

**Chapter 11**

**FAMILY HEALTH ROUTINES:**

**THE SOCIAL CONSTRUCTION OF FAMILY HEALTH**

Chapter 11 Content Outline

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**Chapter Objectives:**

At the conclusion of this chapter, students will be able to:

- Explain ways rituals enhance family life.
- Define what is meant by the concept of family health routines.
- Discuss family health routines as the structural aspect of the household production of health.
- Describe relationships between contextual and functional factors and family health routines.

*The function of ritual is to give form to human life, not in the way of mere surface arrangement, but in depth.*

-Joseph Campbell  
“Myths to Live By”

*This chapter provides a comprehensive view of family routines as a structure used by family members within the household niche to discuss knowledge, resources, and behaviors that address health needs. The Family Health Model posits that all families have ritual-like practices relevant to health that members can recall and describe regardless of the family configuration, member traits, or cultural context. Steinglass, Bennett, Wolin, and Reiss (1987) studied alcoholic families and found that routines and rituals were excellent clinician-research tools because (a) daily routines can be observed and specific behaviors recorded and (b) family members could verbally reconstruct family rituals. Family-focused practice implies that family routines should be a central focus for practitioners targeting family health. Routines provide insight into the actual behaviors pertinent to health and are amenable to nursing’s scope of practice and nursing actions.*

## **RITUAL AS A FOUNDATION FOR FAMILY HEALTH**

### **Rituals**

Rituals are often considered from anthropological and sociological perspectives, but less attention has been given to potential biological, health, or nursing perspectives. Rituals or routines are widely discussed in some literature, but have been ignored largely by nurse clinicians, educators, and many researchers (Denham, 1995). Ritual has been defined

as “an act or actions intentionally conducted by a group of people employing one or more symbols in a repetitive, formal, precise, highly stylized fashion” (Myeroff, 1977, p.199). Rituals are “conventional acts of display through which one or more participants transmits information concerning their physiological, psychological, or sociological states either to themselves or to one or more participants” (Rappaport, 1971, p. 63). Ritual is a social performance (Goffman, 1959), a systematic occurrence with characteristics of prescription, rigidity, and rightness (Bossard & Boll, 1950), and a stabilizing force for past patterns and “responses to changes in the present and anticipation of the future” (Cheal, 1988, p. 642). Rituals link private and public meanings and create opportunities to express acceptance or demonstrate rejection of social standards (Roberts, 1988). Secular rituals tend to include the relationships between individual behaviors and collective ceremony without offering specific explanations, while religious rituals seem to provide a canon of principles to explain behaviors (Moore & Myeroff, 1977).

Ritual has a form of sanctity in human communication and a process described as having three key properties: transformation, communication, and stabilization (Wolin & Bennett, 1984).

Transformation is the time that precedes the actual ritual (e.g., shopping for Thanksgiving dinner, planning vacation) and has been described as liminality, a time where the fullness of what is to happen as a result of the ritual has not been completely realized (Turner, 1977). Communication is

the dynamic interactive stage of the ritual where participants actively engage in the experience and invite emotional involvement and interactions in ways that differ from non-ritualized events. Stabilization has to do with the continuance or predictability of the event and provides a means for linking the past, present, and future.

### **Family Rituals**

Bossard and Boll (1950), in a study of family rituals from 1856 to 1949, defined family rituals as “a pattern of prescribed formal behavior pertaining to some specific event, occasion, or situation, which tends to be repeated over and over again” (p. 9). Family ritual is “a symbolic form of communication that, owing to the satisfaction that family members experience through its repetition, is acted out in a systemic fashion over time” (Wolin & Bennett, 1984, p. 401). Family rituals are formal repetitive patterns that enhance the family’s self-image and express it to members and non-members (Reiss, 1981). Weisner (1984) suggested that daily routines were central to the family’s drive to construct and sustain a pattern of care, supervision, and stimulation for children that fits with family goals and meanings. The household niche provides opportunities to model and reinforce family values. Family rituals sometimes include a sense of social consciousness where family members demonstrate their family pride (e.g., entertaining guests, attending church together). “Family rituals may be perceived as being a fairly reliable index of family collaboration, accommodation, and synergy” (Denham, 1995, p. 17).

Family rituals provide information about members' relationships, changes occurring within the family, the ways crises and information affects needs, things members value and believe, and ways families celebrate and live daily lives (Imber-Black & Roberts).

Imber-Black and Roberts (1992) identified four types of family rituals. The first type is day-to-day essentials (e.g., eating, sleeping, hello, goodbye), meaningful actions that provide set patterns in the course of the day that provide expression of family identity and member connections. A second type of ritual is traditional times when usual patterns are altered to celebrate special events (e.g., anniversaries, birthdays, reunions, vacations) accompanied by memorable customs with unique family adaptations. A third type of family routine is holiday celebrations (e.g., Christmas, Kwanza, Passover, Halloween) or events that link the family to the outside community and culture. The fourth type of routines was noted as lifecycle rituals (e.g., baby showers, confirmations, Bar and Bat Mitzvahs, graduation, weddings, retirements) or events that mark life course journeys and only happen once. Table 11.1 provides an overview of some other ways that family rituals have been interpreted in the literature.

