

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

**Chapter 15:  
MOTHERS AS FAMILY HEALTH LEADERS**

**Chapter 15 Content Outline**

**GENDER AND FAMILY HEALTH**

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**MOTHER'S ROLES AND FAMILY HEALTH**

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**Chapter Objectives:**

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

- Identify gender specific roles that affect mother's health.
- Describe mothers' health roles from contextual, functional, and structural perspectives.
- Explain mothers' roles as the orchestrators of family health.
- Differentiate between mother as gatekeeper, sentinel, steward, and care-tender.
- Discuss implications of mothers' roles on family-focused practice.

## **GENDER AND FAMILY HEALTH**

*You will not grow if you sit in a beautiful flower garden,  
But you will grow if you are sick,  
If you are in pain, if you experience losses,  
And if you do not put your head in the sand,  
But take the pain as a gift to you with a very, very specific purpose.*  
Elizabeth Kubler Ross

*The literature reflects that mothers play key roles in influencing health for family members. Although nurses and others are clearly aware of the important roles mothers play in family health roles, this is not often addressed when interventions are planned or implemented. The family health research completed by the author identified that mothers often assumed major responsibilities for family health; played key roles in decision making about health concerns; taught, directed, and oversaw health behaviors; coordinated and supervised activities associated with health needs; and provided most caregiving tasks. Mothers are often the primary health care providers, medical consultants, and gatekeepers for health care services, as well as being most accountable for socialization needs related to health practices. It is posited that mothers' health roles have implications for those in family-focused practice.*

Mothers were present for and participated in all family interviews when the family health studies were conducted (Denham, 1997, 1999a, 1999b, 1999c). In all 24 families, mothers played prominent roles related to health protection, promotion, and maintenance; illness care; and resource use. Mothers were primary care resources, health teachers, and decision-makers. Roles that

emerged from the findings of the research were gatekeeper, steward, sentinel, and care-tender. Mothers orchestrate the family's health routines, determine how some resources are used for health needs, and provide the major portion of caregiving when family members are ill. Mother's family health roles also include:

- Protecting against illness and disease.
- Teaching health promoting behaviors.
- Instructing risk reduction and safety promoting behaviors.
- Modeling health related behaviors.

Mothers with preschool children were likely to have primary care roles for children and the household, hold jobs outside the home or be busily engaged in family work, and be actively involved with family health tasks (Denham, 1997, 1999a). The second family health study included families who had used hospice care when their loved one was dying; findings about members from various familial generations supported previous conclusions about mothers roles and afforded insight about times of transition and loss (Denham, 1999b). When a family member was dying, mothers and other female family members assumed primary caregiving roles, directed family care activities that often included extended family and friends, and were generally unwilling to leave the terminal member's bedside for even short time periods. If the dying person was the mother, then the father was strongly supported by the children and close family members, but it was often the female children or relatives that assumed

leadership in managing the household to care for the ill member and assure that other family needs were met.

In the final study, the subjects were lower income families with less organized lifestyles, but mothers still described family health roles similar to others. However, these mothers were more bent on merely getting through each day, described fewer safety nets or support networks, had fewer resources (i.e., kinds and amounts), were less apt to discuss goals for which action plans had been created, had more casual interactions with neighbors, and seemed generally less hopeful about the future than other families (Denham, 1999c). While most families in all three studies were present oriented, mothers in the more disadvantaged families had fewer goals and mostly focused on present needs. They often seemed to describe health as an ideal and frequently expressed despair when they perceived stressors and environmental threats outside their control. While all mothers described some personal stress associated with roles and responsibilities, low-income mothers reported more stress and illness and seemed to have more complex family health needs than other families.

### **Gender and Family Health Roles**

Until the last few decades' gender was not often associated with health care needs. In recent years, knowledge and understandings about differences between the health care needs of

men and women has increased. Deepened awareness about gender orientations has also informed about the variations in cultural expectations about gender and roles. Women in American society are largely responsible for meeting health needs in families. While a rapidly growing body of literature reflects extensive study of maternal roles in children's health and illness needs, fewer studies have examined roles with spouses, domestic partners, adult children, extended family, dying members, and older members with chronic illnesses or disabilities. While much is known about mothers' parenting roles, less is known about mothers' health roles related to well families, health promotion, prevention, well-being, and the household production of family health.

In the three family health studies, mothers were primarily responsible for roles related to the household and children, while fathers or male partners were more responsible for outside tasks. Mothers' household roles were complex activities that started when they awakened and lasted until bedtime, while fathers' tasks were more often occasional events. Men who were employed considered their work their primary roles and most participated in few household chores and minimal childcare. Males were likely to be responsible for yard work, automobile maintenance, household repairs when they were skilled, and trash! One father said:

Yeah, I generally take care of the car and do the maintenance on it. Growing up on a farm you learn to work

with your hands and think things through as far as fixing something...and that's what I've been trying to do all of my life.

