Chapter 17
PARTICIPATING IN FAMIY-FOCUSED PRACTICE

Chapter 17 Content Outline

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Chapter Objectives:

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

- Describe what is included in family-focused practice.
- Identify the knowledge and skills needed to provide family-focused care.
- Discuss assessment of the contextual, functional, and structural domains of family health.
- Identify strategies related to family-focused interventions.
- Explain ways to evaluate family-focused care.

PREPARING FOR FAMILY-FOCUSED PRACTICE

Describing Family-Focused Practice

Every model or system of care delivery must achieve desired patient outcomes and contribute to staff satisfaction, retention, and productivity in an environment that is good for patients and where professionals are energized and can make a contribution.

Nursing Leadership for the New Millennium:
Essential Knowledge and Skills
Maryann Fralic, PhD, RN, FAAN

Professor, John Hopkins University

The Family Health Model suggests that family clinicians, educators, or researchers approach practice from different perspective than those customarily used when caring for individual clients. This chapter describes various practice dimensions relative to family-focused practice and discusses concerns those working with families in embedded contextual systems need to bear in mind. Additionally, the chapter provides directions for comprehensive family health assessment of the embedded context, functional processes of interacting members, and family routines. Family assessment can occur in all three areas and produces baseline and evaluative data for designing meaningful family interventions that target family health concerns and evaluating household outcomes.

Family-focused practice utilizes each encounter with an individual patient or client as a means to target the household production of health. The family is the target or unit of care even when individuals are encountered. Assessments include identification of interactions among multiple members and their embedded contexts relative to specific health objectives and family goals. The nurse collaborates with family members and others to provide interventions for an array

of health concerns related to the bio-physical, psychological, emotional, spiritual, ethical, economic, cultural, or social nature of family health and well-being across the life course and evaluates outcomes. Family-focused practice includes focusing on families' functional, developmental, historical, temporal, and contextual dimensions. The focus of care is persons-in-context and aims to understand the ways multiple members interact to socially construct health behaviors related to family themes and goals. Family-focused practice aims to assist members optimize resources, attain family goals, and potentiate the household production of health. Box 17.1 provides a list of assumptions about family-focused care.

<<<<<<**INSERT BOX 17.1>>>>>**

Mauksch (1974) described the interdependence of the health of the family and the individual members as a fusion of member's unique qualities in ways that creates a 'family health estate.' This estate is characterized by health values, habits, risk perceptions and involves developmental processes associated with family roles and health status. "Family health is a dynamic changing relative state of well-being which includes the biological, psychological, spiritual, sociological, and culture factors of the family system" (Hanson, 2001, p. 6) and a "holistic term referring to functional and dysfunctional families" (p. 420). Linking processes between members may positively or negatively affect internal and external member interactions, influence developmental processes and well-being, and alter health. Family health needs are often enmeshed and not easily differentiated, thus practitioners must be highly skilled and knowledgeable about family dynamics.

The novice practitioner initially engaging in a family-focused practice might be overwhelmed at the complexity of care needs. Just as first encounters with the nursing process may have seemed overwhelming and difficult when first introduced as a way to think about individuals; family-focused practice presents a vast number of different tasks and concerns. New learning experiences often seem cumbersome and burdensome at first, but progressive learning allows the novice to become an expert. Every aspect of family assessment is not broached on every family encounter, but appraisals, interventions, and evaluations are driven by identifiable needs. While individual care is mostly incident-based, family-focused practice is more relationship-based because the care is intended to build on prior encounters over time. As nurses become more expert in family care, they gain knowledge and intuitive abilities that are directive in knowing who, what, where, when, and how to assess and intervene.

The primary tasks of family-focused practice are similar to other nursing concerns: the relief of suffering, the prevention and treatment of illness, and health promotion. However, family-focused care includes life course and household perspectives. “Primary care that is truly family-focused uses the family unit as the basis for data gathering in assessing and meeting patient needs” (Green-Hemandez, 1999, p. 8). Family-focused care is not strategized by seeing the family as extensions of individuals, but instead addresses actual or potential family concerns related to members. Primary care is a key aspect of family-focused care, but practitioners should not be shortsighted as they incorporate interventions related to families’ embedded context.

Preparation for Becoming a Family-Focused Practitioner

Besides possessing clinical skills and a comprehensive base of knowledge relative to nursing and family practice, those practicing family-focused care must also be cognizant of what is occurring in the human population, the economics associated with the health care industry, legislation and regulations affecting health care policy, corporate interests, and the influences of the public and private sector. In order to be become competent family providers, nurses must be versed in the professional, political, business, and social issues affecting family health and aware of past, present, and possible future trends. In addition to knowing about health care systems in general, understandings about the cultural diversity of the nation, region, and community where they work are also needed. Expertise in technology and computer information systems is desirable. Nurses choosing to do family-focused practice might look at themselves as pioneers and be prepared to assume leadership in the redesign of practices and care delivery systems.

Nurses working in family-focused care need to be comfortable working with interdisciplinary teams; collaborating with families, professionals, and others within communities; and partnering with agencies providing family services. Familiarity with a broad range of health resources for family members with common developmental needs, as well as awareness about particular resources for unique family problems is needed. Finally, family nurses must also be prepared to provide evidence-based practice if they are going to meet societal mandates for effective, efficient, and quality care. A family nurse specialist prepared at the graduate level should have expertise in family theories and practice associated

with assessing health problems, delivering family interventions, and evaluating outcomes related to the household production of health. Desirable characteristics of family nurses include: possess an attitude of inquiry; exhibit scientific integrity; possess investigative skills; act as a team player; be prepared to evaluate, utilize, and disseminate research findings; and participate in research studies. Family nurses should apply evidence-based outcomes in the practice setting and be prepared to champion issues related to family health policy.

Unnumbered Box 17.1
Cooperative Learning
Students should write definitions that capture their personal perceptions about family-focused care and relationship-centered practice. When students have had time to complete this task, then form groups of three to discuss ideas. Group members should discuss each definition separately and then identify the common themes and differences in their definitions. Ask groups to develop a consensus definition of family-focused care. After all groups have had time to complete the activity, then have the entire class discuss the consensus definitions and ascertain where they agree or disagree. Discuss implications of the definitions for practice and the fit with other nursing theories.
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Clinician Roles and Family Advocacy

Family nurses are in unique positions to be advocates in ways that may be somewhat different from those working with individual clients. Closer alignment with multiple members and on-going family relationships surrounding primary care issues over the life course should increase the nurses' awareness of family needs and limitations. Movement from the institutional setting to the household eliminates the isolation of particular family concerns and opens a frontier of lived reality as the practice setting. Family nurses are more apt to see access and barriers to care from the family's perspective as they strategize with members to create meaningful interventions and evaluate outcomes.

