferences and no longer need to discuss options. They are comfortable with their lifestyle choices and how they implement lifestyle decisions.

In the preceding excerpts, participants provided accounts of how talking as a family process can be productive in terms of supporting individual health and facilitating individual health-related decisions. What is implied in each of these excerpts but not stated is that there are adequate family financial resources for a range of food choices, there is time for food preparation and money and time for recreational activities.

Thinking things through together, expressing health values, corroborating on health-related issues, and problem-solving are energized family interchanges that provide an individual with rationale for, and inspiration to make, healthful decisions. Productive talking occurs in a family climate characterized by respect, trust, care for other members, openness, and adequate resources for healthful living — a family climate of comfort. As emotional stakes rise in the problem-solving process, characteristics of a family climate of stress begin to appear. This points to the complexity of the relationship between family climate and talking as a family process that influences individual health-related decisions. In the next section, a less effective way of talking is described: unproductive talking.
Unproductive Talking

Unproductive talking, as a conceptual label, refers specifically to talking that does not lead to desired change in health decisions. Unproductive talking stalls movement toward healthful lifestyle choices. Unresolved differences about family, personal health issues or contextual stress contribute to unproductive talking. Since these differences are often unrecognized, ongoing interpersonal issues and interpersonal tensions interfere with resolving the identified health concern. Inadequate resources, time and/or money and/or information, raise the emotional tenor and further complicate the problem-solving process. Family members tend not to feel heard and feel stuck in health patterns they would like to change. Unproductive talking erodes individual members’ sense of agency and may contribute to a reduced sense of self-worth because of lack of success in making desired change. Whereas attributes of a family climate of comfort are dominant during productive talking, characteristics of a family climate of relational and contextual stress dominate during unproductive talking.

Unproductive talking was evident in several families in which the parents were concerned about the implications of their lifestyle choices on family members. In one such family, both parents work as professionals to support their five children aged 3-16. She is concerned about the family’s risk for heart disease and he is concerned that she is overweight and inactive, and that this may lead to an ever-widening gap in their interests. I met with this family three times about their health-related concerns. They perceive that they have digressed rather than progressed in their efforts toward more healthful family eating and regular
exercise for the parents over the research period. Two months before the third interview the
woman assumed a new, full-time position; her husband had to replace her as the primary
family cook. In these excerpts, the couple explore once again how they might begin to make
change.

Woman: Well I've found that since I've started working full time, it's more
difficult for me to get home in time to make dinner so J. [her husband] or R.
[her daughter] will start it or make the whole dinner and then I'm home
probably around six. One dinner in particular we had french fries and then we
were still hungry so J. decided to cook bacon. So we had a pound of bacon and
french fries for dinner [laughter] because J.'s not a cook [laughter]. The other
difficulty with working full time is I find we eat fast food more.

Lack of time to fulfill her usual role as family cook meant that her cooking duties
passed to her husband and teenage daughter, a role not welcomed by a man who elsewhere in
the interview speaks of his lack of interest in and skill with food preparation. Further, from
his comments, he has limited knowledge about healthful eating. Their differences about the
effects of diet and exercise on health are apparent in their interchanges:

Woman: I think if we ate better too I'd have more energy, you know, just
eating fruit and vegetables I think would be better, better for us.

Researcher: [To the man] What do you think about that, eating more fruits and
vegetables?

Man: That would definitely be a good start.

[Raising the topic of cooking classes moves the topic from healthful eating to teasing the
husband about his cooking skills.]

Woman: That's what I'll get him for Christmas, a cooking class.

[Seemingly in response to teasing that verges on sarcasm, the husband shifts the discussion
from cooking to exercise, something that he successfully engages in and his wife struggles to]
maintain. This shifts the conversation to sparring about who is right about priorities for health.]

Man: Well, you know, I think between diet and exercise I suspect exercise is more important.

The woman now shifts the topic from exercise to budgeting, a contentious topic in this family.

Woman: I think too that, for us, with a large family and a lot of the expenses, groceries tend to be something that sort of is, well whatever money you have left you have to spend on groceries and I kind of feel that maybe what we should be doing is just saying, “Okay, we need to improve the way we eat” and if this means spending a bit more than we spend, that should be a priority. I mean if healthy eating is going to be part of our family life, I think we have to be willing to spend more too or spend more wisely.

The man shifts the topic back to eating, a contentious topic for the woman who struggles with weight gain. She replies by shifting the topic back to budgeting and takes an opportunity to raise his tendency to eat junk food.

Man: If we ate less we might save money. [laughter]

Woman: Well you know, that's true. If we didn't eat baked goods or things from a bakery, you might save money in those areas.

While it may appear that the couple is discussing everyday mundane issues, diet and exercise, more is revealed if we look beneath the surface. In this short exchange a number of contentious and emotionally loaded issues are raised: body image, a sore point for her, food preparation, which he dislikes but carries out, and financial management, a very touchy topic for her to raise in this way. It seems that they are sparring, hitting each other's sensitive areas accurately and swiftly. They are stuck and have been for some time, unsuccessful in changing family health patterns in spite of a stated desire to do so.
Another family demonstrates a similar pattern, a family of parents in their late thirties with three young children who live in the suburbs of a large urban centre on a lower middle-class income. Both parents work full time. She is exhausted and dealing with gradual weight gain. He has been overweight for a number of years, a health problem they are both concerned about. She worries about their family eating patterns and the implications for their weight and the heart health of all family members. They agree that there is a dire need to change their eating habits but, like the other couple, lack the capacity to do so. In this lengthy passage, the ambiance in the family is revealed as stressful and both parents seem overwhelmed with their responsibilities. This seems to be augmented by difficulties with the planning process. When they manage to organize healthful meals, the children request less healthful ones which adds to the family stress and reinforces usual family patterns.

Woman: Yeah, right, I think it was after W., our first one was born, that's when we started saying, “We've got to start eating healthier. We've got to get this family to start eating healthier.” We've been saying that for, you know, almost eight years now and it's just hard to get it organized. We don't eat healthy, we don’t meal plan ahead of time and pull out the salads and the veggies, we just say, “Okay, beans and hot dogs tonight.”

Researcher: Yeah.

Woman: It feels like such a big chore to even eat healthier. I want to start the kids eating healthier now so they get those habits when they move out on their own.

Researcher: Now since you've been getting the information from the nutritionist, what's happened?

Man: Well, I do pretty well all the grocery shopping and I found myself looking for symbols to let me know what is in this and looking more specifically at the fat content and determine whether because it says low calories or whatever it doesn't necessarily mean it’s low in fat. So I found myself looking at that more and buying light cheese whiz and light cheese, you know a lot of things like that.
Woman: Yeah, we went down to one percent milk instead of two percent, just really simple things. But as far as your actual whole meal, like, not just those little things, but we haven't really got that going yet as far as meal planning and this is what we're going to try this new recipe or anything like that, it hasn't really kicked into gear yet.

Researcher: Can you talk about why, even though you've got the information, it isn't happening?

Woman: Well a few weeks ago he was going grocery shopping and he had this list going and I was upstairs and I had these recipes that I got from the nutritionist and they were down the basement. I said, “Oh really, I should go and get those recipes and go through and get those things, oh well I should but [laughing] but I'm not running downstairs right now to get it.” So, yesterday when he went to get groceries, I kind of pulled out the list and we just looked through it and we added a few, you know, the celery and the carrots and these things and bran, you know, things for these different recipes so now we've got a few of the things to get us started now. I really think for us to do it properly is to sit down for your one week, you have your menu every day and this is what you're going to make and this is what you need and we just haven't done that yet. We just haven't put the time in to do that. I think our biggest barrier is the planning process.

Researcher: [To man] So what about you, C.. Can you elaborate on that?

Man: I guess you know, from my point to be really honest, I just sort of expect, okay well that's my wife’s job.

[Laughter]

Researcher: Oh, okay.

Man: And maybe that is from my background, you know my mother did all the cooking, good dinners, meat, potatoes, and vegetables. My father he cooked the steaks on the barbecue on special occasions so, and I guess really that's what it comes down to.

Woman: And of course I feel that we both work, we have to share all these things and my dad helped my mum you know, that kind of thing.

Researcher: So then what happens there when you get into that kind of mind set where you're having differences?

Man: Nothing happens. [Laughter]
Man: That's the whole thing, we haven't started anything, nothing happens.

Woman: Well, no, it's not like I'm waiting for him to do it. But everytime he goes grocery shopping he says, "We really should plan meals." Everytime, that's what he says, every week we really should plan these meals and I'm saying, "Oh yeah, we should" and that's where it ends. It's not, I don't know if we're waiting for each other to do it or if we just haven't, okay tomorrow at one o'clock we're going to sit down and plan meals, we haven't, that's what we need to do and we haven't done that yet.

Man: Actually I was talking about doing it on the computer, setting up you know, get all these standard recipes . . . and then just have that all in there so all you've got to do is just punch it in . . . the ingredients would come out and okay, we have enough . . . check it off.

Woman: So why haven't you done it? [teasing sarcastically]. That's my biggest stop is the planning and the prep work and even when you're learning a new recipe it takes you twice as long to do it or whatever. Things like that.

Researcher: What gets in the way?

Man: [Cook during the week] To me it’s the time. Like I was telling you, it’s an hour commute and we all want to eat by six. So it ends up being so much quicker to go for the preprocessed and ready to roll food, you know the sandwiches, the egg rolls, things that you can put in the toaster oven and it’s ready to go.

Woman: For me, it’s the energy. I come home after work and oh I don't feel like making supper, I get home quarter after four with the three kids and . . . with the back packs in the door you've had it, that's it.

Researcher: Yeah.

Woman: And also in the morning too you think, "I have to take something out of the freezer to defrost for supper", and you never remember. So that's all part of it.

