Family Routines: A Structural Perspective for Viewing Family Health

Although rituals are considered in the anthropological and sociological literature, less attention is given to associated biophysical and health perspectives. Three ethnographic studies were conducted to identify the ways family health was defined and practiced. Findings indicated that routines were an important aspect of family health. Families described routines linked to family health and discussed how they evolved, ways they were modified over time, and how families recreated them when stress and change were encountered. Findings indicated that routines provide a structural perspective for assessments, interventions, and outcome evaluations related to health and useful to nursing practice. This article explains some of what is known about family routines, describes the author's findings, and suggests implications for nursing. Key words: *Appalachian families, family, family health, family routines, routines*

Sharon A. Denham, DSN
Associate Professor
Ohio University School of Nursing
Athens, Ohio

RITUALS AND ROUTINES

The loose use of the terms *ritual* and *routines* in some literature without clear differentiation between the concepts clouds understandings and makes application difficult. Family rituals and family routines are discussed in some health-related literature, but conceptual slippage often occurs, as terms are used arbitrarily. Although family rituals and routines are widely discussed, nurse clinicians, nurse educators, and many nurse researchers have overlooked their potential for practice.[1,2] A literature review indicated that although these phenomena often are ignored by health care professionals, routine behaviors of multiple-member households have potential for assessment of health and illness concerns, provide a structure to link therapeutic interventions, and afford a means to evaluate individual and family health outcomes.[3]

Ritual has been described as a social performance,[4] a systematic occurrence characterized by prescription, rigidity, and right-

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ness,[5] a stabilizing force for past patterns and somewhat predictive of future actions.[6] Ritual is "an act or actions intentionally conducted by a group of people employing one or more symbols in a repetitive, formal, precise, highly stylized fashion."[7(p199)] Secular rituals include relationships between individual behaviors and collective ceremony, while religious rituals provide a canon of principles to explain behaviors.[8] Rituals are predictable acts used by individuals to transmit information about their physiologic, psychological, or sociological states,[9] and they serve as linkages between private and public meanings to express acceptance or demonstrate rejection of social standards.[10]

Family rituals provide information about relationships, changes within the family, the ways crises and information affect needs, things members value and believe, and ways families celebrate and live daily lives.[11] Family ritual is "a symbolic form of communication that, owing to the satisfaction that family members experience through its repetition, is acted out in a systemic fashion over time."[12(p401)] Family rituals are formal, repetitive patterns that enhance the family's self-image or identity[13] and serve as central tenets for the ways family members align family goals and meanings with the ways care patterns are constructed and sustained.[14] Family rituals comprise routine factors, meaning factors, and rigid roles with some flexible practices, and they are symbolic ways families use to make sense of their interactions.[15] "Family rituals utilize the existing strengths and resources of family members who work together to meet the family's needs."[16(p336)]

The literature about family routines identifies them as protective in childhood respiratory conditions,[17] related to child health outcomes,[18] interrupted by family stress in alcoholic families,[19] linked to the management of asthmatic conditions,[20] and associated with coping in chronic pain situations.[21] Family routines have been described as "observable, repetitive patterns which involve two or more family members and which occur with predictable regularity in the ongoing life of the family."[22(p194)] Family routines have varied degrees of member ritualization, include regularly practiced behaviors important to family identity, hold potential for health-related outcomes, and provide ways to understand the household production of family health.[1,23] Family routines provide information about predictable family behaviors[18,24]; supply a fairly reliable index of family collaboration, accommodation, and synergy[1]; and have "universal attributes that vary in content and frequency from family to family."[25(p565)] Family routines can be viewed as "behavioral units of family life" that provide "order and structural integrity to the course of daily events."[26(p201)]

A distinction can be made between family rituals and routines with activities with significant meaning viewed as rituals and patterned activities regarded as routines.[27] For instance, family routines and rituals were both identified as excellent clinician research tools in alcoholic families because daily routines can be observed and specific behaviors recorded, and family members can verbally reconstruct family rituals.[19] Family rituals provide information about ways families organize the interactivity of their lives and find meaning in these interactions.[20] In comparison, family routines provide more discrete information about explicit areas of family life and member inter-

actions related to the health or illness concern or that might be at risk or interrupted because of health problems.[20] It seems that family routines could provide a structural perspective for assessment, intervention, and evaluations germane to health outcomes within nursing's scope of practice and amenable to nursing actions.

