CHAPTER 13

Thinking Ups
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This chapter addresses the issue of overreliance on theories that define nursing in terms of a one-to-one relationship at the expense of theoretical perspectives that emphasize the societal context of health. When individuals are perceived as the focus of nursing action, the nurse is likely to propose intervention strategies aimed at either changing the behaviors of the individual or modifying the individual's perceptions of the world. When nurses understand the social, political, economic influences that shape the health of a society, they are more likely to recognize social action as a nursing role and work on behalf of populations.

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environmental, and political determinants of health. This perspective results not only in a restricted range of intervention possibilities for the nurse, but also in a distorted impression of clients' behaviors. An understanding of the complex social, political, and economic forces that shape people's lives is necessary for nurses to promote health in individuals and groups. If nurses are not given an opportunity to appreciate the gestalt of populations and societies, they will be unable to develop a basis for analyzing problems.

This chapter addresses the issue of overreliance on theories that define nursing primarily in terms of a one-to-one relationship and the inherent conflict between these theories and the goal of enabling nurses to promote health through population-based interventions.

Nursing's Role in Pushing Upstream

In his description of the frustrations of medical practice, McKinlay[2] uses the image of a swiftly flowing river to represent illness. In this analogy, physicians are so caught up in rescuing victims from the river that they have no time to look upstream to see who is pushing their patients into the perilous waters. The author uses this example to demonstrate the ultimate futility of "downstream endeavors,"[2(p. 9)] which are characterized by short-term, individual-based interventions, and he challenges health-care providers to focus more of their energies "upstream, where the real problems lie."[2(p. 9)] Upstream endeavors focus on modifying economic, political, and environmental factors that have been shown to be the precursors of poor health throughout the world. Although the analogy cites medical practice, it also aptly describes the dilemmas of a considerable portion of nursing practice, and although nursing has a rich historical record of providing preventive and population-based care, the current American health system, which emphasizes episodic and individual-based care, has done woefully little to stem the tide of chronic illness, to which 70 percent of the American population succumbs.

What is the cost of a continued emphasis on a microscopic perspective? How does a theoretical focus on the individual preclude understanding of a larger perspective? Dreher[1] maintains that a conservative scope of practice often uses psychologic theories to explain patterns of health and health care. In this mode of practice, low compliance, broken appointments, and reluctance to participate in care are all attributed to motivation or attitude problems on the part of the client. Nurses are charged with the responsibility of altering client attitudes toward health, rather than altering the system itself, "even though such negative attitudes may well be a realistic appraisal of health care."[1(p. 505)] Greater emphasis is paid to the psychologic symptoms of poor health than to socioeconomic causes; "indeed the symptoms are being taken as its causes."[1(p. 505)] The nurse who views the world from such a perspective does not entertain the possibility of working to alter the system itself or empowering clients to do so.

Involvement in social reform is considered to be within the realm of nursing practice.[3] Dreher[1] acknowledges the historical role of public health nurses in facilitating social change and notes that social involvement and activism are expected of nurses in this area of practice. The American Nurses' Association (ANA) Social Policy Statement delineates, among other social concerns, the "provision for the public health through use of preventive and environmental measures and increased assumption of responsibility by individuals, families, and other groups"[3(p. 4)] and addresses nursing's role in response to those concerns. However, in her review of the document, White[4] notes an incongruence between nursing's social concerns, which clearly transcend individual-based practice, and the description of nursing as "a practice in which interpersonal closeness of the professional kind develops and aids the investigation and discussion of problems, as nurse and patient (or family or group) seek jointly to resolve those concerns."[3(p. 19)] White[4] also notes the document's neglect of the population focus and possibilities for modifying the environment. Clearly, nursing has yet to reconcile many of the differences between operationalization of a population-centered practice and policies that define nursing primarily in terms of individual-focused care.

Three theoretic approaches will be contrasted later here to demonstrate how they may lead the nurse to draw different conclusions not only about the reasons for client behavior, but also about the range of interventions available to the nurse.

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the client's perceptions of benefits and barriers. For example, clients with problems accessing adequate health care might receive counseling aimed at helping them see these barriers in a new light; the model does not include the possibility that the nurse may become involved in activities that promote equal access to all in need.

True to its historical roots, the model offers an explanation of health behaviors that, in many ways, is similar to a mechanical system. From the health belief model, one easily concludes that compliance can be induced by using model variables as catalysts to stimulate action. For example, an intervention study based on health belief model precepts sought to increase follow-up in hypertensive clients by increasing the clients' awareness of their susceptibility to hypertension and of its danger.[7] Clients received education, over the telephone or in the emergency department, that was designed to increase their perception of the benefits of follow-up. According to these authors, the interventions resulted in a dramatic increase in compliance. However, they noted several client groups that failed to respond to the intervention, most notably a small group of clients who had no available child care. Although this study demonstrates the predictive power of health belief model concepts, it also exemplifies the limitations of the model. The health belief model may be effective in promoting behavioral change through the alteration of clients' perspectives, but it does not acknowledge responsibility for the health-care professional to reduce or ameliorate client barriers.