R: Right.

Woman: I think our biggest barrier is the planning process, the knowing what to buy ahead of time. The initial thing is to buy the right things to have in your cupboard, the right, the whole wheat flour, the bran, all the proper stuff which you need to stock up to even start the whole eating better. It’s not that we don't want to do it, we know it's good, we know. It's just getting started. You would think for the sake of the family and your children and your health that you
would put it right up there on your priority list to just go and do it, but you don’t.

Researcher: So what makes it easy not to?

Woman: Well one thing is when I do make a nice big meal the kids, they say, “I don't want that, I don't want that, I want toast for supper, toast and peanut butter.” So that's a real kick because well why do I go to all this trouble of doing this and all these pots and pans to wash after when I could just make toast, give them a bowl of yogurt or something.

Man: Yeah, that's fairly common for them to do that.

Woman: That could be because of a cycle we started of doing those easy meals, you know, that's what they're used to, quick food.

Family eating patterns are out of control in this family. Unlike the first family, the husband in this family is concerned about the family eating habits and appears to have a reasonable level of knowledge about healthy foods. Yet, when it comes to actually preparing a meal, he produces high-fat meals. Talking so far has been fruitless for this couple in their efforts to make significant change. When they talk, while they agree something has to be done, they differ with regard to how to go about making change. Like the family quoted immediately before this one, lack of co-operation, teasing, and sarcasm are apparent in their interactions. Contextual stress is a significant drain, reducing their energy for making change. In families in which unproductive talking was apparent, time and money pressures were a concern. Unresolved interpersonal issues, family tensions, set patterns, and time pressures appear to underlie the lack of co-operation that contributes to their failed efforts to make change.

Above are examples of unproductive talking, talking in families that does not facilitate individual health-related decisions. Characteristics of family relational and
contextual stress predominate in unproductive talking. Lack of co-operation accompanies unproductive talking. This kind of talking may have a negative influence on health agency and may have a negative influence on self-worth.

Dismissive Talking

Another kind of talking evident in some families is dismissive talking. Dismissive talking is family dialogue in which one member, in a position of power, dismisses the health interests or concerns of other family members. Dismissive talking silences family members and may lead to inaction, reaction, or the escalation of family tension. Dismissive talking occurs in a family climate of comfort when the wishes of one member are silenced out of concern for a member who is perceived to be less knowledgeable on a health matter. It may be an outcome of a family climate of stress, or it may be part of, and contribute to, perpetrated stress.

Dismissive talking occurs when one family member who is in a dominant position blocks another member’s attempts to speak of or adopt new health patterns. An example of this is evident in a family in which the twelve-year-old boy decided to become a vegetarian for his health. Since his father did not agree that a vegetarian diet was healthful, plans were never implemented.

Research [to 12-year-old]: Your mum mentioned that you were thinking about being a vegetarian and I wondered if you could talk about that.

T. [12-year-old]: That was just like for a little bit.

Researcher: What made you think about being a vegetarian?

T: Because when you're a vegetarian you live a longer life.
Researcher: And, where did you learn that?

T.: I don't know, people just say it.

Researcher: People like...

T.: My friend is a vegetarian, and he says that you live a longer life because meat will slow you down if you eat too much of it.

Researcher: Then did you try it?

T: No.

Mother: No.

T.: Because my dad really didn’t agree.

Mother: Well T.'s dad, he just thinks the opposite. You've got to have meat everyday. He thinks that these are growing boys and they've got to have their meat and their vegetables. So, different generations...

This is an example of how dismissive talking affects individual health-related decisions and exemplifies how a family member in a position of authority can dismiss the concerns of another family member out of concern for that person’s health. The one in authority provides a clear rationale for not changing, and in this case the idea to change was dropped by the boy.

Another example of dismissive talking was evident in a rural family introduced earlier. In the following interchange, the mother and her two daughters and I are talking together. They describe the father/husband as the gate-keeper on decisions in the family. If he does not agree with a decision, the woman sometimes overrides his decision and implements a plan because she is in control of the family finances.

Researcher: How does power operate in this family? Who gets heard?

S. [11 year-old daughter without hesitation and almost whispered]: Dad.

Woman: [Laughs.]
T. [14-year-old daughter]: Dad.

Researcher: Uh, uh, and how does that work?

T. & S.: Well . . .

T.: It's the big hierarchy. If we want something, we usually ask mum and then we can get it but then it has to go through dad too.

Researcher: So, how is power working then?

S.: He wants it.

Woman: Well, it's really hard to explain that. Okay, for instance, my husband and I had this conversation last night because he basically said something to me about how I get something in my mind and I want it and I'm not happy until I get it.

T. [14 year-old daughter interrupting]: Hey, you always say that to me.

Woman: Basically how it works with us is we don't sit down as two partners and say "Okay, this is what we're going to do and this is good."

T. [Interrupting]: He sort of gets his own way.

Woman: Anyway, I don't feel that I can sit down and say to him, "Let's talk about doing this." He takes it as a threat that I'm going to run out and spend a bunch of money and do it. Even though I have all the control over the money like I get the money and I do the banking [spoken with pride] and I, I have that control.

T.: Dad has all the, has all the power to make us miserable.

Woman: Like if I want to buy new bikes for the kids or if I want to buy, I talked about, you know, maybe we should try and build up this deck this year and get a pool, an upright pool just something to do here, something to make our lives a little bit more fun and happier.

S.: Mum said last night that we should get horses and then dad said, "We're never getting horses, forget it" [imitating a mean, aggressive male voice].

Woman: You know and it's always like, "No way." That was another thing that I had wanted to do was maybe get, I love these, Icelandic horses and I wanted to get one of them to start, you know, just something, you know, a family type thing to do and he says, "No, they don't deserve it."
T.: He doesn't like it.

Woman: And it's always been, it's always been a battle. I finally, I just put my foot down and I said, “We're getting the pool” and it's worked out really good. [Daughters both interrupting still on the topic of the horses]. But, what I end up having to do is I'll save the money myself and then I'll just do it.

The woman and her daughters describe how their views are dismissed. In spite of her husband’s disapproval, the woman reasons that her decision has potential for health benefits and on that basis she overrides his decision. She explains that she can do so because she has access to financial resources. This dismissive process is stressful for the mother and frustrating for the daughters. Thus, while dismissive talking could occur in a climate of comfort or stress, it represented efforts of one family member to block the health agency of another.

Summary of Talking

Productive talking, facilitated by respect, trust, concern and resources of time and/or money occurs in and contributes to a family climate of comfort. Productive talking provides the rationale for and inspiration to change. Productive talking is not always comfortable and can be stressful. It can deepen relationships and may lead to comfortable familiarity with health-related concerns. Unproductive talking is characterized by unresolved interpersonal issues, interpersonal tensions, and inadequate time and/or money or skill. Lack of cooperation, teasing, and sarcasm that accompany unproductive talking have potential to undermine self-worth and health agency. Dismissive talking may silence family members, lead to action, reaction, or may escalate family tension. It is also characterized by lack of cooperation. Talking — productive, unproductive, or dismissive — is a key family process
related to rationale and inspiration (or lack of) for health agency in response to heart-health initiatives. Characteristics of a family climate of comfort predominate in productive talking and family climate of stress predominates with unproductive talking. Dismissive talking can occur in a family climate of stress or comfort.

**Modelling**

Participants used phrases such as “role model” and terms such as “children model what they see at home” to speak of this process. They made numerous references to how modelling in their family-of-origin and their current family unit influences lifestyle choices. Modelling provides individuals with an opportunity to compare and contrast their health-related decisions to those of other family members. Like talking, modelling provides rationale for and inspiration to change by contributing ideas, values, and a sense of what is possible within the constraints of family access to resources and services. Further, modelling reveals what is probable in light of shared genetic predisposition.

One family exemplifies the power of modelling to shape health behaviour in families. The woman models healthful eating which was modelled in her family-of-origin. This excerpt provides a comprehensive example of many facets of modelling apparent in other families.

**Researcher:** How was the change to low-fat food made? What were some of the steps?

**Woman:** Yeah. I don't actually remember how I introduced this to the family, just kind of just did it. I don't think anybody complained as long as something was cooking [laughter].

**Man:** Actually, I think the kids like that way of eating.
Woman: We eat a fair amount of vegetables and salads.

Researcher: Has that been something you've always done then?

Woman: Yeah, my mum has always had a garden, a huge garden. And we always had two vegetables and a salad for dinner, you know meat and potatoes ... 

Researcher: Really? When you were growing up?

Woman: When I was growing up.

Researcher: Do you have a garden?

Woman: Personally, I don't like gardening, but the Quebec farmer here just can't leave the ground. He puts in things, potatoes and I got some corn this year, corn and onions ... 

Man: ... cucumbers and squash.

The woman and man describe how they grew up with healthful food and how they continue to produce fresh vegetables in their own gardens like their parents before them.

[A bit later in the interview.]

Man: My dad died. He smoked all his life. I quit smoking shortly after that.

Woman: That was in '81.

Researcher: Did your dad die of a smoking-related illness?

Woman: He had heart problems.

Man: Heart problems, oh yeah, heart trouble. I quit smoking right there on the spot plus I can't afford it. The kids are just at me when I get home at night. I just come back from work and I just open my cigarette, you know, like regular people do, but then the kids [makes noise representing dislike].

This man quit smoking for three reasons: he finds it too expensive to smoke, his father, a smoker, died of heart disease, and his children disapprove of his smoking. With regard to
modelling, he noticed that his father, who smoked, succumbed to heart disease gave him the rationale to quit smoking.

Woman: Now, they [the children] don't smoke or drink coffee.

Researcher: Sounds as if they're very health conscious.

Woman: I don't know where it comes from.

Researcher: What it is that makes some kids health conscious and some not? Why do you think your kids have become health conscious?

