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# Extending Family Nursing: Concepts From Positive Psychology

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## **Abstract**

This article identifies the burgeoning field of positive psychology as an important extension to the knowledge base of family nursing. Representing a new emphasis from the traditional social and human sciences, which have largely focused on problem- and deficit-based approaches, positive psychology focuses on optimal functioning and is an ideal complement to the strengths-based orientation of family nursing. Domains of positive psychology are presented and exemplars of supporting research offered. Finally, suggestions are given for ways to apply concepts from positive psychology to family nursing practice, research, and education.

## **Keywords**

family nursing, positive psychology, family strengths, resilience, positivity, optimal family functioning, family interventions

In the last decade of the 20th century, scholars and practitioners with overlapping interests in positive psychological states formed a movement later called “positive psychology” (Csikszentmihalyi & Csikszentmihalyi, 2006). Conceived as an attempt to rebalance the medical model tradition of disease and

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disorder, positive psychology is devoted to understanding what goes well in a life and examines how and why, and under what conditions, human beings flourish. As an umbrella term, it is used to organize disparate lines of theory and research into strengths, virtues, excellence, resilience, flourishing, and optimal functioning and, in general, quantifies what makes life most worth living (Peterson & Park, 2003). While not a replacement to the more problem-focused or deficit-based paradigms, it is conceptualized as a complementary and important dimension to understand the full range of human experience.

Family nursing shares a rich history of scholarship that features the importance of strengths and resiliency in families in both assessment and intervention (Black & Lobo, 2008; Feeley & Gottlieb, 2000; McCubbin & McCubbin, 1988; Wright & Leahey, 2009). This article introduces key concepts of the positive psychology field along with exemplars of supporting research. Linkages are made between concepts from positive psychology and the domain of family nursing. Finally, suggestions are offered for ways to begin to apply concepts from positive psychology to enhance and extend family nursing practice, research, and education.

## The Rise of Positive Psychology

Since its formal introduction at the American Psychological Association Convention in 1998, and the seminal millennium issue of the *American Psychologist* on "Happiness, Excellence, and Optimal Functioning" (Seligman & Csikszentmihalyi, 2000), the positive psychology movement has blossomed, giving rise to a community of scholar/practitioners devoted to improving the quality of life for individuals, families, and institutions. The rapid growth and popularity of the movement has also invited criticism. Ehrenreich (2009) claimed the movement is contributing to the vulnerability of America. She argues that the relentless promotion of positivity is to blame for everything from global warming to medical mismanagement.

The purpose of this article is not necessarily to contribute to the promotion of positivity, but rather to introduce concepts and supporting scholarship with relevance to the science and practice of family nursing. As Ehrenreich rightly points out, many claims of positive results are based on correlational associations and subject to liberal interpretation. Seligman himself agrees that enthusiasm for positive psychology has outstripped the science and that efforts need to be focused on increasing methodological rigor (M. Seligman, personal communication, June 19, 2009).

As a field, positive psychology is the scientific study of positive experiences, positive individual traits, and the institutions that facilitate their development.

It was founded on the belief that people want to lead meaningful and fulfilling lives, cultivate what is best within themselves, and enhance their experiences of love, work, and play (Duckworth, Steen, & Seligman, 2005). This has led to a focus on what individuals do well, or in other words, on understanding and fostering concepts such as strengths, resilience, and positivity. These concepts warrant discussion from a family perspective and ways that these concepts might influence family functioning.

For the purposes of this article, family will be referred to as two or more individuals who depend on each other for support, membership being self-defined (Kaakinen, Gedaly-Duff, Coehlo, & Hanson, 2010). This self-defining property highlights the importance of viewing “family” as a concept of meaning, not as the number of individuals in a treatment room. Optimal family functioning considers autonomy and connectivity, as well as self and other, to be two sides of the same coin. The family is entrusted with the responsibility to nurture both sides, and when it does its job well, these dichotomies fade (Hughes, 2009). Such a perspective requires nurses to make a paradigm shift—one that accounts for dynamic reciprocity between multiple levels of analysis and requires an ability to hold the dialectical tension across these dimensions of relational practice.

## **Individual and Family Strengths**

Family nursing has been in the forefront of advocating for a strengths-based approach that targets a client and/or family’s capacities, competencies, and resources (Clausson & Berg, 2008; Erlingsson, 2009; Garwick, & Seppelt, 2010; Feeley & Gottlieb, 2000), and a specific family nursing intervention called “commendations” has been developed to highlight these strengths (Houger Limacher, 2008; Houger Limacher & Wright, 2003, 2006; Wright & Bell, 2009; Wright & Leahey, 2009). The family nurse attempts to identify, work with, and cultivate the strengths that exist within the family system and surrounding community and does so from a collaborative or partnering relationship. Bell (2009) advocated for a strengths-based orientation that moves the therapeutic conversation toward individual and family competencies as a focus for family systems nursing.