Women employed outside the home still had primary responsibilities for children and the household. Fathers who were home while mothers worked or when they were briefly away from the home did assume responsibility for childcare and assisted with some selective household tasks. However, when mothers returned responsibilities reverted back to them. One mother described her husband:

His job is to come in and sit down and crash. We don't argue about that too much! If I ask him to... like I'm in a hurry or something, he will take the trash out on Wednesday morning, but only if it is necessary. Otherwise it is up to me!

Another mother explained the activities of her live-in domestic partner:

Yes he does have a few jobs. He knows there is certain things he has to do. We don't drink the water around here. So, he goes down to his parent's house, we have plastic jugs that he takes and makes sure that we keep...have a water supply. If I get groceries, he helps me carry them in and he will take out the garbage. I still can't get him to pick his dirty clothes up off the floor. He tries to clean. His clean and my clean are two different things.

Another mother explained that her husband strongly believed that women should care for the house and do the cooking, but he consistently fixed breakfast for the grandchildren and was willing to run the vacuum. Another husband was willing do some childcare if necessary and fix lunch, but refused to prepare

breakfast. Interesting that many of these mothers were teaching male and female children to participate in some household chores such as sweeping, dusting, washing dishes, and food preparation activities. Fathers often saw themselves as ‘pitching in’ when women needed assistance, mothers usually saw themselves as doing ‘everything.’

Parents recalled that in their families of origin mothers were the primary providers of health instruction, information, and guidance. Few parents recalled an emphasis on health like it is today. One father explained:

In growing up... and being young... You don't think about health or nothing, you know. I just remember my parents, especially my mother, saying “you got to eat your lettuce or spinach before you leave the table.” And I spent many long nights at that table!

He described things a bit differently in his wife's family of origin:

Like her mother taught her how to wash hands and this and that and to be clean and so forth. On my side now, living on a farm was a little rougher! I can't say that I was taught that way as far as washing your hands before dinner and like that... It seems like on the farm it's just a rougher atmosphere. When we got together, then her traits was carried over from her mother and so forth. It might have caused a little friction between us, you know.

His wife described her own family of origin experience:

Everything was spotless. Spotless! ...And her house still is! You had to wash your hands. If you come to the table as a guest, she would tell you that you have to wash your hands. Everything is spotless. You know, when she had company. As soon as you hit the back door, you can smell the bleach! So, you know she had company. Any outsiders, she always puts bleach in the dishwasher.

In families where extended family lived nearby, mothers often experienced role ambiguity as the mothers from the husband's or partner's family of origin continued to give them directions about how health conditions should be handled. One mother, a nurse by occupation, explained differences between her ideas and the paternal grandmother who they lived with:

Her and I have a lot of different opinions like one I can think of right off the top of my head is... She thinks suntan is healthy and I don't! I don't like (my son) out in the sun and if he is out in the sun, I like to put sunscreen on him. And she is always trying to get him to go out in the sun cause 'he needs a tan... he needs a tan...you need some sun.' She is always preaching to me about how I need some sun because I'm so pale, but I don't think that's healthy. I don't really want [him] out in the sun.

Mothers raised in two different generations often differed on what was and was not healthy.

### **Unnumbered Box 15.1**

#### **Reflective Thinking \*\*\*\*\***

Engage the class in a discussion about fathers' roles and family health. What roles do fathers play related to family health? Ask the students to recall personal memories about the family of origin experience. What roles did fathers play in family lives that were associated with health concerns? Were these more similar or different from others in your family? What about the father's of close friends, what did they do? What do you recall about adult male relatives and health or illness? Are there things that you recall from your childhood that your father always said or did that were related to health? If you are living in a family other than your family of origin, what roles do adult males play related to health? Are there any implications that can be drawn from the discussion applicable to family-focused care?

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#### **Mother's Health**

Mothers often described inequitable stress burdens, emotional fatigue, and spiritual turmoil associated with family roles and responsibilities. Close attachments to extended family meant that many mothers still had caregiver roles in families of origin along with those in the family of procreation. Mothers described obligations to families of origin, even when they worked, had young children, or other responsibilities. For some mothers stress was prolonged and many described on-going affects such as diminished self-esteem and self-worth. Some mothers were medically treated for depression, others described depression associated with childbirth, child care tasks, or other caregiving roles, some said they were depressed, and others described symptoms that identified them as high risk. While most mothers would only seek help from family physician, one single parent mother actually described going for counseling and to a psychiatrist for medications to cope with her depression and sleeping difficulties. She said,

I get myself worked up over stuff that really there is no reason to get worked up over, and it gets me down to where I don't feel like doing nothing. I think I make it hard for myself. It makes me feel like I don't want to do nothing, just be lazy and not get up and cook or not get up and take 'em [children] to the park like I should.

Another single mother said, "I have trouble with anxiety and depression and I take medication for all of this." She said that she thought the stress of being a single parent could be a reason for her

feelings. Several other mothers described present or past histories associated with alcohol and drug abuse or misuse.