<<<<<<INSERT TABLE 11.1>>>>>>>>

### **Family Routines**

The terms ritual and routine are sometimes used interchangeably when discussed in terms of celebrations and traditions, but far fewer references are identified about relationships with health promotion, health maintenance, disease prevention, illness care, health recovery, or end-of-life care. Routines have been described as “repetitive behaviors that may or may not have symbolic significance to the family and often lack historical embeddedness” (Denham, 1995, p. 15). Family routines are behavior patterns related to events, occasions, or situations that are repeated with regularity and consistency (Bossard & Boll, 1950; Fiese, 1993; Imber-Black & Roberts, 1992; Reiss, 1981; Steinglass et al., 1987). Patterned behaviors are characterized by exactness or precisioned occurrence, a degree of rigidity in performance, and a sense of correctness in their existence (Bossard & Boll). Family routines appear to have a strong intergenerational component and are a way families teach members valued behaviors (Denham, 1997, 1999b; Fiese, 1992, 1995; Niska, Snyder, & Lia-Hoagberg, 1998; Wolin, Bennett, Noonan, & Teitelbaum, 1980) and may be a way to dialogue about family care when talking with individual patients” (Rogers & Holloway, 1991). Family meals are an example of routines that reflect the ways members share life together as well as family themes (DeVault, 1991).

Family routines have been identified as key structural aspects of family health that can be assessed by nurses, provide a focus for family interventions, and have potential for measuring health outcomes (Denham,

1999a, 1999b, 1999c). Routines provide a means for family members to conceptualize and discuss the household production of family health (Denham, 1997). Family routines have “universal attributes of family life, varying only in content and frequency from family to family” (Sprunger, Boyce, & Gaines, 1985, p.565) and provide information about predictable family behaviors (Keltner, Keltner, & Farran, 1990). Routines supply information about behaviors and their predictability, member interactions, family identity, and specific ways families employ values. Patterned routines help members define roles and organize daily life, but participants seldom consciously plan them (Bennett, Wolin, & McAvity, 1988). Routines are recognized with great consistency by multiple members and can be recalled, discussed, and taught (Denham, 1997; Fiese, 1995). While routines are dynamic and evolving, once patterns are patterned, members usually strive to retain these patterns. Routines appear to be resilient and unique to family households, but potential to modify them still exists.

**\*\*\*\*\*Unnumbered Box 11.1**

**Cooperative Learning \*\*\*\*\***

Ask students to find a partner and brainstorm together about family routines they can recall from their childhood. These routines may or may not have to do with health concerns. After a list has been created, have students prioritize the three most important routines in their family of origin experience. Then have the class share together about how family routines have changed over the years. Discuss whether these routines are still continued within families of origin and ways they have been altered over time. If some students are now part of another family, then discuss ways routines are different. Discuss new routines class members may have intentionally tried to initiate in their family.

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**Therapeutic Rituals**

Although nurses have not usually considered the use of ritual as a therapeutic intervention, the concept has been used widely in family therapy. In 1977, Palazzoli, Boscolo, Cecchin, and Prata first described the use of prescribing family rituals in family therapy as a valuable intervention and since then many have referred to the therapeutic merit of rituals (Bennett, Wolin & McAvity, 1988; Cheal, 1988; Rogers & Holloway, 1991; Starr, 1989; Whiteside, 1989). Doherty (1997) described the “intentional family” as one who deliberately creates meaningful actions associated with repeated behaviors. Therapeutic rituals can be used to assist families resolve conflicts and resentments, negotiate roles and boundaries, develop shared meanings, and mobilize resources for healing and growth (Bright, 1990). The successful use of ritual as a therapeutic modality with families by other disciplines appears to provide support for considering their use in nursing practice and family-focused care.

### **THE CONCEPT OF STRUCTURE**

In the Family Health Model, the term structure is used to understand the ways family members use beliefs, values, attitudes, information, knowledge, resources, and prior experiences to structure behaviors that impact health. It is posited that family routines provide a structure for understanding the complex interactional patterns that affect the household production of health and give insight into family lifestyles, member behaviors, and actual practices. “Family routines provide a predictable environment and predictable timing for interaction among

family members” (Keltner, 1992, p. 129). Box 11.1 provides a list of assumptions derived from the family health research and author’s knowledge and experiences about relationships between families, health routines, and family health.

<<<<<<INSERT Box 11.1>>>>>>>>

The Family Health Model suggests that health routines are important ways to measure interactions among embedded contextual systems, family functional status, and member health variables within the household. Routines provide a way for nurses, family members, and others to discuss health practices, behaviors, and knowledge, identify family goals, and create plans for optimizing processes of becoming, health, and well-being. Routines also provide ways to strategize about care needs related to illness, episodic or acute conditions, health promotion and protection, and health seeking actions. According to Jensen et al. (1983), “family routines may be viewed as behavioral units of family life which provide order and structural integrity to the course of daily events” (p. 201). Steinglass et al. (1987), researchers who have studied alcoholic families, have described routines as “Background behaviors that provide structure and form to daily life” (p. 63). Daily routines reflect a family’s temperament and “the way these routines are structured is more directly determined by such properties as the family’s characteristic energy level, preferred interactional distance, and behavior range” (Steinglass et al., p.64).

## **Differing Perspectives About Structure**

Structure has been widely discussed in the literature for decades. Structural perspectives are used to observe, measure, and illuminate processes and procedures of small groups (Cattell, 1953), provide information about family relatedness and interactions (Straus, 1964), and suggest ways to view absolute, relational, comparative, and contextual properties of complex organizations (Lazarsfeld & Menzel, 1969). Eshelman (1974) discussed structure based on power (e.g., matriarchal versus patriarchal), family form (e.g., nuclear family versus single parent family), and marital patterns (e.g, marriage within a racial group versus bi-racial marriage). Family lifestyle has been viewed as structural patterns of family organization (i.e., value system, communication networks, role systems, power structure) that are important when the family faces stress (Parad & Caplan, 1965). Structure has been described in terms of being closed (i.e., stability through tradition), open (i.e., adaptation through consensus), and random (i.e., exploration through intuition) (Kantor & Lehr, 1975). Family types were considered in relationship to access distance regulation (i.e., space, time, energy) and target distance regulation (i.e., joining-separating, freedom-restriction, sharing-not sharing).