The idea of structure has been used to refer to ways families are organized, the subsystems they contain, and rules relevant to the ways interactional patterns are governed.[28] Structure also has been used to describe family characteristics such as member roles, family subsystems, family form (eg, nuclear, single parent, blended), power structures (eg, matriarchal, patriarchal), communication processes, and value systems,[29] and it has been used to identify the family actors affecting and responding to health-illness needs and crises.[30] Family routines have been identified as key structural aspects related to family health; they are visible and describable phenomena that can be used for health assessment, family interventions, and outcome measurements.[31–33] Routines as structure might be used to describe the ways a person or a family receives, stores, processes, and recalls information, knowledge, and experience. Although these ideas are certainly applicable to social sciences and useful to nursing, clear ideas about which organizational structures nurses should use to address biophysical and sociocultural health outcomes are lacking. As a result of the author's research, it is posited that the habitual patterned behaviors used by family members in daily lives provide a structure to assess similar and unique qualities of family health, identify interventions pertinent to individual and family health, and assess health outcomes.[31–33]

THE FAMILY HEALTH RESEARCH

Three ethnographies were completed over a period of 5 years in two southeastern Appalachian Ohio counties to study how families defined and practiced family health.[23,31–33] Although family health is often referred to as a goal of nursing intervention, it is seldom defined.[34] Family health should be defined holistically; include wellness and illness variables; and focus on families' interactive, developmental, functional, psychosocial, and health processes.[35] Conclusions drawn from a literature review about family health found that the concept was poorly understood, and operationalization of the construct often failed to clarify the complex related variables.[23] The dissertation research provided clearer understandings about the broad ways well families viewed and practiced family health.[31] The second study aimed at providing more insight into the ways families who were more economically disadvantaged viewed family health.[33] A final study targeted families experiencing transition and identified more about the ways family health was defined and practiced at the time of dying and during bereavement.[32]

Approximately 6 to 9 months were spent in data collection for each study, but the length of time needed to complete three to four family interviews varied (ie, 6 weeks to 6 months). Family interviews included multiple members, took place in family homes, and lasted about 2 hours each. Informant interviews usually lasted 1 hour and most

often occurred at employment locations. The taped and later transcribed interviews (n = 125) captured data from multiple members in 24 families and community informants (n = 45). Additional interviews were conducted, but not taped; the use of ethnographic methods (ie, observation, field notes, other data sources) further informed the studies about the larger community. Community agencies, key informants, or others in the study referred subjects; they were selected based on their ability to contribute to the family health study. Families had preschool- or school-age members in two of the studies,[23,31,33] whereas families in the other study had adult children and grandchildren as participants.[32] Semi-structured questions were used to guide family interviews that included multiple members. Questions checked for consistency in responses within and between member reports. Narrative responses provided rich data about beliefs and practices of absent members, which were often verified at later interview sessions.

Data were analyzed using descriptive domain matrixes,[36,37] continuous comparative measures, and cross-case analysis.[38] Data analysis was an iterative process that began with coding interview data into health-related categories relative to health beliefs, health behaviors, health knowledge, and family context. Family data were viewed as primary; community informants added contextual enrichment that better explained the embedded community and phenomena of interest. Categorical analysis was used to compare and contrast children, parents, and families. As the data were analyzed, themes related to contextual, functional, and structural categories relative to family health emerged.

OVERVIEW OF THE THREE STUDIES

The families and key informants were Appalachian, persons geographically located in counties designated as such by the Appalachian Regional Commission (ARC). Most family members and many informants reported an ancestry of multiple generations linked to the region. Even after 35 years of attention from the ARC, these counties continue to lag behind much of the rest of the nation in numbers of college graduates, poverty levels, and unemployment rates, and they are viewed as medically underserved areas. Appalachia is frequently described as if the people and communities were snapshots encountered earlier in history, while influences of time, changing social contexts, politics, economics, and policies are rarely considered. The use of ethnographic methods allowed this investigator to consider the impact of the embedded cultural context on the definition and practice of family health in this Appalachian population.