While other family members could be ill, mothers did not have the time. Although other members were encouraged to participate in preferred activities, mothers often sacrificed personal interests for the sake of the family. When others were relaxing, mothers often reported being occupied with caregiving tasks. Some mothers seemed to have difficulties identifying priorities and were encumbered with child and household tasks, work responsibilities, extended family needs, and neighborhood concerns. Mothers often reported transporting children to school and extracurricular activities and seeing that they were involved in church and other social activities as stressful. As roles and responsibilities were recounted, mothers often described feelings of endless pressures and exhaustion. Mothers repeatedly said their actions were unhealthy, but had no concrete plans to alter the ways households functioned or family care was provided.

Fathers' reports of stress were more likely associated with family economics, work outside of the home, or fulfilling roles as the man of the house. If fathers felt stress related to children's health concerns, they spoke less about concerns than mothers did. However, husbands who described caregiving roles during the terminal illness of their wives and tasks associated with end-of-life

care reported personal and family stresses. In the families with greater economic disadvantage, unmarried mothers often discussed stressful relationships with partners who lived in the household, but did not fully participate in caregiving tasks leaving them to assume the burden of responsibility much like other mothers.

Mothers more often suggested that inconsistencies between health beliefs and behaviors were a problem for them than fathers did. Three areas that mothers repeatedly described were weight, diet, and exercise. In the dissertation study, four mothers suggested that their spouses were overweight, but only one described this as a personal concern and he did not intend to alter his behavior. Most fathers viewed current levels of exercise as adequate, in contrast mothers usually said that they needed to alter behaviors and increase activities. Children in most families did not appear overweight. The few heavier children were aware that they should eat and exercise differently, but were usually not consistently directed by parents in these behaviors.

Most mothers believed they were healthier prior to marriage and children. They often described personal health concerns that developed subsequent to marriage or childbirth such as weight gain, inadequate exercise, little personal time, and continual stresses from role demands. One mother said that she was very healthy prior to marriage exercising regularly and eating

a healthy diet, but when asked about the present she reported, “I slipped a great deal being married. You know, you cook junk food... and of course, they are heavy into this meat and potato thing.” She described her behaviors before and after marriage:

I don't get the exercise I should. I mean, I just look at myself and I am thinking... 'my gosh, this is a person who use to run everyday when I lived with my grandmother.' That was when I was at my best. I ate well. I got my sleep. I rode my bike. I exercised.

This mother believed that her pregnancy 4 years earlier caused her “whole body to change to a whole different size and weight.”

Another mother identified her healthiest time, “For my part, it was before my kids were born.” Still another said, “When I think I was the healthiest, I think it had to be... right before my first child!” A different mother said, “I use to exercise, when I started having kids the exercise started going down the drain” and in another interview said, “I know that I'm overweight, I wasn't even this big when I was pregnant.”

Mothers were asked what the family did if she got sick, one mother responded, “I guess nobody cares! I still have to keep doing what I did before.” A different mother said, “I have to do it all, I don't have time to be sick.” Another mother said, “I'm not allowed to be sick. If I'm sick, I get up and function like a normal person. Basically, it's like I'm not sick!” A mother in her late 20s had been diagnosed with thyroid cancer while she was pregnant with her

youngest son and had undergone treatment with radioactive iodine. She was to go every six months to a specialist for a cancer check-up and was distressed that her family physician also wanted her to come and see him every four weeks. She said, “I don’t know why, but every four weeks he wants you to have a check-up. I don’t think if I’m not sick, I shouldn’t have to go! Usually I don’t go unless I feel bad or something like that.” She reported that she had not seen her doctor for three months, but was confident that everything was all right and saw little need to do follow-up care unless she experienced new symptoms.

Some mothers described trying to comply with medically prescribed regimens related to mental and physical health conditions, but others seemed to avoid taking medications. For example, one mother said, “My back was killing me yesterday and I didn’t take one [Motrin]. I just kept thinking, ‘Oh, I’ll wait a little bit longer. I’ll wait a little bit longer.’ ‘Cause I don’t think that’s good, to just keep taking those things. I don’t think that’s healthy!” Another mother referring to the way her doctor prescribed her medications for arthritis said:

I had a few real bad nights and I would take a half of one and then that was it! No more. If I took all he wanted me to take... In fact, when he starts writing a prescription, he’ll say, ‘now you will not get hooked on this.’ I told him years ago I don’t want to get hooked on no medication because I don’t want to live my life depending upon a pill or a shot. I suffer a lot of arthritis, but I would rather do that than stay stoned on medicine.

This mother, in her late 60s, was hesitant to take even small amounts of medication even when she was experiencing a great amount of discomfort. Many mothers appeared ambivalent about what medical directions they should follow for themselves or other family members. Several described neglecting their health when they were caring for others. One mother explained what happened when her husband was dying from a terminal illness:

There were days when I didn't even take my medicine. I would forget to take my medicine. My daughter-in-law would say, 'Have you taken your medicine today?' I would say, 'I really don't know!' I just didn't know. I was solely concentrating on him, making sure he got his medicine on time and taking care of him.