## ***Family Resilience***

Resilience is thought to be an important component to a strengths-based orientation (Walsh, 2006). Originally identified by examining the positive adaptation of children under adverse circumstances (Rutter, 1987), resilience is

defined as those properties of individuals that help them bounce back from crisis or disruption (McCubbin & McCubbin, 1988). More recently, it has been applied to the study of family systems (Black & Lobo, 2008; McCubbin, Balling, Possin, Friedrich, & Bryne, 2002; Walsh, 2006). However, this work has still generally been approached from an individual, and not systemic family, lens.

Most, if not all of the variables of interest in positive psychology, such as growth, positive affect, efficacy, and meaning, are of relevance to the domain of family resilience. Black and Lobo (2008) identified prominent factors of resilient families based on a review of research and conceptual literature. These included positive outlook, spirituality, family member accord, flexibility, family communication, financial management, family time, shared recreation, routines and rituals, and support networks. Resilience can be developed all along the family life cycle, and learning positive interactions can enhance individual and family functioning during normative and unanticipated challenges (Patterson, 2002). In a strength-based orientation, challenges are viewed as opportunities for growth and healing (McCubbin & McCubbin, 1988; Walsh, 2006).

It has been argued that the concept of resilience can best be understood in this broad, systemic, interrelational network (Luthar, Cicchetti, & Becker, 2000). This allows us to account for the exchange of a variety of individual coping responses within a family and to identify the factors that are more salient than others to overall family resilience. Currently, there are many measurement challenges involved with the complex concept of resilience and no universal agreement. To date, positive psychology has focused on the individual, and no attempts have been made to conceptualize the variables of interest at a couple or family level. Therefore, it would be useful at this point in the development of both fields for conceptual and methodological cross-fertilization.

### ***Positivity***

A central concept from positive psychology is positivity. In order to clarify the amorphous idea of positivity or "happiness," and make it scientifically less unwieldy, the concept has been organized into three domains (not exhaustive or mutually exclusive). These domains can be thought of as the three different routes to happiness. They are pleasure (the pleasant life), engagement (the purposeful life), and meaning (the meaningful life). Research suggests that people reliably differ according to the type of life they pursue, but that the most satisfied people are those who orient their efforts toward all three,

with the greatest weight carried by engagement and meaning (Peterson, Park, & Seligman, 2005).

*The pleasant life.* The pleasant life represents positive emotions about the past (contentment, satisfaction, and serenity), the present (immediate but momentary somatic pleasure, plus more complex pleasures that require learning), and the future (optimism, hope, and faith). The pleasant life is one that maximizes positive emotion and minimizes pain and negative emotion (Seligman, 2002).

An impressive array of scholarship now documents the various components of subjective well-being, thought to include the presence of positive emotion, absence of negative emotion, and a cognitive judgment of satisfaction and fulfillment (Diener, Lucas, & Oishi, 2002). A variety of widely used self-report measures (see Duckworth et al., 2005, for specific instruments) all correlate highly with one another. Obviously, self-reports of well-being—though moderately stable over time—are also influenced by mood, the salience of other information, and beliefs about experiences that are, in part, culturally determined. One's subjective appraisal of their level of satisfaction and well-being is an important consideration in states of health or illness. Bringing the family nurses' attention to the patient's areas of high functioning, often overlooked, can provide a more complete understanding of psychological processes underlying disorders. For example, in a longitudinal study of adolescents, Suldo and Huebner (2004) found that youth who expressed positive life satisfaction were less likely to act out in the face of stressful life events.

Of particular relevance to family nurses are the studies that suggest the important influence of family relationships on subjective well-being (Diener, Kesebir, & Lucas, 2008). There is considerable attention being paid to the relationship between various states of subjective well-being and adjustment to illness. For example, findings demonstrate that high optimism increases longevity and improves prognosis in cardiovascular disease (Buchanan, 1995; Giltay, Geleijnse, Zitman, Hoekstra, & Schouten, 2004). Kubzansky, Sparrow, Vokonas, and Kawachi (2001) found a strong positive relationship between emotional vitality and lack of cardiovascular disease. In a study of health and subjective well-being in later adulthood, individual coping was more strongly associated with subjective well-being among those with high illness burdens (Schüz, Wurm, Warner, & Tesch-Römer, 2009). Optimism and positive affect were also found to be protective against physical deterioration. Following 1,558 initially nonfrail older persons for 7 years, Ostir, Markides, Peek, and Goodwin (2001) found that those with high positive affect had a significantly lower risk of frailty onset. Increasingly, subjective well-being (as measured by

optimism and other positive emotions) is being found to protect one against physical illness (Lyubomirsky, 2007).