Woman: I have no idea, I don't know why they'd be that way. It could be, I know when they were still in elementary school and I was, you know, going to exercise class and stuff, I don't know if that had anything to do with it.

It appears that this woman does not link her children's current health patterns to what is modelled at home.

[Researcher continues to probe this area a bit later in the interview.]

Researcher: So, you were both smoking and they [their children] were encouraging you not to and doing these kinds of subversive things to get you to quit. Where did that came from?

Man: We used to camp quite a bit in the camper and we'd smoke inside the camper you know, and the kids didn't like that.

Woman: I don't know what we did but neither of them like cigarettes or coffee which is fine.

Man: They don't drink either.

Woman: But G. doesn't drink at all, he doesn't like it, I don't know why.

Man: We keep the kids busy all the time.

Woman: Yeah, they don't lay around and watch TV and stuff.

Researcher: [To man] It sounds like when you were home you did a fair bit with your kids as well.
Man: Oh yeah, in the summertime, fishing.

In this final segment of the excerpt it is apparent that in this family, modelling healthful behaviours crosses generations — the children model a value for not smoking and the parents model a value for active living. Modelling in this family appears to have a significant influence on individual health-related decisions but is not consciously recognized as an important factor by the mother.

In the above lengthy excerpt, the effects of modelling on several risk factors for heart-health are demonstrated through three generations. Evident here is an example of the how appraisal of genetic risk provides a rationale for quitting smoking and how health values are transmitted between generations. In this family, a climate of comfort characterized by respect, trust, and togetherness seems to catalyze the effects of modelling.

Modelling an orientation to health seems to be a significant aspect of a woman’s role in one family. In the following excerpt, a new Canadian from Iran and her 7-year-old daughter shed some light on how mothers influence children’s health patterns. The woman is married, works full time as an aesthetician, and is in her early thirties. Both she and her daughter are attractive, slim, well groomed, and very health conscious. In this excerpt, the daughter demonstrates a similar level of interest in and knowledge about health as is illustrated by her mother. There is a high level of trust, affection, and respect between the mother and daughter. This passage opens with the researcher talking with the 7-year-old.

Researcher: What do you do to take care of yourself so that you're healthy?

H. [7-year-old daughter]: Eat food, healthy food and drink water sometimes and drink juice and lots of good healthy food and that keeps myself healthy.

Researcher: Can you tell me kind of the healthy foods that you eat?
H.: I eat fruits and vegetables and I eat oranges, apples and grapes and I even eat sometimes soup and carrots sometimes lemon.

Researcher: Lemon, oh.

H.: For breakfast sometimes. I eat bread and sometimes I eat bread and cheese and butter. When I go to school I make myself some cheese sandwich sometimes and I put fruit and I just put a little bit of chocolate.

Researcher: [laughter] How do you know those are healthy foods?

H: Because they have protein in them. My mum tells me. And they even have calcium and what else do they have? Vitamins, and [to her mother] what else?

Mother: And they're good for you.

Here, the daughter shows how she turns to her mother for advice on health and the mother relays the value that healthful eating is in her daughter’s best interest.

H: And you're not supposed to eat things that have caffeine a lot everyday because it’s not good for you and you'll get fat.

Mother: Makes you hyper.

Here, the mother demonstrates how she uses coaching to relay health values.

H: Yeah makes you hyper and you'll go like this [shakes her arms] [Laughter]

Researcher: Do you know what has caffeine in it?

H: Em, em, chocolate has caffeine and coke, coca cola and sprite and candy does and not gum but —

Mother: Gum has lots —

H: Gum has caffeine. What? [to mother]

Mother: Sugar.

H: Sugar … people sometimes eat things that have sugar everytime and I always see them at school.

Researcher: What do you think about that?
H: I think they're going to get fat.

Researcher: Oh and being fat to you is not healthy? Why would you not want to be fat?

H: Because I want to be pretty and I don't want to change my body and I don't want to, people to think H. eats lots of junk, na, na, na, na, that's why I don't eat lots of junk.

Researcher: Do kids say that to other kids in your school?

H.: No.

Researcher: Or you just think that in your mind

H.: Yes I think it in my mind, Sophia (a classmate) brings lots of junk food

Researcher: What kind of junk food is it?

H.: Smarties, chocolate and Kit-Kat, sometimes Mars bars and M. & M.'s and those candies, those little ones and she always brings those and she even brings lollipops that have gum inside . . .

Researcher: Do you learn about this at school or do you learn it as you said from your mum?

H.: Yeah, I learn it from my mum.

This 7-year-old girl has a grasp of what is healthful and an apparent commitment to staying healthy. Even at this young age, she links health choices to physical beauty, a message frequently communicated to me by her mother elsewhere in the research session. Her mother relays health messages to her daughter both by what she says and by what she does. In this next excerpt, the woman ties her commitment to healthful living and her skill in implementing her beliefs about health in everyday life to her own mother.

Researcher: It looks from your home as if you keep things organized and you keep your family healthy. What do you think it is about yourself that allows you to do that?
Woman: I just like to do it. Yeah I'm a very organized person, my mum brought me up like that [laughs]. It just bothers me if something isn't okay, something isn't done properly.

Researcher: Em, em.

Woman: Food, especially when you have a child, it's your responsibility right? Just to keep yourself and your child healthy because if I'm not healthy how can I just keep her, do a good job?

It appears that this woman's mother modelled an orientation to health which she adopted and is now modelling to her daughter, a pattern evident in many other families. Like the previous family, modelling health-related patterns is evident across three generations. In their words these participants demonstrate an abiding respect, an emotional connection, to their mothers. Unlike the previous family, this woman seems to be aware of the powerful effect of modelling.

In another family, one participant attributes the role modelling of her mother to her tendency to neglect her needs. She says:

I haven't done a very good job of taking care of me. It's partly my nature. Maybe it's buying into a belief system without even being conscious of it, of self sacrifice ... certainly that's what my mom did. She never ever did a single thing on her own, not one single thing that wasn't family-task oriented.

Bonds to home and family appeared to constrain this woman and this is traced by her to her mother's value for family. Family members articulate the influence of their parents on their health choices.

Modelling contributes to a family stance on health. One man describes the influence of his family-of-origin on his orientation to health. Health messages he received in his family-of-origin provided him with a mental frame of reference for health. When he left the
family, he had to work out the meaning of the health messages for himself. Now married, the meaning of health shifts again as his wife models different health patterns. He says:

I think about all the messages that I got in my family about health and I'm sure my parents got in their family and the messages that I carried out of that... so that's what as a young adult I was working on trying to integrate some of their ideas about what health meant. P. [my wife] has got a different background in foods and I've learned a lot from her so there's been a shift. I think even though some of the health practices in my family were unhealthy the overall stance was one of health.

This notion of a family stance on health was evident in other family stories. In particular, the reflections of a 31-year-old male capture this. Heart disease is a genetic risk in his family and while this man has some concerns about his risk for heart disease, he refers to himself as present-focused, a value modelled in his family. The passage opens with the researcher exploring what beliefs underpin this man's health choices.

Researcher: Exercise and health are kind of related for you?

Man: I think it maximizes health, I don't think it's the only component or necessarily the most important, I think attitude plays a part, I think that genetics play a part, I guess I have a bit of fatalistic streak in that, you know, if there's a family history of something then I think by exercising or following a healthy lifestyle you may minimize your risk but you don't completely clear yourself of any risk.

Researcher: So where do you come by those beliefs? Could you identify a few places?

Man: Well, I think as far as my grandparents go, my grandmother died when she was seventy-nine of a stroke. My paternal grandfather died of heart disease when he was seventy and my dad had his first heart attack when he was 39, he's now 66 and in 1977 he had open heart surgery and a couple of months ago he had a heart attack. So, I don't think you can get away from that family, family history or genetics. So, I would feel that I'm probably at risk for both of those diseases and no matter how healthy my life style is, I don't think I can really forget about that family history. On the other hand you know, I haven't been particularly adhering to a real health-seeking behaviour... it's always a niggling concern that, gee, maybe I should be doing more.
Researcher: What keeps you from doing more?

Man: I think part of it is just a sense that when your time is up, your time is up. Enjoy yourself because you don't know when your time is coming. I've always been present-oriented... so I don't deny myself necessarily a lot based on tomorrow's consequences because I am present-focused.

Researcher: What were some of the influences you can track that lead you to being present-oriented?

Man: Probably growing up with parents who had significant health problems and knowing that either one of my parents could have died while I was quite young I think sort of instills in one a sense that well, I'll make the most of life while I can, enjoy the present because you don't know what the future is going to bring and I think my parents reinforced that too.

This man appraises his risk for heart disease based on the experience of earlier generations in his family. Even though he appraises himself at high risk for heart disease, his behaviour reflects the family stance on health driven by a family value for living in the present. Here, the family stance on health overpowers secular heart-health messages.

