

Chapter 12
FACTORS AFFECTING FAMILY HEALTH ROUTINES

Chapter 12 Content Outline

FAMILY IDENTITY

TEMPORAL PATTERNS

Cultural Factors

An Example of Cultural Experience and Health Routines

Family Themes, Member Interactions, and Family Health

Accommodation of Life Events

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USING ROUTINES AS A MEASURE OF FAMILY HEALTH

Accommodating Changes Across the Lifespan

Factors Influencing Routines

Chapter Objectives:

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

- Describe what an ecocultural niche implies.
- Discuss factors involved in acquiring and learning health behaviors.
- Explain how health behaviors are modified.
- Identify how family themes and ecocultural domains affect family health routines.

KEY VARIABLES RELATED TO FAMILY HEALTH ROUTINES

The only way to keep your health is to eat what you don't want, drink what you don't like and do what you'd druther not.

--Mark Twain

In the family health research, routines were characterized by highly ritualized individual practices and complex multiple member interactions (Denham, 1997, 1999a, 1999b, 1999c). Some routines appeared quite resilient, while others were more irregular, created in response to immediate needs. Some routines were highly ritualized, while others occurred less frequently and with less regularity. Routines had dynamic elements which were affected by individual characteristics, household factors, and member values. While common patterns and themes were noted, there were also unique variations among families and among members within families. This chapter provides readers with descriptions about potential effects on family health routines.

In the family health research, member's communication styles, levels of cooperation, patterns of interpersonal caregiving, and valuing affected the structure and practice of health routines. Family members differed in (a) level and specificity of participation in various health behaviors, (b) consistency and rigidity in following routines, (c) exact content and style of routines, and (c) flexibility in modifying routines. Subjects said health routines were modified as:

- Members' beliefs and values changed.
- Individual's experiences differed from the family of origin.
- Developmental changes occurred.
- Alterations in the embedded context occurred.
- Unpredictable life events were accommodated.
- Boundaries of member interactions shifted.
- New information and experiences were valued.

Family members encounter a profound number of variables with potential to enhance or threaten the health-illness experience. It is easy to focus on isolated factor and over-look the complex dynamics of interacting issues that impact family health. It is neither the contextual nor the functional processes alone, but the equivocal nature of their interactions that impacts the household production of health. As family members engage within their embedded contexts, they encounter many alternatives that shape their social constructions. The quandary of complementary and contradictory messages about health and illness is continually faced. The Family Health Model suggests that family routines are a

viable way to assess household use of health information, member experiences, and contextual resources of unique families.

Unnumbered Box 12.1
Critical Thinking

You are family case manager assigned to a new family. The Lopez family has three children ages six months, 2 years, and 5 years old. This southern California family immigrated here before the birth of their first child. Although the two younger children appear to be healthy, the oldest child has had repeated bouts of asthmatic attacks over the last six months with each one seeming more severe. The family has seen their family physician on several occasions and has brought the child into the emergency department a number of times during the last few months. The parents have been instructed about medications, use of inhalers, possible causes of asthmatic attacks, and been advised about prevention. Mrs. Lopez usually brings the child in for care. On the present visit she reports that her husband has recently been lost his job and they are not sure how they will pay for their son's medications.

Develop a series of interview questions that you might use in a family assessment that will help you plan effective care. Mrs. Lopez speaks some English, but she looks perplexed at times when you try to explain things to her. Make a list of at least three questions for each aspect of family health (i.e., embedded context, family functional processes, family health routines). You should have a minimum of 15 assessment questions. After you have listed your questions, provide a rationale for why each question is pertinent and explain how you might use the information in your role as case manager.

After students have completed the exercise as an out-of--class activity; use their work as a cooperative learning activity. Place students in groups of three and ask them to compare their questions in each assessment area, discuss their rationale for questions, and compare ways they would use the information. After students have had adequate time for discussion, ask the group to develop a single list of questions for each of the three dimensions, then discuss their choices, and determine how a case manager could use information obtained through assessment for family-focused interventions.

FAMILY IDENTITY

Family identity implies “the family’s subjective sense of its own continuity over time, its present situation, and its character” and refers to an “underlying cognitive structure, a set of fundamental beliefs, attitudes, and attributions the family shares about itself” (Steinglass, Bennett, Wolin, & Reiss, 1987, p. 58). Family identity is a “gestalt of qualities and attributes that make it a particular family and differentiate it from other families” (Steinglass, et al., p. 58). These researchers viewed family identity as challenged throughout the life course with one of three fates resulting:

- Continue unaltered into the next generation.
- Blend with aspects of the identity of the other spouse’s family of origin.
- Disappear as the new family embarks of a new and novel family identity.

A family can “establish a set of traditions and shared beliefs that are powerful enough to demand full adherence by all family members across multiple generations” (Steinglass, et al., p. 61).

Individual identity is weakened or subjugated when the family identity is of high caliber. In the study of alcoholic families, the researchers concluded that daily routines and family rituals provide ways to view the regulatory processes of family temperament and identity.

TEMPORAL PATTERNS

Time factors are on-going influences on family routines that create stress, direct choices, and influence perceptions. "Time is a major organizational principle that structures and regulates social life" (Ludwig, 1998, p.169). Alan Lightman (1993), in his fictional work entitled "Einstein's Dream," paints word-pictures that describe multiple interpretations of time as it links past, present, and future.