Since the late 1980s, significant changes in health care delivery have occurred as the U.S. has moved from fee-for-service to managed health care. Despite the failed efforts of the Clinton Administration to enact a comprehensive reform of the health care system, incremental changes have occurred to increase some benefits for preventive care, increase access to care for children and persons with disabilities, and reduce reimbursements for some high cost procedures. All problems have not yet been resolved and in many ways new troubles have surfaced. Issues still not resolved are things such as the Patients' Bill of Rights, prescription coverage under Medicare, medical malpractice, drug review processes, and privacy and security of medical records. Other concerns center on drug costs and practices of pharmaceutical companies, abilities to get new drugs approved and available in more expeditious ways, and the rights for persons to have access to life-saving drugs even when they live in less privileged nations. Consumer protection, the right of patients to sue health plans that deny or delay benefits, and the large number of uninsured continue to be concerns. Catalysts for future changes include things such as advances in biotechnology, development of new pharmaceuticals, information technologies, electronic commerce, and continued soaring costs. Consumerism implies that families are more self-reliant, knowledgeable, and interested in health care alternatives than in the past. All of these issues are pertinent as nurses consider potential family advocacy roles.

Family advocacy may take on different venues as care delivery continues to change in the 21st century. As more care is provided in outpatient settings, how will nurses' advocacy roles be affected? What systems will be employed to

increase safety, reduce errors, increase quality, and decrease costs? What issues will be debated as telehealth and use of computer information systems increase? How will care provided in more autonomous settings affect liability? What are the issues related to licensure that might need to change in order to accommodate family health needs? How will demand, access, and safety be weighed across international borders? Will price controls be needed to assure affordability for insurance payers and family consumers of health care? What costs are too formidable for the benefits achieved through innovation? What implications does the Human Genome Project have for the futures of family-focused practice? How can employers create programs that better address the household production of health (e.g., medical savings accounts, vouchers, use of alternative therapies). How can practitioners better meet family health needs for increasing numbers of poor uninsured families? Family-focused practice provides great opportunity and responsibility on nurses to understand the long and short term affects of changes in policy and service delivery. Although the future holds positive prospects, the potential for disparities among families may be greater than ever before.

Family-Focused Care

Hanson (2001) defined family nursing as ”the process of providing for the health care needs of families that are within the scope of nursing practice. Family health care nursing can be aimed at the family as context, the family as a whole, the family as a system, or the family as a component of society” (p. 420). Family nursing should be primarily directed toward the family group rather than merely viewing them as the patient’s context because the health of the family unit is both

a determinant and outcome of family care (Gilliss, 1991c). Family-centered care is ”an approach to child health care based on the assumption that the family is the child's primary source of strength and support” (Hanson, p. 420). Gilliss suggested that family as context means that the members are sources of information about the patient or client (e.g., health history, health practices, lifestyle), but as unit of care provide information about group values, supportive interactions, decision-making, affective relationships, caregiving, and health habits.

Assessment is an important skill learned by all nurses. Initially the focus of assessment is on individuals, but this is broadened as students are taught about families, groups, and populations. While family assessment provides baseline data, it is a reoccurring phenomenon that should occur with each nurse-client interaction as a ways to evaluate the effectiveness of interventions, determine whether goals have been met, and measure care outcomes. The primary focus for assessment usually rests on skills learned about primary care and meeting needs of individuals. Primary care is "recognized as the provision of integrated, accessible health care services by providers who are accountable for addressing a large majority of personal health care needs" (Singleton, Green-Hermandez, & Holzemer, 1999, p.3). Primary care encourages the development of sustained partnerships, caring, and trust between patients, families, health care providers, and others within the community. Singleton et al. discuss relationship-centered care as care that redefines the patient-provider interactions and recognizes the value of relationships between providers, families, and communities Relationship-

centered care requires (a) partnerships that see patients as unique persons; (b) practitioners that are reflective and willing to relinquish preexisting perspectives and paternalistic views; (c) technical proficiency; (d) professional competence; and (e) interdisciplinary practice (Singleton et al.). Family nurses have a broad array of goals to accomplish in family-focused practice (Box 17.2), but clinicians must be aware of potential competing family and professional goals.

<<<<<INSERT BOX 17.2>>>>>>

A number of important points need to be included when thinking about what comprises family-focused practice. Although intensive assessment and evaluative measures related to families and the household niche are inextricably tied to family health, these are usually interpreted in terms of the care recipients. Family-focused practice must also include systems effectiveness for the adequacy, accessibility, appropriateness, and affordability of care delivery. In the delivery of individual care, the nurse often views the patient separate from the context and too often identifies problems, conflicts, and dilemmas as if they originated from within the patient or family rather than the health care system. It is incumbent for family nurses to examine systems from the family's perspective when outcomes are measured.

FAMILY-FOCUSED CARE AND CONTEXTUAL ASSESSMENT

Family Context

Robinson (1995) described four ways to conceptualize families and care within a family. The first is to view nursing care for a single individual family member or individuals where the individual is viewed as foreground and the

family unit perceived as background. The second perspective is to perceive the care of an individual or a family sub-group and two or more persons with the family identified as the background or the context for the family sub-group. The third view is that of nursing of a family group. In this perspective, the family is viewed as distinct, separate, and different from individual members with the family viewed as foreground and the individual becoming background. Finally, the nursing care of the individual and family system is a schema that invites consideration of the interactions and affects of the individual upon the family and the family upon the individual with both individual and family system identified as foreground. Robinson argues that this schema of family views presents a common language for nurses to discuss family practice and clarifies some understandings about the family unit. Based upon this schematic, family-focused care is viewed as the fourth perspective with the family and individual viewed as foreground.

Contextual Assessment

A number of traditional measures have been used to assess the home environment including the Home Observation for the Measurement of Environment (Bradley & Caldwell, 1984; Caldwell & Bradley, 1984), the Family Environment Scale (Moos, Insel, & Humphrey, 1974; Moos & Moos, 1986), the Family Adaptability and Cohesion Evaluation Scale (Olson, Partner, & Lavee, 1985), and the Home Quality Rating Scale (Meyers, Mink, & Nihira, 1990). The Home Observation for the Measurement of Environment is an observational inventory for families of preschool children, the Family Environment Scale and

the Family Adaptability and Cohesion Evaluation Scale are used to measure the psychosocial climate of the home, and the Home Quality Rating Scale is designed to assess child-rearing attitudes and family adjustment when a child has a developmental delay. These instruments are usually viewed as environmental measures, but they have mostly been used in research rather than practice to measure member interactions. The value of these family instruments is undisputed, but they may not be practical for clinical use or assessment of family context as defined in the Family Health Model.

Comprehensive assessment of the ecological context is often overlooked in health assessments of individuals and families. Identification of contextual perspectives can provide data about things that are modifiable, as well as things that are fixed, inflexible, or permanent. Contextual assessment allows nurses to differentiate among household membership, family relationships, circumstances, events, conditions, and situated systemic contexts. Data about the context can assist in family-focused practice by providing the nurse with means to identify:

- Contextual factors within the control of the family.
- Contextual influences outside the control of the family.
- Combinations of internal and external contextual factors that contribute to or inhibit family health, individual well-being, and members' processes of becoming.

Assessment data are meaningless unless used in conjunction with multiple members to develop, implement, and evaluate a plan of care specific to the goals of individuals and the family.