*The engaged life.* This consists of using one's strengths and talents in pursuit of goals and to meet life's challenges. "Flow" is the reward of total engagement (Csikszentmihalyi, 1990) and a qualitatively different sort of gratification.

In a first attempt to complement the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, (American Psychiatric Association [APA] ) of the APA, Peterson and Seligman (2004) published a classification of strengths. Their general idea relies on six overarching virtues that almost every culture endorses: wisdom, courage, humanity, justice, temperance, and transcendence. Under each virtue are listed various strengths. For example, under the virtue courage are the strengths of persistence, authenticity, and bravery, and under humanity are the strengths of kindness, love, and social intelligence. The relationship of flow to strengths is that once someone has identified their signature strengths, they can begin using them as much as possible in work, love, play, and parenting. The outcome is more flow, but not necessarily more pleasure.

Of particular significance are the findings supporting the universality of these 24 individual strengths. Correlations in the rankings of endorsements in 40 different nations are approximately .80 and defy cultural, ethnic, and religious differences (Park, Peterson, & Seligman, 2005). The same ranking of greater versus lesser strengths also characterizes all 50 U.S. states and holds across gender, age, and education. As we might expect, various character strengths contribute differently to overall life satisfaction or fulfillment. For example, "heart strength" (i.e., zest, gratitude, hope, love, etc.) is more robustly associated with life satisfaction than with more cerebral strengths, such as curiosity and love of learning (Park, Peterson, & Seligman, 2004).

Engagement would be a particularly important domain for family nurses because it goes beyond the identification of particular strengths to the circumstances in which those strengths are employed. For example, how does a client's bravery or courage in the face of illness demands become mobilized and sustained? What is the role of the nurse and family members as facilitators of such a process? How does the hope displayed by one family member impact another, especially one who is less hopeful? How can a love of learning be called upon to promote a client's involvement in his/her health-care regime?

*The meaningful life.* This refers to the myriad of ways we make sense of our world—not the "meaning of life," but the meaning we make *in* life. It is about understanding where we've been, where we are, and where we're going. The outcome of such an endeavor is comprehension/understanding and purpose.

It involves being connected to a context, though what individuals connect to varies widely. For example, some find particular meaning in connections to family and friends, some to their faith community, while others find greatest meaning in work. Most of us seek meaning from multiple, overlapping contexts.

The scientific study of meaning has repeatedly demonstrated that people who believe their lives have meaning or purpose appear better off (King, Hicks, Krull, & Del Gaiso, 2006; Lyubomirsky, 2007; Mascaro & Rosen, 2005; Reker, 2005). Those who find meaning following adversity or traumatic life events report better outcomes than those who do not (Bower, Kemeny, Taylor, & Fahey, 1998; Janoff-Bulman & Yopyk, 2004). Meaning in life has also predicted successful aging, greater well-being and physical health, and less psychopathology (Steger, 2009). Skerrett (1998) reported that couples who constructed a unified meaning for a cancer diagnosis (specifically defining it as “our problem”) found that it lent coherence, provided direction, and helped them manage the accumulation of stressors and illness demands. Furthermore, a 10-year follow-up of couples suggested continuity to adjustment styles for which meaning-making proved pivotal (Skerrett, 2009).

Thus, while we have a growing understanding of the components of a pleasurable, engaged, and meaningful life, and it is useful to have these arenas differently conceptualized and examined, it is important to emphasize that they all represent reports of individual functioning. Considerable work lies ahead in conceptualizing a relational strength, for example, which is quite different than the summation of strengths of individuals. Much could also be done to apply various individual strengths and other positive dimensions of functioning to various family contexts.

## **Implications for the Practice of Family Nursing**

Family nurses, who utilize a wide lens in which individual distress is nested within a complex network of relationships, routinely assess and plan for optimal development, growth, and the prevention of illness. While few clients actually say, “Make me happy,” they often want a better understanding of what is happening to them (meaning), greater involvement in effecting outcome (engagement), and an enhanced sense of well-being (pleasure). Each of these domains has been examined in relation to positive states that we know to be qualitatively different than the absence of negative states. For example, positive emotion represents entirely separate physiological processes, mediated by a separate neural substrate and serving an evolutionary function distinct from negative emotion (Davidson, 2000; Fredrickson, 2006).