Modelling emerges as a powerful referent for individual health-related decisions. It is a process through which family members express or transmit health values to others, reinforce the health decisions of others, appraise the lived experience of health of other family members, and learn health-related skills. Thus, individuals formulate a sense of what health means and learn skills to support potential health choices. Modelling alerts family members to what is possible within the constraints of family access to resources and services that support health. Modelling entrenches health values into everyday family life. Modelling, like talking, can provide a rationale for and/or inspire change.
Summary

Participants’ stories are rich in their descriptions of family influence on individual health-related decisions. At the core of family influence on individual health-related decisions in response to heart-health interventions is family impact on individual self-worth or health agency. Family climate, one of comfort or stress, is a central context for health decisions. Individual will to construct healthful decisions depends on the family context — a context of comfort enhancing self-worth that strengthens the will to be healthy, and a context of stress that consumes this will. Family climate of stress or comfort is not a binary opposite but rather like the weather, ever-present and changing and variously perceived by family members. Relational and contextual factors intervene between family context and individual health outcomes. Family climate of comfort and stress have both relational and contextual dimensions. Family stress has an additional dimension, perpetrated stress which is a form of family stress that is a combination of relational and contextual factors perpetrated by one member with deleterious effects on the health of other family members. Two family processes, talking, either productive, unproductive, or dismissive, and modelling, are family action strategies that interact with relational and contextual factors to determine the ultimate family influence on individual health-related decisions. Family processes, talking and modelling, are the primary family processes through which family influence on individual health-related decisions operates. Talking and modelling provide inspiration and the rationale for change thereby influencing health agency. Lack of co-operation characteristic of unproductive and dismissive talking may thwart action.
Discussion

This study was designed to identify how family processes influence individual health-related decisions in response to a heart-health initiative. In Chapter Five, the first of the findings chapters, findings reveal that heart-health messages are primarily directed at the individual, not the family. Further, it was concluded that heart-health messages that address the everyday realities of family life have potential to enhance the effectiveness of heart-health messages. Then, in Chapter Six, to ground the research in key concepts of the research question, family and health were defined from the perspective of participants. In the course of defining family and health, participants discussed important links between family and health and emphasized the link between families, health, and society. Here, it was found that the core of health is self-worth. It was also found that family plays a role in fostering self-worth. Now, in Chapter Seven, findings suggest that family influences health agency by fostering self-worth and that specific aspects of family life, family climate and the family processes talking and modelling, influence health agency. In this discussion, findings of this study are compared to those in the empirical literature under the headings family climate and talking and modelling. Then, the theoretical relevance of this study to family theory development and health promotion theory is discussed.

Empirical Contribution

Family Climate

The California Family Health Project (CFHP) (Fisher, Ransom, Terry, Lipkin & Weiss, 1992b) is a research programme that offers empirical evidence of the link between family climate and the health of individual members. This research programme accessed a
community sample of 255 families with children over age 13, that is families in which no medical or psychiatric problems have emerged. The investigators developed a family assessment protocol derived from four domains they identified as salient to family and health from an extensive review of the literature: Structure/Organization, World View, Problem Solving, and Emotion Management. Variables in these domains were measured using well-known scales such as the Moos Family Environment Scale (Moos & Moos, 1986). Additional family data was collected using a videotaped family problem-solving game and the videotaped Emotion Management Interaction Tasks (EMIT) exercise. Health was measured using a large battery of health measures including the well-known RAND Health Questionnaire. Participants completed the self-report forms and RAND Health Questionnaire at home prior to the laboratory session (3 hours) during which the problem-solving exercise was videotaped. One week later, adult family members returned to the laboratory to complete the final set of questionnaires and to participate in the EMIT exercise. Using principal component analysis, multidimensional scaling analysis, and canonical correlation, the investigators explored the structure and patterns of the variables in each domain to assess the relationship between these domains and the self-reported health of husbands and wives (Fisher et al., 1993a; Steinglass, 1992), and adolescent family members (Ransom & Fisher, 1995). Comparing the findings of the California Family Health Project with the findings from this study is revealing.

Using a mapping technique, the CFHP investigators identified core family variables that positively influence health: Organized Cohesiveness, Family Coherence, Family Optimism, and a cluster of Emotion Management variables. Two of the core variables are similar to the findings of my study. Organized Cohesiveness, as a family variable, reflects the
clarity of family roles and rules and the closeness of ties, a finding consistent with the notion of family comfort, a family context in which family closeness and predictability are evident. The CFHP core variable, Family Coherence, reflects members' confidence that the world is comprehensible, manageable, and meaningful. The investigators note that this construct encompasses others evident in the literature that link health with self-esteem, personal security, and the feeling that one is cherished. Their discussion of the core variable, Family Coherence, echoes the finding in my study that family climate of comfort fosters self-worth. In addition to these findings, another finding that is similar to the findings of my study is that family influence may be experienced differently by different family members.

In an extension of this work, the investigators later explored the utility of a subset of variables to identify global family styles or family types that account for differences in the health of adult members (Fisher & Ransom, 1995) and adolescent family members (Ransom & Fisher, 1995). Exploratory and confirmatory cluster analyses were conducted separately by gender. Eleven family variable composites differentiated four family types for both husbands and wives: Balanced, Traditional, Disconnected, and Emotionally Strained. Both husbands and wives from the Balanced and Traditional families reported higher health scores than spouses from Disconnected and Emotionally Strained families.

The Balanced and Traditional families demonstrated characteristics reminiscent of the concept of family comfort identified in my study. In these families, members work well as a group, they are effective problem-solvers, do not avoid emotion or affective intimacy, and they balance separateness and togetherness. Traditional families score high on emotional closeness and prefer stability and consensus to risk taking. They prefer order and structure.
These themes reflect participants’ accounts that suggest that trust, connection, predictability, and flexibility contribute to a family climate of comfort.

The Disconnected and Emotionally Strained families are reminiscent of family climate of stress. Disconnected families are characterized by low scores on orderliness and closeness. Daily stresses are the highest of all four family groups for Disconnected families which, in the extreme, operate in chaos. Emotionally Strained families are tense families who spend considerable energy on long-standing, unresolved emotional issues. Their problem-solving effectiveness is weakest of all four family types. These results reflect the finding in my study that family climate of stress is characterized by disrespect, silencing, dismissing, disagreement, and disconnection.

When the CFHP typologies were used to examine the relationship between family type and adolescent health, it was found that the results were related to whether the typology was derived from mother’s or father’s perceptions of the family. In the father-based typology, adolescents from Traditional families scored highest on physical and emotional health and alcohol abstinence. In the mother-base typologies, adolescents from Balanced, Traditional, and Emotionally Strained families scored equally high while those from the mother-based Disconnected families scored low on health measures. Adolescent gender did not interact with family type to affect any of the three health indices. The authors conclude:

As we have speculated, the family conveys a sense of satisfaction and comfort for its members. This intimate environment shapes the developing person in profound ways. The net effect is a sense of self-worth and high morale, and it is in this abiding sense in all its complex ramifications that protect against disease and promotes health. Among our family types, it is easy to identify these qualities with Balanced and Traditional family environments. Interestingly, even the Emotionally Strained families might not fare too badly in these terms: Only the Disconnecteds would stand out as short on what is needed to raise a healthy person (Ransom & Fisher, 1995, p.195).
Studies from the CFHP lend support to the findings of this study. Participants' accounts in my study speak to the link between of family comfort and self worth that the authors of the CFHG speculate exists. Further, participants bring into view the centrality of family to health agency. How the intimate family environment shapes family members' self-worth to effect health agency is far from clear. However, this study suggests that the family processes talking and modelling may be mechanisms involved in shaping health agency for heart health.

Another contribution my study makes is to identify a specific kind of family stress that is harmful to family members' health — perpetrated stress — a situation not identified in the CFHP. Perpetrated stress in the family appears in the literature in terms of family violence. Types of family violence that have received some attention in the literature are child sexual abuse, wife abuse, and intimate feminicide, however the findings of this study suggest that less violent forms of perpetrated stress and its effects on health is an area for further inquiry. Family violence is fundamentally related to power issues in families (Mandell & Duffy, 1995), thus inquiry into how power operates in families to influence health and health agency of members is an area for further inquiry.

Finally, this study differs from the CFHP in that it details a variety of contextual factors that impact on families to shape their influence on individual health experience. The CFHP does identify some effects of gender differences and accounts for these differences by suggesting that culture shapes gender-role behaviour. However, the use of preconceptualized instruments and laboratory assessment of family processes is an empirical approach in which the context is controlled and therefore not considered relevant. The links between individual
health, family, and society evident in both studies, provide a beginning level of understanding of how health is influenced at all three levels.

**Talking and Modelling**

In a review of the literature on family influence on individual response to recommendations for prevention and treatment of disease, Becker and Green (1975) conclude that a family approach is useful to understand and enhance co-operation with those recommendations. From this review of 35 studies, several family patterns are identified as influential. Of those, interspouse communication is consistent with the finding in this study that family “talking” shapes individual members’ health decisions.

One study within the California Family Health Project supports the finding in this study that talking and family climate are linked. As the reader may recall, talking in this study was a family process that encompassed “talking it over”, “talking about it”, “discussing”, engaging in “dialogue”, “thinking it through”, “working it out”, “planning”, “setting goals”, “organizing”, “identifying issues”, “coercion”, “fighting”, and “battling”, all patterns characteristic of the problem-solving process. One study within the CFHP project examined family problem-solving (Ransom, Locke, Terry & Fisher, 1992). Two hundred and eleven families participated in this study. Multidimensional scaling analysis demonstrated that family problem-solving behaviour involved a means-end sequence of family behaviours in which background style serves problem-solving effectiveness.

In Balanced families, members worked well to solve problems and displayed effective mechanisms to resolve conflict in the family. This resonates with the finding in this study that productive talking is evident primarily in a family climate of comfort. Emotionally Strained
families were weakest of all four types in problem-solving effectiveness. While these families go through repetitive behaviours to deal with problems, they do not learn from their mistakes. Hostility and tension lie close to the surface in these families and emerge frequently. There is a striking similarity to the concept of unproductive talking and the problem-solving process apparent in Emotionally Strained families.

Role modelling has been identified as an important aspect of family influence on individual health for some time (Becker & Green, 1975). The influence of family members’ attitudes and behaviours on lifestyle choices of other family members has been thoroughly demonstrated in the literature, as was discussed in Chapter Two. The findings of this study lend further support to the importance of this. This study brings into view the centrality of modelling as an influential process on individual health decisions; it was one of two key family processes identified in the analysis. Further, this study supports earlier research that demonstrates that modelling occurs not only from adults to children but also from children to adults (Shattuck, 1948).

