Family Rituals as a Protective Factor for Children With Asthma

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Objective: To examine how one aspect of family life, notably family rituals and routines, may protect children with asthma from anxiety-related symptoms.

Methods: Eighty-six families (43 children with asthma, 43 healthy comparison children) participated in the study. Children completed measures of anxiety (Revised Child Manifest Anxiety Scale) and health. Parents completed measures of stress (Parenting Stress Index), family rituals (Family Routines Questionnaire), and family health.

Results: Families that reported more meaning in their family routines had children who reported lower levels of anxiety. Mother endorsement of family ritual meaning and father endorsement of family ritual routine were most strongly related to lower levels of anxiety. Support for the protective function of meaningful family rituals was stronger when a general health stress model was used rather than the presence or absence of asthma alone.

Conclusions: Family rituals may serve a protective function for children with asthma under conditions of heightened parenting stress.

Key words: pediatric asthma; family routines; child anxiety; protective factors.
proposed to explain variability in child outcome, including the identification of different asthma subtypes based on genetics (Mrazek & Klinnert, 1991) and psychophysiological reactivity (Miller & Wood, 1994). Specific family factors also moderate the relationship between asthma and anxiety. Children with asthma who experience heightened anxiety have families characterized by either overinvolvement (Baron, Veilleuz, & LaMarre, 1992) or high levels of harsh criticism (Wamboldt, Wamboldt, Gavin, Roesler, & Brugman, 1995). Whereas previous research has focused on family factors that may be detrimental to child outcome, new research may consider family factors that promote child well-being. The creation and maintenance of family rituals appears to be one such process.

Family rituals range from stylized religious observances, such as first communion or bar and bat mitzvahs, to less articulated daily interaction patterns like dinnertime. Two dimensions have been identified as important in understanding organization in family life: the degree to which routines are an integral part of family practices and the degree to which these activities have meaning for family members (Fiese, 1992). The routine aspect of family practices includes the regularity of an activity, who is responsible for planning and carrying out the activity, and what roles are assigned. The meaning aspect of a family ritual includes expectations for attendance, expressed affect, symbolic significance of the activity, and commitment to continue the activity into the future.

Wolin, Bennett, and colleagues provided the first empirical evidence that family rituals may serve a protective function in high-risk families. Families able to preserve their rituals in the face of parental alcoholism were less likely to transmit alcoholism to their offspring (Bennett, Wolin, & Reiss, 1988; Bennett, Wolin, Reiss, & Teitelbaum, 1987). Furthermore, Fiese (1993) demonstrated that the meaning associated with family rituals protected children of alcoholics from heightened levels of anxiety.

Family routines may play an important role in families with a chronically ill member. Quittner and colleagues (Quittner, DiGirolamo, Michel, & Eigen, 1992) found that specific measures of family stress and problems associated with family routines were better predictors of adjustment in families with a child with cystic fibrosis than global measures of family stress. Families who maintain regular family routines have children less likely to develop respiratory infections (Boyce et al., 1977). Bush and Pergament (1977) report that patients with chronic pain are better adjusted when there is predictability in their family routines.

Stressful life events, the family environment, and variations in acute and chronic health conditions can all affect outcomes of a pediatric condition. Just as multiple risk indicators best predict child emotional health in high-risk environments (Seifer et al., 1996), in the context of chronic illness, multiple indicators of health may best predict child outcome. The presence of an illness may not be as reliable a predictor of child outcome as life stresses and health factors in the family. Therefore, this study examined not only the presence or absence of asthma in relation to child anxiety but also included the relation of multiple family stressors to child outcome.

The purpose of this study was to examine the potential for family rituals to serve a protective function against anxiety for children with asthma. We employed two analytic strategies. First, we examined whether the presence of asthma placed the child at increased risk for anxiety and whether family rituals would protect these children from anxiety when compared to healthy peers. Our second strategy was to include the presence or absence of asthma as one of several indicators of family health risk. We reasoned that a chronic illness alone may not place children at risk but that a disease in the context of family life stress is associated with poor child outcome. Therefore, we also tested whether family rituals would serve a protective function when considering multiple risks in the family context. Thus, we addressed three questions: (1) Would rituals serve a protective function against anxiety for children with asthma when compared to healthy peers? (2) Would the protective function of family rituals be stronger in the family context of stress and illness rather than in the presence or absence of asthma? (3) What can we learn about family factors associated with multiple health risks in children with asthma?

