Thinking upstream: Nurturing a conceptual understanding of the societal context of health behavior

This article 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, and 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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DESPITE acknowledgement that an understanding of population health is essential in professional nursing, descriptions of one-to-one relationships predominate in the literature read by most nurses. Such portrayals often emphasize the evolution of the relationship between nurse and client with minimal attention to forces outside the relationship that have been paramount in shaping the client's health behaviors. Yet for most people their cultural heritage, social roles, and economic situation have a far more profound influence on health behaviors than do interactions with any health care professional. Examination of nursing problems from a "think small" perspective[1(p504)] fosters inadequate consideration of these social, 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

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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 article 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(p9)] 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(p9)] 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 while 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% 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(p505)] 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(p505)] 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(p4)] 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(p19)] 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 below 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.

THE DOWNSTREAM VIEW: THE INDIVIDUAL AS THE LOCUS OF CHANGE

The health belief model evolved from the premise that the world of the perceiver determines what he or she will do. The social psychologists[5,6] who outlined this model were strongly influenced by Lewin and the view that a person's daily activities are guided by processes of attraction to positive valences and avoidance of negative valences. From these inceptions evolved a model that purports to explain why people do or do not engage in a preventive health action in response to a specific disease threat. The model places the burden of action exclusively on the client; only those clients who have distorted or negative perceptions of the specified disease or recommended health action will fail to act. In practice, this model focuses the nurse's energies on interventions designed to modify the client's distorted perceptions. Although the process of promoting behavior change may be masked under the premise of mutually defined goals, passive acceptance of the nurse's advice is the desired outcome of the relationship.

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Although the health belief model was not designed to specify intervention strategies, it can lead the nurse to deduce that client problems can be solved merely by altering the client's belief system. The model addresses the concept of "perceived benefits versus perceived barriers/costs associated with taking a health action."[6(p563)] Nurses may easily interpret this situation as a need to modify 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 sys-

tem. 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(p436)]

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 are strongly influenced by community and national locale and include the availability and cost of health services, environmental protection, safe shelter, and the penalties or rewards given for failure to select the given options.

Milio notes the fallacy of the commonly held assumption in health education that knowing health-generating behaviors implies acting in accordance with that knowledge, and she cites the life styles of health professionals in support of her argument. She proposes that "most human beings, professional or nonprofessional, provider or consumer, make the easiest choices available to them most of the time."[10(p435)] Therefore, health-promoting choices must be more readily available and less costly than health-damaging options if individuals are to be healthy and a society is to improve its health status.

The opportunities for a society to make healthy choices have been a central theme throughout Milio's work. In a recent book she elaborated on this theme:

> Personal behavior patterns are not simply "free" choices about "lifestyle," isolated from their personal and economic context. Lifestyles are, rather, patterns of choices made from the alternatives that are available to people according to their socioeconomic circumstances and the ease with which they are able to choose certain ones over others.[11(p76)]

Milio is critical of many traditional approaches to health education that emphasize knowledge acquisition and consequently 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(pp188,189)]

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 life style 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(p664)] 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(p75)]

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]

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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(p277)]

Chopoorian[19] takes a different tack, emphasizing the concept of environment and suggesting that nurses develop a consciousness of the social, political, and economic aspects of environment. She maintains that a static portrayal of the environment precludes nurses from acting as advocates for people who lack adequate housing and health care and live in intolerable circumstances. She charges nurses to move beyond a psychosocial conceptualization of the environment into a sociopolitical–economic conceptualization. Through this reconceptualization, nurses will see that human responses to health and illnesses "are related to the structure of the social world, the economic and political policies that govern that structure, and the human, social relationships that are produced by the structure and the policies."[19(p46)]

THE NEED FOR ALTERNATIVE PERSPECTIVES

The danger of the conservative perspective lies not within its content, but rather in the omission of other, larger theories that enable nurses to view situations from both a microscopic and a macroscopic perspective. In discussing the dilemmas of "studying health behavior as an individual phenomena [*sic*], rather than in the context of a broader social change phenomena [*sic*]," Cummings[20(p93)] reminds us that the approaches are complementary, and both are necessary to a comprehensive understanding of health promotion. The strengths and utility of each theoretic approach are most clearly revealed through an understanding of alternate approaches.

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.

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