In this world, time is like a flow of water, occasionally displaced by a bit of debris, a passing breeze. Now and then, some cosmic disturbance will cause a rivulet of time to turn away from the mainstream, to make connection backstream. When this happens, birds, soil, people caught in the branching tributary find themselves suddenly carried to the past. (p.13-14)

Lightman, later describes what he calls mechanical time or time that is "rigid and metallic as a massive pendulum of iron that swings back and forth, back and forth, back and forth" and body time or time that "squirms and wriggles like a bluefish in the bay" (p.23). He suggests that persons are mostly stressed when the two times meet, but content and at peace when they go their separate ways. He proposes that time is visible everywhere:

Clock towers, wristwatches, church bells divide years into months, months into days, days into hours, hours into seconds, each increment of time marching after the other in perfect succession. And beyond any particular clock, a vast scaffold of time, stretching across the universe, lays down the law of time equally for all. (p.33-34)

He concludes that time is absolute and "a world in which time is absolute is a world of consolation" (p. 37). The predictability of

time allows us to recognize its motion while people in motion seem to be more obscure and complicated.

Time marks history that can be recalled and gives evidence that past and future are entwined with the present. Time is a paradox rarely contemplated and mostly deciphered according to events and circumstances across the life course. Time gives order to life and organizes beginnings and endings. Lightman (1993)

notes:

Children grow rapidly, forget the centuries-long embrace from their parents, which to them lasted but seconds. Children become adults, live far from their parents, live in their own houses, learn ways of their own, suffer pain, grow old. Children curse their parents for trying to hold them forever, curse time for their own wrinkled skin and hoarse voices. These now old children also want to stop time but at another time. They want to freeze their own children at the center of time. (p.73-74)

It is the individual and collective memory of time that provides shared meanings of history. While some cling to the past and nostalgically view earlier times as most meaningful, some hope for a better future, and others see the present as most valuable.

Humanity moves in response to time, some want to hasten it, others want to slow its hands, and some deny its existence.

Time is a visible dimension of family and family health. It is impossible to fully understand individual behaviors or family health routines without including temporal meanings. Time is linked to perceptions and energy rhythms that vary within

members in single households and among families within a cultural context. Time has significance, as family members perceive differences between health and illness. Daly (1994) suggests that families internalize time and schedules and are mostly taken for granted until a crisis occurs. Friedemann (1995) identified the six rhythms of time that can be described and assessed as activity/rest, sleep/wake, time orientations (past, present, future), social time/private time, structured versus unstructured time, and developmental stages. Time might be viewed as reversible or non-reversible. In other words there are times when events are repeated and have the possibility of being altered, but there are also times when events can neither be overturned nor altered. For example, parental work patterns affected parental involvement, child monitoring, sibling caregiving, and child involvement in summer activities and concluded that summer recess and the school year represent different family ecologies with vastly different social processes occurring (Crouter & McHale, 1993). Use of time is culturally conditioned, influenced by subjective meanings that in turn are reflected in the social constructions of daily life, and have economic value (Ludwig, 1998). Families with children with special needs tend to fit family and child needs into culturally

relevant contexts (Gallimore, Weisner, Kaufman, & Bernheimer, 1989; Segal & Frank, 1998).

In the family health research, seasons, clock time, calendar days, traditional times, developmental stages, and significant events were all times that impacted family health patterns (Box 12.1). Time influenced the ways routines were structured and prioritized. Subjects often described ideal routines, but then explained reasons to veer from the ideal. For instance, families with preschool children often described optimal dietary routines, but explained that on shopping or busy days it was usual to alter ideal routines by eating at fast food restaurants or fixing less nutritious meals. After-school activities, work schedules, and family activities often interfered with meals and resulted in poorly planned meals with food eaten in a hurry. Subjects said activity patterns, stress levels, schedules, and family relationships were often based on seasons with some mothers viewing summer as a healthier time, less stressful, and more chances for casual family interaction (Denham, 1997). Clock time affected (a) sleep and rest patterns, (b) ways members spent time together, and (c) stress levels. Weekends were often prized as favorite calendar days because such things as leisure, relaxation, hobbies, and spiritual ties brought the family closer together. Families with school age children had routines based upon the school calendar.

<<<<<<INSERT BOX 12.1>>>>>>>>

Holidays, celebrations, and traditional times were viewed as events and often meant variations from usual family patterns. Events were often tied to family identity and valued as special times the family could spend together. Some subjects said vacations were times when family members shared new experiences and found renewal (Denham, 1997). In the bereaved families, the terminal phase of the loved one was an 'event,' a time when family members were together more than usual, recalled shared memories, and provided support for one another (Denham, 1999b). Health routines of those providing support to the terminal member were often out of control and some were especially affected when the dying person's symptoms were severe and poorly controlled, when caregiving demands were prolonged or intense, immediately post-death, and during bereavement.

