

Chapter 13:

CATEGORIES OF FAMILY HEALTH ROUTINES

Chapter 13 Content Outline

EMERGENT UNDERSTANDINGS ABOUT HEALTH ROUTINES

The Emergent Categories of Family Health Routines

Childhood Socialization About Family Health

SELF-CARE ROUTINES

SAFETY AND PRECAUTION

MENTAL HEALTH BEHAVIORS

FAMILY CARE

ILLNESS CARE

FAMILY CAREGIVING

Chapter Objectives:

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

- Identify attributes of the six categories of family health routines.
- Discuss ways nurses can use family health routines to meet individual health needs.
- Describe a plan of family care that includes family health routines.
- Identify family health routines as ways nurses can target family-focused care that can potentiate the household production of health.

EMERGENT UNDERSTANDINGS ABOUT HEALTH ROUTINES

The Emergent Categories of Family Health Routines

Time is neutral and does not change things. With courage and initiative, leaders change things.

Jesse Jackson

Although the family health studies were not explicitly about routine behaviors, family narratives obtained through the interviews and observations in family homes provided rich data about routines. Family routines were regularly practiced behaviors with varied degrees of member ritualization that were important to family identity and appeared to hold potential for health-related outcomes (Denham, 1995). Family routines provided understandings about the ways members interpret health knowledge, beliefs, and traditions into patterned behaviors and have potential to increase health, wellness, and protect members against disease or illness. This chapter discusses the six categories of family health routine identified in the findings about family health (Denham, 1997, 1999a, 1999b, 1999c). The Family Health Model suggests nurses and others interested in providing family-focused care should target the household production of health by viewing family health routines as primary objectives.

Family health studies have provided support for a care model that includes daily lives in an embedded household where members interpret personal experiences and knowledge into health behaviors (Denham, 1997, 1999a, 1999b, 1999c). Health routines are described as interactions

affected by biophysical, developmental, interactional, psychosocial, spiritual, and contextual realms with implications for the health and well-being of members and family as a whole. Family health routines are complex evolving social constructions used by the family to interpret their perceptions about health into structured behaviors. Table 13.1 compares the categories of family health routines from the three research studies. In the dissertation research seven categories of routines were identified, five categories were noted in the study about health in hospice families, and six categories emerged from the study of economically disadvantaged families with young children. Important factors about health routines noted in the research are:

- Families varied in the types and number of patterned behaviors in their routines.
- Individuals and families did not equally value all routines.
- Individuals and families did not value all aspects of family routines equally.
- Individuals had some unique variations in the ways they practiced health routines.
- Families had different expectations about member roles and rigidity of routines.
- Health routines were modified over time.
- Routines are sometimes enmeshed with one another.

<<<<<<INSERT TABLE 13.1>>>>>>>

In the dissertation study, members indicated they practiced patterned behaviors that were adhered to with great regularity (Table 13.2). Parents recalled some behaviors from families of origin and compared past and present patterns and could describe:

- Differences in past and present health beliefs and practices.
- Member health behaviors.

described exchanges with one another that were connected to member beliefs, values, and perceptions. Contextual and functional aspects of the family household influenced families' social construction of health patterns, but the embedded context was a powerful determinant for creation and retention of health routines. Regular interactions between individuals, family sub-systems, families, and embedded contextual systems created feedback loops where bi-directional exchanges occurred across time and space. Feedback loops provided information and experience that influenced family's health perceptions and routines.

Unnumbered Box 13.1

Cooperative Learning *****

Students should take a few minutes to think about their personal dietary routines and identify how the routine varies from day-to-day. Which routine aspects are consistent? What causes variances to occur? Are the variances mostly positive or negative? After a few minutes are allowed for this activity, students should then consider the dietary routines of another family member and think about how the routines are similar and different. Are they more alike or more different? What causes the differences? Do the differences imply that one member incorporates more or fewer nutritional guidelines into behaviors than the other member?

When students have had enough time to consider personal and other member dietary routines, then have the students come together in groups of three to discuss what they discovered. Are student's family experiences more alike or more different? Ask groups to be prepared to describe the major findings from their discussions and have the class talk about implications of dietary routines as a way to think about family health.