According to many participants in this study, the modelling of lifestyle patterns by parents and or grandparents in early life has an effect throughout life. Other terms are evident in the literature to describe what appears to be a similar phenomenon. For example, social referencing is a process that establishes the capacity of a child to regulate behaviour in accordance with parental rules in the absence of the parent (Emde, Biringen, Clyman & Oppenheim, 1991; Hoffman, 1975). Participants’ accounts suggest that the modelling of lifestyle patterns by parents and grandparents is a form of learning that may continue from early childhood through life rather than a specific feature of early development alone. The patterns that are modelled are a point of reference for constructing health decisions. That is,
as new information and new perspectives emerge, interpretations of the modelled patterns are revised to inform health decisions. Modelling, as a reference for learning, is a family process that contributes to health choices.

Findings of this study are consistent with research that demonstrates the influence of family behaviours and attitudes on health decisions of other family members. Participants' accounts suggest that the lifestyle patterns of parents and grandparents that are observed in their early years operate throughout life as a reference for on-going interpretations as new information and perspectives emerge. Modelling provides a perspective on what is accessible to support lifestyle choices with the family resources that are available.

Summary

Findings of this study are consistent with those reported elsewhere in the literature. Findings and discussion of the CFHP lend support to the finding in my study that family climate and individual health are related, that there is a dynamic in families that fosters self-worth, and that this dynamic supports health, that family influence on health is experienced differently by different members, and that focused problem-solving effectiveness is related to a background family style. Family variables in the CFHP that related to health were identified from an extensive review of the literature, whereas, categories identified in my study were identified from the perspective of participants. There is congruency between the literature and perspectives of family members on what family dimensions influence health. My study contributes to this empirical work by identifying perpetrated stress as a type of family stress that influences individual health. Further, my study brings to view the family as a unit with potential to foster health agency. Modelling is demonstrated in my study, as elsewhere, as an
important family influence on individual health-related decisions. The findings of this study suggest that early childhood influences may last over a lifetime and that contextual factors influence modelling.

In the grounded theory, key concepts from the empirical literature are evident and create an interrelated pattern of contexts and processes that supports health agency. It has long been recognized that simple communication and role modelling are processes through which family beliefs and behaviours influence other family members (Becker & Green, 1975). This study brings into focus the influence of two processes that reflect these categories, talking and modelling, and the contextual influences that combine with them to shape their ultimate influence on individual health agency. Its contribution lies in the detailing of these processes and the link to health agency. Thus, this study fills a gap in the empirical literature on families and heart health.

**Theoretical Relevance**

The key theoretical perspectives informing this study are family and health promotion. Here, the theoretical relevance of this study is discussed for each of these fields in turn.

**Family Theory**

Family theory development is currently in a period of transition (Klein & White, 1996). Formal theory construction in the family field can be traced to the thinking and writing of Hill (1966) whose work inspired family scholars to use deductive and inductive methods to create theories. At the same time, Nye and Berardo (1966) wrote the first book devoted to family theory. These authors proposed the development and testing of grand theories to
identify, explain and predict regular family patterns (Klein & White, 1996; Sprey, 1988). Commonly used grand theories in the family field are systems theory, exchange theory and development theory (Klein & White, 1996; Mercer, 1989). Reflecting epistemological issues apparent in scholarship in other fields, Sprey (1988; 1990) and Baber and Allen (1992) are leading scholars in the family field who question the relevance of grand theories for practice. These theories are considered by some to be discourses that generate research about what family should be rather than theories that reflect how families live their lives (Gittens, 1993). Further, grand theories are criticized for obscuring the influence of power on family relations (Mandell & Duffy, 1995). Systems theory tends to view families as a system comprising equal participants, all of whom contribute equally to the production and maintenance of problems. Systems theory ignores issues of individual rights and responsibilities. Thus, such theories tend to obscure the impact of such phenomena as power or violence (Mandell & Duffy, 1995). Scholars call for theorizing about family that captures the complexity of the lived reality of family life (Gubrium, 1994; Sprey, 1988; Thorne & Yalom, 1992).

The contribution this study makes is in constructing a theory of the social processes of everyday family life that contribute to individual health-related decisions. By constructing the everyday lived reality of families, this grounded theory contributes a depiction of participants' perceptions of lived reality of health experience in the family in the particular context of heart-health initiatives. Using grounded theory as a method allowed for the development of a mid-range theory that highlights family strengths as well as areas of concern, variability of perception of family life among family members, and variability of perception of family life under different circumstances. This theory also accommodates the misuse of power in families. As well, it has revealed the influence of broad social factors on
family processes. This study differs from much family research in that it involved families living in a wide variety of circumstances including diversity of ages, family types, geographic locations, and socioeconomic status. The variance in living conditions and family types was particularly useful for identifying contextual factors that impact on the family-health link.

Health promotion theory

The findings from this research suggest that family is a powerful influence on individual health-related decisions. Even though empirical evidence has long demonstrated the centrality of family influence on individual health decisions, family as a unit of concern is absent from most conceptualizations of health promotion. Catford (1994) observes that health promoters need to put family centre stage since family is a key context for the health promotion process. The absence of family from health promotion frameworks keeps family largely invisible as a focus for health promotion practice. This may account for the absence of family as a specific target for heart-health interventions as was apparent in this study. The recent trend in health promotion toward ecological perspectives (Green et al., 1996) which explicate family as a context within which health is constructed, has potential to expand conceptualizations that value the family unit in health promotion interventions. In this section, I offer an explanation for the near-exclusion of family from health promotion theories and compare the inclusion of family in nursing theory with the near-absence of family in health promotion theory to draw conclusions.

Family has long been visible in theoretical perspectives on nursing. In the 1800s, Nightingale wrote instructions for nurses to tend to the family context (Doherty & Campbell, 1988; Miller Ham & Chammings, 1983; Whall & Fawcett, 1991). Nurses in the early part of
the twentieth century were often engaged by families to care for the sick and developed health knowledge about families to improve conditions in hospitals, homes, and communities (Chinn & Kramer, 1991; Wright & Leahey, 1994). The work of Lillian Wald, a nurse who practised in New York City in the early twentieth century, exemplified nursing and its concern for families and health. Concerned for the health of families and children living in poverty, Wald established stations from which safe milk was distributed to families and developed centres for educating mothers in the care of their families (Wald, 1971).

In a review of theoretical perspectives of nursing that focus on the family, Whall and Fawcett (1991) note that a number of theoretical perspectives on nursing developed by American nurses since 1975 suggest family and health are linked. They cite the work of King, Neuman, Orem, Rogers, Roy, and Chinn as advancing theoretical understanding of the link between families, health, and nursing. Canadian nurse theorists have also explicated this link. Wright and Leahey (1994) base their theoretical perspective on the family on systems theory arguing that it is useful for nurses to assess the impact of illness on the family and the influence of family interaction on health. Dr. Moyra Allen, one author of the McGill model for nursing, is acknowledged for her contribution to nursing theory that places family at the centre of care (Gottlieb & Rowat, 1985). In this model, the nurse is seen as the primary promoter and facilitator of family health (Gottlieb & Rowat, 1985). Models of nursing that feature the family have four distinguishing characteristics according to Whall (1993): 1. nursing takes a holistic view with an interest in needs beyond psychic needs; 2. nursing has an educative role with families; 3. nursing interventions for families focus on the environment and; 4. nursing supports family health.
In contrast, theoretical perspectives in health promotion, other than ecological perspectives, do not explicitly link health and family (Epp, 1986; Green & Kreuter, 1991; Lalonde, 1974; Ottawa Charter for Health Promotion, 1986). That the disciplines of nursing and health promotion deal with families differently raises some questions. Could this difference be accounted for in terms of practice contexts? Could this be related to the dominance of women in nursing? Family is associated with the private world of women (Baines, Evans & Neysmith, 1991), a realm in which nurses have historically practised.

Historically, family has been part of the private realm of society (Elshtain, 1981; Lenz & Myerhoff, 1985; Okin, 1989; Thorne & Yalom, 1992). The public and private realms are viewed as ordering diverse activities, dimensions, and structure of human social life and ways of thinking about that life (Elshtain, 1981). The public realm entered human social life with the notion of politics as action, one of the great achievements of Greek civilization (Elshtain, 1981). Central to political action at this stage of civilization was men’s engagement in public speech for political purposes. Private speech was carried on within the household. This led to spheres of human discourse — with male voices privileged in the public domain since women and slaves were confined to private discourse (Elshtain, 1981). The perspective of voices from the private realm was valued for domestic purposes, not for purposes of social or political action. Hence the separation of the private, domestic realm from the public world, with family the primary domestic unit. Nursing historically has had access to the private world of family and hence family has entered the theoretical discourse of nursing.

Feminists see this public-private dichotomy as problematic in that this distinction contributes to social problems such as devaluing of women’s work and domestic violence (Gittens, 1993; Thorne & Yalom, 1992). Thorne and Yalom (1982) take the stand that, “In
envisioning and working to create a better world, we will necessarily have to transcend a separation between private and public, or family and society” (p. 20). Health promotion theory that includes family as unit of concern has potential to transcend this separation. Health promotion is concerned with “the combination of educational and environmental supports for actions and conditions of living conducive to health” (Green & Kreuter, 1991, 4). Family emerges as a context that affects individual health status and individual will to make healthful decisions, and is therefore an important context for health promotion.