Developmental stages also affected family routines. Family members described changes in health practices influenced by family transitions (e.g., marriage, birth, death, school attendance, adolescents). Mothers were actively engaged in health teaching of young children during the preschool years and continued to reinforce teaching and provide new information for school age children (Denham, 1997, 1999c). However, adult children often consulted their mothers as they wrestled with some decision-

making about non-acute health issues and family health decisions (Denham, 1999a, 1999b, 1999c). Developmental tasks or stages seem to have universal qualities as families are faced with the challenges of sequential life cycles over the life course, a process Steinglass et al. (1987) called systemic maturation. Regardless of culture, ethnicity, race or family characteristics, families are confronted with rather predictable developmental tasks. While individual developmental tasks vary according to age, properties, and experiences of family members, family developmental tasks often arise in response to individual needs. According to Steinglass et al., families have three fundamental developmental issues; it is posited that these issues can become organizing factors for family routines:

- Define internal and external boundaries.
- Choose a limited number of major developmental themes (e.g., use of resources, care of chronically ill member).
- Develop a set of shared values and views about the world and identity of the family.

Assessment of routines should include these criteria.

Time has many perspectives and is a continual force impacting family life. Its emergent properties unfold in expected and unexpected sequences throughout family life. More needs to be known about the ways that public time (e.g., school, work, social engagement) affects private time (i.e., individual, family) and ultimately impacts the household production of health. In time,

members face attachment, stabilization, and loss that cause members to construct health routines in response to organizing family themes. Routines of children first become synchronized with those of the family, later with the schools where they attend, and finally with the larger society (Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990). The Family Health Model suggests that time is pertinent whenever routines are considered; it is a crucial factor too often over-looked when considering lifestyle variances.

Unnumbered Box 12.2

Reflective Thinking

Consider how time affects your personal health routines. What variations do you experience based upon clock time, seasons, or calendar days? Do you view the variations as mostly positive or negative? Provide an example of a positive variation and a negative one. What about your family of origin, can you think of variations in the ways time affects various members? Describe how the differences are positive. What are some negative variations? What things might a nurse do to assist a family address the affects of time on health routines?

Cultural Factors

All persons and families have culture and ethnicity, even when they are not consciously aware of the impact. In the mainstream culture, it seems increasingly difficult to identify discrete familial roots. Many families are less focused on generational heritage and identify as American with few references to ethnic tradition. Few citizens recognize that mainstream values

are derived from legacies associated with early settlers that have been reshaped as history evolved. The face of America's people continues to be amended as persons from diverse cultural and ethnic contexts continue to immigrate to the U.S., settle throughout the land, become citizens, and challenge prior viewpoints. For many new citizens, assimilation of mainstream values while living with the customs of their ethnic, racial, and religious heritage means that they become bicultural. Unfortunately the biculturalism does not always serve them well and many live as marginal societal members unable to satisfy the expectations of either culture.

Consciousness about needs to become culturally competent continues to increase in nurses and other health professionals. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis & Isaacs, 1989; Isaacs & Benjamin, 1991). Cultural competence is a process with incremental levels: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competency, and cultural proficiency. Davis (1997) said cultural competence implies assimilation and transformation of knowledge about individuals

and people into standards, policies, practices, and attitudes for appropriate use in sundry settings to increase quality and produce better outcomes. The National Center for Cultural Competence at Georgetown University's Center for Child Development stated:

Despite recent progress in the overall health status of the nation, all segments of the U.S. population have not equally benefited. A long-standing and well-documented pattern of disparity continues to plague racially and ethnically diverse populations in this nation as it relates to the incidence of illness, disease and death. This pattern of disparity is evident both in health care outcomes and utilization. While the complex array of causes for health disparity are neither well documented nor well understood, it is evident that disproportionate poverty, discrimination in the delivery of health care and the reluctance of health care organizations to provide culturally and linguistically competent care are indeed contributing factors. (Goode & Harrison, 2000)

The ability to work with culturally diverse communities (e.g., neighborhood advocacy associations; ethnic, social, faith-based organizations; public media) and support natural helping networks is a key of cultural competence (Cross et al.). Understanding the contextual experience and the events that maintain and promote health are essential ingredients for appropriately planning health services (Boyle, 1984). Alternative belief systems, intuitive health experiences, and health myths often contradict the institutionalized or formally sanctioned health care delivery system (Thorne, 1993). Culture is at the heart of family values, themes, routines, and health.

Culture, along with spirituality and ethnicity, is one of the core requisites of rituals; core requisites along with their associated variables (i.e., behaviors, traditions, values, patterns, rituals) are the antecedents of family health routines (Denham, 1995). In many families, it may be nearly impossible to separate the enmeshed cultural, spiritual, and ethnic influences affecting patterned behaviors. These influences give rise to language and perceptual meanings that affect family identity and alter family themes. Culture is not dormant, but a continual integration of knowledge and experiences into life patterns that are transmitted intergenerationally. Health is in part a human response to cultural experience. Conflict often arises between the dominant and subordinate culture as those in the dominant culture view others as marginal, ineffective, or less valuable. While the dominant culture assumes to take a helpful or assistive mode, it often distorts the other culture and approaches it in pejorative ways.