According to Minuchin (1974), structure refers to the ways a family is organized, the sub-systems it contains, and the rules relevant to family interactional patterns. The family therapy model views family as an open sociocultural system faced with internal and external demands and

change. Families are comprised of subsystems with differentiated boundaries that provide indicators of family function (e.g., disengaged family versus the enmeshed family) and the goals of therapy with this framework is to assist the family to restructure themselves in a more functional way (Minuchin & Fishman, 1981). The structural-functional perspective implies that members' abilities to cope with demands and change are influenced by their interactions, responses to change and demands, and family organization.

Pratt (1976) viewed family health as a result of a family energized and structured so that developing members could fully develop their unique potentials to support interdependent actions that contribute to health. A sociological perspective described family health as the "general level of health in a family so inextricably intertwined with the patterns of family relations that health itself becomes a vital aspect of the fabric of family life" (Pratt, p. 139). Pratt's energized family structure includes:

- Family responsiveness to individuals' autonomous needs and interests.
- Abilities to actively cope with life's stresses and necessities.
- Flexibility in task accomplishment.
- An egalitarian power distribution.
- Regular and diverse forms of member interaction with family and others.
- Positive personal and composite health practices.

Pratt's view of family structure is connected with both context and functional status.

### **Nursing Perspectives of Structure**

The term structure is repeatedly used in the nursing literature to discuss family organization and is identified as an important aspect of family health.

We propose that the nursing perspective of family health should link family structure, function, and health variables (including both wellness and illness), incorporate the biopsychosocial and contextual system aspects of nursing, specify the paradigm view, and address the levels of family interaction with the nurse. This definition suggests a paradigm shift where family health embraces more than the health of individuals as parts of a family, but recognizes the family health system as the central phenomenon of the study. (Anderson & Tomlinson, 1992, p.59)

Gilliss (1991b), when discussing the nature of family, noted “there is a lack of consensus about what should be evaluated and how selected methods might access the data that make the family unit more than the sum of its parts” (p. 198). Much in the current literature related to family structure seems more germane to therapy and focuses on members’ psychosocial interactions.

In nursing, the concept of structure has been used to describe characteristics such as member roles, family form (e.g., nuclear, single parent, blended), family subsystems, power structures (e.g., matriarchal, patriarchal), communication processes, and value systems (Friedman, 1998). Friedman uses a structural-functional approach to understand the ways families use structure and function within their systemic context to strive for equilibrium. Rather than take a systemic view of stability obtained through feedback loops and circular causation, the structural-functional perspective “tends to resort to more “part analysis,” linear

notions of causality, and more static views of family” (Friedman, p. 165). The structural-functional approach primarily focuses on the ways family parts are arranged to form the whole and concentrates on the ways they function to meet society and sub-system needs. Friedman targets communication patterns, power structure, role structure, and family values for assessment and intervention. Structure and function are viewed as equally important content areas.

In the Calgary Family Assessment Model, family is described in relationship to its internal structure, external structure, and context (Wright & Leahey, 2000). The internal structure consists of six sub-categories: family composition, gender, sexual orientation, rank order, subsystems, and boundaries. The external structure is comprised of the extended family members and larger systems. The context consists of ethnicity, race, social class, religion, and environment. These authors suggest that assessment tools such as the genogram or ecomap provide visual tools for decreasing ambiguity about the family’s internal and external structure. They perceive that change is determined by structure of the system. Structural determinism suggests the unique status of an individual’s structure determines whether interpersonal, intrapersonal, and environmental influences are interpreted as agitating or bothersome (Maturana & Varela, 1992). This implies that distinct structural aspects affect the ways change occurs across the life course.

In the Framework of Systemic Organization, Friedemann (1995) refers to family structure as persons in the household, other family members, children, significant persons of support, and persons who drain resources. The model focuses on family ability to maintain congruence in the midst of change. The ability to adjust to normative changes and reestablish congruence within the family as a whole, between family members, and between the family and the environment are ways to consider health in families. This systems model uses structure as a way to identify the family actors who affect and respond to health-illness needs and crises. The framework is a “structure to organize assessment data of complex situations, determine on what level to enter the system, set goals with the clients, and find ways to pursue them” (Friedemann, p.348).

**Unnumbered Box 11.2**  
**Critical Thinking**

Think about the concept of structure and consider the ways you structure your daily life. List all of your routines that are related to health. How often do you participate in these routines? Do other members participate in these routines? Is your life highly structured with many routines or is it mostly unstructured with few routines?

Choose one routine area that you would like to change? Have you tried to make changes in the past unsuccessfully? If you failed, why do you think this happened? Do others in your family think you need to alter this routine? Do other members in your family influence your routine? In what ways are you influenced? Are there things within the family context that influence your routine? What are those things?

Think about nursing practice. If you met a person with concerns similar to your own, then what kinds of interventions might you provide? What kinds of support might a family nurse provide to assist families in making changes in routines? What would the nurse need to know in order to help families in meaningful ways? How much support would families need? How long would they need it?

If you had to write a nursing care plan for yourself, what would it look like?

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## **STRUCTURAL PERSPECTIVES AND FAMILY HEALTH**

### **Use of Structural Perspectives in Research**

Two concerns exist related to the use of structure to understand family health. The first concern is that although an extensive body of research has used a structural perspective for decades to investigate topics such as psychological processes, health and illness concerns, parenting effectiveness, substance abuse, risk behaviors, and treatment outcomes. While findings in many of these studies may have some relevance to nursing practice, applicability is not always clear. For example, Silver, Stein, and Dadds (1996) studied psychological adjustment and illness severity s in children with chronic illness by dividing them into four different family structures (i.e., two biological parents, mother plus another adult relative, mother plus unrelated spouse or partner, mother alone). Findings indicated that greater relationships existed between children's health and adjustment when children lived with the mother and unrelated partner or mother alone families, than when the mother lived with either the biological father or another adult relative. Children in the mother plus unrelated partner group tended to have poorer overall adjustment than children in the other three groups. While these findings have relevance to understanding the impact of family structure on children's health, the nurse may be able to do little about altering the

partnering relationship status. Another study found that boys in both mother-father and mother-male partner families were significantly less likely than boys in mother-alone families to be rated as aggressive by teachers is interesting information (Vaden-Kiernan, Ialongo, & Kellam, 1995). Family structure gives little information about other family processes that may also be predictors of the aggression nor does it assist in choosing preventive actions. Nurses interested in impacting health of families may not identify the findings from many structural studies about families useful.