Findings indicated that these families were more focused on present needs, with fewer concerns about wellness or future health. Cultural influences (eg, "a-wait-and-see" attitude, kin and friend influences) influenced families' decisions about when and where to seek medical care.[39] Cultural perspectives were useful in understanding simi-

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larities among the ways families defined and practiced family health. For example, although many community informants described male dominance in local Appalachian families, when health was the issue, mothers assumed the prominent role. Spiritual values, family traditions, and expectations of the larger community influenced parents' health beliefs and values and child teaching about health behaviors, but the media and other societal sectors were also influential. Subjects described health in terms of abilities to perform usual daily activities, balancing multiple life roles, the absence of illness or disease, and holistic dimensions beyond the biophysical realm. In the dissertation study, participants described family health as the dynamic ways members holistically care for one another using communication, cooperation, and caregiving to develop and sustain health routines within their contextually embedded households.[23]

The findings from the three studies provided more comprehensive appreciation for factors relevant to family health and routines. Family health is a phenomenon that includes the complex systems, interactions, relationships, and processes of multiple household members and has the potential to maximize processes of becoming, enhance individual and family well-being, benefit from the household production of health, and capitalize on contextual resources.[40] Family health routines are dynamic patterned behaviors relevant to individual and family health that are rather consistently adhered to by individuals, family subsystems, and families within a household niche, but are susceptible to change as members interact with larger contextual systems.[40]

Family health routines were identified in all studies, with seven categories identified in the first study, five more inclusive categories in the second study, and six categories in the third study (see the box entitled "Comparison of Categories of Family Health Routines"). Families and individuals had different characteristics, but all had health routines associated with dietary practices, sleep and rest patterns, activity, dependent care, avoidance behaviors, medical consultation, and health recovery. Specific domains were identified for each family health routine, for example, family health routines in families with preschool-age children included the following seven categories:[23,31]

1. dietary practices
   - cultural variations
   - nutritional consumption
     - –food selection
     - –food procurement and storage
     - –food preparation
     - –meal consumption patterns
     - –snacking patterns
2. sleep and rest patterns
   - family rest patterns
   - temporal patterns
3. activity patterns
   - purposeful activities
   - functional activities
   - social activities
   - exercise
     - –deliberate exercise
     - –family fun
4. avoidance behaviors
   - health risk related
   - safety related
5. dependent care activities
   - nurturant care
   - assistive care
   - resource care
6. medical consultation
   - when to consult
   - who to consult

7. health recovery activities
   - individual responsibilities
   - family responsibilities

In the study pertaining to loss of a family member, the following five categories were identified:[32]

1. self-care routines
   - dietary
   - sleep and rest
   - personal hygiene
   - exercise
   - safety and protective behaviors
2. member caregiving
   - support for members with health alterations
   - compliance with medical regimen
3. medical consultation
   - diagnosis of health disorder
   - interaction with health care providers
4. habitual high-risk behaviors
   - smoking
   - substance abuse
   - work
5. mental health behaviors
   - family fun (eg, relaxation activities, hobbies, vacations)
   - traditions and special events
   - spirituality
   - pets

Comparison of Categories of Family Health Routines

Study 1
- Dietary practices
- Sleep and rest patterns
- Activity
- Dependent care
- Avoidance behaviors
- Medical consultation
- Health recovery

Study 2
- Self-care routines
- Member caregiving
- Medical consultation
- Habitual high-risk behaviors
- Mental health behaviors

Study 3
- Self-care routines
- Dietary
- Mental health
- Family care
- Preventive care
- Illness care

The study about disadvantaged families identified the following six routine categories:[33]

1. self-care routines
   - personal hygiene (eg, toileting, dental care)
   - physical activity
   - sleep-rest patterns
   - health promotion
   - sexuality
2. dietary
   - nutrition
   - shopping
   - preparation
   - meals
   - snacks
3. mental health
   - substance abuse (ie, drugs, alcohol, smoking)
   - family stressors
   - self-esteem
   - maintenance of personal integrity
4. family care
   - family fun (eg, vacations, holidays, traditions, special days)
   - humor
   - individual/group activities
   - coping with chaos
   - creating special times

5. preventive care
   - health protection (eg, immunization, seat belts)
   - neighborhood risks
   - risky behaviors (eg, alcohol, drugs, smoking)
   - abuse and violence
6. illness care
   - medical consultation
   - health care services
   - medical regimens

Although the data analysis from each study identified categorical differences, similarity was noted. The box entitled "Synthesis of Family Health Routines from Three Studies" provides a summary of the routines identified.