Casual and formal interactions of persons with different life perspectives means routines are continually being shaped and reinterpreted. American rituals are like a tapestry of changing social rules and cultural meanings that are increasingly reorganized on the basis of theatrical metaphors and anonymous elites (Deegan, 1998). When the embedded context supports ethnic and cultural patterns because they are perceived as functional and beneficial to

the family, they can be retained in a rather pure state (Friedemann, 1995). However, patterns viewed as traditional and normative continue to be challenged by change. While the cultural context might imply certain behaviors and traditions are expected, media, societal, and developmental influences persist in altering patterns. However, even in the face of change, some cultural patterns remain resilient and enduring. The enduring qualities often instill stereotypical images in society's collective memory that remain even when behaviors are altered.

Cultural routines are associated with birth, death, religion, valued traditions, and other meaningful family behaviors and usually involve complex behaviors of multiple members. The ethnicity and religion of a family are closely aligned with actions taken in some family's daily routines. A study about young Hmong children with developmental problems studied families' cultural beliefs because choices that families make about health and educational services are influenced by their beliefs (Meyers, 1992). Weisner, Beizer, and Stolze (1991) studied affects of religious beliefs and those who were nonreligious on the support systems used by U.S. families with children that had developmental delays. They found that religious families focused more on family for support and nonreligious families focused more on outside resources. Religious families were more likely to see their child as

an opportunity than as a burden, receive more interpersonal support, and use their faith to interpret circumstances. Family-focused care implies that assessments of the household niche, appropriate use of interpreters, and family reports about faith, values, and traditions provide information about cultural meanings of health behaviors.

Unnumbered Box 12.3
Cooperative Learning

Students should work together in small groups to identify desirable characteristics of a culturally competent nurse. After each group has had time to develop their list and then ask them to provide a rationale to support each of their ideas. Have a class discussion and try to identify the top five traits needed to be a culturally competent nurse. Discuss how being culturally competent differs from being culturally sensitive? Ask the class how they could evaluate the nurse's performance to ascertain if a nurse exhibits these qualities. Discuss how one obtains and maintains proficiency in cultural competence. Talk about why cultural competence is important for understanding family routines.

An Example of Cultural Experience and Health Routines

In the family health research, family members and community participants were mostly identified as Appalachian. Some argument exists about how one defines an Appalachian and whether it is truly a culture or sub-culture of American society. In this research, families were identified as Appalachian because they lived in Appalachia, had multiple generations of extended family located in the area, and could describe a family history of many generations tied to the region. Most highly valued their heritages and kin, were intimately connected to the community, and

expressed a strong sense of place and love for their homeland. Subjects were similar to others described as Appalachian, but differed some when the topic was family health.

These families focused more on present needs and had less interest in wellness or future health. Cultural influences were important in decision-making about when to seek medical care. Cultural context better explained the similarities in family health definitions and practices than socioeconomic indicators explained differences. Although family health was somewhat influenced by the availability of medical services, health insurance, and health knowledge, member beliefs, values, traditions, and prior experiences were more important. Some parents could recall folk practices and home remedies used by their families of origin, but few used any today and instead described use of mainstream medical practices similar to those of other Americans.

Appalachians have been described as fatalistic or behaving as if they were powerless in some situations. These families accepted life as it was encountered, but still strove to find answers and obtain help related to pressing medical concerns especially those involving children. Appalachians are often characterized as being non-confrontational. While this may be true in some life areas, family members provided numerous examples about how they were indeed confrontational when health needs were at stake.

While many Americans tend to be future oriented, some cultural perspectives tend towards a present orientation, valuing the past and present more than the future. Appalachian families may possess some cultural uniqueness, but they have many qualities similar to others. Close social ties to extended family, a sense of pride and independence, and a reverence for faith and religious heritage were familial factors also characteristic of other cultures. Most had little interest in relocating and were strongly rooted to a familiar place where family had lived for generations with extended kin were nearby. While the slower pace of life may be some different from those in more urban regions, these hill people still shared many similarities with others in the nation.

Culture often affects dietary patterns and in these families, cultural heritage shaped food preferences, meal patterns, and roles associated with food preparation. For example, while men in parts of the U.S. enjoy cooking, a home economist said: "Men just aren't as likely to cook because food is women's work." She further explained:

You'll occasionally run into somebody who will throw things on the grill. You may find someone who likes to cook wild game. I think food is not looked upon as much as an eating experience as it is something you need to do in order to be healthy and keep going. Although the social aspects of food are important too, when you look at home comings, you look at a lot of meetings...they have food attached to them, but it's not a dining experience. It's more of 'breaking bread together' and 'sharing what you have'

rather than a dining experience ...you frequently see the 'covered dish'.

Fathers generally viewed food preparation as woman's work, but some were willing to assist with meals when their wives worked or cooked when the wives or partners were absent. For example, a grandfather in one family frequently cooked for the family and prided himself in his gourmet preparations and his adult son described his ability to make homemade noodles and times when he enjoyed cooking.