Although studies often provide attention-grabbing findings related to family structure and functional outcomes, the results are not extremely helpful to nurses interested in health care perspectives. For example, a longitudinal study of three ethnic groups identified increased family conflict over 3-years for all groups, but significant differences were found between nuclear and single-parent families (Baer, 1999). Another study about family functioning and adolescent well-being compared parenting styles and family configuration and found parenting was the main determinant of both family functioning and well being of the adolescents not family configuration (McFarlane, Bellissimo, & Norman, 1995). Jenkins and Zunguze (1998) compared drug use in adolescents in grades 8, 10, and 12 who lived in single-parent (both mother- and father-headed), stepparent, and intact families from northeastern Ohio. Findings indicated the largest significant group differences were between single-parent,

father-headed, and intact groups, with adolescents from father-headed families showing more frequent beer and liquor consumption at the 10th grade level. Another study compared adolescent drug use and parent-adolescent distress in a sample of African American 10<sup>th</sup> graders found no significant differences in the ways either gender or family structure moderated the relationship, but peer influence and drug use increased with the level of mother-adolescent distress (Farrell & White, 1998). Decision-making of Australian adolescents from one- and two-parent families was compared and findings indicated that those with one-parent participated in a greater number of family decisions (Brown & Mann, 1990). A study of families from the Netherlands examined the effects of transitions in family structure (i.e., stable intact families, conflict intact families, single-parent families, stepfamilies) on physical health, suicidal ideation, mental health, relational well-being, and employment and found that young people from single-parent families had the lowest scores (Spruijt & Goede, 1997). Nurses are seldom able to alter many aspects of family structure, but they are able to assist and support family members in ways that are pertinent to processes of becoming, health, and well-being.

Other examples from the family research literature also suggest that minimal application to nursing practice is derived from some structural perspectives. For example, structural analysis has been used to study family, households, and care of frail older women with findings indicating significant differences between arrangements between childless

and other older women and less striking, but consistent differences depending on the number and sex of living children (Soldo, Wolf, & Agree, 1990). Family structure and changes in living arrangements were compared in elderly non-married parents and findings indicated that those with more children are more likely to change from living alone to living with a child (Spitze, Logan, & Robinson, 1992). While the number of children does not affect the odds of moving from living with a child to other arrangements nor does child's gender affect tendencies to begin co-residence, but a slight increase in the movement out of co-residence was noted with sons. Results of studies such as these are interesting, but how do they apply to nursing's scope of practice?

How can a nurse use knowledge about family structure? Assisting families to stay intact is certainly of concern to nurses, but when the structure has already fractured prior to the nurse-family encounter, then what interventions can the family nurse use to address the areas of practice where nurses have the greatest concern? It seems that nurses need more tangible ways to focus on the structural issues pertinent to nursing practice and family's health-illness needs. Merely knowing about family structure does little to inform nurses about how to optimize the structure and suggests little about how to intervene in health concerns. Knowing that families with children and those that are childless may have different needs certainly is useful information, but how can nurses use this information to address family health needs?

Family scientists and family physicians tend to use inconsistent definitions of family health and to approach the concept primarily from a psychosocial functioning perspective without integrating specific health variables of significance to nursing. In part this is a consequence of compartmentalized knowledge and methods designed to study intra- and inter-individual interactions, not systemic and ecosystem interactions. (Anderson & Tomlinson, 1992, p.60).

Perhaps it is time for nurses to investigate some alternative ways to consider structure that might be more amenable to nursing practice and aimed at health concerns.

### **Structural-Functional Perspectives and Family Health**

A concern about the use of structural-functional perspectives to guide nurses' thinking about family health has to do with conceptual confusion in the model itself. Although the range of concepts included in a structural-functional perspective certainly have relationships to family health; historically, the model has not clearly focused nurses' thinking about family-focused practice in ways that targets family health concerns. The model seems to focus on analysis and linear causality of family interactions that are not always pertinent to nursing or family health.

Nursing has long used theories developed by disciplines external to nursing, as long as the application of the theory was appropriate and meaningful. A problem has been that the interpretation of appropriateness and value has mostly been an individual act without consensus from the discipline. The consequence of private interpretations being the rule rather than the exception is a lack of empirical evidence in many practice areas. Nurses are often more willing to be followers than leaders, trusting the

traditions of practice without critically thinking or judiciously weighing effectiveness or outcomes. For example, in family nursing many standardized measures available have been based on theoretical frameworks derived from family therapy. Although the validity and reliability for family instruments have been well established (e.g., F-COPES, FILE, FACES), less attention has focused on critically evaluating the merit of these instruments for family-focused practice. Ann Whall (1995) said:

Because each discipline has its own societal mandate and perspective, theories external to nursing were not adequate to the task unless they were reformulated. Moreover, I believed then, as I do now, that nursing could and should not just reform existing theory external to nursing but should also develop its own family theory. (p.vii)

According to Friedemann (1995), the theoretical formulations presently available to nurses are still not “specific enough to serve as practice guidelines and models for family research and the formulation of hypotheses” (p. ix).