As families narrated their stories about family health, it was often obvious that a great amount of inconsistency existed in daily practices even when mothers may have received medical care and obtained medications and directions about treatments. Mothers often described incongruity about personal health practices and related stresses. For example, mothers often said they believed a particular thing or had knowledge about something, but described conflicting practices. Mothers, whether fulltime homemakers or employed, stated that family demands left little times for themselves. A few tried to engage in a social life outside of the home, but said stress and guilt kept them from doing things for themselves. Although mothers described characteristics of

emotional and psychological well-being as part of being healthy, they often depicted a sense of hopelessness about coping with an endless list of stressful demands. One mother, a fulltime homemaker said, “I feel kind of out of control! I feel almost like a puppet, my strings are being pulled one way or another at all times. I don’t get to pull any of those strings.” When asked who pulled the strings, she answered:

Well, part of the time it is the farm, [husband’s] expectations, and three little kids’ expectations. There is chicken to be put away. There is corn to be put up. There is this, that, and the other thing that needs to be done here. There is just not enough time in the day to take an hour for me.

Another mother said, “I wish I had more time for me, just time to spend by myself! Seems like I am always around somebody and I would like to be by myself sometimes, and I don’t have much time for that.” One mother said that she thought some counseling might be helpful in relieving some of her personal and marital stress, but expressed reluctance to seek professional help because of what others might think.

A mother employed outside of the home described her personal situation since she and her husband had assumed responsibility for two grandchildren’s care a few years earlier:

It’s just very hard to get time to myself because we have four other grandchildren. We try to attend their ballgames. You end up almost like raising your own family. You have no time for yourself. I need an hour by myself at night. [Husband] gets upset with me because I stay up late at

night, but by the time the children get to bed and you do the laundry and everything else you do... But, I'm getting older and I can't stay up as late as I use to! I'll get up out of bed and he doesn't understand it. It just feels good being alone.

This grandmother explained how she coped with some stress and her spouse's misunderstandings. Some mothers practiced short-term solutions to cope with stresses, but most lacked concrete plans or intentions for even changes they seemed to think would be helpful. Although mothers often described biological risks associated with family histories, few described consistently practicing health protecting behaviors. One mother often explained about risks associated with a family history of diabetes and cardiac disease. She said, "I think because of my weight, I am more or less staring down the barrel of future problems. They concern me, but apparently not enough! I haven't lost any weight." An overweight mother discussed risks for heart problems and while she limited her sodium intake, she rarely participated in exercise. Although mothers were aware of personal needs, they seemed more focused on needs of others.

### **Conclusions About Gender and Family Health**

While many conclusions might be drawn about gender and family health, three seem especially striking. First, mothers or females seem to be socialized within their families of origins to assume leadership in the household production of health. Although males play some roles in family health and contribute to some

health tasks, they do not have primary responsibilities. Second, household tasks, caregiving roles, and role expectations often place inordinate amounts of stress on mothers or females that may compromise their own health at times. Third, mothers often seemed unaware of alternative solutions and lacked the energy to seek them if they did not already know about them. The implications for family-focused care related to gender include assisting families to better understand parental roles and responsibilities relevant to family health and identify ways to distribute household tasks in ways that potentiate all members' health. This means that interventions should target males and females about (a) the household production of health, (b) the affects of contextual systems and functional processes on health, and (c) ways to share roles so that processes of becoming, health, and well-being of all household members are realized. Family-focused practice should consider gender roles and responsibilities and include (a) assessment of the cultural and ecological context that mediates family values, themes, goals, and behaviors, (b) identify expectations within family as well as across families, and (c) supportive family interventions across the life course.

## **MOTHER'S ROLES AND FAMILY HEALTH**

### **Mothers as Orchestrators of Family Health**

When the findings about mother's roles and responsibilities related to family health were analyzed, four roles were identified: gatekeeper, steward, sentinel, and care-tender. If an analogy of an orchestra is used to understand mothers' roles, then mothers would be the conductors, family members the musicians, and the musical theme would be family health. As conductors, mothers' assured that household members would readily join the chorus refrain with full vibrato, play their parts when it was time, and harmonize with others. However, mothers were more than just conductors; they also served as the rhythm section, the chorus refrain, and the pizzicato. In all three studies, mothers were like a percussion section that maintains consistent rhythms. They instituted changes to maintain harmonic patterns, emphasized important family themes, and encouraged solos and ensembles vital to the synchronization of the household production of health. As the chorus refrain, mothers played prominent roles in the measures of core functional processes fundamental to family health and kept the members focused on the necessary and meaningful passages that undergirded ecocultural themes. They taught new behaviors, reinforced information and skills pertinent to health needs, sought needed health information and resources, and cared for illness needs. As the pizzicato, mothers poignantly warned about risks, dangers, and safety, enforced behaviors that supported family

themes and goals, and mediated discord as resources for competing priorities were instrumented. When mothers were out of sync due to inordinate stresses, coping inadequacies or insufficient supports, then family dissonance, lack of harmony, and incongruence often occurred.