Some dietary patterns were influenced by ethnicity, a farming heritage, and times for family sharing. Most families purchased meat at the grocery rather than raising it, but the hunting and gathering past seemed to be a continuing influence for some Appalachian families. Even when parents held full-time employment, some families continue to farm. Many took pleasure in the family garden and enjoyed growing vegetables and fruits, sharing their crops with family, neighbors, and friends, and freezing or canning foods for later use. Several families still butchered their beef and raised chickens for eggs and meat. Some male members enjoyed hunting and fishing and obtained some meat by hunting deer, rabbit, squirrel, and wild turkey. Most families planned meals around meat and potatoes and many enjoyed simple fare such as cornbread and beans or biscuits and

gravy much like their forefathers. A community informant described childhood practices:

We lived on a farm, so you have big meals. The men were out working and mom was always fixing fried potatoes, we had a lot of...of course, the only kinda meat that I remember butchering was a hog. Now the older ones [siblings] say that there was occasionally beef, but beef couldn't be kept like pork could. You could salt it down and keep it. And so we had hogs...and chicken! Mom was always gett'en chickens and kill'en it and fix'en it for us...But the food, I guess...I know by today...would be considered not good for you, maybe. Because maybe gett'en too much fat and everything, but I don't think that any of that hurt any of us.

Cultural traditions were significant influences on family routines.

However, it should also be noted that these families enjoyed fast-food restaurants and 'eating out' in similar ways to others. While family members were not always adept at discussing culture, individuals gave narrative descriptions about daily routines. Intra-cultural differences are important! Stereotypical views ignore the diversity that survives within race and culture and wrongly conclude that a uniformity of beliefs, values, and practices exists. While the stereotypical caricature can most likely be identified, it fails to allow for the prevailing diversity. Family-focused care implies a need to carefully consider within group variations whenever family health routines are considered.

Unnumbered Box 12.4 Cooperative Learning

Ask volunteers to share some specific differences they have personally experienced related to cultural variations. Examples can be from family of origin experiences, interactions with friends,

neighbors or acquaintances from other diverse cultures, or from patient care experiences. How might these variations be pertinent to family health? Have students identify:

- What nurses need to know about culture and family health.
- How nurses should be prepared to provide care to persons from diverse cultures.
- Things nurses can do to increase cultural competence and avoid stereotypical assumptions.

Family Themes, Member Interactions, and Family Health

Family members interact based upon valued themes. For instance, a family earning a modest income may be very content with their material state, but a family making a six-figure income may desire more wealth and a higher standard of living. Money may mean ability to meet daily needs or it may be linked to social status, personal achievement, success, or greed. Themes about money, finances, economics, and resources within families govern interactions and provide a basis for understanding some routines. When new situations occur, established family routines perceived effective at earlier times may have their utility tested and force families to adapt and create new patterned behaviors (Campbell, 1991; Thomas, 1990).

Family's ecocultural domains were discussed previously, but it is important to remember that valued themes juxtapose with domains and are enmeshed with family interactions and routine behaviors. Domains include variables imposed by contextual resources, constraints, family values, goals, and accommodations.

Members often interact based on themes associated with ecocultural domains. For example, if the domain of concern is social support and the family values individuation then they may be less likely to offer or seek support from others outside the immediate family. If the family has strong 'familial values' or believes that extended family should be close and involved then expectations about kin roles will be placed on extended family members. If the family believes that the village or the community; however, it is defined, should act like a family then they may be open to receiving support from others, expect others will help in times of need, and recognize personal responsibility to assist others in times of need. Another example related to the ecocultural domain of caregiver roles might affect themes related to ways a family with a member who has a developmental disability or a member with a chronic illness seek help. If the family theme is strong 'familial values' then the family might expect kin to share in caregiving responsibilities. If the theme is individuation, then the family may be independent and refuse help from others outside the immediate family, but a family viewing themselves as part of a community might expect that others outside the family circle will assist. Family's themes guide interactions and the ways routines are socially constructed.

Different themes cause families to interact differently and develop rules and routines that support valued themes in each of the ecocultural domains. Steinglass et al. (1987) said, “themes are found in the family’s implicit directions, its notion of “who we are” and “what we do about it”” (p. 58-59). The term ‘family rules’ are binding directives that obligate members to one another and the outside world (Ford & Herrick, 1974). A study examined the changing structure of American families and found that family rituals and togetherness was one of eight dimensions of strong families (Kelley & Sequeira, 1997). Knowledge about valued themes provides a basis for creating and implementing interventions related to family values and goals. Routines “may be perceived as being a fairly reliable index of family collaboration, accommodation, and synergy” (Denham, 1995, p. 17). Members are usually unaware of the large number of accommodations they make regularly within the household as they simultaneously (a) balance the limitations and resources related to the ecocultural domains, (b) adapt to continuous unfettered demands from many unrelated sectors of the embedded context, and (c) utilize member’s functional processes to interact as a household unit to meet the unending needs of individual members.

Accommodation of Life Events

The accommodation process was discussed earlier, but it is important to reiterate that it is an active process that can be contrasted with the passivity found in adaptation. Adaptation is less intentional and often an unconscious response to circumstances, events, or situations that disrupt, threaten, change, or alter usual household patterns. Accommodation is “proactive efforts of a family to adapt, exploit, counterbalance, and react to the many competing and sometimes contradictory forces in their lives” (Bernheimer et al., 1990, p. 223). Accommodation not only occurs as a response to distress or problems, but also happens when members are motivated to achieve particular goals or attain something highly prized. Family accommodation is a response to “serious concerns and mundane problems in daily life” (Gallimore et al., 1993, p. 188). Family-focused practice aims at accommodation processes and targets them as potentially enabling actions to increase coping, modify behaviors, and plan changes.