In fact, some of the proponents of the health belief model readily acknowledge the limitations of the model and caution users against generalizing it beyond the domain of the individual psyche. In their review of 10 years of research with the model, Janz and Becker[8] remind researchers that the model can only account for the variance in health behaviors that is explained by the attitudes and beliefs of an individual. Melnyk's[9] recent review of the concept of barriers reinforces the notion that, because the health belief model is based on subjective perceptions, research that adopts this theoretic basis must take care to include the subjects', rather than the researchers', perceptions of barriers. Janz and Becker[8] address the influence of other factors such as habituation and nonhealth reasons on making positive changes in health behavior, and they acknowledge the influence of environmental and economic factors that prohibit individuals from undertaking a more healthy way of life.

The health belief model is but a prototype for the type of theoretic perspective that has dominated nursing education and thus nursing practice. The model's strength—its narrow scope—is also its limitation: One is not drawn outside it to those forces that shape the characteristics that the model describes.

The Upstream View: Society as the Locus of Change

Milio's Framework for Prevention

Milio's framework for prevention[10] provides a thought-provoking complement to the health belief model and a mechanism for directing attention upstream and examining opportunities for nursing intervention at the population level. Milio moves the focus of attention upstream by pointing out that it is the range of available health choices, rather than the choices made at any one time, that is paramount in shaping the overall health status of a society. She maintains that the range of choices widely available to individuals is shaped, to a large degree, by policy decisions in both governmental and private organizations. Rather than concentrate efforts on imparting information to change patterns of individual behavior, she advocates national-level policy making as the most effective means of favorably affecting the health of most Americans.

Milio[10] proposes that health deficits often result from an imbalance between a population's health needs and its health-sustaining resources, with affluent societies afflicted by the diseases associated with excess (obesity, alcoholism) and the poor afflicted by diseases that result from inadequate or unsafe food, shelter, and water. In this context, the poor in affluent societies may experience the least desirable combination of factors. Milio notes that although socioeconomic realities deprive many Americans of a health-sustaining environment, "cigarettes, sucrose, pollutants, and tensions are readily available to the poor."[10(p. 436)]

The range of health-promoting or health-damaging choices available to individuals is affected by their personal resources and their societal resources. Personal resources include one's awareness, knowledge, and beliefs, including those of one's family and friends, as well as money, time, and the urgency of other priorities. Societal resources

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expect behavior change. In addressing the role of public health in primary care, Milio voices concern that "health damage accumulates in societies too, vitiating their vitality . . . [and charges nurses to redirect energies] so as to foster conditions that help people to retain a self-sustaining physiological and social balance."[12(pp.188,189)]

One cannot help but note the similarities between Milio's health resources and the concepts in the health belief model. The health belief model is more comprehensive than Milio's framework in examining the internal dynamics of health decision making. However, Milio offers a different set of insights into the arena of health behaviors by proposing that many low-income individuals are acting within the constraints of their limited resources. Furthermore, she goes beyond the individual focus and addresses changes in the health of populations as a result of shifts in decision making by significant numbers of people within a population.

Critical Social Theory

Just as Milio uses societal awareness as an aid to understanding health behaviors, critical social theory employs similar means to expose social inequities that prohibit people from reaching their full potential. This theoretic approach is based on the belief that life is structured by social meanings that are determined, rather one-sidedly, through social domination.[13] In contrast to the assumptions of analytic empiricism, critical theory maintains that standards of truth are socially determined and that no form of scientific inquiry is value free.[13,15] Proponents of this theoretic approach posit that social discourse that is not distorted from power imbalances will stimulate the evolution of a more rational society. The interests of truth are served only when people are able to voice their beliefs without fear of authority or retribution.[13]

Allen[14] discusses how nursing practice can be enriched by enabling clients to remove the conscious and unconscious constraints in their everyday lives. He states that women and the economically impoverished are especially vulnerable to being labeled by pseudodiseases that are rooted in social formations, such as hysteria and depression. Health care providers often frame such problems only within the context of the individual or, at best, the family. But critical social theory can enable a nurse to reframe such an interpretation to gain an understanding of the historical play of social forces that have limited the choices truly available to the involved parties. Through exploration of the societal forces, traditions, and roles that have created the meanings of health and illness, clients may be freed of the isolation and alienation that accompany individual problem ownership.