Now at the forefront of the work of leading neuroscientists and physiologists, emotion is being given a central role in the body's ability to galvanize change and guide healing. In *The Healing Power of Emotion*, Fosha, Siegel, and Solomon (2009) provide a comprehensive overview of both clinical and scientific data regarding the role of emotional regulation and transformational healing. From the neuroanatomic to the interpersonal levels, relationships form and nurture the self-regulatory circuits that enable emotion to enrich, rather than enslave, our lives. Until relatively recently, there was little evidence that an intervention could reliably produce or enhance positive states. However, data now exist about the effectiveness of positive interventions, and there is growing evidence that building positive emotion, engagement, and meaning may actually counter disorder itself. For example, the influential broaden-and-build theory of Fredrickson and her colleagues (Fredrickson, 2001; Fredrickson & Branigan, 2005; Fredrickson & Joiner, 2002) suggests that positive emotions (a) broaden people's attention and thinking, (b) undo lingering negative emotional arousal, (c) fuel psychological resilience, (d) build consequential personal resources, and (e) trigger upward spirals toward greater well-being in the future. She found that individuals who experienced more positive emotions were more likely to find positive meaning in stressful situations. Fredrickson (2006) writes that as these effects of positive emotion accumulate and compound over time, they carry the capacity to transform individuals for the better, making them healthier and more socially integrated, knowledgeable, and effective.

Specific evidence-based interventions from positive psychology have potential relevance for family nurses. Burton and King (2004) employed a randomly assigned, placebo-controlled design to test the effect of a writing intervention on mood and physical health. Participants wrote intensely about positive experiences while control participants wrote about neutral experiences. Writing about positive experiences caused a mood boost and fewer visits to the health center over a 3-month period.

Research on gratitude interventions, in which participants are asked to keep gratitude journals, found that relative to control groups, those in the gratitude condition reported feeling better about their lives in general, more optimistic about the coming week, more connected with others, and had more positive and less negative affect (Emmons & McCullough, 2003).

In a "count your blessings" intervention, Lyubomirsky (2007) found that after only 6 weeks, participants who counted their blessings weekly reported greater happiness. The intervention that targets subjective appraisals of blessings were routinely evaluated by participants as "positive." In a review of the research on happiness interventions, Lyubomirsky writes that kindness



interventions (coaching participants to do various acts of caring and compassion) were associated with numerous life-extending and life-enhancing benefits.

In a rigorous random-assigned, placebo-controlled intervention study with 471 participants, Seligman (2002) compared five positive interventions with a placebo control. Using a variety of exercises such as the “Three Good Things,” “Gratitude Visits,” and others focusing on character strengths, all participants (regardless of their assigned exercise) were happier immediately posttest. Interestingly, at 6 months, participants who voluntarily continued their assigned exercises beyond the required week were most likely to experience continued benefits.

While these studies were conducted on nonclinical populations, studies on clinical populations indicate the efficacy of these positive interventions (Seligman, 2008).

The relative simplicity of these interventions make them ideally suited to a range of clinical settings. Families in hospitals, clinics, private practice offices, and community centers can be taught gratitude modification, count your blessings, and other positive interventions. They are also easily adapted to a range in ages: Even children can identify things that they are thankful for. Skerrett (2009) has added these interventions to psychoeducational groups (Resilient Partners) designed for couples facing chronic illness and disability, with promising results. Participants remark that when both partners practiced the gratitude and acts of kindness interventions, the resulting sense of hope and optimism boosted relational resilience and coping.

It is recommended that nurses familiarize themselves with the possible range of evidence-based positive interventions. Then those options could be matched to the needs and goals of specific families. For example, the “meaning-making” interventions might be most useful in geriatric or hospice settings, applied both with the client and various family members. Focusing family members on the salience of acts of kindness and compassion (not only for their loved one but for each other as they are challenged to grieve and let go) would be a simple, yet powerful, intervention. Likewise, a meaning-making focus would be particularly useful in the acute phase of diagnostic work-ups when clients and families are struggling to understand and make sense of new and overwhelming experiences. Introducing this early on in the nursing encounter would communicate the dynamic and vital nature to the meaning-making process that will be an aspect of the family’s adjustment along the entire illness journey.