An assessment of family interactions and core functional processes reflects past accommodations and adaptations presently incorporated into daily life. The Family Health Model posits that patterned behaviors generally continue as long as they are perceived as meaningful or satisfactory ways to address needs and goals. Family problems occur when adaptations or accommodations inadequately deal with concerns. Ineffective

patterns may need to be deconstructed and new ones reconstructed to better fit changing themes, goals, dilemmas, or crisis. Family-focused care provides opportunities to assist families with these social constructions that accommodate health and illness concerns. The model suggests that availability of resources may predict whether families can make accommodations to meet goals.

Family health routines are visible patterns of behavior where nurses and others can assist families to plan and structure meaningful actions within households to address health and illness needs. While nurses or others may view some family routines as inadequate or impacting the family in health negating ways, it is probable that the members view them as meaningful or adequate to accomplish goals. Most families do not intend to be deviant, but often choose adaptation or more passive methods to address the immediacy of needs rather than planning more effective long-term measures. Although outsiders may not view family adaptations as positive or optimal, it is speculated that family members have used their functional processes and resources in ways they view as appropriate. It is possible that other families embedded in similar contextual systems and faced with comparable concerns might adapt in equivalent ways. It is also conceived that families from similar cultural contexts experiencing similar dilemmas might choose actions or routines similar to others. Family-focused

practitioners will be challenged to think more systemically about population-based family health needs and assist families to accommodate specific health concerns or risks. As families encounter problems that require special knowledge, skill, and resources to construct health routines, nurses can assist by facilitating functional processes and working with contextual systems. Family-focused practice targets family as the unit of care and family routines even when single individuals present the health need. Family adaptation of atypical routines or aberrant behaviors that compromise health or threaten well-being will be particularly challenging for the family nurse.

Unnumbered Box 12.5

Reflective thinking

Engage the students in a conversation related to accommodation. Ask for volunteers. When a student volunteers, ask him/her to stand up behind their chair without touching it. Continue with your discussion ignoring the volunteer student while they continue to stand. After a few minutes, ask for another volunteer. If one agrees to volunteer, then ask them to also stand behind their chair without touching it. Again continue your conversation with the rest of the students while ignoring the two standing students. After a few minutes, thank the two standing students and ask them to sit down.

Now engage the students in a conversation about differences between adapting and accommodating. Use their feelings about having the first student standing while others were sitting as a springboard for the conversation. In what ways did they adapt? How was this different from accommodation? What kinds of questions or feelings did they have? What about when the second student stood up, did that alter their feelings? How were they different? How were they the same? How did the volunteers feel? What were they thinking while they were standing there? How long would it take for this 'unusual' experience to become 'usual'? What would need to happen to normalize this experience? Continue the discussion about accommodation and ask students to

identify how they personally accommodate changes. Discuss positives and negatives related to accommodation. How does this apply to family-focused care?

Parental Beliefs, Values, and Traditions

In the family health research, participants used family stories to describe health behaviors, influences from various media formats, social and health policies, and legislative influences. Compliance with immunizations, seat belt use, well-child care, and use of hospice services were examples of behaviors that were responses to contextual influences. However, knowledge alone was not a predictor that health information was incorporated into routine behaviors, the level of consistency in behaviors, or consistent adherence to behaviors. While maternal beliefs and values mostly influenced young children's health routines, developmental processes, peer influences, and social contexts also influenced the ways routines were modified. For example, many described ways friends, the news, and extended family influenced dietary patterns, exercise and activities, smoking behaviors, and substance abuse.

The Family Health Model suggests that parental beliefs acquired within families of origin have great stability and influence over the life course. However, patterns of behavior continue to evolve and are subtly altered by complex embedded factors not easily discerned. Parental influence does not occur within a

vacuum, but within a household niche that is regularly impacted by varied and unpredictable contextual forces. Teaching about values and ideals may be incorporated into children's beliefs and behaviors, but impact by the larger environment also plays subtle roles. Social norms, peer expectations, and media influences create synergistic affects with great potential to negate or potentiate parental influence. Although researchers have been studying the impact of parenting on youth outcomes for decades, less investigation of relationships between parenting behaviors and health outcomes has been completed.

Empirical studies provide evidence that family composition, marital categories, quality of family lifestyle, and daily activities affect the variances in households and family practices (Bloom, 1981; McLanahan, 1983, 1985; White, 1982). The implicit assumptions that better education, higher income or a two-parent family produce better developmental consequences and consequences are widely documented. However, traditional views of home environment have mainly focused on (a) the environmental process or affects of home on a learning environment, (b) the psychosocial climate of the home perceived by family members, and (c) variations between parent's child-rearing attitudes and child development (Nihira, Weisner, & Bernheimer, 1994). When families are faced with children that

have developmental delays, they often reorganize their households, everyday lives, and ways to measure family dimensions differently from more traditional home measures (Nihira et al.). Discussions about ways family restraints and resources are coupled with member values, specifics about the household context, and actual member routines may provide better ways to understand and impact family health. A pressing need in preparing a professional workforce to provide family-focused care is educational preparedness that succinctly emphasizes the impact of family themes and goals, the household context, and ways unique members interact and shape the household production of health.

