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Timely opportunities for families and their healthcare providers: a commentary on Pyle et al. (2005).

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Abstract

This commentary on S. A. Pyle, C. K. Haddock, N. Hymowitz, J. Schwab, and S. Meshberg (2005) addresses the complex nature of establishing family rules about exposure to tobacco smoke (ETS). Particular attention is paid to how family rules are established and the challenges in enforcing rules among adult family members. Findings are also discussed in terms of the limits of family rule making and the need for negotiation and conflict resolution. The compounding influence of socioeconomic status and parental education in monitoring ETS deserves serious attention in future research. Healthcare providers are urged to discuss family rules with their patients with an eye toward preventative interventions.

Families are responsible for establishing a variety of rules: How much TV viewing is allowed, bedtime on school nights, curfews, when a child can have dessert, and who gets to sit in the front seat of the car on a long trip are but a few examples of everyday family rules. In their article, Pyle, Haddock, Hymowitz, Schwab, and Meshberg (2005) have brought to our attention the establishment of family rules about exposure to environmental tobacco smoke (ETS). The results of this study are important as well as somewhat disturbing in terms of the amount of exposure that occurs in households and family vehicles. As the authors pointed out, exposure to ETS is a public health problem of grand proportion. It threatens the health and well-being of children and adults at risk for respiratory illnesses and can also contribute to the development of disease. The establishment of rules about exposure to tobacco smoke is not a simple issue. The authors have added to a small but growing literature suggesting sociodemographic variations in exposure to tobacco smoke. Consistent with previous reports, lower levels of education and minority status were associated with greater exposure (Wamboldt et al., 2002). What Pyle et al.'s study adds is a description of the types of rules that families endorse. It also raises the issue of who makes the rules and examines the limits of family rule making. I address each issue in turn.

WHO MAKES THE RULES?

The focus of Pyle et al.'s (2005) report is on family rules that are established among adult family members as well as adults outside the household. Frequently, one thinks of rules being established between children and adults, with adults setting the rules. In the case of adult-to-adult rule formation, several elements come into play that are not a pan of child-adult rule making. When rules are established between adults and children, typically, the best interest of the child is at the heart of the matter. Bedtimes are set to protect sleep, food options are restricted to encourage better nutrition, and curfews are set to prevent adolescents from getting into trouble. When adults set rules for other adults in the household, there is a need for self-sacrificing behaviors in the service of others' needs. One can consider the results of Pyle et

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al.'s study as one illustration of the extent to which families feel empowered to impose rules on adults who may not be in agreement with such restrictions.

Overall, approximately 60% of those surveyed by Pyle et al. (2005) do not allow smoking in their house, 20% allow adults to smoke in certain rooms at certain times, and 55% request that adults smoke outside the house. There were important subgroup differences depending on ethnicity and whether there was a smoker in the house. In households in which a spouse or others in the home smoked, there was a two to three times greater likelihood that smoking was allowed in certain rooms or at certain times. Reading between the lines, one can speculate on the negotiation process within families. If one member of the household decides that there is a need to restrict exposure, then another member of the family must agree that this is a priority. It is somewhat unlikely that this is a smooth and uncontested transaction. Tobacco is, after all, an addictive substance. Setting rules among adults presents an opportunity for conflict. It was not possible in Pyle et al.'s (2005) survey study to determine how families went about the process of setting rules, and, thus, the issue of conflict was not raised. However, it is important that future efforts determine how conflict is resolved and examine the key elements of negotiation in setting rules.

In my own studies, I have found that family members do not always agree on how to address health risks. I have considered how the establishment of routines associated with healthcare may promote adherence and well-being (Fiese, Wamboldt, & Anbar, in press). I have found that families who are able to create regular healthcare routines experience better overall quality of life, and children experience fewer illness-related symptoms. Implicit in establishing routines is a shared agreement among family members that there are certain rules to be followed. Violation of the rule disrupts the routine and can be a source of conflict. In identifying treatment strategies associated with family-level organization, I have noted that if family members disagree about the relative importance of a routine, the conflict must be addressed before any intervention will be successful (Fiese & Wamboldt, 2001). In my studies of families with a child with asthma, I have found anecdotal evidence that exposure to cigarette smoke is a topic of potential conflict. Although exposure to cigarette smoke is toxic for children with asthma, an alarmingly high percentage of households with asthmatic children include smokers. Evidence suggests that exposure is no different for children with asthma than in other households (Chilmonczyk et al., 1993). In my interviews, I have found that adults are often hesitant to ask other family members not to smoke in the house. As one parent remarked, "What am I supposed to do? Send my mother outside in the cold?" Thus, setting rules can evoke strong emotions even when another family member's health is at risk.

WHAT ARE THE LIMITS OF RULE MAKING?

One of the strengths of Pyle et al.'s (2005) report is that the researchers considered not only what rules were established in the home but also how the rules were enforced outside the home. Whereas approximately 60% of those surveyed do not allow smoking in their house, slightly less than 40% ask people not to smoke in the presence of their children, and less than 50% responded that they do not allow smoking in their car. The discrepancy in these numbers points to the difficulties in enforcing family rules outside the home. Although one might assume that the owner of a family vehicle could set the rules for its passengers, the car seems to be a venue in which it is more difficult to be consistent. This is quite distressing, given the higher concentration of smoke in an enclosed space and increased levels of health risks. This issue appears to present a prime opportunity for healthcare providers to educate their patients and to empower them to restrict exposure in cars. According to the results presented in Pyle et al.'s report, families whose pediatrician had discussed the health risks of ETS were more likely to have rules about smoking in cars and to ask people not to smoke in the presence of their children. Perhaps the pediatrician's voice gave power to the family to enforce these rules.

ETHNIC AND ECONOMIC CONTEXT OF FAMILY RULES

Pyle et al. (2005) noted some differences across ethnic groups. However, the most consistent differences were between those who were more or less educated and those who had lower or higher incomes. It was not possible for Pyle et al. to disentangle the relative contributions of ethnicity and socioeconomic status (SES). Examination of variability across ethnic groups would benefit from studies exploring beliefs about exposure to tobacco smoke and health prevention in general. The socioeconomic findings are consistent, as those with less than a high school graduation and those earning less than the median income were less likely to establish rules in or outside the home. Because cigarette smoking is inversely associated with SES, it is crucial to attend to these differences. Higher rates of cigarette smoking have also been found to be associated with higher stress levels and poorer overall quality of life (Wamboldt et al., 2002). Thus, when one considers rates of exposure in relation to education and ethnicity, one must also consider the broader ecological context of low income and limited education. Perhaps one way to understand ETS and SES is to adopt more of a process-level approach. Although Pyle et al. suggested that they collected useful information regarding how parents establish rules, the questions included in the survey focus on whether parents enforce rules rather than how they go about setting rules, in the first place. A fruitful avenue for future research is to more clearly outline the process by which families come to make rules, the regularity with which they enforce rules, and the obstacles they face in trying to garner support from all family members in setting down the rules. In-depth interviews may provide a greater understanding of why rules are more difficult to implement when there are high levels of stress and limited resources in the family.

Healthcare providers can apply the findings of Pyle et al.'s (2005) study to their own practices. It is interesting to note that the data collected for this survey were part of a pediatric resident training project. It is reasonable to apply the method of this report to other health risks, such as poor nutrition, lack of exercise, and extensive TV viewing. In this regard, healthcare professionals may use family rules as a framework for addressing multiple health concerns. By identifying the process by which families create rules and enforce them as part of their daily routine, professionals may be better poised to partner with their patients in the service of prevention and more optimal family health.

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