When asked how they learned to take care of family health concerns, mothers mostly described families of origin experiences. One mother said, “probably just from my mom doing for us and stuff. I learned from that and that and other people that I know or related to me or my friends.” Another mother said, “How your parents take care of you when you were sick, I think that taught me a lot! If [daughter] is sick, I basically take care of her like my Mom did me.” Several mothers said that they did not recall much discussion about health or health topics when they were growing up. Mothers agreed that no formal learning about health occurred in their families, but things were mostly learned experientially over the life course.

### **Unnumbered Box 15.2**

#### **Reflective Thinking \*\*\*\*\***

Take some time to consider your own family history and what you recall about your own mother’s roles related to family health. What were the roles of your mother? Was your own mother more like those of your friends or was she different? What do you recall about other women in your family and family health? Were their actions more similar or different from your mother? Are there things that you recall from your childhood that your mother always said or did related to health? Were there some things that your mother did that you now find yourself repeating? What are they? If

you live in a household other than your family of origin, how has this affected your roles?

After some time has been provided for reflection, have a class discussion about the experiences. Make a list of the common things that most mothers did and then see if the group can identify some unique differences that might be based on cultural experiences, race, ethnicity, religion, geographic or regional differences.

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### **Mothers as Gatekeepers**

Women were gatekeepers for families' medical care and key decision makers about disease and illness care, health promotion behaviors, and use of health information. One mother said, "I'm basically the decision maker and he agrees with me!" A single mother when asked about how she makes health decisions said, "I don't know, I just make my decision! Whatever I feel is right." Another mother said, "It's just common sense to know that your kids sick and you can't do anything for them and you just take them to the doctor." Mothers said that they sometimes used information learned through the media to guide decisions. Several described how they consulted with their mothers prior to deciding what to do. Males that expressed greatest concerns about health issues either had education or skills in health-related fields or had recently encountered the death of a loved one, but a few exceptions were noted. Most males did not assume principal health care roles, but mothers checked with them and discussed problems related to health issues. Males were most likely included in decisions about

diet, children's safety, and illness care in non-emergency situations. However, mothers said they had often already decided what they intended to do and were usually informing others about intentions rather than seeking direction.

Community informants consistently described male dominance and patriarchy in Appalachian families and said that mothers assumed prominent roles when the issues were health related. A local expert about Appalachian culture said:

In the Appalachian culture, women seem more subservient to men, but, on the other hand, women are probably stronger. They know when to pick their battles and some of them are worth picking and others are not. Some have associated saving face with an Appalachian society and men are supposed to be the providers and have the leadership in regard to family. Some women have to work to make sure that the man saves face, although she may be the strongest person.

Males appeared willing to defer to their wives when it came to medical care, children's health care needs, and family health.

Mothers informed spouses or partners about doctor appointments, treatment decisions, and prescribed medical regimens.

Nonconfrontation was a cultural trait of these Appalachian families, the Appalachian expert said:

We don't always confront them. We would rather not confront. And because of that you allow things to build up. I think it's a cultural thing. It's been referred to as an ethic of neutrality. It may show up in noncompetitiveness and not taking stands on issues. You know, you might take a stand on an issue back in your own home, but to come right out in public and do this... You don't always do that because you may be viewed in a negative light or you've

just been taught that 'you don't kick up a fuss.' This has been used for an explanation of domestic violence... That people don't do well bringing out issues and confronting them, and so you just let them build... And then go from being very passive to very violent. In the community, you tend to know that within families! Sometimes it backfires if you use that in a positive sense that if the female should happen to expose the circumstances, sometimes the family would turn on her because she exposed something within the family.

Although a nonconfrontational stance might be true about some issues, when it came to health issues mothers were often confrontational! Several described incidents where they sought care for children's illnesses, but thought that physicians did not really listen or treatments and medications ordered were not helpful. Some mothers described how they found new doctors or went other places for care when they thought providers were ineffective. One mother had three children with chronic health care needs and described many physician encounters where she voiced concerns and questioned advice. She often called a local pharmacist prior to talking with physicians about medications. A local physician said he was often confronted when he tried to give medical instructions about health concerns, chronic problems, and risk reduction activities.

Mothers incorporated knowledge about medical services, health information, and other community resources into their decision-making. When problems or concerns arose, mothers identified available options, initiated contacts to obtain information

and resources, saw that children were taken to medical appointments, obtained and administered prescribed medicines, and determined when follow-up care was needed. The degree and frequency of mother's discussion with significant others about health issues differed by family. One mother said, "I usually make all of the decisions, he just goes with what I say. I just do whatever I think is best!" A father in another family said, "Whatever she says goes." Another mother said,

I'll ask his opinion. Actually it is that way. I'll ask his opinion on a lot of things, but it usually ends up whatever I want to do. I usually know ahead of time [what she intends to do]. I just throw in my words so that he'll know what's go'en on and if he thinks it should be done different. Then we'll talk about it.

Parents were both exposed to health information, but mothers usually paid more attention and had more interest than others. Males tended to be more casual users of health information, while mothers were purposeful purveyors related to specific needs. A father, who was self-employed as a farmer, had a television in the barn that he watched in the mornings as he milked. He said he often heard health information and later casually shared it with his wife. His wife explained that his telling her about specific health information probably meant that he thought it was important and if she agreed with its significance then she might try to incorporate it into the household. However, her husband said that he told her

things, but then forgot about them and seldom incorporated the new information into his behaviors.