USING ROUTINES AS A MEASURE OF FAMILY HEALTH

Accommodating Changes Across the Lifespan

Individual and family development is erratic across the life course, but many might view normative as periods of great energies expended in activity and change followed by the longer stability periods where usual lifeways transpire. Family life is dynamic, but most seek stability or homeostasis where patterns of behavior become more ritualized and constant. Potential for constructions of new patterns of behavior occur whenever individuals encounter new information, acquire skills that challenge prior knowledge, face unpredictable life events, or when

ambiguity prevails. In the family health research (Denham, 1997), six factors pertinent to modifying health routines were noted:

- Parental beliefs and values.
- Experience beliefs and behaviors different than the family of origin.
- Family and community context.
- Ability to accommodate unpredictable life events.
- Family interaction patterns.
- Valuing of information and/or experiences.

Families identify individual and collective actions to respond to constraints and concerns that sustain valued routines or modify ones less desirable (Gallimore et al., 1993, p. 187). Families do not create problem-solving methods each time they confront a challenge, instead “the family, over time, develops a characteristic style of problem-solving, a style that is distinctive enough as to be recognizable by an outside observer—a kind of family trademark” (Steinglass, Bennett, Wolin, & Reiss, 1987, p. 68). Three important dimensions related to family problem solving are:

- Predictability of the family’s response to destabilizing events.
- Affective expressiveness associated with problem solving.
- Degree of family cohesiveness during the problem solving.

Members of parental dyads each may prefer adherence to health beliefs, values, and behaviors learned in families of origin, but negotiation occurs when committed relationships that imply intimacy, mutuality, and continuance occur. According to Golan (1981), optimal transitional processes imply:

- Continued opportunities for personal development.

- Role changes that minimize discord.
- Reorganization of behavioral patterns learned in the family of origin.
- Development of harmonious mutuality that balances stresses and strains.

Family rules pertain to what family members view as acceptable and these rules are guided by family values or themes that “provide the stability, commonality, and guidance” members use in daily lives (Friedman, 1998b, p.329). Family rules provide information about family function, the things valued, and give information about how routines are maintained and changed. Accommodation is a life course process with potential to positively shape routines in ways that maximize health outcomes and is a place where family-focused care can be targeted.

Factors Influencing Routines

Family health routines created in accord with members’ values and beliefs tend toward greater stability. Daily routines are organized so that they are “sustainable, meaningful, and congruent with individual needs of all family members” (Gallimore et al, 1993, p. 188). Steinglass et al. (1987) identified two constructs significant to family routines as systematic maturation and developmental distortion. Systematic maturation purports that all families have life cycles where they “proceed through a developmental process that can be conveniently divided into three phases (early, middle, and late) based on the sequential emergence

of a set of developmental themes” (p. xiii). For example, alcoholic families, families with a member who has a developmental delay, families with a member coping with diabetes, or families with a terminal member might have similar forms of developmental themes that affects routines in some similar ways. Consideration of whether the family is in an early, middle or late stage may provide explicit information about the concreteness of family themes and the resilience of routines. Developmental distortion refers to “those changes and alterations in the customary shape of systemic maturation that are the consequences of specific unique experiences with which the family is forced to deal” (p. xiii-xiv). In other words, families may be similar to others, but also have unique characteristics derived from their membership and embedded context that significantly impact routines in different ways regardless of the phase of development. As one learns more about specific population-based needs, then understandings about systemic maturation and developmental distortion on family health routines can be better understood.

Routines significant to family health may have arisen from rather passive indiscriminate actions or be characterized by planning, precision, and predictability. Behaviors are individual and mutual traits affected by the presence of others used to maintain family stability and balance growth, maturation, and

change. While families mostly strive for homeostasis, equilibrium, and balance, they are faced with how to actualize their potentials, optimize possibilities, and transcend boundaries. Routines are affected by things such as member participation, tasks to be completed, motivation of members, goals to be accomplished, effectiveness of the core functional processes, and constraints or resources in the embedded context. Families use routines to regulate behaviors and care mechanisms and have these defining qualities:

- Routines are strongly related to family themes and associated with ecological domains.
- Routines are time bounded and have beginnings and endings.
- Members recognize routines as special behaviors with associated member expectations.
- Routines have correlated symbolic aspects.
- Routines have predominance and often preempt or interrupt other activities.
- Routines are connected to family heritage and transmitted across generations.

Steinglass et al. (1987) found that family temperament and identity are regulatory structures of routine behaviors.

Temperament is defined as “a psychological construct that refers to a set of enduring behavioral response styles and activity patterns that have their origins in an individual’s early life” (p. 53). Family temperament is defined as “characteristic activity levels and response styles exhibited by families as they go about shaping their daily routines and solving problems” and it is also “the unique fit

between individual temperaments” (p. 53). For example, nine temperamental dimensions identified in newborns are activity level, rhythmicity, approach-withdrawal behavior, adaptability, threshold of responsiveness, intensity of reactions, quality of mood, distractibility, and attention span and persistence (Thomas & Chess, 1979). Steinglass et al., when they studied alcoholic families, noted three dimensions of temperament:

- The family’s typical energy level.
- The family’s preferred interactional distance.
- The family’s characteristic behavioral range.