The Family Context Assessment

The Family Context Assessment (FCA) is a comprehensive tool that can be used to gather individual and family information pertinent to family health (Appendix B). If the FCA has not previously been reviewed, then the reader might find it helpful to review it now and refer back to it as necessary. While the FCA instrument is suggested for contextual assessment, it is possible that agencies or practice settings may want to modify this instrument, design their own tool, or use aspects of some pre-existing instruments to collect some data. It is highly unlikely that the family nurse would complete the FCA during a single visit, but would collect some baseline information and then select the areas most pertinent to specific individual, family sub-system, or family concerns. Additional information could be collected over subsequent interactions with the same or other family members. A comprehensive assessment would take a fair amount of time to complete, but cost-effectiveness and efficiency might be measured in terms of future timesaving. Use of an electronic record could make previously collected data more easily retrievable and eliminate the need to repeatedly ask the same questions unnecessarily. The nurse may collect data through a face-to-face interview or the use of various computer-assisted data collection techniques (e.g., computer kiosks, the Internet, portable computers, and telephone call-in) that would minimize time and economic resources.

If the FCA was constructed as an electronic file, then follow-up visits of single members or data related to multiple family members can create a continuous rather than an episodic family record. Agencies, hospitals, and

institutions interested in developing electronic family records could incorporate preferred instruments already in use, but link information of multiple family members into a single file. Development of an electronic database would enable use of the file over the lifetime of an individual while retaining links to the family of origin, decrease the collection of data previously obtained, make family-related data easily accessible, and provide ways to look at intergenerational information. As children mature and leave the family of origin, new family links could be created but connections to original records retained. An electronic record provides a way that family members could access their own information and the opportunity to make it available to other health care providers when needed. Agencies and family-focused practices could adapt the FCA to reflect the agency mission, care philosophy, standards of care, and family populations. A family database should include baseline information and be updated whenever the family nurse or other health care provider has sequential family contact. Deciding on ways to approach the FCA will depends upon things like the purpose of the encounter, availability of family members, and assessor expertise. Table 17.1 provides an overview of the breadth of the contextual areas that can be assessed and can serve as a guide for data collection.

<<<<<<<<INSERT TABLE 17.1>>>>>>

Unnumbered Box 17.2
Cooperative Learning Activity************************
Divide the students into four groups so that each will look at a different aspect of the Family Context Assessment (Appendix A; Figure 17.3). Students in should divide their section of the assessment tool into different areas so that two students are looking at different sections of the assessments. Students should identify an

area they might assess in each target area and write questions that might be used with families. After students have had adequate time to write their questions, then have them take turns asking one another and evaluate the usefulness of the information gathered.

Ask the four groups to have a small group discussion about the over-all assessment data they would be collecting and ways the data might be used to develop family-focused interventions. Have student groups list their ideas. Next have a class discussion that involves students in all four sections about the data collection process and usefulness of data collected. Finally, collect the questions and lists, compile the questions and ideas about usefulness of each section and give students copies.
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Genograms and Ecomaps

Genograms and ecomaps provide additional ways to collect assessment data, represent relationships important to family members, and summarize some data relevant to family health. A genogram provides a way to quickly visualize data of interest about multiple generations. A family genogram usually identifies family of origin relationships, birth dates, marital or partner relationships, occupations, offspring, deaths, and health-related data. Genograms can also be used to demonstrate the strength of attachments, conflict in relationships, estranged, and broken relationships (McGoldrick & Gerson, 1985). Ecomaps provide an overview of relationships between the family and other institutions, agencies, and persons with variations in the connecting lines signifying the nature of the relationships. Thorough discussions about genograms and ecomaps are accessible in other nursing texts (Friedman, 1998c; Hanson, 2001b; Roth, 1989; Wright & Leahey, 2000). If the family nurse lacks experience in their use, then some time spent engaged in learning activities is suggested.

Culturally Competent Family-Focused Care

Much has already been said throughout this text about the importance of culturally competent care. Learning about culture and becoming competent in family assessment is not something fully learned in any classroom. While basic skills can be taught, it is through practice and experience that one realizes the full breadth needed to address unique cultural needs. Although one might be viewed as culturally competent in providing care to one cultural group, it requires great sensitivity on the part of the family nurse to discriminate their abilities and limitations in working within diverse cultural contexts. Family-focused care demands competence and sensitivity from practitioners as they practice and personally validate whether or not they are proficiently and equitably addressing needs. Nurses who sense their adversity towards persons of color, foreign speaking individuals, hypochondriacs, homosexuals, welfare recipients, or others will need to take remedial steps to overcome these stumbling blocks if they desire to respond in culturally competent ways. Asking myself whether I am a novice or an expert in my ability to be culturally responsive may be insightful.

Family Communication

Interviewing and communication skills are a must for collection of meaningful family data, responding to families in culturally competent ways, and developing interventions that include multiple members. Nurses learn basic communication skills for individual interactions early in their nursing education, but more advanced skills are needed for working with family sub-systems, families, community groups, and interdisciplinary teams. Although nurses may be equipped to gather some data through histories and physical assessments, they

may require to more fully develop communication skills relevant to family health. For instance, nurses may find themselves less comfortable or prepared to address topics in communication such as goal exploration, engagement, exploring alternative solutions, or collaboration. The third edition of the Calgary Family Assessment Model provides an excellent resource to use in conjunction with the Family Health Model as it provides specific ways to approach an interactive interview using linear and circular questions to identify family health needs (Wright & Leahey, 2000). Family-focused care commands a need for nurses who are capable communicators and able to attend to family values, perceptions, and needs. Time spent in role-play and clinical experiences observed and discussed with faculty or preceptors can enhance the family nurse’s abilities to refine and optimize communication skills so that time with family members is productive and achieves intended goals.

FAMILY-FOCUSED CARE AND FUNCTIONAL ASSESSMENT

In order to fully understand the implications of family-focused care, the family clinician must not only have a thorough understanding about family context, but also be cognizant of the impact of functional processes on health. Concerns and coping with the instrumental aspects of life and activities of daily living are closely related to family members’ interactive relationships. Activities of daily living pertains to capacities needed by all persons to attain, maintain, and regain the usual life processes that sustain life and family health. Examples of daily living include things like meal preparation, eating, sleeping, exercising, etc. Instrumental aspects of life are the unique and specific capacities needed by

individual members and families to relate to the embedded context where they live, work, and play. For instance, instrumental activities might be related to things like communication, learning, transportation, problem solving, physical, or mental limitations. Family Functional Assessment (FFA) should ascertain strengths and limitations of individuals, family sub-systems, and the family as a whole. Family-focused care seeks to build strong dyadic and triadic relationships within and external to the family that potentiate family strengths, minimize limitations, and optimize resource use. It is posited that strong trust and respectful relationships formed between family sub-systems and nurses have great potential to positively enhance family health by creating bi-directional channels for teaching and learning. Issues related to the FFA and the core functional processes include:

- Operationalizing what members mean by health, illness, and family health.
- Understanding the complexity of family dyads and triads.
- Differentiating innate member traits.
- Discovering relationships with networks of persons, agencies, institutions, and providers outside of the family microsystem.
- Linking functional expectations with developmental stages of individual members and the family as a whole.

Table 17.2 suggests the types of assessment questions to ask related to the core functional processes and provides some considerations when planning care.

<<<<<<<INSERT TABLE 17.2>>>>>>

Although the developmental stage may be directly linked to the context of the family, the affects of member and family status are expressed through actions, relationships, and interactions. Steinglass, Bennett, Wolin, and Reiss (1987) have

provided a way to envision family development from an early, middle, and late phase perspective (Table 17.3).