Mothers were interested in health topics directly applicable to members and family problems. Health information viewed helpful often focused on things like pregnancy and childbirth; acute and chronic illnesses pertinent to members; communicable diseases; safety and protection; self-care; inherited or genetic diseases; alcoholism and substance abuse; exercise; and a few mentioned wellness lifestyles. They discussed consciously seeking information from popular magazines; television and radio; friends, families, and co-workers; food and product labels; medical experts; general reading of health related literature; and supportive networks, agencies, or institutions. Few mothers read newspapers or gained health related information through formal programs. When asked how health information was obtained, one mother said:

I get a lot through the health department. There was a nutrition class through the extension office and I went through it last winter. I learned a lot of things there. You could just watch one [TV} show, like maybe the “Today Show” or whatever. You catch things, you know, in passing.

Most information was gathered informally or brought to their attention by a health care provider.

One mother with a young son previously treated for leukemia now in remission described how she would go to the

library to learn more about his disease. She said, “Having information... It made me feel in control, cause you don’t have no control over it. It just made me feel better cause like they’d [hospital staff] give you like a list of side effects and stuff to look for. If you wasn’t in medical school, you wouldn’t understand half those terms.” Many mothers noted health information was obtained from physicians, nurses, clinics, and brochures they sometimes read while waiting in health care facilities. However, obtaining information or learning about specific topics did not assure that the information became part of the family health routines even if it might be beneficial. Mothers seemed to use an 8-step process related to their gatekeeping role and the household production of health:

- Mothers have a purpose(s) for health information and/or medical resources.
- Mothers are aware that pertinent health information or medical resources exists.
- Mothers have prior understanding or knowledge confirms the value of new or different health information and medical resources.
- Mothers’ use of health information and/or medical resources is supported by member beliefs, values, and needs.
- Mothers have some measure of communication and/or cooperation with other household members that support the use of health information and/or medical resources.
- Mothers have access to the health information and/or medical resources.
- Mothers make a conscious decision to use health information or medical resources.
- Mothers actually use the health information and/or medical resources available.

### **Unnumbered Box 15.3**

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

Divide the class into three groups and have the students in each group brainstorm about mother's roles as gatekeepers, stewards, sentinels, and care tenders. Discuss whether these roles seem appropriate for thinking about mothers' health roles across family cultures, variations in family social status, and families with different economic conditions. Next, identify the types of general health and illness information mothers might need in each of these roles ways if they had pre-school or school age children. Third, identify how this information might be different for teenagers. Fourth, consider the kinds of information mothers might need as children become adult and leave home. Finally, brainstorm about some ways nurses might interact with mothers in assuring they have needed information.

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#### **Mothers as Stewards**

Mothers assumed responsibility for the judicious use of resources to meet competing family health needs. Some needs were directly related to family bio-physical aspects, but other needs competed for assets. Mothers acted as stewards as they monitored, dispensed, and oversaw the distribution of available resources for things such as family members, personal time, finances, health insurance, health knowledge, material goods, and access to health services. Extended family was viewed as a primary resource and mothers often consulted them prior to seeking medical care or when uncertain about courses of action to take. Mothers learned some things germane to family health in families of origin or through more traditional forms of education, but most practical knowledge was gained through life experience in the family of procreation. One mother said, "I have to see how

much resources I've got, then I make my decisions." As stewards, mothers assumed roles as overseers to see that caregiving tasks were met; this often meant they were self-sacrificing in order to provide for other's needs.

The household production of health was closely aligned with the stewardship of family resources needed to meet competing demands and mothers were usually most responsible for decision-making. A large amount of the family's economic resources was connected to diet and a significant part of the families' income was spent for food. Some mothers explained how they spent more or shopped less wisely when children accompanied them to the store or when spouses did the shopping. Mothers with lower incomes that received food stamps for purchases said there was plenty of food at the beginning of the month, but selections were more limited as the month went by. Some explained how WIC coupons were used to assist to improve children's diets.

When unpredictable life events were met or the family faced multiple pressing demands simultaneously, it was usually the mother that made decisions about resource use. For instance, if families had a child with a chronic illness, mothers managed the resources to "make ends meet." Mothers often described ways financial resources were used, but reported hesitancy about

spending money on themselves, as they saw this as selfishness or self-indulgence. The needs of others took priority over personal needs. A mother with limited financial resources and several young children with chronic health problems said she seldom bought new things for herself. Her husband chided her because she refused to buy some new clothing for herself, but her response was that the children's needs were great and she felt guilty when she bought things for herself. Although many mothers indicated that they probably should think differently, they seemed powerless to make changes. Family resources were greatly impacted by employment status of the family, but local policies, legislation, and other embedded factors were also influential.