“Families whose temperament allows them a greater range of behaviors, a greater tolerance for uncertainty, a greater flexibility in the patterning of behavior will probably accommodate new members in a more flexible fashion” (Steinglass et al, p. 54). In family-focused care, family’s systemic maturation, developmental distortion, temperament, and the relationships with family routines all need to be understood.

Unnumbered Box 12.6

Critical Thinking *****

Ask students to recall a clinical situation where their patient interactions were such that they wanted to label the patient as ‘non-compliant.’ Ask them to identify those things that made them think the person was ‘non-compliant.’ Make a list of these ideas on the board.

Then ask the students to brainstorm about possible reasons person might behave as if they were ‘non-compliant.’ Explore examples related to the family’s context, functional interactions, and family routines. Discuss what steps family nurses should take if ‘non-compliant’ behavior is suspected. Ask the students to identify nurse factors potentially relevant to identifying someone as ‘non-

compliant.’ Identify possible outcomes related to nurses’ behaviors. Discuss what nurses should do to assure that they limit their judgments and provide equitable care.

SUMMARY

Family-focused care needs to incorporate family health routines as a usual part of practice, but more needs to be known about best practices in using them to address chronic illnesses, developmental disabilities, caregiver needs, health promotion, disease prevention, and health maintenance. The timing and types of interventions must fit with family composition and context, member ages and developmental stages may represent distinct differences in needs. Routines provide a target for family-focused care that can direct assessment of health behaviors, assist members to identify values and set goal pertaining to health, plan interventions related to valued family themes, identify resources to support family goals, measure member’s health outcomes, and evaluate family health outcomes. Although medical care is an important part of the health equation, family-care seems at least equally important during transitional times (Doherty & Campbell, 1988). Unfortunately care approaches are often shortsighted, fail to include multiple family members, and neglect ascertaining the concrete household routines pertaining to family health. The Family Health Model suggests that medical services solely aimed at single individuals diminish the likelihood that health outcomes

of multiple members or the household production of health will be impacted. Incorporating routines into therapeutic family interventions could provide meaningful ways to assist families to construct behaviors that potentiate the household production of health. More needs to be known about the affects of competing family needs, resource distribution that optimizes member health, factors affecting usefulness of resources, resources most predictive of family health outcomes, and cost effective ways to use resources to benefit the family household.

Test Your Knowledge

1. Identify three factors that influence the ways children acquire health behaviors.
2. Discuss ways families modify health behaviors and explain how the nurse can positively intervene in this process.
3. Give an example of a health behavior that might need to be modified if a person is newly diagnosed with a chronic illness and describe how a nurse might use information about family themes to assist the family establish routines to assist the ill member.
4. Identify three ways the family's embedded context might affect family health routines.
5. Explain how family functional processes and embedded contextual systems might affect family health routines.
6. Discuss three different ways a nurse providing family-focused care might use family health routines to promote health.
7. Identify five skills or areas of knowledge that a nurse might need to acquire in order to most effectively use family health routines as a target area for practice.

Figure 12.1
Factors affecting the modification of the family health
construction

Box 12. 1

Definitions of clock time

Seasons: Those periods of the year (e.g., spring, summer, fall, winter, past, present, future) clearly demarcated by the calendar. Meanings, roles, and family expectations are often associated with seasonal times.

Clock time: Associations tied to actual measured minutes and hours (e.g., morning person, night person, activity/rest, sleep/wake). Many health routines are tightly associated with clock rhythms.

Calendar days: Differences attributed to particular days of the week (e.g., weekends, Monday mornings, Friday afternoons, “Hump Day,” social time, private time). Family members often attribute special meanings and activities to specific days with potential to alter routine behaviors.

Traditional times: Days given special meaning by one or more family member (e.g., holidays, celebrations, special instances) where interactions may include multiple members, extended family, close friends, peer groups or others with shared values and ideals.

Developmental stages: Specific points in time when relationships among members diverge from prior experience (e.g., marriage, childbirth, transitioning from school age to adolescent, adolescent to adulthood). Sometimes these times are clearly separated, but usually they are evolving with more than one stage experienced simultaneously.

Significant events: Out of the ordinary times (e.g., hunting season, vacations, school starting/ending) that signal exceptions to usual behaviors. These variations may be brief or prolonged over days, weeks, or months and have different boundaries and expectations from other times. Events may require active involvement of several members or a solitary member, but the consequences of the events have broad family implications.

FIGURE 12.1

LEGEND

Factors affecting the modification of the family health construction

TEXT

Parental beliefs & values

Spirituality

Traditional rhythms

Valuing lived experiences

Coping with illness events

Knowledge Exposure

Formal education

Source of information

Significance of information

Relational Interactions

Dyadic/triadic

Partnering

Peer

Extended family

Social relationships

Accommodation of unpredictable

Relocation

Job loss

Substance abuse

Accident

Chronic illness/disability

Temporal Patterns

Seasons

Calendar days

Clock time

Events

Developmental lifespans

Ecological Context

Economic

Social

Educational

Environmental

Cultural

Family Health Construction