Fawcett and Whall (1991) said that the frameworks needed for family nursing practice must be distinguished from those used by other disciplines and should incorporate nursing knowledge, nursing actions, and incorporate family and member goals. Feetham (1991) indicated that “a clear and explicit conceptual or theoretical framework derived from existing family perspectives” is needed to provides a “complete and logical linkage of the framework to the empirical aspects” (p. 58) of family practice and research. As nursing increasingly focuses on

outcomes, evidenced based care, and measurable interventions, attention to the ways frameworks from other disciplines are used to answer nursing questions or direct practice becomes increasingly important. Answering questions with current interpretations of structural dimensions may continue to produce knowledge that is less applicable to family-focused practice.

Friedemann (1995) has suggested several problems inherent in the use of linear approaches derived from structural-functional models:

- Linear models defy systemic principles and offer no provisions for exploring continuously evolving processes.
- Claim to leading to objective truth are challenged when individual views of family and health are subjective.
- Lack solution to the unit of analysis for family problem.
- Focus tends toward central tendencies, but neglects issues of diversity.
- Fail to consider change over time. (p. 182-184)

Substantive programs of research relevant to family health are needed to extend the body of knowledge relevant to nursing. Models that include member roles, family processes, and health indicators using systematic and contextual perspectives are needed to guide family-focused practice. Nurses need to explore the continuums, dichotomies, and holistic perspectives pertinent to family behaviors and embedded household niches.

In Friedman's (1998) Family Assessment Model, the health care function includes the following assessment areas:

- Family's health beliefs, values, and behaviors
- Family's definition of health
- Family's perceived health status and illness susceptibility

- Family's dietary practices
- Sleep and rest habits
- Physical activity and recreation
- Family drug habits
- Family's role in self-care practices
- Medically based preventive measures
- Dental health practices
- Family health history
- Health care services received
- Feelings and perceptions regarding health care services
- Emergency health services
- Source of payment
- Logistics of receiving care

Although relationships between these criteria and family health exist, the generality of the topics do little to inform nurses about relationships and give little guidance for how to use assessment data for planning interventions. Although the structural-functional model serves nursing practice well in some areas, the schema lacks the specificity needed to direct family-focused practice.

Use of structural-functional models has mostly targeted individuals with families viewed as the context of care rather than the unit or target of care. Nurses less prepared to address family concerns may not be able to use individual assessment data in ways that result in valued family interventions. Hoffman and Lippitt (1960) identified 11 approaches to family life and child development that may be pertinent to family health:

- Parental background
- Current setting
- Family composition
- Relationships between parents
- Character of the individuals who parent
- Child-oriented parental attitudes
- Overt parental behaviors

- Child orientation toward parents and siblings
- Overt child behaviors toward other family members
- Personal character of the child
- Behavior of the child away from parents

While these assessment areas target structural-functional relationships and consider some contextual aspects, emphasis on biophysical or specific health areas is lacking. Vagueness about structural-functional perspectives may not necessary directions for attending to the breadth, depth, and scope of family health.

Structural models mainly focus on internal nature and less effectively consider powerful contextual factors that are potentiators of family health. The Family Health Model suggests that nurses consider structure as ways families receive, store, process, and respond to health information, knowledge, and experiences and socially construct patterned behaviors. The model implies that family routines provide a structural perspective that captures health beliefs, values, traditions, experiences, knowledge, skills, and behaviors of multiple members in a household niche. As structure, family routines provide ways to assess, intervene, measure, and evaluate factors related to the contextualized family's usual functional interactions germane to health.

## **FAMILY ROUTINES AS A SOCIAL CONSTRUCTION**

### **Introduction to Social Constructionism**

Family health routines are basic structures of family life that can be operationalized according to cultural rules related to health and illness situations. Health routines are also a powerful language that gives insights

into the societal notions, policy, and politics about health and illness. A social constructionist view allows for cultural pluralism, an understanding that truth and knowledge are culturally specific and embedded in the routines of family life. Kuhn (1970) said science does not proceed by a slow growth of facts, but by revolutionary shifts where an accepted paradigm replaces another. The idea of modern refers back to the end of the 17<sup>th</sup> century, a time often referred to as the enlightenment period when reason, rationality, and science rather than the religion or myth began to be used to explain the world. For example, in earlier times people thought that the earth was the center of the universe and the sun moved around it. It was not until the time of Galileo (1564-1642) that this absolute truth was brought into question and the earth discovered to be part of the larger universe. Fact became fiction when new truth was uncovered and revolutionized thinking. Perhaps it is time to revolutionize some thinking about nursing's' scope and methods of practice!

Arnold Toynbee first coined the term post-modernism in 1939, when he proposed the idea that the modern era ended somewhere between 1850-75. Although the idea of *post-modernism* is a concept appearing in a variety of disciplines, the term is difficult to define. Modernism often refers to an objectivity once provided by an omnipotent narrator with a clear-cut moral position undergirded by faith in humankind's advancement through technology and rational planning. Post-modernism is an academic term used to refer to times or things that are dynamic, evolving, and

changing. Post-modernism favors parody and irony and focuses on reflexivity, fragmentation, discontinuity, ambiguity, and simultaneity and is often associated with terms such as structuralism, *deconstruction*, *reconstruction*, and *social construction* to describe a world rich with diversity, pluralism, and evolving science, information, and technologies. Relativism, often associated with ideas of post-modernism, argues that there is no such thing as absolute or objective truth and reality has no meaning apart from what is viewed as real.

Deconstruction implies the need to look at systems or structures, rather than at individual concrete practices, because structures have a point of origin or something that created the system in the first place. Thus, one might argue that the family is the center of the household production of health and the embedded cultural context is a significant point of origin for family structures or routines relative to family health. The embedded context and functional processes provide the impetus for the ways ideas and behaviors related to health are formed. Routine structures or patterned behaviors are family members' social constructions through which the household production of health can be observed, measured, evaluated, and provide an entry for intervention over the life course of the family.