Method

Participants

We recruited two groups of families with children between 6 and 12 years of age. Forty-three families with a child with asthma and forty-three families with a healthy peer participated in the study. The children with asthma were diagnosed at least 1 year prior to the study. The children in the study had mild to
were done through the American Lung Association in two cities and through an asthmatic group in one of the two cities. Advertisements were run in local newspapers, a national magazine, and the newsletter of Mothers of Asthmatics. Participants contacted the principal investigator through a postage-paid postcard or by phone. Healthy friends of the participants with asthma (matched on gender and age) were recruited as comparisons to approximate similar demographic backgrounds (Eiser, Eiser, Town, & Tripp, 1991).

Children had to be diagnosed with asthma for at least 1 year to be included in the asthma group. Children in the asthma and comparison groups were excluded if they were diagnosed with a chronic illness (e.g., diabetes, cystic fibrosis, congenital anomalies, obesity, anorexia, severe chronic allergies, or chronic ear infections) based on parent report. Because it is not yet known how rituals operate in single-parent families, single-parent families were excluded from this analysis. Where a parent remarried, one or more years must have passed since the remarriage. Families were paid $15 for their participation.

Written consent was obtained from both parents. Mothers and fathers completed a family ritual questionnaire, a parenting stress measure, a health questionnaire, and they provided demographic information. Children completed a measure of child anxiety and answered questions regarding their health. Measures were presented in packets in a counterbalanced order. In the first three cases, the forms were delivered directly to the family’s home by the first author. All families understood the di-

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<tr>
<th>Table I. Participant Characteristics</th>
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<td><strong>Asthma (n = 43) group</strong></td>
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<td><strong>Comparison (n = 43) group</strong></td>
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<td>Mother’s age</td>
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<td>Health factors during past year</td>
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<td>Asthma attacks</td>
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<td>School days missed</td>
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<td>Emergency room visits</td>
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<td>Mechanical ventilation</td>
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We conducted a power analysis to determine the likelihood of finding significant effects, given our sample size. In regard to detecting significant group differences on the child anxiety measure, we calculated power based on the mean and standard deviation published in the manual. Two groups with 43 participants in each group resulted in estimated power of .75, a medium to large effect size according to Cohen. Based on Cohen’s (1992) recommendation, an adequate sample size for conducting an analysis of variance (ANOVA) with two groups with a medium effect size at the .05 level would be 64 members per group. An adequate sample size for conducting an ANOVA with two groups with a large effect size at the .05 level would be 26 per group. Thus, our sample size is somewhat small to detect a medium effect size.

**Procedure**

Participants were recruited through a number of sources. Posters with letters and return postcards were posted in physician offices, public locations, and local medical centers in two cities. Mailings were done through the American Lung Association in two cities and through an asthmatic group in one of the two cities. Advertisements were run in local newspapers, a national magazine, and the newsletter of Mothers of Asthmatics. Participants contacted the principal investigator through a postage-paid postcard or by phone. Healthy friends of the participants with asthma (matched on gender and age) were recruited as comparisons to approximate similar demographic backgrounds (Eiser, Eiser, Town, & Tripp, 1991).

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reactions; thus, the forms were mailed to subsequent participants.

**Measures**

*Children’s Manifest Anxiety Scale-Revised (RCMAS)* (Reynolds & Richmond, 1992). The RCMAS is a 37-item self-report questionnaire designed to measure anxiety in children ages 6 to 17 years. A total anxiety score was calculated for this study. Internal consistency of the scale has reported to range from .50 to .90. As reported in the manual, test-retest stability coefficient of .68 was found for over a 9-month period. Children completed the RCMAS.

*Family Ritual Questionnaire (FRQ)* (Fiese & Kline, 1993). The FRQ, a 56-item forced-choice format questionnaire, assesses family rituals in seven settings (dinner time, weekends, vacations, annual celebrations, special celebrations, religious celebrations, and cultural traditions) and by eight dimensions (occurrence, roles, routines, attendance, affect, symbolic significance, continuation, and deliberateness). Internal consistency coefficients have ranged from .52 to .90. A test-retest reliability of .88 was established over a 4-week period (Fiese & Kline, 1993). Two dimensions have been identified through factor analysis (Fiese, 1993; Fiese & Kline, 1993). A Family Ritual Routine score may be calculated by summing responses to the roles and routines dimensions. A Family Ritual Meaning score may be calculated by summing responses to occurrence, attendance, affect, and symbolic significance. Alpha coefficients calculated for item responses on the current sample for mothers were Meaning (.89), Routines (.69), and for fathers were Meaning (.90), Routines (.76). At the time of the study, the FRQ had not been adapted for use with children; therefore, mothers and fathers completed the questionnaire individually.