<<<<<<<INSERT TABLE 17.3>>>>>>>

In each phase families have specific goals to accomplish and tasks that correspond to either normative or non-normative family situations. These developmental phases, goals, and tasks can provide important assessment data for the nurse and other health care practitioners as they plan care. The FFA should include assessment of families' core functional processes, and family developmental stages. Family-focused care implies that data should be updated with individual and family encounters.

Communication and Family Functional Assessment

Family-focused communication related to the FFA must include opportunities to obtain multiple family perspectives, as well as those of distinct individuals comprising the household.

According to Wright and Leahey (2000), "family functional assessment is concerned with details of how individuals actually behave in relation to one another" (p. 128). The authors differentiate instrumental functioning or those things that regularly occur related to the usual daily activities or business of the family. In comparison, expressive functioning pertains to nine distinct family areas: emotional communication, verbal communication, nonverbal communication, circular communication, problem solving, roles, influence and power, beliefs, and alliances and coalitions. Instrumental and expressive issues are closely intertwined with family health concerns. For instance, if the father in a

family with two school age children has just recently experienced a myocardial infarction and suffered severe cardiac damage, the family has both instrumental and expressive issues. Instrumental issues pertain to diet changes, a need to stop smoking, alter patterns of alcohol consumption, and to begin a rehabilitation program that includes progressive activity and exercise. Expressive issues related to roles might be:

- How is my husband's not working going to affect our ability to pay the bills?
- Who is going to help with the child-care while Dad is sick?
- Is grandmother going to want to come to stay with us?
- Daddy was supposed to coach our baseball game on Saturday, who is going to do it now?
- What is the length of time that he is going to be off work?

Other expressive areas give rise to different sets of questions for individuals and the family.

Families are in continual transition and these evolutions incessantly tax communication resources within families. For example, Golan (1986) said that the inability to cut loose or create meaningful distances from relationships, persons, places, or things from the past might create inherent decision-making problems when families try to make changes. Families in transition may have the inability to (a) separate from the past, (b) adapt to new roles or conditions, (c) make decisions, and (d) locate and mobilize resources for implementing decisions (Golan). Family-focused care means that nurses must communicate effectively to engage multiple members in change and interventions related to health concerns. While traditional practices usually engage single individuals, family-focused care

requires the ability to interview family members together so that interactions can be observed and the interactional responses identified.

Unumbered Box 17.3
Cooperative Learning Activity *****************
Divide the class up into seven groups and assign one of the core functional processes to each.
Ask each group to select a recorder. Groups should turn to chapter #10 and review the material that describes the core functional process they are assigned. Using Figure 17.1 as a guide, have each group identify questions they might ask individual members about themselves, about others in the family, and about the family. (If also using the Wright & Leahey text, refer to Chapter 4). Ask students to note whether questions address cognitive, affective, or behavioral areas. Keep lists of these questions. After the questions are compiled, ask the groups to describe how they would use the data collected through this assessment to develop family-focused interventions.

INSERT FIG. 17.1

When students have completed the activity, conduct a class discussion about assessment of the core functional processes. Compare and contrast the kinds of information obtained with questions that address cognitive, affective, and behavioral areas. Discuss how data about
core functional processes could be used in family-focused care. Collect the students' work, compile it, and return it to them for future reference.
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FAMILY FOCUSED CARE AND FAMILY HEALTH ROUTINES

The functions of rituals are many, but they can assist the family to achieve a sense of solidarity, enhance identity, regenerate commitments, and strengthen loyalties. Rituals provide order, links with traditions, a form or structure, provide the families with roots and wings, increase organization, and reduce chaos. Rituals can promote or diminish healing (Boyle, 1998). Families that tend toward moderation in family health routines rather than either highly ritualized or lacking rituals may possess a more resilient family health paradigm (Denham, 1995). Family routines can be characterized by degrees of ritualization and participation.

Figure 17.2 provides a schematic that suggests ways high ritualization, low ritualization, and balanced ritualization differ.

<<<<<<INSERT FIGURE 17.2>>>>>>

Individuals and families differ on levels of involvement and ritualization, ways participation in routines occurs, and daily or occasional practices

Various types of routines can be identified in households: patterned behaviors, habits, rituals, individual routines, family routines, family health routines, family traditions, and family celebrations (Table 17.4).

<<<<<INSERT TABLE 17.4>>>

Assessment of different forms of routines can provide insight into family themes and identify practices that might be pertinent to family routines.

Rituals are often influenced by the prior experiences in the family of origin. Daily rituals and life-cycle rituals may be affected by different factors that may have "reverberating effects on your sense of self and others" (. Imber-Black & Roberts, 1987, p. 57). It might be helpful to think about possible styles of rituals within families as:

- Minimized (few rituals, convey little sense of family identity through time)
- Interrupted (response to crisis events more important than ritual practice)
- Rigid and unchanging (highly prescribed and unvarying behaviors)
- Obligatory (events are celebrated out of sense of obligation rather than meaning)

- Imbalanced (inability to balance member's histories, legacies, and valued rituals)
- Flexible (capture and express member and family changes over time) (Imber-Black & Roberts, 1992)

Routines may differ in families with traditional versus non-traditional divisions of labor and based upon the character and changing needs of members. Primeau (2000) noted that parents must create and maintain daily routines that are sustainable, meaningful, provide opportunity to shape children's development, and also meet conflicting and competing needs of individual members. When Steinglass et al. (1987) studied structurally intact alcoholic families with reasonable occupational and economic histories concluded, "The impact of alcoholism on the fundamental aspects of daily life-daily routines, family rituals, family problem-solving strategies that affects many families dealing with alcoholism so profoundly as to shape the entire course of their life history" (p. 24). It is possible that other health conditions also impact routines.

Families raising children with attention deficit hyperactivity disorder were interviewed about the ways they construct daily schedules and routines. Parents scheduled times for homework, dinner, and free time after considering their children's abilities to concentrate, other physiological and emotional needs, and parental work schedules (Segal & Frank, 1998). Parents often had to change their daily routines in order to develop and use strategies that enabled children's activity competence (Segal, 1998). According to Segal (1999) some carefully scheduled and constructed family activities provide families with time and space together that are idealized family images embedded in experiences of togetherness and good relationships. When families have children with special needs, the

routine times together often include sharing and provide learning opportunities. Ludwig (1998) conducted a study of Caucasian, college-educated unemployed middle-class women to see how they changed routines in later life and found that although they used routines to care for their well-being, they reported doing so to a lesser extent than when children lived at home or when they worked. Subjects desired more freedom as they aged and health care interventions should be compatible with changing themes and routines. Although nurses have largely ignored family routines and rituals, a growing body of literature indicates that they could contribute to better family assessments and interventions.

Assessment of Family Health Routines

Families are paradoxical in that they are both resilient and fragile. The influence of time, knowledge, perceptions, experience, and events affect boundaries, values, behaviors, and social relationships. Interactions among traditions of cultural, ethnic, and spiritual origin over the life course impact accommodations to normative and non-normative life events and take on patterned characteristics. Routines may differ in patterns of rhythm, cadence, accent, quality, and meaningfulness based upon various factors that need to be assessed:

- Process factors (e.g., relationships, perceptions, motivation)
- Resource factors (e.g., information, health insurance, skills, support, experience)
- Form factors (e.g., plasticity/rigidity, resilience/transitory, stable/volatile, cohesiveness/fragmented, openness/closedness)

Table 17.5 provides an overview of areas related to routines to assess when planning for health care needs.