This study provides valuable insights into the impact of heart-health messages on recipients, definitions of family and health and the link between the two, and family influence on individual health-related behaviours in response to a heart-health initiative. These insights have potential to guide practice and presents avenues for future research. Implications for health promotion practice and research are discussed in the next chapter.
The objective of this study was to explore social processes in families that influence individual health-related decisions in response to heart-health initiatives. Grounded theory informed by critical and feminist perspectives was the methodology of this study. Twenty-eight families participated, representing considerable diversity with regards to family type, socio-economic status, age, and geographic location. Participants' accounts are rich and generate a theory of family influence on individual health-related decisions. Family climate, one of comfort or stress, emerged as important for health decisions. Individual will to make healthful decisions is influenced by family climate — a climate of comfort enhances self-worth and strengthens the will to be healthy, while a family climate of stress consumes this will. Family climate of stress or comfort is not a binary opposite but rather like the weather, ever-present and changing. Further, family climate may be perceived differently by individual family members. A family climate of comfort and stress has both relational and contextual dimensions. Family stress has an additional dimension — perpetrated stress — a form of family stress that is a combination of relational and contextual factors that is perpetrated by one member and affects others. Perpetrated family stress has harmful effects on the health of affected family members.

Two family processes, talking (either productive, unproductive, or dismissive), and modelling are family action strategies that interact with relational and contextual factors and family climate to determine the ultimate family influence on individual health-related decisions. Talking that is productive and modelling provide inspiration and rationale for individual health-related decisions. On the other hand, the lack of co-operation characteristic of unproductive and
dismissive talking may lead to inaction. Family exerts its influence on individual health-related decisions in response to a heart-health initiative by shaping self-worth and agency with regard to heart health-related responses.

Although findings of this study are in some ways consistent with those reported in other research that examines family influence on health, this study brings into focus the salience of family climate, the influence of two processes, talking and modelling, and the contextual influences that combine to exert a conjoint effect on individual health agency in the context of heart-health decision making. Its contribution lies in the detailing of these processes and the shift in focus to health agency, assisting to fill a gap in our understanding of the empirical literature on families and heart health. The relevance to family theory is its contribution of a mid-range theory that explains the social processes of everyday family life that contribute to individual health-related decisions. The theoretical relevance of this study to health promotion is that, in linking family processes and context to individual health status and health agency, it underscores the importance of family to health promotion.

In this chapter, I discuss the implications for health promotion practice and research which are not discipline specific, but are relevant for those in disciplines in which health promotion is part of or central to practice. Nursing, health promotion, medicine, and nutrition are disciplines for which the implications of this study may be relevant.

Implications for Health Promotion Practice

Health promotion is defined as “a combination of educational and environmental supports for actions and conditions of living conducive to health” (Green & Kreuter, 1991, p. 4). In this section, the implications focus on health promotion practices with this definition in mind. The
family as a focus for planning is discussed first, followed by advocacy approaches to health promotion. A short discussion of approaches to health promotion practice concludes the section.

Family as a Focus

The interpretation and discussion of participants' accounts point to a need to create venues for contact between the lay public and health professionals and for programmes that address everyday life experience. Programmes such as community kitchens that bring health professionals and the lay public together while building skills and providing resources for healthful living is an example of a programme. Another strategy by which the lay public can access professional opinion about controversial heart-health messages is telephone hot lines. In addition, a health promotion approach that has potential to reduce confusion about heart-health messages is a food labeling programme. A family approach to such a programme would be to design labels so that children and adults can interpret them (Green & Ottoson, 1994).

Community development approaches could be used to plan heart-health initiatives for families. Intersectional and multidisciplinary collaboration may lead to family-focused initiatives such as community gardens, family fun runs or walks, and educational materials that address second-hand smoke in the family. As well, school programmes could be designed in partnership with parents to foster the development of health knowledge and skills of children and parents (Green & Ottoson, 1994). Thought might be given to planning family-focused initiatives for families in communities more specifically defined, for example, by ethnicity, language, geographic location, or socioeconomic status. There may be heart-health issues of particular concern or relevance to specific communities such as the need for clean air, access to food supplies, or recreational activities.
In addition to targeting families from the general population, this study suggests that members of families in which there is considerable stress may be at higher risk for poor health. Two groups of families emerged as particularly at-risk for stress in this study, families living in poverty and families in which the parent(s) work full time. For such families, a community kitchens programme may be an effective strategy. This kind of programme combines education about risk for heart disease with skill building and community building while providing families with inexpensive and healthful food. For busy families, convenience would be a central consideration in planning the time and location of such a programme. An important component of a community kitchens programme for families is child care and/or programming. Findings from this study suggest that a community kitchens programme designed to include men may appeal to some families. As well, including children in the planning and cooking of meals may be perceived as supportive for parents in their attempts to change their children’s eating patterns to more healthful ones. Community kitchens could be offered through health units, schools, pre-schools, churches, or community centres. Another programme that has potential to support the healthful living of families living in poverty is a community gardens programme. Such a programme provides families with fresh produce, exercise, companionship, skill building, and pride. An intersectoral approach has potential to ensure that the initiative is affordable.

As health professionals with a mandate to work in the family setting, nurses, family physicians, and dietitians have a role in health promotion practice to work with specific families to foster health. Family-centered counseling guided by a professional may be an effective approach in working with families toward their desired lifestyle changes for heart health. Guided by this theory and the related body of knowledge, the professional would work with the family to address issues related to family climate, family communication patterns, and modelling in the family. Further, the professional might be alerted to the influence of family on individual self-
worth and health agency. He or she could observe how family members talk with each other about heart-health issues and how health behaviours are modelled in the family. Then, based on these observations, he or she could engage the family in discussion about how family communication patterns and role modelling influence the health agency of members.

Furthermore, being sensitized to the contextual influences on family climate and health agency, the practitioner might engage the family in discussion of how family resources, such as time and money, foster or impede individual health agency. A primary implication of these findings, therefore, is to legitimize professional involvement in the social and economic dimensions of family life by making explicit their impact on health.

A number of intervention studies have demonstrated the effectiveness of family-centered counseling interventions in reducing risk for heart disease (Campbell & Patterson, 1995). A recent and ambitious study is the British Family Heart Study (Family Heart Study Group, 1994). This was an evaluation of a heart-health intervention that included 12,000 middle-aged couples in Britain. Couples were screened for risk factors and received family-centered counseling from a nurse. After one year, the men and women in the intervention group had a 16% overall reduction in their risk scores, a rate that exceeds the secular trends discussed earlier in this dissertation.

The health promotion practice initiatives identified here draw on the themes and the theory that emerge from this study. Several recommendations pertain to the themes of the analysis of the impact of heart health messages. Others address contextual factors that are related to family stress. Because heart-health promotion involves initiatives at all these levels, intersectoral approaches have potential to strengthen links between individual health, family, and society.
Advocacy for Families and Heart Health

Advocacy is a primary strategy for health promotion practice (Green & Kreuter, 1991). This study points to the need for advocacy in several areas: family policy to relieve the financial distress of female single parents, worksite policy to relieve family time pressures, and advocacy for access to recreation facilities for the impoverished.

Seven families in this study were headed by single women living in or close to poverty. A study of the gender differences in one-parent families reveals that 45% of women who are single parents live below the poverty line compared with 15% of men (Oderkirk & Lochhead, 1992). Further, single parents who are women tend to be younger and less well educated than single parents who are men (Oderkirk & Lochhead, 1992). Early pregnancy, low education, and little or no support from the children’s fathers make it difficult for women to gain economic independence (Mandell & Duffy, 1995). This constellation of burdens was evident in the lives of several of the single mothers in this study. Family policy in Canada leaves many women and children vulnerable to financial stress once families break up (Baines et al., 1991; Mandell & Duffy, 1995). The population health implications of failing to address family policy issues are considerable given that currently one million Canadian children under the age of 16 live in poverty (Barter, 1992). Participants’ accounts and the work of other scholars suggest that an important aspect of working toward the reduction of heart disease in Canada is to advocate for law that protects women and children from financial stress.

Families living in poverty were not alone in facing economic struggles. Middle-class families with two working parents showed signs of strain that interfered with health agency. Mandell and Duffy (1995) write “Because it is getting more expensive to live up to the standards set by and for middle-class society, and because fewer and fewer jobs have long-term security attached to them, more and more families find it necessary to have two incomes to make ends
meet . . . . Economic struggles are produced by and produce conflicts [in the family] around work” (p. 250). Advocating for workplace policies such as flextime, that reduce family strain, could create potential health benefits for family members. Intersectoral and multidisciplinary collaboration will be necessary to achieve these kinds of advocacy goals (Green & Ottoson, 1994).

Related to this advocacy is the need for efforts to improve access to recreation facilities for the impoverished. Advocating for more economically accessible team activities, such as soccer, at schools has potential to provide children living in poverty with opportunities to build skills, confidence, and physical strength in their early years. Thus, there are numerous social and family policies toward which health promotion theorists could direct their attention.

**Approach to Health Promotion Practice**

While there is a role for health promotion practitioners to demonstrate leadership with regard to planning and implementing health promotion interventions for heart health that target families, there is an additional role implied by the findings that suggests that benefits for both health promotion practitioners and families could be gained by fostering partnerships between them. Findings suggest that families have a particular kind of knowledge about their lives that is essential to access if heart-health interventions are relevant for the perceived everyday lived realities of family life. If health promotion professionals work in partnership with families to plan heart-health initiatives, each would bring special knowledge to the task, the family contributing expert knowledge on their everyday life and the health promotion professional contributing professional knowledge. Such partnerships can create the context in which health promotion knowledge can be disseminated, interpreted, and applied.
Health Promotion Research

This study documented the significant family influences on health. Findings of this study imply that the family influence on individual health-related decisions depends on the capacity of the family to foster self-worth which supports health agency. As this dynamic is not yet well understood, research to generate knowledge about the role family plays in fostering self-worth that contributes to health agency is indicated. The influence of the family processes, talking and modelling, as they relate to health agency in families especially needs to be clarified. Specifically, investigating family communication as it relates to individual health-decisions is warranted. The mechanism of modelling, as a family process that has an impact on an individual's social construction of health, emerges as important. Qualitative research, informed by critical and feminist perspectives with families living in diverse circumstances, socioeconomic status, geographic location, family type, and ethnicity, has potential to elucidate the dynamic processes in families that contribute to health agency and the related influence of contextual factors. Feminist research on this topic has potential to clarify issues pertaining to the influence of gender relations on health. Critical research with families may reveal ideological influences on health agency that operate through the family.