Childhood Socialization About Family Health

In the family health studies, parents recalled childhood as times when some health beliefs and practices presently viewed as important and/or practiced were learned. Households were the places where children learned health information and were socialized about health practices.

Parents' health beliefs and routines continued to evolve as they interacted with others, obtained new information, responded to specific member health needs, accessed health resources, and were influenced by other contextual factors. Parents not only taught children about health behaviors, but also modeled behaviors that influenced future beliefs, values, and traditions. In all families, mothers assumed primary roles in establishing the patterned behaviors for children's health needs. The birth or presence of children was a strong key in the ritualizing of family health routines. Fathers and mothers described the value of life experiences as aids to health learning. Although fathers participated in family health routines, they described less consistent and active participation in directing children's behaviors.

Parents could describe whether their current behaviors were consistent with childhood routines, modified over time, or rejected because of childhood experiences. Teaching and learning about health was recounted as casual, mostly unplanned, and largely aligned with parental priorities. Parents could also discuss congruency between their family of origin experiences and what their children were being taught. Parents did not easily recall discussions about health practices prior to marriage or partnerships, but mostly described negotiations that occurred as ways to balance differing member needs. Families with close adult members, extended family members, and relatives from more than one generation described differences between what was experienced in families of origin

across and often within families depending upon member's developmental stages and other temporal factors. Health routines related to hygiene practices included such things as cleanliness, dental care, and toileting activities. Mothers with preschool children said they knew little about infant and child-care needs prior to pregnancy and either learned through trial and error or sought guidance from their mothers. Many mothers had received prenatal care through local public health programs, where they also gained additional information and support through well-child clinics and the Women, Infant, and Child programs (WIC).

The depth and breadth of data obtained about self-care routines was extensive, but only diet and sleep and rest will be discussed here. Dietary practices were the most complex health routines identified and usually mentioned first as a key family health factor. Dietary routines were strongly rooted in family of origin patterns, varied greatly within and between families, and were often modified due to member schedules, events, and family traditions. Family members described dietary practices in terms of (a) individual and family food selection, (b) food procurement and storage, (c) types of food preparation, (d) meal consumption patterns, (e) snacking patterns, (f) member roles, and (g) resource availability. Families differed in the freedom allowed members regarding selection and consumption of foods that conflicted with the mother's ideals. Although mothers mostly prepared meals and children in a single family were usually provided the same menu at meals, the nutritional value of foods

consumed by members within the same family was different. Even when mothers were consistent in planning and preparing meals, individual eating patterns and members present for meals varied. When work or activity schedules conflicted with meals, mothers were apt to allow family members to consume less healthy or even unhealthy food items. Dietary patterns were largely influenced by (a) mother's knowledge about nutrition, (b) personal choices and food preferences, (c) dietary beliefs and values, (d) work and school schedules, and (e) member cooperation in caring for one another's needs. Families had different dietary rules such as eating what is prepared; tasting new foods; ways food should be prepared, served, purchased, and stored; when and where foods could be eaten; and who had to have what for breakfast, lunch, and supper. Most adults said they tried to be consistent about adhering to healthy diets. Several described reasons for dietary inconsistencies tied to observations of ancestors and family friends who had lived to be 80-90 years of age without watching their diets, worrying about exercise, or seeking medical care.

Nutrition has been widely recognized as a key modifiable lifestyle factor with broad health implications. Healthy People 2010 has identified overweight and obesity as a leading health indicator pertinent to broad public health issues (U.S. Department of Health and Human Services, 2000). The intention of leading health indicators is to increase understandings about health promotion, disease prevention, and encourage

wide participation in health improvement in the next decade. Nurses have some education about nutrition and understand dietary relationship to diseases, illness, but they most often educate and counsel about nutrition with little emphasis placed upon the lived household experience or routines. Diet histories are often used to assess nutritional intake, but family patterns influencing diet are less likely to be considered. Family-focused care implies a holistic response to nutritional needs that includes things such as member values, family meal patterns, cultural and ethnic influences, personal preferences, family rules about diet, finances, knowledge about nutrition, and special dietary needs. In order to assist families to construct routines they will value and ones beneficial to health needs, families need knowledge and skills to alter behaviors and maintain changes over the life course.