Health routines are complex systems, structures characterized by binary pairs or the opposition of terms placed in some sort of relationship to one another (e.g., health/illness, life/death, fit/feeble, strong/weak, potentiating/negating, support/isolation). Jacques Derrida (1976), a

leading figure in the thinking about deconstruction, argues that in Western culture all binary pairs value the first term over the second (e.g., light/dark, masculine/feminine, right/left). According to Derrida, deconstruction has to do with overthrowing and displacing the hierarchy. Newly created families often need to disassemble accepted or valued practices from the family of origins as they create different systems of meaning. Claude Levi-Strauss, a French anthropologist, is known for his development of structural anthropology. In his book “The Elementary Structures of Kinship,” he argues that kinship relations represent a specific kind of structure and in his book “The Raw and the Cooked,” he explains how myths are structures that provide understandings about cultural relationships. He discusses binary pairs or opposites as the basic structures for all cultural ideas and explains that different cultural myths have some similarity because they are based on structural sameness. One might say that family routines are the structure or embodiment of the family’s myths about health! Routines provide an imperative to consider health from cultural and population perspectives influenced by embedded contexts. Levi-Strauss argued that myths consist of units put together according to rules that use binary pairs or opposites to form associations and provide structure. In the Family Health Model, it is posited that binary pairs (e.g., well or sick, health or disease, pain-free or pain, dependent or independent) are culturally defined within families. Family values and

themes result and inform members about ways to socially structure their lives and incorporate health routines.

If gender is viewed as a system of cultural signs, then the meanings that constitute gender have a direct effect on how individual lives are lived, how social institutions operate, and how health is understood and practiced. Gender is an area where we continue to have discourse. If we look at the binary opposition (i.e., masculine/feminine), masculine is almost always privileged and privilege has the direct effect of enabling men to occupy positions of social power more often than women.

Bricolage is the use of terms without acknowledging the whole system of thought that produced these terms and ideas. An example of bricolage is our common use of Freudian terms like penis envy and Oedipus complex without fully understanding the whole system of thought that leads to the meaning. Judith Butler (1999), a feminist, discusses Freud's forms of psychoanalysis as a meaningful way to think about gender in a postmodern form. She questions the idea that a person is male or female, masculine or feminine and tries to demonstrate that gender is a social construction and a performance where persons use signs, symbols, and costumes or disguises. Butler's discourse frames questions from perspectives different from Freud and suggests that many possibilities of gender arise from family narratives. She concludes that gender is neither a primary category governed by single identification with one sex nor a set

of properties governed by the physiological processes, but instead gender is a set of internalized signs imposed on the mind and body.

How do cultural contexts shape everyday lives? Deconstruction is a way to show the multiple layers of meaning at work in any interactive process. Michel Foucault (1926-1984) studied history from a position of discourse and attempted to show that the ways people think about truths, human nature, and society change over time. He used discourse, a formal and orderly way to think and write that has no fixed rules about how language is used. Discourse is culturally determined and possesses power to engage, but under certain conditions, some discourses are preferable. For instance, Foucault suggested that the idea of madness described persons in an earlier historical time as demon possessed or village idiots, but they are now considered mentally ill. When society embraces a common body of thought it is then interpreted by behaviors, actions, symbols, and ideas in a universal way. Therefore, the present discourse about health is different from a century ago and even several decades ago. The historical period provides a language for the discourse about health/illness and family routines emerge that respond to the current discourse. A discourse about health might argue that the imposed context presently based upon payment for medical care largely determined by insurance companies, employers' willingness to pay, reimbursement systems, managed care organizations, and policy has little to do with societal needs pertaining to health. The foci of the present discourse are illness orientations, medical management of

disease, and profit, whereas a different discourse might talk more about well-being, self management, and population needs.

One could discuss binary understandings and the discourses as part of social constructions made by distinct cultural groups. A structuralist model argues:

- Language produces reality
- Perceptions of reality are framed by the structure of language
- Meaning is understood through language
- Identity is intrinsically linked to the linguistic system

The Family Health Model suggests that the following premises guide the family's social construction of the household production of health:

- Meaning is understood through difference.
- Opposites structure meaning.
- One knows the whole by its parts.
- Signs and symbols have attributed meanings.
- Health is constructed through the signs and symbols of the culture.
- Health becomes part of collective family experience as signs and symbols are interpreted based upon cultural directives.
- Cultural signs and symbols identify ways to construct family health routines.
- Family relationships govern participation and forms of family health routines.
- Family health routines become more meaningful as they are shared.
- Meaningful family health routines are the structural language of family health.

A post-modern view suggests that society is not based upon absolute truth, but instead ideas of relativity offer many explanations from a variety of perspectives. A post-modern view allows for the possibility that each question has an infinite number of answers all equally valid with no single paradigm providing an absolute answer. Post-modernism tolerates fragmentation of ideas, possibilities, progressive arguments,

pluralism, discontinuity, and contextual indetermination. The Family Health Model suggests that (a) family health routines are a social construction for considering health from a structural perspective, (b) family health is closely linked to the family household, member routines, and embedded context, (c) family routines are socially constructed within household niches in response to embedded contextual systems, (d) social constructions of family health differ when embedded contextual systems differ, and (e) routines structure and order members' lives and serve to organize health in the household niche.

### **Unnumbered Box 11.3**

#### **Critical Thinking**

Suppose you were working with a first-time mother seeking prenatal care. Think about those things important for giving the newborn a healthy start. Make a list of things that the mother should know and do that will potentiate the newborn's health during the first year of life. Consider the possible variations in culture and think about what differences might imply about mother's knowledge, experience, and concerns related to parenting. Think about how those things might be incorporated into family routines.

Identify three family routines that could give the newborn a healthier start and would be health promoting for future development. For each routine, identify specific outcomes in terms of both the mother and the newborn that nursing can achieve in each routine area. Next, list specific nursing interventions appropriate for routines that could be addressed during the prenatal period. When will the intervention occur? Will it need to be reinforced, if so how often and by whom? What resources or supports will the mother need? Who else in the family might need to be involved in the intervention?