While this study captured considerable diversity with regard to family type, age, and socioeconomic status, and to some extent ethnicity, few studies have done so. Future research should seek to build knowledge with people living in diverse circumstances. It may be beneficial to conduct similar studies with families from marginalized groups to further illuminate the link between families and health in especially challenging circumstances. For example, in this study, some of those living in strained circumstances managed to live healthful lifestyles while others had difficulty doing so. Qualitative studies that construct theoretical understanding from the
particulars of everyday family life and the broad social factors that impact on it can uncover processes that contribute to family risk and resiliency for heart disease. This study suggests that there is a need for a clear understanding of risk and resiliency in families as it pertains to risk for heart disease so that supports and interventions can be designed to strengthen families. A focus on research with families living in poverty has potential to generate important knowledge related to a recognized at-risk group. For example, participatory research with families living in poverty could be undertaken in conjunction with overcoming barriers to healthful living, for example, children’s limited access to sports activities.

Because of its harmful effects on health, perpetrated stress is a phenomenon worthy of focused investigation by nurses. More research is warranted to clarify the incidence of various types of perpetrated family stress. Population studies are indicated to generate this evidence. Moreover, since perpetrated stress is likely fundamentally a power issue related to societal forces, inquiry into how power operates in families to influence the health and health agency of members has potential to shed light on systemic factors that create a family climate in which perpetrated stress is possible. At the family level, understanding this kind of family stress using a critical methodology could provide participants with an opportunity to raise awareness of how societal forces act on their lives to sustain perpetrated stress in the family. A participatory methodology could engage victims of perpetrated stress in an emancipatory process while building knowledge about such stress in families.

Policy research may be the beginning step in unraveling the complex impact of family policy on healthful living. Policy research examining the adequacy of Canadian family policy to support the well-being of mothers and their children following separation and divorce is warranted. Further, a study to evaluate the effectiveness of family-friendly worksite policy on
family functioning and the health of family members may provide data that can be used to lobby for work policy that is sensitive to the strains of family life.

Family emerges as an important, albeit complex, context for health promotion. Future research could replicate this study with families in which one member is a participant in a heart-health initiative following heart surgery, a heart attack, or referral to a lipid clinic. Such studies have potential to shed further light on the complexities of family influence on health agency by studying family influence in a critical health circumstance. Family influence may be more or less influential when an acute onset of a heart condition is experienced. Another way to build knowledge about family influence on individual health is to design population health surveys with the capacity to follow family functioning and individual health over time.

There is little research that examines the family-health relationship with families in which no members are self-identified as ill. Further, there is little research that collects family-level data. More research at the family level seeking to understand the family-health relationship has potential to generate knowledge about families and their influence on health. Research that takes into account the social forces that shape the family-health experience has potential to generate knowledge that can shift our capacity to conceptualize health from the level of individuals alone and toward a level of families, communities, and societies. This study’s findings point to the importance of links between individual health, family, and society, an area not well understood. While the relationship between individual and family health is increasingly attracting research attention, there is an on-going need for inquiry into the interaction between family and community health.
Conclusion

Cardiovascular disease remains a significant health issue in Canada. An exemplary body of knowledge contributes to our understanding that risk for cardiovascular disease is related to lifestyle choices. In Canada, there is extensive activity in the media and popular press to disseminate messages about these risks to citizens. Moreover, community-based initiatives have been widely implemented in Canada to address heart health. It was found that heart-health messages are focused on the individual not the family. Family, however, is viewed as an important context for individual health-decisions. Further, this study brings to view the notion that recipients of heart health messages construct their health response within a broad definition of health of which heart health is a part.

Research on the link between families and health points to the importance of the background style of the family on the individual health experience. This study and others have identified talking and modelling in the family as two key family processes that influence health and health agency. Thus, family emerges as a unit of central concern for health agency. Yet the family is often absent from theoretical formulations of health promotion and the family as a unit is seldom the focus of investigation in health research. Bringing the family more clearly into view in theories of health promotion and research has potential to generate essential knowledge about health agency. Heart-health initiatives that draw on knowledge about the family influence on health experience have the potential to foster individual health agency, and healthful lifestyle patterns, and to reduce the risk for cardiovascular disease.
REFERENCES


Daly, K. (1992). The fit between qualitative research and characteristics of families. In J. Gilgun, K. Daly, & G. Handel (Eds.), *Qualitative methods in family research* (pp. 3-11). Newbury Park, CA: Sage.


Green, L. W., Glanz, K., Hochbaum, G. M., Kok, G., Kreuter, M. W., Lewis, F. M., Lorig, K., Morisky, D., Rimer, B. K., & Rosenstock, I. M. (1994). Can we build on, or must we replace, the theories and models in health education? Health Education Research, 9(3), 397-404.


APPENDIX A
FAMILY INFLUENCES ON HEART HEALTH

1. Familial aggregation of risk factors

<table>
<thead>
<tr>
<th>STUDY</th>
<th>FAMILY PARTICIPANTS</th>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laskerzewski et al. (1980)</td>
<td>Parents and children</td>
<td>Nutrient intake</td>
</tr>
<tr>
<td>Eastwood et al. (1982)</td>
<td>Spouses</td>
<td>Diet, cholesterol</td>
</tr>
<tr>
<td>Venters et al. (1984)</td>
<td>Married couples</td>
<td>Smoking patterns</td>
</tr>
<tr>
<td>Connor et al. (1984)</td>
<td>Family groups of men, women and children</td>
<td>Relationship between familial dietary patterns, B/P, HR,</td>
</tr>
<tr>
<td></td>
<td>weight</td>
<td></td>
</tr>
<tr>
<td>Staessen et al. (1985)</td>
<td>Father-son/Mother-daughter pairs</td>
<td>Body fat &amp; urinary excretion of Na and K</td>
</tr>
<tr>
<td>Proia (1987)</td>
<td>Father-mother-sons</td>
<td>Familial aggregation of cv risk factors</td>
</tr>
<tr>
<td>Patterson et al. (1988)</td>
<td>Families</td>
<td>Familial aggregation of dietary fats, Na and calories</td>
</tr>
<tr>
<td>Sallis et al. (1988)</td>
<td>Families</td>
<td>Familial aggregation of physical activity</td>
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## Influence of family members’ attitudes and beliefs about CV risk factors

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<tr>
<td>Smoking</td>
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<td></td>
</tr>
<tr>
<td>Chassin (1981)</td>
<td>Grade 6-12 students</td>
<td>Influence of parental attitudes and behavior on children’s smoking</td>
</tr>
<tr>
<td>Nolte et al. (1983)</td>
<td>Grade 7-12 students</td>
<td>Influence of parental attitudes and behaviors on children’s smoking</td>
</tr>
<tr>
<td>Hunter et al. (1982)</td>
<td>Children 8-17</td>
<td>Factors influencing trial and adoption of smoking</td>
</tr>
<tr>
<td>Physical Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melcher &amp; Sage (1978)</td>
<td>Grade 6-10 students</td>
<td>Parental influences on daughters’ physical activity</td>
</tr>
<tr>
<td>Snyder &amp; Purdy (1982)</td>
<td>Fathers and mothers</td>
<td>Parents’ view of socialization into sport</td>
</tr>
<tr>
<td>Butcher (1983)</td>
<td>Grade 6-10 students</td>
<td>Parental influences on daughters’ physical activity</td>
</tr>
<tr>
<td>Dietary Intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shattuck et al. (1992)</td>
<td>Husbands and wives</td>
<td>Long-term effects of wives low fat diets on husbands dietary intake</td>
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3. **Influence of family processes**

<table>
<thead>
<tr>
<th>STUDY</th>
<th>FAMILY PARTICIPANTS</th>
<th>TOPIC</th>
</tr>
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4. **Effectiveness of family intervention in risk factor reduction**

<table>
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<th>STUDY</th>
<th>FAMILY PARTICIPANTS</th>
<th>TOPIC</th>
</tr>
</thead>
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<tr>
<td>Epstein (1981, 84, 85, 87)</td>
<td>Parents &amp; children ages 6-12</td>
<td>Impact of parent participation on outcome of child weight loss programme</td>
</tr>
<tr>
<td>Barbarin &amp; Tirado (1985)</td>
<td>Couples</td>
<td>Influence of family support on outcome of weight loss programme</td>
</tr>
<tr>
<td>Baranowski et al (1990)</td>
<td>Families</td>
<td>Effectiveness of family-based aerobic activity programmes</td>
</tr>
<tr>
<td>Johnson (1994)</td>
<td>Families</td>
<td>Efficacy of targeting families for health education</td>
</tr>
</tbody>
</table>
BROAD QUESTIONS TO GUIDE RESEARCH SESSIONS AND DATA ANALYSIS

1. What are participants' perceptions of the family, specifically with regard to place, time, physical features, activities, other family members, and the roles they assume?

2. What are participant's perceptions of the interrelations among the major settings influencing family life and how various aspects of these settings impacted individual health-related decisions (For example, the school, other families, work, church, and peer group/influential others)?

3. What are participant's perceptions of the influence of formal and informal structures on family life and how these structures impact individual health-related decisions (For example, the world of work, the neighbourhood, the mass media, agencies of government)?

4. What beliefs do participants of the study hold related to the family as a 'natural' or 'functional' entity that influence individual health-related decisions?