Sleep and rest patterns were affected by time, role demands, work schedules, seasons, and special events, but less often than dietary routines. Preparation for sleep often occurred in close proximity to other routines such as dietary practices and hygiene care, although snacks and baths were often closely aligned to sleep routines they were actually other health routines. Unique variations in sleep and rest patterns were related to (a) bedtime and awake time, (b) sleep or rest time requirements, (c) sleep locations and with whom, and (d) strings of sleep related behaviors. Sleep and rest patterns were influenced by (a) biological rhythms, (b) personal time demands, (c) family patterns, (d) developmental stages, and (e)

seasons. Families living with unpredictable life events (e.g., children with special health care needs or developmental delays, terminal illness) most often expressed concerns related to interrupted sleep routines. Mothers were the most likely to experience sleep deprivation when members were ill or unpredictable life events occurred. Inordinate stress levels with potential 'pile-up' effects seemed to place these mothers at risk for depression, lowered self-esteem, and other health risks. Several mothers reported stress symptoms due to sleep deprivation. In fact, several parents indicated that when routines were out of sync, personal stress and family discord occurred.

SAFETY AND PRECAUTION

Safety and prevention routines were primarily concerned with (a) health protection; (b) disease prevention; (c) avoidance and participation in high-risk behaviors such as smoking, abuse and violence, alcohol and misuse of other substances; and (d) efforts to prevent unintended injury across the life course. All families practiced some routine behaviors associated with safety and precautions, but families had different concerns and practices. These families were intergenerationally linked to kin and were well advised about familial risks for genetic disorders and diseases linked to hereditary. Some described concerns about genetic predisposition to disorders for themselves or others, but they also told stories that described inconsistencies between their beliefs, knowledge, and actual behaviors. For example, one mother said multiple extended

family members had problems with diabetes and voiced concerns about her own risk. Although she said that her diet needed to be controlled and exercise was needed regularly, her overweight condition and descriptions of inactivity were indicated that knowledge does not assure behavioral changes in the household experience.

Personal health values and beliefs indicated that the ability to perform usual life roles and actively participate in daily life had strong themes related to safety and child protection. Mothers were vigilant in teaching preschool children about keeping safe inside and outside the household, avoiding illnesses and diseases, and evading situations that might result in injuries. Mother's knowledge about children's developmental stages was associated with safety concerns both inside and outside of the house. For instance, nurses at the health department had been doing active community teaching about the risks associated with lead poisoning; children in several families had been tested for lead poisoning and were found to have marginal risk levels (Denham, 1997, 1999a). A state law regarding child car seats and seat belts and an aggressive law enforcement agency assured that these mothers buckled preschool children into car seats and seat belts, but the same law seemed far less effective in assuring that teens and fathers also complied. Mothers with preschool children were all conscious about safety needs and cautioned children about risks, guided play activities, and warned about neighborhood concerns.

Many family members discussed routines related to actual or potential health risks such as smoking, alcohol or drug use, and non-adherence to medical routines. Some members said that they desired members to alter high-risk behaviors and described levels of participation in risky activities as an on-going concern. In the hospice study, community informants and family members described how they or others neglected their health when caring for a dying member. One mother said she had neglected to take her medications when her husband was sick. Others reported stress, weight loss, poor eating habits, physical exhaustion, and mental anguish as they assumed caregiving roles. Kin households were affected by the death of a family member.

Smoking is a habit generally viewed as deleterious to health. Participants discussed risks and negative attributes associated with smoking and drinking alcohol. One mother said, “Neither of us smoke and I don’t want my kids to do it. We don’t drink. I don’t want to introduce my kids into that kind of life.” Two mothers who smoked described long histories and pack-a-day habits, but were not concerned about health risks. Several parents, raised in households where their own parents had smoked, were well informed about smoking risks associated and actively taught their children avoidance at early ages. In several families where one parent smoked and the other did not, young children were often given mixed messages about the benefits and hazards created by smoking. Some parents that smoked described times when they had tried to quit, one

mother said: “The times I’ve tried to stop, I didn’t like myself. I’d be real hateful! I didn’t want to be around nobody. I just kind of like went into a little depression.” However, having knowledge about health risks related to smoking behavior was not enough to deter some from smoking.