Next, list assessment areas to be completed prior to the baby's birth. What things will need to be assessed after the birth? How and when will outcomes be evaluated? How would interventions related to routines be addressed after the birth of the child? Do you think nurses can be effective in assisting new families in forming health routines? What impediments might you foresee? How would practice need to be adjusted to include family health routines?

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### **Routines in Early Childhood**

Early childhood is a time when health information is absorbed and health practices are formed, this period of life is when family health routines with lifelong implications are socially constructed. It seems that better interventions for assisting families create meaningful health routines that incorporate empirical evidence about health practices into everyday life are needed. For a long while it has been thought that young children do best when they have consistent care provided with regularity and in predictable ways (Bailey & Wolery, 1984; Crittenden, 1989). While nurses need to assess the care parents' provide, families also need assistance in designing routines that address nutrition, health, safety, and interactions (Lubeck & Chandler, 1990). Families with young children need to be taught about environmental, developmental, and behavioral issues or the ecobehavioral daily care-taking tasks related to health, nutrition, and safety (Lubeck & Chandler). It has been identified that families with infants were more likely to describe meaningful rituals associated with being a couple, while families with preschool children described meaningful rituals centered on their children (Fiese, 1993a). Families in early stages of parenthood with preschool children reported practicing a greater number of meaningful rituals than families with infant children and those with more rituals had greater marital satisfaction than those with fewer routines (Fiese, Hooker, Kotary, & Schwagler, 1993). Meaningful family rituals appear to be associated with greater marital

satisfaction in mothers than fathers. Mothers use routines to facilitate children's development and sense of self (Giddens, 1991; Ludwig, 1998).

Assessment of family household, parental traits, member interactions, and related contextual systems are areas with implications for family routines. It has been identified that parents who consistently retain daily routines for childcare tasks may be better prepared to implement interventions for improving children's health, participate in family-focused interventions, and address practices that create health risks (Chandler, Fowler, & Lubock, 1986). A study about Black preschool children found that those with predictable home routines (e.g., meals, bedtime rituals) were more likely to be cooperative and have interest in participating in a Head Start program than children adhering to fewer routines (Keltner, 1990). A later study by Keltner (1992) found that families with more structured home environments and family routines positively affected child health status in ways that extended beyond genetic traits or basic caregiving considerations. An interesting contrast can be made between what has been found about children and Ludwig's (1998) findings about older adult women. She expected to find that older women increased their routines in older age to accommodate age-related changes, but instead discovered that they had fewer routines than in earlier life periods. More needs to be known about the affects of family routines across the life course.

In the author's research about family health, parents recalled some health beliefs and practices learned in early childhood and could compare some things about their family of origin experiences with the ways they were parenting their children. In the family health research, parents could describe whether their current behaviors were consistent with childhood routines, modified over time, or rejected because of childhood experiences. Health beliefs and routine practices were modified as developing persons engaged in peer and social relationships and established procreating or partnering alliances. Parents did not easily recall discussions about health practices prior to marriage or partnerships, but mostly described negotiations that occurred later related to prioritizing needs. Other important findings about routines were:

- The birth or presence of children meant family routines were developed.
- Differences in intergenerational values meant some parents had conflict when new routines were different from those of the family of origin.
- Teaching and learning about health was recounted as casual, mostly unplanned, and largely aligned with parental priorities.

#### **Unnumbered Box 11.4**

##### **Cooperative Learning \*\*\*\*\***

Spend some time discussing with the class what the term "household production of health" might imply. First, identify what health products a nurse might assist the family household to produce. Second, identify areas the nurse might need to assess related to the "household production of health." Next, name some barriers a nurse might encounter in trying to assist the family (e.g., contextual, functional, structural perspectives). Finally, decide what kinds of nursing interventions might be done to enhance the "household production of health."

Discuss ways nurses might include family themes and goals into individual patient or client encounters. How could nurses use the idea of "household production of health" as they work with community health or

take part in a health fair? Describe the knowledge and skills family nurses would need to focus on the “household production of health.”

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### **Routines and Chronic Illness**

As life increases in length, the potential for chronic illnesses increases. Present and future concerns related to chronic illness have to do with the ways families are affected as they care for their members. Asthma and upper respiratory infections (URI) are examples of conditions where acute exacerbations mean emergency visits, hospitalization, and other forms of high-cost care. Family-focused care that includes interventions aimed at the family routines pertinent to the chronic condition could reduce the exacerbations and better control the chronic condition. For example, a study about childhood URI found that levels of family routines and family organization affected health status (Boyce et al., 1977; Hart, Bax & Jenkins, 1984). In poor Black preschool children, episodes of URI were shorter when families had more patterned routines. When Markson and Fiese (2000) compared families that had children with asthma with families with healthier children, a lower level of anxiety was noted in the families that reported more meaningful routines. The researchers concluded that rituals could be protective for children with asthma when parents experience heightened stress. Although routines of families that had children with asthma were not significantly different than those not having an asthmatic child, it may be possible that routines are a protective factor related to anxiety (Markson, 1998; Markson & Fiese, 2000).

Chronic conditions such as asthma and URI are of major concern and may

be conditions that could respond to interventions that target family routines.