<<<<<<<INSERT TABLE 17.5>>>>>

Daily routines provide an observable expression for families and practitioners to discuss the social construction of family health that most consistently occurs within the household niche. Planning effective care is dependent upon identification of high-priority family goals that are congruent with values, themes, ecocultural niche, ecocultural domains, and routines. Inclusion of the family in the assessment, planning, and evaluation processes is essential if consequential goals are to be met and meaningful outcomes achieved. Family routines have similar properties, dimensions, and variations across some families, but unique differences must be identified for effectual planning, intervention, and evaluation (Table 17.6).

<<<<<INSERT TABLE 17.6>>>>

Interventions can be maximized when they are harmonious with other family features. Themes associated with family workload, access to health services, family economics, and response to social support imply crucial factors for development of facilitative interventions. Family-focused care implies that care providers understand that changes in tenacious behaviors are often difficult and members over-taxed by stress, caregiver burdens, or comfortable in the safety and security of usual routine may have difficulty accommodating changes. Family care must be imparted with flexible, but comprehensive approaches that use available resources to support members over time as accommodations are made.

Unnumbered Box 17.4
Cooperative Learning Activity
Ask students to review the family health routines in chapter 13. Divide the class so that several students will be working with each of the family routines. Ask each group to compare and contrast the assigned routine, planning, and interventions that might be associated with health promotion, chronic illness care, and end-of-life care. Ask groups to list assessment questions and describe interventions for each area (i.e., health promotion, chronic illness care, and end-of-life care). When the groups are finished, have a class discussion about their ideas.
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Communication and Family Health Routine Assessment

Family-focused care emphasizes the need to assess and plan care with multiple members, preferably building on strengths of family dyads and triads. Family Health Routine Assessments should identify agreement and disagreement about areas that impact family health such as:

- Rituals, traditions, and celebrations
- Religious beliefs and affiliations
- Issues surrounding race, ethnicity, and culture
- Valuing and perceptions about habits, changes in patterned behaviors, daily routines
- Collective memory about individual and family past
- Satisfaction with present habits, patterned behaviors, and routines
- Hopes for future life course alterations

Larson (2000) suggested that eight processes associated with family orchestration exist: planning, organizing, balancing, anticipating, interpreting, forecasting, perspective shifting, and meaning making. Assessment and interventions germane to routines use all these processes.

Nursing care aimed at routines will be more effectual when interactions include a triadic perspective and include at least two family members as this has potential to obtain a broader perspective of family themes, resources, strengths, and barriers. Assessment of dyadic and triadic relationships helps determine to

whom health information or interventions should be directed (Olsen, Russell, & Sprenkle, 1983; Wright & Leahey, 1994). The nurse should aim to be a neutral observer, but able to introduce new ideas and information germane to routines, suggest alternative ways to construct or deconstruct behaviors, and assist members to reframe attitudes and behaviors to address health concerns in accord with family themes and goals.

FAMILY-FOCUSED CARE MAPS

Family-focused care requires coordinated, comprehensive, and integrated approaches to deliver primary care that addresses unique member and family needs. Broad discussions about the usefulness of care maps exist in the literature (Bergman, 1999; Currie& Harvey, 1998; Ellrodt, Cook, Lee, Cho, Hunt, & Weingarten, 1997; Garbin, 1995; Messer & Ozmar, 1999). Care maps are useful tools for nurse practitioners, family nurses, case managers, and clinicians delivering primary care as they provide approaches to assess, plan, and evaluate quality and cost related to a variety of health care needs. These are tools developed and used to manage clinical processes, identify potential strategies to achieve health outcomes, guide interventions, and record family responses. Care maps depend upon family input; concerns of individual members; and include expertise of multiple disciplines as guidelines and algorithms are created for decision-making and care delivery. Care maps can be used to determine variances from policies, standards, guidelines, or protocols and evaluate the effectiveness of interventions in achieving goals. Care maps afford opportunities to consider evidence-based care from individual, family, caregiver, and practitioner

perspectives and have potential to decrease costs and increase quality measures. Care maps can be used across practitioners and settings in association with outcome and performance measures relative to family needs.

Conceptual slippage often occurs when trying to differentiate critical pathways and clinical pathways. Critical pathways have mostly been viewed from providers' perspectives rather than those of care recipients with quality mainly measured in terms of cost savings achieved through the avoidance of variances. Critical pathways are most often aimed at acute episodic incidents related to individuals with little focus on family. It is posited that clinical pathways, in contrast, can utilize quality measures that allow for life course considerations, target family concerns, and utilize life course perspectives to understand the household production of health. A clinical pathway is a comprehensive method of planning, delivering, and monitoring care (Garbin, 1995). Clinical pathways that focus on achieving family outcomes related to member health/illness needs have not yet been developed and tested, but the concept holds potential for family-focused practice. Use of diagnostic tools, data collection measures, algorithms, and multi-foci family outcomes seem a natural fit with clinical pathways to not only consider variances and cost effectiveness, but also weigh evidence related to family perceptions, satisfaction, and outcomes; error and risk reduction; standardization of practice; quality indicators; and caregiver needs. Care maps might include some aspects of clinical pathways and be useful in case management. Case management of family groups sharing similar needs for clinical expertise, having comparable contextual needs, and requiring equivalent

care management supports may benefit from the use of care maps or clinical pathways. Family nurses might use what is known about case management and clinical pathways to assume participatory roles and collaborative relationships with other care providers in the design of care maps relevant to specific health and illness foci.

Unfortunately, a scarcity of well-designed research studies that document effective use of critical or clinical pathways in individual-focused care does little to assure that pathways or care maps will be useful in family-focused practices. As family-focused practices are conceptualized and care is delivered, it will be vital for family nurses and nurse scientists to collaborate in the development of studies that collect assessment and outcome data in standardized ways and devise methods that lend themselves to reporting outcomes in ways that can be accessible to others. Timely dissemination and ease in access of practice outcomes, research findings, recommendations, and conclusions will enable those in family-focused practices to share the effectiveness and limitations of care strategies relevant to family health. Bergman (1999) suggests that knowledge dissemination has been less than effective and networks of practice sites need to be developed to share knowledge, experiences, and validation about the usefulness of guidelines. Judicious sharing about the implementation and usefulness of clinical pathways and care maps related to family-focused care will advance knowledge development and practice outcomes. Practice improvements are most likely to occur when (a) pathways and maps reflect current knowledge

and practices and (b) outcomes from guidelines and care management tools are widely disseminated through practice networks and continuing education.

Thorough understandings about family context, functional core processes, and family health routines equips the family nurse with a wealth of information to assist in family collaboration in devising interventions that address family health needs. Analysis of assessment data should provide evidence for decision-making and may suggest treatment priorities in relationship to the health foci targeted. Planning for a family-focused care map also necessitates time spent reviewing areas related to family health, as well as priorities, goals, supports, and threats (Table 17.7).