### **Mothers as Sentinels**

Mothers assumed roles as protectors and guardians of health and acted as sentinels as they instructed, cautioned, and warned members about illness, disease, and injury. Although fathers provided some protection for their children, especially in the areas of safety and injuries, mothers were mostly responsible. As sentinels, mothers were accountable for maintaining health, teaching and reinforcing health behaviors, and minimizing risks associated with disease, trauma, or injury. These families defined health in terms of freedom from illness and an ability to actively participate in life tasks; therefore, mothers vigilantly engaged in

sentinel behaviors as they alerted, cajoled, and nagged throughout the course of the day.

Mother's childcare roles included socializing the child about expected health practices and illness responses and had roles associated with initiating, developing, and overseeing family interactions. Instructions about health behaviors appeared to be based upon (a) health beliefs and behaviors important in mothers' family of origin, (b) a willingness to accommodate the differences arising in the family of procreation, (c) boundaries related to involvement of extended family and others, (d) availability of health care resources, and (d) personal valuing of health information. The cultural context, societal influences, local health policies, and medical service and provider availability were factors in mothers' choices.

Mothers were the primary health teachers for children and used what they knew about health to guide children in behaviors that increased health and reduced risks, but they seldom had organized plans to achieve health goals. Mothers teaching, guiding, and counseling seemed mostly impromptu and without much premeditated planning or intention. Mothers seemed to offer information in response to children's actions, as they provided guidance about things to do and not do and corrected those who failed to complete expected tasks, ignored rules pertaining to risks,

or blatantly disobeyed instructions. While conducting the family interviews, mothers were often observed correcting children when they engaged in risky or dangerous behaviors. Some mothers were vigilant in their admonitions, others were more relaxed, and some seemed completely oblivious to behaviors even when they appeared quite precarious to the author. Mothers were attentive to young children's instructions about self-care activities such as personal hygiene, sleep and rest, and diet. Even when children were adolescents, mothers continued to direct behaviors and offer instructions.

Families often had many extended members living nearby and most had regular interactions with them. Close relationships meant that mothers were aware of biological risks associated with the family's heritage and also some environmental exposures. One mother identified diabetes as a family concern and said, "I am worried about sugar diabetes, because my mother died of it." Another mother said, "It [diabetes] seems to affect the women in the family, that is why I hate to see granddaughters born." This same mother described her son's asthma:

We didn't know where it was coming from and we've tracked it down to my mom's side of the family. In fact, some of her aunts died from asthma, but she was real little when they died. So, she didn't know until we got with some of the older relatives who said, 'oh yeah' [referring to the family history of asthma].

A different mother said, “My mother has high blood pressure and she had an angina attack and she has diabetes. All these things concern me.”

As mothers discussed health of family members, they often elaborated about the intergenerational links that served as warnings for family members. A mother described how her husband’s mother had died at the age of 26 years with leukemia and she had investigated her family’s genealogy and discovered several deaths from leukemia and was especially concerned about her daughter because of the high incidence of female deaths. Another mother said:

I look at my past family history on health, things that run in the family. Like my dad’s side, his parents have diabetes and his sisters have it, he [father] doesn’t! My mother’s side, her mother had strokes and my grandfather, his mother had a cerebral hemorrhage. On his side [father], there’s like diabetes and heart problems too. I try to keep up with that and connect with what I do and try to block it off so that the kids and me don’t have these problems.

She was concerned about her 3-year-old son’s risk:

I worry about [son], ‘cause [he] has had thirst. He was constantly wanting something to drink and I know that is one of the signs. I talked to his pediatrician about him and he checked him. He doesn’t [have it]! They’re keeping an eye on that... with him especially and the other kids.

When mothers spoke of health risks, they often described observing children for symptoms, teaching them preventative activities, and encouraging pertinent risk-reducing behaviors. In many families, mothers promoted the avoidance of behaviors like

alcohol use and cigarette smoking. Mothers said that they cautioned their children about avoidance and abstinence. Although some fathers were fully supportive, in families where fathers smoked or drank alcohol, children were often exposed to conflicting ideas about behaviors.

### **Mother as Care-tenders**

Mothers nurtured, supported, encouraged, and provided actual care to meet member needs. As the persons most responsible for the core functional processes of family health (i.e., caregiving, cathexis, celebration, change, communication, connectedness, and coordination), mothers acted as care-tenders to meet family health needs. Care-tending responsibilities included parenting and childcare related to health, assisting chronically ill members or those with disabilities, enabling ill members to regain health, protecting others from getting sick when a members was ill, managing symptoms associated with terminal illness, and attending to end-of-life care needs. Care-tending roles were also related to health promotion, disease prevention, and risk reduction and overlapped the gatekeeper, stewardship, and sentinel roles. Although mothers did not describe modeling gender roles, it seemed an unconscious behavior.

Some mothers described care-tending behaviors in their families of origin that they did not want to replicate. For instance, one mother with an ill sister when she was growing up said:

Where my sister had polio... Me and my brother... If she couldn't go somewhere, we couldn't go. She [her mother] didn't like people around. A few close relatives, but that was it. We weren't encouraged to have friends. We couldn't enter activities because my sister couldn't. That's why being home was an issue, because me and my brother, even if we had a fever... We wanted to go to school. We wanted to be with kids.