Diabetes is another example of a chronic condition where the numbers of those affected continues to increase. The condition is greatly influenced by adherence to a medical regimen, an activity program, and a dietary plan. The trajectory of the disease is affected by household practices as members reinforce behaviors that can increase control and reduce complications. A qualitative study about the attitudes and views of diabetic patients and their responses to diabetes interventions found responders differed in the ways diabetic care was incorporated into daily routines (O'Connor, Crabtree, & Yanoshik, 1997). Not only the diabetic individual, but also the family could benefit from interventions that enable them to make changes that support care needs. An interesting case study about parental coping and social support in two Finish families with diabetic daughters found six phases of parental coping used by the family to gain control and accommodate the changes presented by the chronic disease (Seppanen, Kyngas, & Nikkonen, 1999). Family functional status, composition of household, family resources, and the larger context all have potential to affect the diabetic member's ability to accommodate needed changes and modify routine patterns. Variations in perceptions and use of time may enhance interventions related to health routines. For instance, a study about diabetic control in adolescents found that lack of consistency in summer routines resulted in worsened metabolic control

and higher HbA1c levels than when school resumed (Boland, Grey, Mezger, & Tamborlane, 1999). The family may need assistance in constructing routines that enable the diabetic member to incorporate a medical regimen into daily practices. For example, in a study about personal illness models, parents of preadolescents and adolescents with diabetes mellitus reported that the major problems caused by the disease were related to the increased need for structure of daily health routines (Drozda, Allen, Standiford, Turner, & McCain, 1997). Presently, education and counsel for diabetic care involves instructing individuals about specific care practices needed, but assessment of customary family practices may be ignored. Family-focused care suggests that the routines of the household need to be assessed with interventions planned that assist members to deconstruct old routines that might be detrimental and construct or modify ones to incorporate behaviors that potentiate health and well-being.

## **SUMMARY**

The Family Health Model suggests that routines are a vital part of the lived health and illness experience and need to be included in assessments, care plans, interventions, and outcome evaluations. The social construction of family health is a maze of complex contextual, functional, and routine structures that are interactive and not easily separated. Paradoxically the household production of health appears to be a coordinated and systematic structuring of ordinary and natural events

that is in continual flux. Considering routines as the ways members socially construct the household production of health provides a concrete way to observe, assess, and measure behaviors and implies that interventions must fit with family values, themes, and goals. Routine behaviors appear to be a logical structure for thinking about nursing practice where family is the unit of care. Nurses can use routines to critically think about family processes and develop interventions that affect decision-making and behaviors germane to health. More needs to be known about the merits of using routines as a measure of health knowledge and behaviors. Compelling evidence is needed to ascertain the relationships between (a) family routines and member health, (b) the embedded context and health routines, and (c) family functional processes and the household production of health.

### **Test Your Knowledge**

1. Define the term ritual and give 3 examples of rituals that might enhance health.
2. Define what is meant by the term family health routine.
3. Discuss what the structural-functional aspects of family care imply.
4. Explain how the idea of family health routines might be considered a structural aspect of family health.
5. Discuss the concept social construction and identify what this might mean for young parents who are expecting their first child as they consider parenting roles.
6. Choose a chronic illness that you are well informed about and describe how a nurse could use the family health routines to improve care for the individual and family.
7. Give three examples of ways a nurse might use family health routines in practice.

**Table 11.1**  
**Ritual Types and Dimensions**

<b>Reference</b>	<b>Ritual types and dimensions</b>
Bossard and Boll (1950)	Described 20 ritual events included in family life
Reiss (1981)	Hypothesized that links existed between the ways families problem-solve and their family rituals and identified four types of families: <ul style="list-style-type: none"> <li>• Environment sensitive or ‘normal’ families</li> <li>• Achievement-sensitive or competitive families</li> <li>• Consensus-sensitive or rigid families</li> <li>• Distance-sensitive or families with delinquent members</li> </ul>
Wolin and Bennett (1984)	Family celebrations Family traditions Patterned routines
Roberts (1988)	<b>Six types of family rituals:</b> <ul style="list-style-type: none"> <li>• Under-ritualized families</li> <li>• Rigidly ritualized families</li> <li>• Skewed rituals</li> <li>• Hollow rituals</li> <li>• Interrupted routines</li> <li>• Flexible routines</li> </ul>
Fiese (1992); Fiese & Kline (1993)	<b>Eight dimensions of family rituals:</b> <ul style="list-style-type: none"> <li>• Frequency of occurrence of the activity pattern</li> <li>• Expectations about mandatory participation</li> <li>• Emotional investment</li> <li>• Meanings of symbolic significance</li> <li>• Demand to continue the activity intergenerationally</li> <li>• Deliberateness or advanced preparation in activity planning</li> <li>• Assigned roles and duties associated with the ritual</li> <li>• Degrees of the activity’s rigidity or flexibility</li> </ul>
Schuck & Bucy (1997)	<b>Four dimensions of family rituals:</b> Structure Meaning Persistence Adaptability

\*\*\*\*\* This table is in a paper presently being reviewed for publication by the J of Family Nursing, paper entitled: Family Routines: A Review of the Literature (will need permission, maybe)

**Box 11.1****Assumptions about family health routines and family health**

- All families have systemic behavioral patterns related to family health.
- Individuals, family subsystems, and families vary in the ways they participate in family health routines.
- Members participate in individual, sub-system, and family health routines that are characterized by patterned behaviors that can be described by household members.
- Family health routines are impacted by the household's embedded contextual systems and the functional interactions of the household members.
- Beliefs, values, traditions, culture, personal experiences, information exposure, resources, and encounters with health care professionals influence the unique social constructions of family health routines.
- Children's socialization about health processes is largely imposed by the family's social construction of health routines.
- Family households are the primary places where children learn about health, develop health attitudes, and establish health behaviors.
- Family themes and goals provide undergirding for the ways family health routines are socially constructed.
- Families use accommodation processes to create, deconstruct, and reconstruct family health routines.
- In most cultures and families, mothers are often the initiators and keepers of family health routines.
- Once family health routines are initiated, members adjust the character of the patterns over time so that they retain consistency with their family health paradigm.
- Family health routines that lose their meaningfulness are dissolved.
- Families create new health routines or alter familiar ones to accommodate normative and non-normative life experiences over the life course.