Family members used health routines to:

- support health processes related to child and family development
- avoid illness, disease, and injuries
- attain, sustain, and regain member health
- communicate with health experts
- obtain and distribute family health resources
- construct family health paradigms

In the studies, subjects used narratives to describe patterned behaviors of multiple members as they interacted within households affected by social and contextual relationships. Family routines had biophysical, emotional, social, psychological, and spiritual characteristics. Although individuals within families had some unique health behaviors, members could usually recall and describe patterns of others with great accuracy. Routines provided understandings about

- member roles in health behaviors
- rigidity and timing of routines
- developmental needs and health behaviors taught to children
- behavior variations over time and across family experience

Synthesis of Family Health Routines from Three Studies

Self-care routines
- Dietary
- Hygiene
- Sleep-Rest
- Physical activity and exercise
- Gender and sexuality

Safety and prevention
- Health protection
- Disease prevention
- Smoking
- Abuse and violence
- Alcohol and substance abuse

Mental health behaviors
- Self-esteem
- Personal integrity
- Work and play
- Stress levels

Family care
- Family fun (eg, relaxation activities, hobbies, vacations)
- Celebrations, traditions, special events
- Spiritual and religious practices
- Pets
- Sense of humor

Illness care
- Decision making related to medical consultation
- Use of health care services
- Follow up with prescribed medical regimens

Member caregiving
- Health teaching (ie, health, prevention, illness, disease)
- Member roles and responsibilities
- Supportive member actions

MEMBER ROLES

Although all members participated in some routines, families had different expectations about roles and adherence. For instance, families had routines related to how, when, where, why, and who sought medical advice or services from health care providers. Individual characteristics, household factors, and support systems all affected member roles and subsequent health behaviors. Member education, family economics, and type or lack of health insurance were predisposing factors for seeking medical care, but accessible health services (eg, physicians, dentists, clinics), supportiveness of kin and others, and agency or institutional responses to family needs also were important influences.

Member valuing, understanding of health information, availability of family resources, social supports, types of health care issues encountered, and the perceived predictability of outcomes influenced family members' routines. Knowledge about health concerns did not predict that it was incorporated into health routines. Parents noted that inconsistent media reports about health issues were troublesome and left them uncertain about what to believe or how to respond. Mothers were most likely to encourage members to incorporate health information into family routines when it was viewed as meaningful, aligned with family values, applicable to member needs, and when adequate resources or supports were available. Some fathers shared health information with other family members, but most were far less involved than mothers.

In these Appalachian families, mothers assumed primary roles in establishing the behaviors viewed as important for children's health needs. The findings consistently identified mothers as primary family health care resources and themes of gatekeepers, stewards, sentinels, and care-tenders emerged. Mothers were the main health care teachers and decision makers. These Appalachian mothers valued "common sense" in caring for family health, a quality they attributed to themselves and others. Fathers who worked in health care, volunteered in health services, or had interests in personal wellness were more likely to be involved in family health routines than those less concerned. Even in families where the father was mostly absent, mothers were often guided by values of the paternal family. Families had caregiving routines, obligatory roles and responsibilities, kinship rules related to illness care in extended members, and variant expectations about levels of compliance with medical regimens. Family beliefs about parenting responsibilities and mothers' health knowledge and experiences influenced the development and continuance of routines.

Parents mostly described self-care, personal hygiene, and illness care when trying to recall health routines from their families of origin and youth. Most adults could recall some specifics about what they learned as a child about health and could compare past and present behaviors. Communication styles, levels of cooperation, patterns of interpersonal caregiving, and valuing of family cohesiveness were affected by ways routines were structured and practiced within family households. The health values, beliefs, and knowledge described by the participants were not always consistent with observed behaviors. Even when family members had information about factors that contributed to health or increased health risks, knowledge did not imply that information was used in health routines.