<<<<<<INSERT TABLE 17.7>>>>>>

Primary concerns to include in the development of care maps are:

- Families' beliefs, values, culture, and perceptions are respected.
- Families can define themselves as they are.
- Families are viewed as experts about themselves.
- Care and services are impartially provided in meaningful ways to regardless of family disparities.
- Information, education, and counseling are supplied in ways families understand.
- On-going support for family needs is available even when their choices conflict with professional perspectives.
- Competent and ethical clinicians work in conjunction with one another to meet family needs across a variety of points of care and time.

Family Participation in Family-focused Care Maps

As patients are being discharged from acute care centers more seriously ill, today's families are being asked to take increasingly larger responsibilities for the care of members and cope with more complex care needs. Family caregivers

administer medications around the clock, monitor intravenous chemotherapy, oversee medical needs of chronic renal patients, change sterile dressings, do urinary catheterization, respond to in-home diabetic and asthmatic emergencies, manage pumps for pain management, and operate ventilators. Additionally, families arrange care for complex care needs with multiple providers, coordinate care prescribed by multiple providers, access the Internet for medical information, make decisions about over the counter medications, use alternative therapies, and work with complicated insurance provider systems. Families assume pseudo-medical roles with little or no preparation and provide care similar to that which professional providers would charge significant fees.

In individual focused medical care, clients are the recipients of care pre-determined by the experts or health professionals with little emphasis placed upon their input or feedback. Inclusion of families in the planning of assessments, determining ways assessments will be implemented, and decisions about care and services to be provided will enhance family care. Family participation in the clinical education of nurses and other health professionals affords alternative perspectives. Family involvement in the development of policies and support services might offer valuable insights overlooked by professionals. Discussions about affordability, accessibility, and appropriateness of care might also be enhanced by inclusion of consumer family viewpoints. Focus of programs and services aligned with family populations needs and safety-net issues distinct to particular populations could improve their value. Ways to systematically obtain family feedback about care, services, and support programs are needed. Inclusion

of family consumers in the design of data collection tools, determinations about ways the tools will be implemented, interpretations of findings could further evaluation processes and provide directions for future changes. Family input should not be viewed as a form of tokenism, but revered as critical for family-focused practice. Greater value for the inclusion of families in all aspects of practice will come as nurse educators and others identify their importance.

Unnumbered Box 17.3
Cooperative Activity ******************
Supply the students with a family case study. Have the class read and discuss the case to decide on the families' priorities and goals. Then ask each student to identify assessment questions they would ask of individuals and the family about context, function, and routines. Have them identify 3 to 5 questions in each area. After the question list is created, then ask them to describe the types of interventions that might be implemented. Finally, ask students to describe ways to evaluate whether family priorities and goals are met.
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INTERDISCIPLINARY APPROACHES TO FAMILY-FOCUSED CARE

Interdisciplinary practices that move the care focus from institutional care to family household and community context are yet to be fully developed. Family health has ubiquitous variables that demand different interventions and care. Interdisciplinary care currently administered from institutional perspectives is often shortsighted in its focus on family. Single unidirectional interventions without consideration of the confounding and mediating factors unique to family households may be a waste of valuable health resources when the complexities of family health require systemic approaches different from those in traditional medical care.

Interdisciplinary care from family-focused perspectives is calling upon new creativity, innovation, and redesign of care modalities. Many commonly cite the

example of how a glass half full represents an optimistic perspective while a glass half empty describes the pessimistic view. However, another viewpoint less often suggested is that there is actually twice as much glass as is needed. While questions of effectiveness and efficiency are included in discussions about outcomes and quality, careful and critical evaluation is needed to determine whether what has been accomplished is needed at all. Making care systems more effective and efficient will be relatively unproductive if, in fact, the care system never touched the real societal needs for family care services. The 21st century is clamoring for ways to develop new partnerships where care systems are redesigned to use resources in ways that best meet the health care needs of the world's families.

SUMMARY

The nurse desiring to provide family-focused care must build upon care provided to individuals and conceptualize practice more broadly so that it includes family health care. Although some clinical or practice issues may be similar when discussing either individual or family care, many factors differ including relationships, site of delivery, and longevity of interactions. While technical nurses may be able to provide individual care, family-focused care is a professional scope of practice that requires specialized knowledge and skills. Baccalaureate education can provide nurses with an introduction to theories, knowledge, and skills related to family-focused care, but one becomes a specialist through graduate and doctoral studies. Family-focused care has not yet been recognized or promoted by most educators or practitioners. Significant questions yet to be answered about family-focused care include: What benefits are

associated with family-focused care? Who will bear the cost of services and how is care to be financed? What are the service delivery options? How is family health promoted, maintained, and improved? Who is responsible and competent to provide family care? How will family-focused care alter life course and risk behaviors? What social and economic policies are needed to shape family-focused practices? What supports are most needed by families to increase the household production of health? Family-focused care appears to have potential to:

- Respond more effectively to family rather than practitioner needs.
- Utilize health care resources to meet a broader spectrum of society's health needs.
- Address health needs from developmental, intergenerational, and life course perspectives.
- Integrate holistic care into each client encounter.
- Develop collaborative inter-disciplinary practices aimed at health needs.
- Provide ore effective, efficient, and robust way to address family household perspectives.
- Move health practice out of institutions and into community or neighborhood settings.

The Family Health Model is presented as a pragmatic argument and a dialectic to engage inquiry and discussion about potentials inherent in moving the focus of health care from individual to family-focused care and encourage conversations about futures for nursing practice. Nurses seem to be logical professional players to assume leadership in family-focused care and practices.

Test Your Knowledge

1. Thoroughly describe conceptual differences between individual and family-focused care.
2. List four knowledge areas or skills that a nurse providing family-focused care might need that are different in at some ways from that which individual care providers might need.
3. Identify three things that would have to change in your individual practice if you were to be able to truly provide family-focused care.
4. Describe the kinds of things a nurse would address in a Family Context Assessment.
5. Explain what a nurse would do with the data obtained after completing the Family Functional Assessment.
6. Identify specific concerns that the nurse might have when completing a Family Health Routines Assessment.
7. Describe how a nurse might evaluate the effectiveness of family-focused care.

Box 17.1
Assumptions related to family-focused care

- Nurse clinicians must have thorough knowledge about families, family context, and family functional status in order to provide family-focused care.
- Health assessments are potentially more meaningful for addressing some aspects of family health when the family context, function, and routines are included.
- Although individuals have much information about their context, members may not be able to easily describe complex inter-relationships between health and context.
- Nurses skilled in communication can assist families provide narrative data that is useful for understanding individual and family health.
- Meaningful narrative data can be collected, interpreted, and analyzed by the family nurse and used collaboratively with family members to meet family goals and achieve health outcomes.

Box 17.2
Goals of family-focused practice

Family-focused practitioners aim to:

- Collaborate with interdisciplinary teams, social institutions, community agencies, legislators, and others to achieve pertinent health outcomes related to family health and societal concerns.
- Obtain, maintain, and sustain optimal family health for diverse family populations.
- Use assessment data about contextual and functional factors to achieve national health objectives for all families.
- Assist individuals, family sub-systems, and families with processes of becoming, health outcomes, and well-being throughout the life course.
- Cooperate with family members and others to construct, deconstruct, or reconstruct daily routines pertinent to processes of becoming, health, and well-being.
- Enable multiple member households to attain potentials vital to future health outcomes.
- Teach members how to reduce risks that threaten the household production of health.
- Assist families to manage illness states whenever they are present.
- Support individuals, family sub-systems, and families with palliative care when a member faces terminal stages.
- Identify resources that support the family's household production of health.
- Provide information, resources, education, and counseling to family members that addresses functional processes related to family health needs.
- Initiate and support policy and legislation that addresses family health needs.