MENTAL HEALTH BEHAVIORS

Mental health behaviors were family routines that dealt with self-esteem, personal integrity, work and play, and controlling stress. Routines in this category are related to the ways individuals and families attend to self-efficacy, and cope with stress. These routines are important for both individuation and family identify. Parents carefully nurtured their children, attempted to use available resources for a broad spectrum of family needs, and appeared concerned for meeting a variety of well-being needs for individuals and family as a whole. Family concerns often included extended family members in these Appalachian families and many regularly provided support to kin. In some families, active participation and care for extended family was viewed as a sign of care and viewed as beneficial, but some members said expectations created additional stress. Mental health care often meant anticipating needs, providing emotional support, re-defining unique boundaries, balancing patterns of attachment and independence, and determining boundary affiliations with extended family, close friends, neighbors, and outsiders. Mothers usually assumed the greatest responsibility for emotional care of family members, but fathers also played roles. These families were not likely to seek

professional assistance for emotional needs as this was often viewed negatively within the larger community. Several members of families using hospice care discussed the emotional pressures of caregiving, but viewed these activities as needful. Other families described frustrations when some members did not meet expectations in fulfilling caregiving responsibilities. Mental health routines, such as shared humor and family fun activities, individual relaxation techniques, stress management styles, participation in family celebrations, pet interactions, and religious practices were described by members as ways to contribute to health.

FAMILY CARE

Family care routines were described as a variety of daily activities, traditional behaviors, and special celebrations that provided shared enjoyment, pleasure, and meaning to family life. These routines included things such as family fun (e.g., relaxation activities, hobbies, vacations); celebrations, traditions, special events; spiritual and religious practices; pets; and sense of humor. Mothers often played key roles in decision-making and problem solving related to use of family assets and resources (e.g., time, money, insurance, knowledge, others), but other members also participated when it came to family care.

Family cooperation was viewed as an important tactic in supporting individual members' mental health needs and spiritual well-being. Many of these parents viewed church related activities as principal social activities, but mothers usually had the prime responsibility to

oversee adherence to religious practices and church attendance. In the studies, many families were regular churchgoers, but more were not. Parents that did not attend church still encouraged their children to participate in some church activities. Faith, prayer, and belief in God was important to these families even when they did not attend church regularly and everyday conversation was often sparked with ideas related to spiritual or religious beliefs. In some families, faith was an organizing theme for family routines. Participants often said that good communication, family and friends, and a household where members shared laughter and tears contributed to family health. Most close friendships in these Appalachian families were with persons they had known for many years, close relationships with kin or extended family, friendships with parishioners at their church, and close connections with neighbors. While outsiders were treated warmly, they were seldom quickly welcomed into lifetime networks of close friendships.

An important aspect of family care routines was associated with creating meaningful rituals that provided opportunities to establish their separateness and yet identify with the family. Culture, religion, ethnicity, and ancestral traditions played important roles in constructing these routines. Unlike many family routines that included regular repetitive actions, family care routines were more intentional and often included decision-making, a period of planning, and emotionally charged symbolic member interactions. Family care routines included special times when

members spent time together engaged in behaviors mutually valued. While these times may be elaborate celebrations, families also organized usual activities into family events. For instance, one family had several evenings a week when the whole family worked together in the garden and as the crops were ready shared in the cooking, canning, and sharing with family and friends. While some traditions and celebrations involved gift giving, signaled a transitional life period, or involved ancestral heritage, other family care routines related to family solidarity and indicated the value of member attachments.

Unnumbered box 13.2

Cooperative Learning *****

Ask students to choose three routine categories and then have the class count off by threes as a means to divide into groups with each assigned a category. Each group should discuss what aspects they view as important characteristics. Ask students to share examples from their own family that fall in this category.