RIGIDITY AND TIMING OF ROUTINES

Family health routines were characterized by highly ritualized individual health practices that included patterned member interactions. Families and members differed in compliance to specific routines, specificity of health behaviors, frequency and consistency of routines, and willingness to modify routines. Although routines were evolving, once patterns became ritualized, members seemed likely to sustain behaviors over time and encourage member adherence. Factors identified as reasons to modify health routines included: changes in beliefs and values, personal experiences external to the family of origin, alterations in the household context, changing boundaries of social interactions, and valuing of new knowledge or experiences. Findings indicated that family health routines were paradoxical; while routines tended to be resilient and consistent, they also were kinetic and evolving. Once established, family members mostly strived to maintain routines. However, when conflicts between abilities to continue meaningful patterns and needs to meet changing family demands occurred, new patterns often emerged.

Respondents described family routines with common patterns and health themes, but unique variations were noted between and within families. Family routines evolved and were affected by factors that included unique member traits and individual and family development. They also were affected by family of origin experiences, differing individual and family values, member and social relationships, health information and knowledge, competing individual wants and needs, changing family priorities, resource availability, culture, tradition, religion, and the embedded household context. Family members within a single household often had differences in expectations about the rigidity of routines, behaviors associated with routines, and member participation. Subjects described various degrees of tolerance for differences in routine practices within families. Flexibility and openness to outside influences also influenced family responses to health information, resources, and supports. Context of the family household and peer relationships, social support, employment status, public policy, and laws were other factors affecting routines.

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Time was identified as a critical influence on the creation and enactment of routines. Time was divided according to seasons, clock time, calendar days, events, and developmental stages. One informant described time as: “family time, self time, couple time, and children time.” Balancing multiple member needs and competing family priorities affected the household production of family health. Informants often described ideal routines, but when questioned about particulars, great variability in practices was identified. For example, families with preschool children often described the importance of dietary routines, but said that when they were away from home it was

usual to eat at fast-food restaurants. Families with school-age children said after-school activities and work schedules often interfered with family meal routines; meals were poorly planned and eaten on the run; and diverse family members consumed different foods.

Informants said seasons altered activity patterns, stress levels, schedules, and family relationships. Many viewed summer as a healthy time with less stress than other seasons and more opportunities for casual family interaction.[23] Time altered sleep and rest patterns, the ways meals were prepared, the valuing of family experiences, and ways members coped with stress. Many families prized the weekends as favorite calendar days because they offered opportunities for leisure, relaxation, sharing interests and hobbies, and strengthening spiritual ties—all things they attributed to individual and family health. Families with school-age children had family routines closely tied to the school calendar.

Events were holidays, celebrations, or traditional times when rituals were enacted and usual family routines were interrupted. Events had special meanings to families, provided valued times for emotional and spiritual closeness, and appeared tied to family identity. For instance, subjects identified vacations as a time when the family members shared new experiences, gathered shared memories, and found renewal in times together.[23] In the study with bereaved families, the terminal phase of a family member was an "event" that meant families spent more time together, revered their shared history, and demonstrated their care and support of one another.[32] Family members who lived in different households often altered routines when an extended family member was terminally ill, had uncontrolled symptoms, when caregiving demands were prolonged or intense, immediately after a death, during bereavement, and when conflicts arose among family members. The scale of routine interruption varied with the degree of member involvement in caregiving, the length of time caregiving continued, and the intensity of caregiving demands.

Individual and family development also affected family health routines. Family members described changes in health practices influenced by transitions (eg, marriage, birth, death, school attendance, adolescents). Mothers were actively engaged in health teaching of young children during the preschool years, continued to reinforce teaching and provide new information for school-age children, and played roles in adult children's health routines even when they moved away from the family of origin. Adult children often talked with their mothers as they wrestled with decision making about non-acute health issues and family health decisions.[23,31–33]

Families were generally better prepared for predictable life events (eg, childbirth, school attendance, adult children leaving home) and less prepared for unpredictable life events (eg, relocation, job loss, change in economics, substance abuse, accidents, chronic illnesses, developmental disabilities, death). Unpredictable life events taxed family resources, placed additional stress burdens on mothers and others, tested family cohesiveness and resilience, affected established health routines, and meant accommodations had to be made in existing routines. As family membership or household context changed, transitions that affected members (eg, emotional, cognitive, or social status) also affected family routines.