Figure 17.1
Ritualization in family routines

*** This figure was previously published/need to get permission:
Denham, S. A. (1995). Family Routines: A construct for considering family health. Holistic Nursing Practice, 9(4), p. 18.

Figure 17.2
Participation in routines and level of ritualization

*** This figure was previously published/need to get permission:
Denham, S. A. (1995). Family Routines: A construct for considering family health. Holistic Nursing Practice, 9(4), p. 20.

Table 17.1
Family Contextual Assessment

Ecological Level	Assessment of Family Health	Planning of Family Health	Issues Affecting Family Health
Microsystem	Family member face-to-face interaction involving one another and significant others about contextual events, situations or experiences associated with the household production of health. Member characteristics. Family status (e.g., education, economics, culture religion). Dyadic and triadic member interactions. Individual and family health routines. Neighborhood and community context. Availability of health services.	Care related to individual member health and illness needs, family interactions, functional status, and health routines that optimize developmental processes and well-being associated with individual and family health. • Six core functional processes. • Family health routines.	**Individual Factors** • Member biophysical • Self esteem • Intelligence • Motivation **Family Household Factors** • Family membership • Economics • Culture • Religion • Neighborhood **Neighborhood or Community Factors** • Schools • Churches • Health care providers • Recreational facilities • Employment opportunities
Mesosystem	Relationships between family members and connections to others where at least one member interacts.	• Peer relationships • Work and play • Home and school • Home and church • Home and neighborhood	• Congruence between settings where members interact and the household niche. • Levels of respect, civility, and tolerance for ambiguity of settings outside the family boundaries.
Exosystem	Settings where significant decisions are made that have potential to affect family health of members even when the member connected to the setting does not interact in the decisions.	• Peer groups • Parent's employment • School administration • Local government • National policies.	• Affects of decisions on individual and family health. • Availability of supportive systems for meeting individual and family health needs.
Macrosystem	Attitudes, values, ideologies, and behaviors of the larger society that organize institutional life, mandate or negate social supports, alter	• Shared societal assumptions • Social policy • Shared ideologies	• Media messages (e.g., substance abuse, violence, nutrition, exercise). • Valuing of disparate groups based upon sexuality, race,

	public policy, and define health policy.		ethnicity, religion, etc. • Level of marginalization of vulnerable members. • Individuation versus collective orientation of support and care.

Table 17.2
Using the Core Functional Processes in Family Assessment

Core Functional Processes	Assessment of the Core Functional Process	Planning for Family-Focused Care
Caregiving	Who requires care? What kinds of care are needed? What stresses are related to the caregiving activities? What are individual and family strengths and limitations? Are care needs short or long term?	Describe family priorities and goals. Identify how individual and family strengths can be maximized and limitations minimized. Ascertain what are usual care needs versus short-term care needs. Determine what supports are available?
Cathexis	What levels of attachment are identified among individuals, dyads, triads, and persons external to the family? What are the ways emotional bonds are expressed? How do family members respond to and interact with one another when they are less attached? How are attachments symbolized in the family?	Determine whether family members are mostly satisfied or dissatisfied with current patterns. Identify relationship strengths that interventions can be built upon. Describe resources that might be assistive in meeting expressed concerns.
Celebration	How does the family celebrate itself and special times? What significant traditions do all members celebrate? What parts do various members play in family fun and ritual celebrations? What role does culture and religion play?	Identify differences in important of family events versus individual activities. Determine the amount of time, energy, and other resources the family wants to contribute to celebrations. Consider possible alternatives that might be of interest to members. Consider whether associated activities or roles might be distributed more effectively.
Change	What changes previously faced were viewed as having positive outcomes? How many changes has the family encountered in the last 6 months? Year? How do different members experience change?	Evaluate ways different members handle change. Differentiate between internal and external family factors influencing the change. Identify the alternatives possible in the ways for handling the change.
Communication	In what ways do members express ideas and feelings to one another? How do individuals express instrumental, spiritual, and emotional needs? What about the family?	Determine individual members' need for skills. Ascertain optimal ways for expressing valued concerns and needs for assistance. Identify family resources and build upon them.

	When and how does the family emphasize its beliefs, values, and expected goals?	
Connectedness	What are the family boundaries and who decides what they are? What are the voices outside of the family to which members attend? How involved are members involved with others in the neighborhood? What are the communities of interest?	Ascertain which family boundaries assist the families' in meeting goals and which create roadblocks. List resources available in the neighborhood and community. Identify areas related to diversity that are strengths and limitations for the family. Compare and contrast supports available from extended family and social networks.
Coordination	Who decides how resources are accessed and used? What are the roles of various family members? How does the family solve problems and make decisions? Whose priorities get met first?	Determine alternative modes for meeting expressed family needs. Identify options for problem solving. Determine whether important family priorities are being ignored. Describe options in ways resources might be used.

Table 17.3
Family Goals and Developmental Tasks

Developmental Stage	Goals to Accomplish	Normative Family Tasks	Non-normative Family Tasks
Early phase	Establish boundaries Identity formation	Optimism about the future Develop independent free-standing system Basic rules for family functioning Loyalty to families of origin Negotiation Space distribution and use	Similar tasks to normative families Challenges and accommodations related to the non-normative issue Deciding whether non-normative issue will become the organizing principle for family themes
Middle phase	Commitment Stability	Focus on day to day activities Commitment to a finite number of organizing themes Commitment to stable and consistent rules Emergence of set of repetitive behaviors for organizing daily life Near end of this phase an inordinate amount of loss is sustained and challenges of new members and ideas	All aspects of family life become organized around the non-normative concerns and result in reinforcement and maintenance of the behaviors Family becomes fully organized to prevent the destabilizing affect of the non-normative event
Late phase	Clarification Legacy	Vacillation between shifts in family life and stabilization of family life Shift from present to future focus Focus on commonality rather than uniqueness Preserving identity and transmitting to next generation	Decide whether non-normative event will become part of the family legacy and how it will be packaged Moving away from the extreme rigidity that becomes part of life in the middle phase Risk of distortion of family identity and stability