At the collective level, Waitzkin asserts that the current emphasis on lifestyle diverts attention from important sources of illness in the capitalist industrial environment; "it also puts the burden of health squarely on the individual rather than seeking collective solutions to health problems."[16(p. 664)] Salmon[17] supports this position by noting that the basic tenets of Western medicine promote the delineation of individual factors of health and illness, while obscuring the exploration of their social and economic roots. He states that critical social theory "can aid in uncovering larger dimensions impacting health that are usually unseen or misrepresented by ideological biases. Thus, the social reality of health conditions can be both understood and changed."[17(p. 75)]

Because the theory holds that each person is responsible for creating social conditions in which all members of society are able to speak freely, the nurse is challenged, as an individual and as a member of the profession, to expose power imbalances that prohibit people from achieving their full potential. Nurses versed in critical theory are equipped to see beyond the perpetuation of status quo ideas and may be able to generate unique ideas that are unencumbered by previous stereotypes.[14]

Other Examples of Upstream Thinking

Recent nursing literature provides several other examples of upstream thinking. In a thought-provoking commentary on an intervention program for middle-aged women experiencing subclinical depression, Davis[18] (cited in Gordon and Ledray) notes a lack of congruence between the study's portrayal of depression as a problem with societal roots and its instruction in coping strategies as the intervention program. While recognizing the merits of the intervention program, she comments that, "if our principal task as progressive nurses is to develop and utilize interventions that will ameliorate these social problems, then the emphasis in nursing education and practice might well be on those social actions that aim to change basic social factors such as ageism and sexism."[18(p. 277)]

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Nursing needs conceptual foundations that enable its practitioners to understand health problems manifested at community, national, and international levels as well as those at the individual and family levels. The continued bias in favor of individual-focused theories robs nurses of an understanding of the richness and complexity of forces that shape the behavior of populations. The omission of theories that relate nursing to the social context of behavior may leave nurses with a minimal understanding of their responsibilities to facilitate change at this level and without the tools to promote such change in an effective and systematic manner.

Maglacas[21] provides a global perspective on the health conditions of societies throughout the world and draws attention to the gaps in service access between the rich and the poor. She then charges nurses within each society and culture to act in response to the inequities in health within that society. If nurses are to be able to enact change at the societal level, they need to be provided with theoretic frameworks that are consistent with such ends and with theoretic perspectives in which social, economic, and political forces are given equal weight with the interpersonal aspects of nursing. Through these means, nurses gain insight into the social precursors of poor health and restricted opportunities and learn rationales for engaging in social action. By tipping the scales of nursing back toward consideration of theories that address health from a societal perspective, nurses can receive not only a richness of understanding but also the means by which to enact this kind of change.

References

1. Dreher MC. The conflict of conservatism in public health nursing education. Nurs Outlook. 1982;30:504–509.
2. McKinlay JB. A case for refocussing upstream: The political economy of illness. In: Jaco EG, ed. Patients, Physicians, and Illness, 3rd ed. New York: Free Press; 1979:9–25.
3. American Nurses' Association. Nursing: A Social Policy Statement. Kansas City: American Nurses' Association; 1980.
4. White CM. A critique of the ANA social policy statement. Nurs Outlook. 1984;32:328–331.
5. Rosenstock IM. Historical origins of the health belief model. In: Becker MH, ed. The Health Belief Model and Personal Health Behavior. Thorofare, NJ: Charles B. Slack; 1974:1–8.
6. Becker MH, Maiman LA. Models of health-related behavior. In: Mechanic D, ed. Handbook of Health, Health Care, and the Health Professions. New York: Free Press; 1983:539–568.
7. Jones PK, Jones SL, Katz J. Improving follow-up among hypertensive patients using a health belief model intervention. Arch Intern Med. 1987;147:1557–1560.
8. Janz NK, Becker MH. The health belief model: A decade later. Health Educ Q. 1984;11:1–47.
9. Melnyk KM. Barriers: A critical review of recent literature. Nurs Res. 1988;37: 196–201.
10. Milio N. A framework for prevention: Changing health-damaging to health-generating life patterns. Am J Public Health. 1976;66:435–439.
11. Milio N. Promoting Health Through Public Policy. Philadelphia: F.A. Davis; 1981.
12. Milio N. Primary Care and the Public's Health. Lexington, MA: Lexington Books; 1983.
13. Allen D, Diekelmann N, Bennet P. Three paradigms for nursing research. In: Chinn P, ed. Nursing Research Methodology: Issues & Implementation. Rockville, MD: Aspen Publishers; 1986:23–28.
14. Allen DG. Nursing research and social control: Alternate models of science that emphasize understanding and emancipation. Image: The Journal of Nursing Scholarship. 1985;17:58–64.
15. Allen DG. Critical social theory as a model for analyzing ethical issues in family and community health. Fam Commun Health. 1987;10:63–72.
16. Waitzkin H. A Marxist view of health and health care. In: Mechanic D, ed.
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