HEALTH BEHAVIORS TAUGHT TO CHILDREN

Parents repeatedly noted the importance of teaching children what is right and wrong in relationship to health. In all three studies, parents recalled childhood as a time when some health beliefs and practices presently followed were learned. Teaching and learning about health were recounted as casual, mostly unplanned, and largely aligned with parental priorities. Although adults had different abilities to recall their childhood health behaviors, all remembered some practices and could discuss whether current behaviors were consistent with childhood routines, rejected because of past experiences, or modified over time. Health beliefs and routine practices were altered as children engaged in peer and social relationships. Parents did not easily recall discussions about health practices prior to having children, but described ways routines were negotiated after the children were born. The presence of children was a strong influence in routine formation and teaching of behaviors to children. Many parents described congruency between their personal childhood routines and ways children were being taught or could explain why things were being done differently.

Findings about the hospice families identified some additional information about intergenerational transmission of health routines and indicated that formation of new families usually meant patterns were co-created by parents.[32] Although some beliefs and health information acquired within families of origin were revered and retained, routines were often modified as parents formed family units. Although respondents viewed their families of origin as important in shaping health beliefs and routine patterns, they could not easily explain why they retained or modified behaviors as they became adults and parents. Differences in intergenerational values meant some families experienced conflict about routines when practices were different from those of the family of origin.

Family routines were social constructions used by members to translate health beliefs, values, and knowledge into structured behaviors. Routines were holistic interactions that included biophysical, developmental, interactional, psychosocial, spiritual, and contextual dimensions. Members could be specific when discussing patterned behaviors. For instance, a single mother reported her daily routine with her school-age daughter as follows:

> We have a routine in the morning, like on school mornings. She knows exactly what we do. As soon as I wake her up . . . I've already got her clothes ready. I wake her up; she goes to the bathroom and gets dressed while I make her breakfast. I get what she is going to eat for breakfast and then while she is eating breakfast, I get her stuff ready to fix her hair. I always fix her hair right after breakfast and that is when she washes her face and brushes her teeth, then it is out the door! But usually, we do it in that order.

Another mother speaking about her school-age daughter said:

> It is good that she has a routine . . . that she has to go to bed at a certain time and get up because in the summer time she just is kind of out of whack. She just wants to sleep the day away and stay up all night. So it [school] is good for her because it gives her a routine.

A father said: "If they learn to eat on time and learn to go to bed at regular hours . . . that makes them healthier persons." Sub-

jects were able to recall and give rather detailed descriptions of other members' routines and often described discord and stress when routines were out of sync. Families reported greater family harmony when routines were consistent, and reported threats to patterned behaviors pertinent to health continually arose from peers, extended family members, and the social context.

Children's dietary routines were largely influenced by mother's knowledge about nutrition and personal motivation; they also were affected by ability to plan, purchase, and prepare nutritional meals. However, unique member factors such as food preferences, cultural values about health and wellness, and work or school schedules also influenced dietary routines. Mothers often had rules associated with meals such as whether all foods put on plates should be eaten, if new foods had to be sampled, and when and where foods could be eaten. Although mothers usually prepared meals, families widely differed in the types of foods prepared, where and how foods were stored, what and when foods were purchased, who ate where and with whom, whether members ate the same foods, times of day foods were consumed, and the types of food and portion sizes consumed by various household members. Even preschool and other young children could tell about their dietary routines and describe some behaviors of other family members.

Sleep and rest was a family health routine identified in all families. These routines tended to be more resilient over time than dietary patterns, but they were affected by biological rhythms, role demands, time, family rules, seasons, special events, and developmental stages. Strings of routines (eg, snacks, hygiene) often were closely associated with sleep. Unique variations in sleep and rest patterns were identified (eg, bedtime and time to awaken, amount of sleep or rest time required, sleep locations, and with whom children slept). Families living with children with special health care needs, ill or dying members, and young children often described interrupted sleep and related stress. Mothers described extended periods of sleep deprivation and reported high levels of stress, feelings of depression, decreased self-esteem, and other health concerns.

Parents did not easily identify subtle influences on the embedded household context or the ways it affected children's health routines, but their responses indicated that the media, social policy, and laws were influential factors. Compliance with immunizations, lead screenings, seat belt use, well-child care, and use of hospice services for end-of-life care was influenced by the embedded community context. Participants gave many examples about the ways peers, media, and policies influenced routines related to nutrition, smoking, alcohol, and drugs.