After some time for general discussion has been allowed then ask each group to consider how they might use their category of routines for health promotion, disease prevention, and medical management of a condition such as chronic obstructive pulmonary disease. Ask groups to create a list of assessment questions for each area (i.e., health promotion, disease prevention, medical management). What needs to be known about individual behaviors and what information is needed to understand family routines? Answer the questions who, what, where, when, and how related to routine category.

After the groups have adequate time to discuss the issues, then ask groups to report the key areas they would choose to assess. Have a discussion about the implications of assessment data on the planning of interventions and evaluations of outcomes. Conclude by discussing how they might personally use family health routines in their present clinical practice.

ILLNESS CARE

The routines in the illness care category relate to ways members make decisions related to health care needs; choose when, where, and how to seek supportive health services; determine ways to respond to medical directives and health information; and actively provide for individual care needs. These routines are related to acute and chronic illness needs, diseases, rehabilitation, and trauma incidents. Key routine aspects are associated with decision-making about who to consult for medical care, how members use health care services, and ways prescribed medical regimens are followed.

In the family health research, families had routines that were sometimes described as obligatory member roles and responsibilities, kinship rules for care of ill members, and expected patterns for compliance with professional care, self-directed care, or family prescribed care regimens. Families had routines related to decisions about which incidents required expert care, if incidents required immediate medical responses, whether symptoms should be observed before action was taken, how long it was okay to wait before taking actions, whether illness trajectories would resolve themselves, and how an emergency response should be handled. Mothers mostly decided who to consult for medical care, but others including extended family often gave input into the final decisions. Member valuing, availability of resources, support, type of health concern, and perceived benefits often influenced the use of health information. Knowledge alone did not predict that health information about illnesses or

diseases would be incorporated into family health routines. Conflicting media reports about health issues and care regimens sometimes troubled parents even when the information was not related to specific family issues. Uncertainty about the trustworthiness of media reports seemed to weaken the family's confidence about the reliability of health information.

In the Appalachian families, illness seemed to carry an underlying message to members that being ill had an associated responsibility for the ill person to get well as quickly as possible. Healthy members understood that they had roles to play in health recovery by assisting ill members overcome health alterations and regain usual functional abilities. Ideally, individuals were expected to recover without passing the illness to others. Parents often suggested to sick children that they needed to get well so that they could go play. Family members cooperatively assumed responsibilities and caregiving that assure roles family resources were used to attend to members' prescribed care needs. While other members were permitted sick days, mothers were more likely to perform usual roles even when they were ill and often reported tending to some family tasks even on days when they experienced sickness. While some Appalachians may still use folk medicine or home remedies, the study families knew little about such treatments, but were inclined to self prescribe, use over-the-counter medications, and share prescriptions leftover from other family members who had suffered similar illness experiences.

In the hospice study, many family members described having concerns about physical symptoms of the ill member for a long while prior to actually contacting medical experts. Sometimes symptoms became quite severe before medical care was sought. One mother whose husband had died said that she had regularly urged him to see a physician for rectal bleeding for several years before he went for care. By the time of diagnosis, the disease was far progressed. In another family, a mother ignored symptoms that included vaginal bleeding even though her husband and children encouraged her to see a physician. By the time she sought medical care, the disease was too advanced for effective intervention. Even when seriously ill members had health information and understood the associated risks, many still delayed seeking medical care. For instance, a grieving wife with knowledge about the importance of following her medical regimen for diabetes repeatedly referred to her obese condition, diabetes and severe arthritis, but denied that non-adherence to her medical regimen was deleterious. She did not seem to connect the fact that her routine of poor nutrition, inactivity, and laxness in taking prescribed medications was harmful to her health.