It is valuable to ask if, when, and under what conditions, it would be premature or otherwise inappropriate to introduce interventions from positive

psychology. As with any clinical intervention, it is fundamentally important to apply evidence-based criteria in evaluating the match between intervention, targeted issue for change, and the population of interest. Positive psychology tends toward a cognitively oriented approach to improving well-being, which encourages the need for clear goals and planned action within a positive frame. Clients who are not inclined toward cognitive approaches, or who have difficulty with self-reflection, would not be as suited to some of the intellectual, abstract interventions of positive psychology. Also, clients who are experiencing psychosis, traumatic reactions, or active substance use would not be optimal candidates for these interventions. Clinical judgment is essential regarding the timing of these interventions in the relationship between the nurse and client, particularly as we build a research base.

### **Implications for Family Nursing Research**

In order to begin to add to our understanding of optimal family functioning, the following areas warrant investigation: positive emotion (the Pleasant Life), positive character (the Engaged Life), and positive institutions (the Meaningful Life). All three domains may be conceptualized as contributing to optimal family functioning.

There are numerous existing measures tapping into each of these areas. Since these realms are all quantifiable, they can be used to predict numerous outcomes of interest. Many of the specific dimensions of family function identified in the literature (Kaakinen et al., 2010; Walsh, 2006; Wright & Leahey, 2009) could be subsumed within each domain as a way to identify the factors that appear to be most salient. For example, are particular kinds of communication such as clarity of expression, collaborative problem solving, or openness to feedback important contributors to the cultivation of positive relationships with the family? Does the capacity to coherently describe an understanding of, and response to, a crisis contribute to positive engagements with community resources for families of particular backgrounds? Are some aspects of social life, such as interpersonal sensitivity/emotional intelligence and self-awareness, so important that they override functioning in other domains?

Researchers can take the big picture approach and pursue the elements of the optimal family life or focus on a specific domain for exploration and development. Despite the point of entry, knowledge would be created toward a truly systemic model of what constitutes optimal family functioning for particular kinds of families at particular points along the life cycle.

The profile of optimal family functioning that emerges can then be linked to a variety of positive-outcome measures on a variety of health-related variables. For example, what aspects of positive family functioning predict the best health outcomes—the best prognosis in the face of family challenges? The aspects of positive family functioning that predict those outcomes can then become targets for new interventions and the refinement of protocols. It is important to test for interactions as well; what combinations of various positive health states are particularly predictive of longevity, prognosis, health costs, and later health status? This provides the added benefit of dissolving the dichotomous thinking of positive physical versus positive mental health. Research such as this lends itself particularly well to multidisciplinary teams who can bring both conceptual and methodological expertise to this challenging task.

What is crucial to this endeavor is the ultimate conceptualization of optimal family functioning as a family-level variable and a dynamic process—clearly a daunting task. While that is evolving, researchers must be clear that the intervention is targeted to an individual family member and must articulate the relationship of that outcome to the functioning of other family members and/or the family as a whole. An ideal design would be rigorous longitudinal studies that represent a variety of family structures, ages, and ethnic diversity and employ mixed-method designs. Families could be recruited who identify themselves as “strong” or “well functioning,” and they could be our co-theory builders in these foundational stages.

## **Implications for Family Nursing Education**

Information from positive psychology and optimal functioning could be added to nursing curricula at various levels of education. It could also serve as a guide for self-study and an ongoing source of personal feedback to inform the learning process. Students might first identify their strengths (for more information see, <http://www.authentic happiness.org>), benchmarking them as a working base as they go through the educational process. For example, a student whose five lead strengths are creativity, curiosity, love of learning, persistence, and kindness could be coached to evaluate whether or not particular projects, work settings, and other life pursuits provide an opportunity to utilize those strengths adequately. First-hand utilization such as this fosters a positive mindset and encourages application of strengths to families and other systems. A course in “Individual and Family Strengths” and/or “Optimal Development in Family Systems” would benefit generalist nursing education but would be particularly suited for advanced practice in family nursing.

A positive, strengths-based focus can powerfully influence the context of nursing education as a whole, and teachers', mentors', and supervisors' positive practices can do much to influence the learning climate. Nurses educated in collaborative, inclusive, and positive approaches with a strength-based emphasis can fortify work environments in nurturing ways that may promote retention and job satisfaction.

## Conclusion

Nurses have been calling for greater understanding of how to enable families to become and stay healthy and to struggle well with health challenges. However, more work is needed to build a strengths-based empirical foundation from which to develop models for family nursing practice. Developing scholarship that identifies what makes life worth living for individuals and families may provide that empirical base from which to leverage health promotion. The search for an optimal life is as old as humanity itself. Fortunately, we can build on the work of related disciplines as we incorporate positive psychology to inform and enrich our efforts to help families in our care to love, work, and live well.

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## Bios

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