LIMITATIONS OF THE STUDY

Attempts were made to stay true to subjects' intended meanings and content experts familiar with Appalachian culture were consulted throughout the studies. Important concerns are whether this Appalachian population is similar to others and whether the health routines identified in these families have broader applicability. For example, determining whether mothers play such an important role in family health in other cultures needs to be ascertained. Although the data collection methods in-

cluded multiple members in family interviews, other data collection methods such as focus groups or comparative member interviews might be used to more fully differentiate routine practices related to individuals within families and routines associated with specific health promotion needs or chronic illnesses. More succinct questions that focus more on routines specific to health and illness might provide additional knowledge about family routines. The breadth of data collected in these family health studies limited the depth of knowledge obtained, and more focused studies on routines seem warranted.

DISCUSSION OF THE FINDINGS

Much of what was discovered in these three studies supports other literature about health, use of health information, and family roles. However, this research has extended some understandings about the importance of mothers' roles in family health routines, the importance of family routines as a structural way to measure family health, and the impact of the embedded context on routines and family health. Findings indicated that family routines might be useful for assessing family organization and member interactions relevant to the household production of family health, planning family care and interventions, assisting mothers to teach children about health routines, and evaluating health outcomes. Family routines have potential for understanding the ways family members organize daily activities relevant to individual and family health, respond to unique health care needs, teach children health behaviors, provide support and care for chronic health conditions, make decisions about medical treatments, adhere to medical regimens, protect themselves against environmental risks, increase household safety, and cope with stressors over time. Family routines could provide a unique way for nurses to target specific family interventions related to individual health care needs, develop family-focused interventions related to health concerns, measure the impact of household production of health on individual health, and evaluate the importance of health policy and social activism on family health outcomes.

Family values, member knowledge, individual experiences, and unique member needs over time are all associated with routine formation, modification, and continuance. Although some variations in routine health patterns existed within and between families, enough similarity exists among the families to conclude that repetitive behavioral patterns provide rather dependable areas for health assessments and interventions. In family research, investigators often question the reliability and validity of family members' reports about others' health behaviors. In these studies, mothers' consistent ability to report and recall health behaviors for others made them compelling information sources about family routines. Routines also may be a useful way to validate member capabilities, identify limitations, determine family strengths and supports, and establish whether information and resources are adequate for adherence to prescribed medical regimens. Nurses might use routines to plan care with family members that promotes desired health outcomes and assists with decision making pertinent to family health issues. Routines may be a concrete way to identify family stresses and individual adherence to health behaviors

and provide information about those personal and professional characteristics that mediate desired health outcomes. Family routines also may be a way to address national health objectives related to chronic illness needs, caregiver risks and burdens, family-focused practice, and the household production of health.

IMPLICATIONS OF THE STUDY

Educators, clinicians, and researchers need to judge thoughtfully the ways routines dynamically interact to affect individual and family health. The question of whether family routines can be used as a structure for family-focused practice seems worth pursuing if the focus of care is to move from individual as client to family as client. Models that address family health and member routines need to be developed. Practice of nurses and other health care providers could benefit from deliberation about the implications of family routines in health teaching, counseling, planning health care, and implementing health interventions. Routines may be a way to better understand influences of intergenerational transmission of health patterns, consider genetic influences on health outcomes, assist families to meet caregiving demands, develop adequate support systems for chronic illness care, evaluate caregiving needs related to parenting and end-of-life care, and determine the importance of routines in aging populations. Family routines seem to be an area amenable to the nursing discipline's scope of practice and one that clinicians can use to focus developmental concerns over time and space.

Nurse educators may need to increase their consciousness and resolve about the importance of routines as a link between family and individual health and the potential consequences of encouraging novice nurses and students to incorporate assessment of routines into practice. Additional research is needed to learn more about the ways routines are created and accommodated within families; relationships between family routines and health promotion, chronic disease management, and caregiving; effects of member roles on family routines and health outcomes; and the interventions most predictive for positively affecting family health. Reliable and valid instruments will be needed to measure routines relevant to individual and family health.

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