Families where a member had a chronic illnesses or a developmental delay had more rigid forms of family routines than those coping with acute conditions. In the family health research, it was surprising to identify that in supposedly well families that so many had members with chronic conditions requiring prescribed medications and

illness care regimens. Persons with chronic conditions such as diabetes, hypertension, and even children with developmental delays often viewed themselves and were viewed by others as healthy. The family routines appeared to support individual needs based upon the severity of their functionality and the unpredictability of the condition. The more able adults were to participate in usual activities, the less likely others appeared concerned about adherence to a medical regimen. However, some families were especially concerned with children's symptoms and were tentative to medical needs. Families with members that had chronic conditions often talked about 'healthy' versus 'less healthy' days. It was during acute episodic conditions that other family members viewed members as ill. In disadvantaged families, many had one or more members with conditions that required medical or professional care. However, these families had fewer resources and seemed to report greater difficulties following prescribed regimens than other families (Denham, 1999c).

Family caregiving required a great amount of energy and effort whether the needs were for normative conditions or unpredictable situations. These routines pertained to the ways members interacted as mutual caregivers across the life course. Parents socialized children and adolescents about a wide variety of health related care modalities that included participation in health and illness care needs and supporting

others when they had needs. Aspects of family life pertinent to family caregiving included things like health teaching, member roles and responsibilities, balancing use of family resources, and providing support for illness care. Caregiving seemed to assume different characteristics when the family encountered normative conditions versus what might be considered unexpected or unpredicted life events. Members were likely to define parameters of care and assume caregiving roles associated with systemic maturation in ways similar to their families of origin. However, when family caregiving demanded more than what was usually expected, then it seemed that families deconstructed old routines and reconstruct new ones.

Mothers with preschool children played more active roles in child caregiving and were more involved in caring for life aspects with health potential than fathers. Mothers had many sources of information that supported child needs, but mothers were often unprepared to assume the complex and responsibilities related to the household production of health. Family caregiving also included member actions needed to assist others comply with medical regimens; these routines included obligatory roles, responsibilities, and sometimes kinship rules. Members described greater stress burden when caring for individuals with chronic or terminal conditions and for members with disabilities. Some family members noted that family misunderstandings sometimes occurred related to provision of physical or medically prescribed needs that resulted in less adherence to

the prescribed regimen. For example, one family had a toddler that had experienced seizure activity and the father wanted to withhold her medicine, as he did not think she really needed it and wanted to avoid the lethargy he had observed in two other children, but the mother thought the medication was necessary. The result was frequent heated family discussions about whether to use the medicine, increased internal tension within the family, and missed doses. Families with chronically ill or disabled members often discussed member conflict and household stress as members vacillated between being supportive and indifferent and when family routines had to be restructured to adhere to prescribed regimens. For example, when caregiving involved a dying member, many caregivers reported interrupted sleep, dietary changes, weight loss, and personal stress that occurred simultaneously with multiple family members. Responsibilities that extended for prolonged time periods sometimes meant adult children had roles and expectations to meet in the family of origin while they retained those in their primary household. Many spouses discussed variations in personal health routines and extreme stress during the time of the member's illness and dying that continued into the bereavement period. Caregiving routines are an area where most families seemed to need the kinds of support and interventions that might be delivered through family-focused care.

SUMMARY

Family's narrative dialogues are potentially useful methods for ascertaining health beliefs and family practices, but the technique is costly

in time and effort and requires highly skilled practitioners. However, additional research focused on family health routines could more clearly identify routine categories, dimensions that characterize them, and interventions most predictive of potentiating the household production of health. The development of psychometrically sound instruments normed on various family groups would be useful for assessment, intervention, and evaluation of outcomes. Future research and practice should: (a) identify within and between family variations in the ways routines are created, deconstructed, reconstructed, and maintained; (b) determine patterns of intergenerational transmission of routines related to enduring concerns and chronic illnesses; (c) clarify pertinent routine aspects related to health promotion, disease prevention, injury and risk reduction, health maintenance, and health recovery; (d) identify interventions for unique health behaviors applicable to health and illness needs; and (e) compare and contrast routine dose rigidity, pattern regularity, and member participatory factors with desired outcomes. Figure 13.1 provides some propositions that might be considered in practice and investigated through research. Cultural variations within groups and family populations may assist measurement of within group similarities and differences. Finally, greater attention needs to be focused on relationships between community context and family health routines.