In a later interview, she said:

Like I said, we were sort of kept in, my brother and myself. So, we went to school no matter if we were sick or not because we wanted to be with other kids, which wasn't good for them. But staying home was never a problem because we just didn't want to.

This mother had experienced negative feelings about her mother's rules in illness care and was determined not to repeat them. She valued open relationships and encouraged family members to have friends, be involved in outside activities, and welcomed interactions with outsiders.

As care-tenders, mothers obtained health information, scheduled and attended members' medical appointments, purchased and administered medications, and saw that medical regimes were heeded. Mothers acted as primary caregivers with ill members, prompted males to seek medical care, encouraged follow-up and preventive care. Although fathers generally left decisions about medical care to mothers, some had strong opinions

about adherence to medical treatment. One father never administered medications to the children except for when he was left alone with them for short time periods. He said that he felt a great deal of anxiety about giving medicines and checked many times before administering them. He said his wife was the expert when it came to the children's health needs. While other fathers with young children reported similar things, those fathers that were care-tending for wives with terminal illnesses described how they shared responsibilities with adult children.

In another family, where a preschool child had experienced seizures, the mother said:

This past spring and last fall.... No rhyme or reason to why we had these [seizures]. There was no illness, no anything! Just play. We had EEGs done, which does show some activity. I don't think anybody believes me... That she actually had seizures. They wanted her to go on and get some medicine and put her on it and try her. [Her father] doesn't want her to go on it.

No further seizure activity had occurred, but this mother was concerned about care-tending behaviors related to her daughter's needs. Her husband and other extended family members had suggested that it was unlikely that this would happen again, but she remained uncertain even after several months without any sign of recurrence.

Disease, illness events, chronic conditions, and members with disabilities required special care-tending skills. Mothers often

had little prior experience or knowledge about how to attend to concerns and sought guidance from extended family members, close friends, medical experts, and incidental media information. When members had conditions that required close attention, it was usually mothers who sat up nights or awakened at intervals to monitor events. Mothers often determined when an acute episode was over or when members could return to work, school or play. Fathers or adult sons most often provided assistance when the illness was a terminal condition, when the ill member was male, or when the person with needs was a wife or mother.

## **SUMMARY**

Mother's seemed poorly prepared to assume many roles and responsibilities related to being gatekeepers, stewards, sentinels, and care-tenders for their families. Family-of-origin experiences were varied and most women entered families of procreation with a limited amount of preparation for the many tasks and decisions that became their duties. Most learning was informal and often more by chance than plan! Visits to health practitioners, opinions of extended family members and others, and media reports were the ways most new information was introduced to families, but it was neither systematic nor organized and mothers were often ill-prepared for the charges they inherited. Even families considered healthy often had members with chronic

illnesses, disabilities, and terminal conditions that placed inordinate demands for knowledge, skills, and resources from family households.

Family-focused practices aimed at potentiating the household production of health need to address family health from systemic and life course perspectives. Individual encounters should be viewed as opportunities to provide the family with information and skills pertinent to member conditions and how to optimize health behaviors. Most services and resources are presently delivered in response to episodic needs initiated by the individual with a need. Family-focused care could more effectively meet the needs of family households if it was planned based upon developmental needs, population-based concerns, and community-based issues. Rather than depending upon self-referral, more meaningful family-focused care could use methods of case finding and target caregiver support, availability resources, and change processes related to incorporating health information into family routines. Family-focused practice would not only target the household production of health, but also populations concerns impacted by embedded contextual systems and social policy.

#### **Unnumbered Box 15.4**

##### **Critical Thinking**

Divide the class into 3 to 4 groups. Assign each group a different health condition for consideration. Perhaps one group might think about a family with a terminal illness, one a chronic illness, one a trauma incident, and one a well functioning family. Ask groups to

choose a recorder. Each group should first list tasks mothers might assume related to the particular health issue, and identify the kinds of health information and resources they might need. If the intended goal is to potentiate well-being for the individual and family, what proactive interventions might nurses use to intervene? After groups have explored the issues, then ask them to share ideas with the entire class and encourage group feedback.

While the discussions occur, identify four student volunteer to maintain lists on the board titled gatekeeper, sentinel, steward, and care tender. Ask these students to listen carefully to the class discussions and as things are mentioned that fit into their category to make notes about it. After all groups have presented their ideas, then conclude the discussion by comparing and contrasting the fit between mothers' personal needs and maternal roles related to family health.

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**Test Your Knowledge**

1. Describe what is meant by the idea of mothers as the orchestrators of family health and discuss the implications for family-focused care.
2. Compare and contrast mothers' roles as gatekeeper, sentinel, steward, and care-tender in relationship to family health.
3. Explain how family's embedded context might alter mothers' family health roles.
4. Discuss how a mother's health condition could affect the household production of health.
5. Identify ways family functioning might strengthen or threaten member roles related to family health.
6. Identify potential risks in families when mothers have a chronic illness, mental or physical disability.
7. Describe differences in nurses' ideas and family goals that might be of concern when creating a family-focused care plan.