5. What structures of power operate in the family related to health-related decisions?

6. What structures of power are evident in socio-political processes that influence family processes impacting on individual health-related decisions?

7. Who has authority and how do technical interests shape reality?

8. By what standards are the facts constituted?

9. Do statements represent ideologically frozen relationships?

10. What are the goals and values that underlie choices participants make?

11. What happened in the programme to assist participants with values clarification?

12. What negotiation processes are at play in choice making?

13. How are practical (normative) interests misrepresented by technical interests?

14. Are affected people treated as objects for whom issues of autonomy are irrelevant?
INFORMATION LETTER

My name is Lynne Maxwell and I am a doctoral student in the School of Nursing at the University of British Columbia. I am doing a study to find out what happened in families when one member participates in a heart-health programme. To do this, I would like to talk with families like yours.

Therefore, I am approaching you to see if you and your family would be willing to participate in the study. If you agree to participate in or to learn more about the study, please let me know and I will set up an appointment at a convenient time and place.

As participants in the study, I will ask you and your family to talk with me about what happens in your family when one member tries to make a change in his or her heart-health patterns of living. I anticipate that there will be two or possibly three interviews which will last for about one hour each. To allow full recall of the interviews, I will audiotape the interviews. To recall what has been said, what was recorded on the tape will be typed on a Word Processor. While I am working on the study, the tapes, floppy disks, and hard copies of the transcripts will be kept in a locked filing cabinet in my office. Your name and those of your family members and other identifying information will not appear on the transcripts, instead code numbers will be used to identify who is speaking. I will not tell anyone that you participated in this study. When I finish the study, the tapes and floppy disks will be erased and hard copies of the transcripts will be destroyed. If I publish the results or talk about the results at a meeting, your name will not be used. If I use anything you said, I will write so that no one will know it was you who said it.

I expect that planners will be able to use the findings to assist with in planning better heart-health programmes in the future.

If you have any questions, please contact me at ____ - ____

Regards,

Lynne Maxwell RN PhD (Cand.)

Established April 1990 to provide a UBC focus for multidisciplinary research, education and consultation in health promotion
APPENDIX D
CONSENT FORM FOR INTERVIEWS

I have read the Information letter that describes the study "Family influence on individual outcome for a heart-health programme". I understand that my participation would involve talking with Lynne Maxwell about what it is like in our family when one member tries to make a change in heart-health patterns of living. I understand that the research sessions will occur during two or three interviews that last about one hour each for a total of four to six hours. To allow full recall, I understand that the research session will be audiotaped and later transcribed. The tapes, I understand, will be destroyed when the study is complete.

I am assured that confidentiality is secured. All information that I provide will be held in strict confidence -- any identifying information will be noted by code numbers, not names or initials, and the data and other identifying information will be kept in a locked filing cabinet in the researcher’s office. I also understand that I am not obligated to participate and withdrawal from the study or refusal to answer questions will in no way affect my future at work or my future participation in heart-health programmes. I give been given a copy of the information letter and consent form for future reference.

If I have any questions or concerns about my participation in the study, I can contact Lynne Maxwell at ____ - ____ or Dr. Sally Thorne at ____ - ____.

Signed: ________________________________

______________________________

______________________________

Date: ________________________________
DEMOGRAPHIC DATA

Family code #: ___

Family Name: ______________________
Address: ______________________

Telephone/FAX/EMail: __________

Parent(s):

______________________________
Age: ___ Occupation: _________ Highest Grade: ___

______________________________
Age: ___ Occupation: _________ Highest Grade: ___

Dependent Children

______________________________ Age: ___

______________________________ Age: ___

______________________________ Age: ___

______________________________ Age: ___
Others in household

__________________________________  Relation: ___
Age: ___  Occupation: ________  Highest Grade: ___

__________________________________  Relation: ___
Age: ___  Occupation: ________  Highest Grade: ___

Pets: ___________________________________

Approx. Family Income: _______________
Ethnicity(ies): _______________________
Religious affiliation: _______________
Language spoken: ____________________
Heart-health programme: ______________

Other: (eg Family history of heart disease)
TRIGGER QUESTIONS FOR RESEARCH SESSIONS

1. What was it like when (participant) participated in the ______ programme? (Or tried to change heart health-related lifestyle patterns?)

2. Did (participant) bring home reading materials, books, or other items from this programme?

3. How were these materials used (by participant/other family members)?

4. What stories did (participant) bring home from the programme?

5. How did these stories affect family members?

6. What changes did _________ make in his/her lifestyle as a result of participating in the heart-health programme?

7. What kind of support for these changes was evident from family members?

8. Can you recall the discussions family members had about changes that affected all family members eg eating/time for exercise?

8. Can you identify advantages/disadvantages to your family life and other family members from the changes (participant) made as a result of the programme?

10. Can you think of any changes (participant) encouraged other members to make as a result of his/her newly acquired knowledge about heart health?

11. What changes did other family members make as a result of (participant's) attendance in the heart-health programme?

12. What is it about your family that makes it easy for family members to decide on new health-related behaviours?

13. Is there anything about your family that makes it hard for family members to decide on new health-related behaviours?

14. What resources are there in your community that strengthens family support for individual members in their decisions to make healthful choices?

15. Is there anything about your community that interferes with family support for individual members in their decisions to make healthful choices?
TRIGGER QUESTIONS FOR VALIDATING INTERVIEWS

1. What would complete this picture of what happened in your family when participated in the heart-health programme (or tried to adopt new heart health-related lifestyle patterns)?
DEFINITION OF KEY TERMS

The following terms are key terms of the grounded theory developed during data analysis of this study. Wherever possible, these concepts were named using the words of participants.

Health:
Health is an energized, balanced or hierarchically-ordered, dynamic, multidimensional state that is related to lifestyle. The dimensions of health include the physical, emotional, mental, and spiritual. At the core of health is health agency.

Health agency:
This term derives from the work of Charles Taylor on human agency. What is distinct about humans, he posits, is the power they have to evaluate desires, regarding some as desirable and others not (Taylor, 1985). Responsible human agency, Taylor asserts, is to have the capacity to make a worthy choice. Hence, the term health agency was the term selected to refer to what was identified in the data as the capacity to take action on behalf of one’s best interest.

Self-worth:
Self esteem, positive self-perception, a belief that one is worthy. Health agency arises from a sense of self-worth.

Family:
A collection of those connected by blood relation, legal bond or life circumstances, and/or those who share daily life, obligations, life history, similar interests, and/or caring, love, and mutual commitment. Family is also as an abstraction basic to which is emotional connection characterized by respect, love, and caring that contributes to a sense of self-worth.

Family climate:
Family climate is an overall family ambience that can be perceived as either one of stress or comfort. Family climates of stress or comfort are fluid conditions, not binary opposites, experienced in disparate ways by family members. Family climate has relational and contextual dimensions that exert a primary influence on health.

Family climate of comfort:
A family ambience that is characterized by a sense of comfort. Relational characteristics of family comfort include respect, caring, trust, intimacy, empathy, unconditional love, support, connection, emotional security, acceptance, togetherness, autonomy, predictability, and flexibility. Contextual characteristics of family comfort include adequate time and money and access to resources and services that support healthful
choices. Family climate of comfort is health-giving in that it fosters a sense of self-worth and health agency that contributes to the will to be healthy.

Family climate of stress:
Family climate of stress is a family climate experienced as stressful or chaotic. Relational stress is characterized by patterns of interaction in which disrespect, silencing, dismissing, disagreement, and disconnection are present. Contextual stress is related to lack of time, money, information, and/or barriers to adequate services or facilities. Perpetrated stress is a particular kind of family stress that arises when one member takes actions that are perceived by others or another as noxious. Emotional and/or physical abuse, neglect, withholding of family resources, and/or violence provoked by a specific family member are expressions of perpetrated stress. Perpetrated stress has deleterious effects on the health of family members. Family stress may undermine self-worth and/or interfere with health agency thereby contributing to health choices that may not be perceived as optimal by the individual.

Talking:
Talking is a central family process that influences individual health-related decisions and encompasses “talking it over”, “talking about it”, “discussing”, engaging in “dialogue”, “thinking it through as a family”, “working it out”, “planning”, “setting goals”, “organizing”, “identifying issues”, “coercion”, “fighting”, and “battling”. Talking influences individual health in that it affects family members’ sense of self-worth and the perception of their capacity to maintain it in light of competing interests in the family. Talking provides family members with ideas, inspiration, and the rationale to take action. Three kinds of talking were evident in the data — productive talking, unproductive talking, and dismissive talking.

Productive talking:
Productive talking occurs as four types of talking: thinking as a family, expressing health values, corroborative talking, and problem-solving. Productive talking occurs in a family climate of comfort, although there may be times that characteristics of family stress are experienced throughout the process of productive talking especially when emotional investment is high. Productive talking moves individuals toward desired health goals.

Unproductive talking:
Unproductive talking is talking that is intended to focus on health issues but strays to unresolved family and personal issues. It is a kind of talking that undermines individual sense of self-worth and stalls movement toward healthful choices. It often occurs in a family climate of stress.

Dismissive talking:
Dismissive talking is family dialogue in which one member dismisses the health interest of another family member. Dismissive talking may silence family members, lead to action or inaction, or to the escalation of family tension.
Modelling:
Modelling encompasses the family processes guiding, leading, parenting, modelling, and teaching. Participants used terms to describe this strategy, “people model what they see” and “role model”. This choice of words could reflect the popular use of the term modelling, a key term in Bandura’s social learning theory (Bandura & Walters, 1963). Modelling, for the purposes of this study, is defined as the display of health-related behaviours and attitudes that run through family life linking the past to the present and derives from participants’ use of the term. Modelling is a family process that inspires and provides a rationale for making health decisions in light of genetic risk.