Test Your Knowledge

1. Select one of the family health routine categories and describe how a family nurse might use this in the assessment process to do health promotion with the family.
2. A nurse is interacting with a family that has a toddler with a developmental delay, identify two categories of family routines that might be related to care needs. Describe why the routines might be important and provide three specific examples of how you might use them in planning and providing care.
3. Choose a category of family health routines pertinent in your personal family life and discuss how a nurse working with your family as the unit of care might target the routines.
4. Think about family care routines and explain ways that you might assess this area and intervene more effectively in your present practice roles.
5. List four things that you would need to change in your personal practice in order to incorporate family routines as a way to think about family health care.

Table 13.1

Comparison of Health Routines in Family Health Research

Study #1 Health Routines*	Study #2 Health Routines**	Study #3 Health Routines***
<ul style="list-style-type: none"> • Dietary Practices • Sleep and Rest Patterns • Activity • Dependent Care • Avoidance Behaviors • Medical Consultation • Health Recovery 	<ul style="list-style-type: none"> • Self-Care Routines • Member Caregiving • Medical Consultation • Habitual High Risk Behaviors • Mental Health Behaviors 	<ul style="list-style-type: none"> • Dietary • Self-Care Routines • Mental Health • Family Care • Preventive Care • Illness Care

* Denham (1997, 1999a)

** Denham (1999b)

*** Denham (1999c)

Table 13.2
Family Health Routines in Families with Preschool Children (Study #1)*

Family Health Routine	Aspects of the Routines	Description of the Routine	Examples of Routine Aspects
Dietary Routines	Cultural Variations	Factors from the cultural, ethnic, racial, and social context influencing diet choices and food preparation.	Food procurement Food security Food choices Food preparation Food selection
	Nutritional Consumption	Actual amount and type of food consumed by individuals.	Meal patterns Snacking patterns
Sleep and Rest Patterns	Family rest patterns	Individuals' usual sleep and rest patterns.	Individual rhythms Family rules Member age
	Temporal patterns	Patterns of sleep and rest that vary based upon time and events.	Work schedules School schedules Weekends
Activity Patterns	Purposeful activities	Usual tasks necessary for meaningful family life and health.	Specific tasks Timeframes for completion Role expectations
	Functional activities	Behaviors associated with work, school or play.	Organized activities School attendance Employment
	Social activities	Interactions that occurred between individuals and others	Friendships Volunteering Community involvement
	Exercise	Intentional activities to increase individual and family wellness.	Deliberate exercise Family fun
Avoidance Behaviors	Health risk related	Protection from risks known to cause illness or disease.	Illness and disease Smoking Alcohol use Substance abuse Social situations
	Safety related	Avoiding high-risk behaviors, persons, and situations that might cause trauma or injury.	Household safety Environmental risks Physical interactions
Dependent-Care Activities	Nurturant care	Activities that enhanced members' physical, emotional,	Anticipating needs Tolerating difference Emotional support

	Assistive care	and spiritual well-being. Assistance directed to meet self-care needs.	Transition and growth Foster attachment and independence Personal hygiene Toileting activities Social skills
	Resource care	Family members as resources to one another.	Caregiver Teacher Counselor Coach
Medical Consultation	When to consult	Determine when care should be sought.	Symptoms observed Mother decides Prior experiences Member willingness Perceived risks
	Who to consult	Determine who could provide care.	Availability Accessibility Reputation
	How to consult	Means used to obtain care.	Health insurance Affordability Informal interactions
Health Recovery Activities	Individual responsibilities	Immediate recovery and return to usual roles as quickly as possible.	Illness Injury Trauma
	Family responsibilities	Family responses to individual needs.	Extended family Friendship circles Family resources Supportive others

* Denham (1997, 1999a)

Table 13.3
 Categories of Family Health Routines (Study #2)*

Family Health Routine	Aspects of the Routine
Self-Care Routines	<ul style="list-style-type: none"> • Dietary • Sleep and rest • Personal hygiene • Exercise • Safety and protective behaviors
Member Caregiving	<ul style="list-style-type: none"> • Support for members with health alterations • Compliance with medical regimen
Medical Consultation	<ul style="list-style-type: none"> • Diagnosis of health disorder • Interaction with health care providers
Habitual High Risk Behaviors	<ul style="list-style-type: none"> • Smoking • Substance abuse • Work
Mental Health Behaviors	<ul style="list-style-type: none"> • Family fun (e.g., relaxation activities, hobbies, vacations) • Traditions and special events • Spirituality • Pets