***** Adapted from Steinglass, Bennett, Wolin, & Reiss (1987)**

Table 17.4
Varied Types of Routine Family Behaviors

Types of patterned behavior	Definition
Patterned behaviors	These are repetitive behaviors conducted by individuals and families that are mostly unconscious and interactive actions, but can be recalled and discussed.
Habits	These are repetitive behaviors engaged in by individuals that may have both conscious and unconscious components and either impair or promote individual well-being and processes of becoming. Habits may have special meanings for individuals and families, be difficult to alter, have links to family health routines, and create bonds with others outside the family.
Individual routines	These routines are time-bounded with clear-cut beginnings and ends and a conscious awareness that special behavior is occurring. These activities often pre-empts other behaviors, may have a strong symbolic component, and are usually linked to a tradition, celebration, or special family event.
Family routines	These routines are imbued with the meanings associated with individual routines, but in addition are given special meaning and attention by multiple members. Participation involves more than a single member and may be supported by kin or extended family. Although these behaviors may be associated with symbolic meanings and special family times, they may also be organizing behaviors of the family structure.
Family health routines	These routines include the meanings of individual and family routines, but add elements of health, illness, medical or health perspectives, processes of becoming, well-being, and the holistic aspects of family related to the embedded context and core functional processes.
Family traditions	Family traditions are specific recurrent behaviors with special meanings for family members. These events require special preparation and are symbolically rich events where immediate and extended family members participate (e.g., birthdays, vacations, reunions, anniversaries).
Family celebrations	These family routines often have a unique family quality but link the family to the larger society. These routines are rich with symbolism; involve complex preparations involving all members; and connect past, present, and future. Family celebrations may be culture specific, religious holidays (e.g., Christmas, Passover, Kwanza), secular holidays (e.g., Thanksgiving, Fourth of July), or rites of passage (e.g., weddings, funerals, baptism, bar mitzvah).

Table 17.5
Assessment and Planning Related to Family Health Routines

Family Health Routines	**Assessment of Family Routines**	**Planning for Family-focused Care**
Family Values	What ideas, attitudes, and beliefs do members regard as meaningful? Which values do members use to guide behaviors? How do religious, cultural, and social influences affect patterned behaviors? What is the impact of popular media and current policies on family values?	Describe important member variations in values and perceptions. Differentiate between family rules and member values. Identify the contextual influences that impact the family. Identify what information and skills family members need to reconcile beliefs or perceptions with other less accepted realities.
Family Themes	What are the norms of daily member interactions? What are the organizing family themes that most members ascribe? How do members regularly express relevant family themes?	Identify ways to assist family members recognize organizing themes. Describe various health-promoting ways to express a family theme. Determine ways family themes can support family health.
Ecocultural Niche	How does the family household affect member's health routines? What factors in the embedded context influence family health? How does members' use of the core functional processes affect family health routines?	Identify the strengths and limitations within the household that influence family health. Describe the resources and threats in the embedded context that impact family health routines. Differentiate alternative ways the core functional processes can create meaningful family health routines.
Ecocultural Domains: • Caregiver roles • Role relationships • Child play mates • Information sources • Family workload • Family economics	What unique ways do the ecocultural domains affect family health routines? How is family members' health routines affected differently by the domains? Are there ecocultural domains where family routines are	Discuss family priorities pertaining to the ecocultural domains. Identify relationships between family health routines and the ecocultural domains. Describe roles of various members in ecocultural domains that affect family health routines.

• Access to health services • Home safety • Social support • Cultural influences • Community influences • Child care tasks	ineffectual?	
Family Health Routines: • Self-care routines • Safety and prevention • Mental health behaviors • Family care • Illness care • Member caregiving	What are the unique family social constructions of family rituals, traditions, and celebrations? Which perceptions about routines do members share? What is the quality of family health routines? How do members differ in their levels of routine participation? How effective are routines in helping members attain goals?	Identify the present existing routines. Describe alternative ways to create routines applicable to family health concerns. Identify ways the family, in the past, has deconstructed routines and constructed new ones. List ways a specific routine might be reframed to better achieve family goals. Determine ways members can participate in optimizing family health routines.

Table 17.6
Routine Properties, Dimensions, and Variations

Routine Properties	**Routine Dimensions**	**Routine Variations**
Routine type	• Individual routine • Family routine • Family health routine • Family ritual • Family tradition • Family celebration	• Ritual selection • Area of ritualization • Level of ritualization • Beginning and endings • Discreteness • Focus
Regulatory behaviors	**Temperamental properties** • Energy level • Interactional distance • Behavioral range **Family Identity**	• Extent across family life • Importance to members • Expectations over the life course • Cohesiveness of family • Homeostasis
Behavioral Characteristics	• Rhythmicity • Intensity • Variability • Predictability	• Rigidity of performance • Clarity of behaviors • Patterning before, after and during • Intentionality • Deliberateness • Affective expressiveness
Participants	• Who participates • Rules of participation • Where participation occurs • Length of participation • Degree of orthodoxy	• Role relationships • Differentiated roles for children, elderly, kin or extended family, others
Meaningfulness	• Family values, goals, and themes • Associated symbols • Heritage factors	• Linkages to past and future • Intergenerational transmission • Keeper of the rituals • Transcendence • Legacy

Table 17.7
Planning a Family-Focused Care Map

Focal Area	Pertinent Questions	Actions to Take	Evaluation of Intervention Processes
Family Priorities	What are the family priorities relevant to problems? Do members differ on priorities in significant ways? What are members greatest concerns related to priorities?	List priorities in order of family importance. Discuss differences and reach consensus. Provide information, education, counseling, resources related to concerns.	Does priority order change over time? Do members identify differences? What additional information, education, counseling, resources are needed?
Family Goals	What does the family most want to accomplish? What strengths do members view in obtaining their goals? What do members view as biggest obstacles to goals?	Rank goals in order of family importance. List ways strengths can be optimized. Identify ways obstacles can be addressed.	Is time effectively used to meet goals? Are there other ways that strengths can be optimized? Are interventions to accomplish goals working? What needs to be altered?
Context Concerns	Do members perceive things in similar or different ways? What boundaries affect the family? Which family dyads and triads can be used to address family goals?	Identify areas of agreement that can be built upon. Provide information, resources, and supports for creating effective boundaries. List dyadic and triadic assets for achieving goals.	Do areas of agreement potentiate goal achievement? Are there things beyond the families' control that impede their ability to achieve goals? Do the family dyads and triads assist in meeting goals?
Functional Concerns	What are the important member roles to consider? What is the motivation for change? Which core processes are needed to support changes?	Describe the levels of participation needed in the proposed plan. Identify rewards in meeting goals. Select interventions to address changes.	How effective and meaningful is member participation? What needs to be done to enhance motivation? Are interventions achieving the desired

			results?
Family Health Routine Concerns	Which routines are most pertinent? Who will be most affected by changes in routines? What attitudes are expressed about willingness, ability, or fears about altering routines?	Describe routine aspects to be reconstructed or constructed. Discuss feelings about changes in routines. What alternatives can be considered in changing routines?	Has the prescribed regimen been incorporated into the family routine? Identify ways feelings and behaviors affect family priorities/goals Who is and is not participating in the routines?
Supports Available	What things are viewed as supportive in meeting goals? Which persons outside the family are seen as supports? What resources are available?	Identify ways to incorporate supports. Find ways to include external supports. Identify, provide, or connect family with additional resources as needed.	Are their additional supports needed to achieve goals? Are persons viewed as supportive assisting in meeting goals? What resources have been used effectively and what else is needed?
Threats Present	What are the greatest threats to accomplishing goals from family and clinician perspectives? What are the actual threats? What are the perceived threats?	Discuss differences in family and clinician perspective and ways to overcome them. Describe responses to actual threats. List alternative ways for coping with perceived threats.	Are differences viewed as barriers? What alternative responses might be possible? Have effective ways been identified to reduce threats?