* Denham (1999b)

Table 13.4
Categories of Family Health Routines (Study #3)*

Family Health Routine	Aspects of the Routine
Self-Care Routines	<ul style="list-style-type: none"> • Personal hygiene (e.g., toileting, dental care, etc.) • Physical activity • Sleep-rest patterns • Health promotion • Sexuality
Dietary	<ul style="list-style-type: none"> • Nutrition • Shopping • Preparation • Meals • Snacks
Mental Health	<ul style="list-style-type: none"> • Substance abuse (i.e., drugs, alcohol, smoking) • Family stressors • Self-esteem • Maintenance of personal integrity
Family Care	<ul style="list-style-type: none"> • Family fun (e.g., vacations, holidays, traditions, special days) • Humor • Individual/group activities • Coping with chaos • Creating special times
Preventive Care	<ul style="list-style-type: none"> • Health protection (e.g., immunization, seat belts) • Neighborhood risks • Risky behaviors (e.g., alcohol, drugs, smoking) • Abuse and violence
Illness Care	<ul style="list-style-type: none"> • Medical consultation • Health care services • Medical regimens

* Denham (1999c)

Table 13.5
Synthesis of Family Health Routines

Family Health Routine	Aspects of the Routines	Description of the Routines
Self - Care Routines	<ul style="list-style-type: none"> • Dietary • Hygiene • Sleep - Rest • Physical activity and exercise • Gender and sexuality 	These routines involve patterned behaviors related to usual activities of daily living experienced across the life course.
Safety and Prevention	<ul style="list-style-type: none"> • Health protection • Disease prevention • Smoking • Abuse and violence • Alcohol and substance abuse 	These routines pertain to health protection, disease prevention, avoidance and participation in high-risk behaviors and efforts to prevent unintended injury across the life course.
Mental Health Behaviors	<ul style="list-style-type: none"> • Self esteem • Personal integrity • Work and play • Stress levels 	These routines have to do with the ways individuals and families attend to self-efficacy, cope with daily stresses, and individuate.
Family Care	<ul style="list-style-type: none"> • Family fun (e.g., relaxation activities, hobbies, vacations) • Celebrations, traditions, special events • Spiritual and religious practices • Pets • Sense of humor 	These routines are comprised of daily activities, traditional behaviors, special celebrations that give meaning to daily life and provide shared enjoyment, pleasure, and happiness for multiple members.

Illness Care	<ul style="list-style-type: none"> • Decisions making related to medical consultation • Use of health care services • Follow-up with prescribed medical regimens 	<p>These routines are the various ways members make decisions related to health care needs; choose when, where, and how to seek supportive health services; and determine ways to respond to medical directives and health information.</p>
Member Caregiving	<ul style="list-style-type: none"> • Health teaching (i.e., health, prevention, illness, disease) • Member roles and responsibilities • Provide illness care • Supportive member actions 	<p>These routines pertain to the ways family members act as interactive caregivers across the life course as they socialize children and adolescents about a wide variety of health related ideals, participate in specific health and illness care needs, and support member's individual routine patterns.</p>

Box 13.1

Propositions about family health routines and family health

- Families that tend toward moderation in family health routines will be healthier than those families who are highly ritualized or those that lack rituals.
- Families with clearer ideas about goals are more likely to effectively accommodate health needs through their family routines than families who are less certain about their goals.
- Families and individuals are more likely to effectively accommodate changes related to health concerns when family routines are supported over time by embedded contextual systems than families who are not supported.
- Family routines that support individual health care needs will more likely achieve positive care outcomes in the individual with the health concern than families that do not have routines that support needs of family members with health concerns.
- Children that are taught health routines in the home that are supported by the embedded context are more likely to practice healthy behaviors over the life course than those children that are taught health routines in the home but are not supported by the embedded context.