*Parenting Stress Index (PSI)* (Abidin, 1990). The PSI, a 101-item questionnaire, assesses stresses within three domains: child, parent, and life stress. Test-retest coefficients (for intervals up to 1 year) have ranged from .55 to .91. Mothers and fathers completed the PSI.

*Asthma Severity.* Because we had to rely on parent report of child health, we were limited in the way we could assess asthma severity. Therefore, levels of asthmatic severity were calculated based on criteria outlined in Perrin, MacLean, and Perrin (1989). This method involves the assignment of subscores based on use of medications, frequency of attacks, and school days missed. Severity is calculated by totaling responses across all questions. Approximately 30% of the sample was classified as mild, 40% as moderate, and 30% as severe.

*Child Health.* Children were asked to rate their general health by marking a graphic thermometer ranging from poor to excellent health, calculated in inches. Children with asthma were also asked to rate the severity of their asthma ranging from mild to very severe.

*Parent Report of Family Health.* Parents were asked to rate on a scale from 1 to 7 their own health and their child’s health (ranging from poor to excellent). Parents answered questions regarding the number of school days missed, hospitalizations, frequency and types of medication, and emergency room visits. Parents of children with asthma were asked about the frequency of asthma attacks and the need for intubation or mechanical ventilation. A summary health score was derived by totaling parent response to the health questions. A higher score reflected more health problems and associated stresses in the family.

**Results**

We employed four steps in our data analysis. First, we contrasted the asthma and comparison group on key demographic variables to assure that they were comparable. Second, we tested the hypothesis that family rituals would protect children with asthma from anxiety. Third, we tested the hypothesis that family rituals would protect children from anxiety when considering multiple indicators of family health and life stress. Finally, we conducted an exploratory regression analysis to determine the relative contribution of child health, family health, and family rituals in predicting child anxiety in children with asthma.

**Asthma and Comparison Group Contrasts**

As expected, the two groups did not differ according to demographic variables as presented in Table I. Thus, the groups can be considered relatively comparable in terms of demographic background. There was, however, a significant difference between how children rated their own health ($t_{1,84} = 3.73$, $p < .001$). Children diagnosed with asthma rated their general health more poorly than the comparison group. Similarly, significant differences were found between asthmatic and comparison groups for parents’ perception of their child’s general
health (mothers, t [84] = 3.29, p < .002; fathers, t [84] = 3.60, p < .001). On average, parents of children with asthma rated their child's health as poorer than the comparison group. Asthmatic and comparison groups were examined for differences in child report of anxiety and parent report of stress and family rituals. There were no significant differences between the groups. Results appear in Table II. There were no significant group differences between means for males and females on the RCMAS.

**Family Rituals as a Protective Factor Against Anxiety for Children With Asthma**

Prior to testing the protective hypothesis, we generated correlations between family ritual scores and child report of anxiety. Overall, child report of anxiety was negatively related to parent report of family rituals: mother’s family ritual meaning r = −.32, p < .01; mother’s family ritual routine r = −.26, p < .01; mother’s total family ritual score r = −.37, p < .001; father’s family ritual meaning r = −.37, p < .001, father’s family ritual routine score r = −.31, p < .01; and father’s total family ritual score r = −.42, p < .001.

To test the protective hypothesis, we followed the guidelines proposed by Baron and Kenny (Baron & Kenny, 1986) and tested the moderating effect of family rituals on child anxiety. Based on previous research, we performed a median split procedure to determine high and low levels of family ritual meaning (Fiese, 1993). To assure that the distinction was not artificial, scores were rank-ordered and a probability plot was performed to confirm that the distribution of FRQ (meaning and routine) scores approximated a normal curve. Using a skew test, normality was approximated on mother meaning (p < .12) and routine (p < .001), and father meaning (p < .01) and routine (p < .001).

To test the first hypothesis, that family rituals would serve as a protective factor in families with an asthmatic member, we conducted a series of ANOVAs. We found a main effect for mother’s report of family ritual meaning and father’s report of family ritual routine in predicting child anxiety (see Table III). For mother report, the high ritual meaning group had lower child anxiety scores (M = 41.72, SD = 9.74) than the low ritual meaning group (M = 46.93, SD = 11.43). Similarly for father report, the high ritual routine group had lower child anxiety scores (M = 41.81, SD = 9.35) than low ritual routine group (M = 46.84, SD = 11.79). The interaction between group and family rituals was not significant.

**Family Rituals as a Protective Factor in the Context of Family Stress and Child Health**

To test whether groupings based on family life stress and health would be a better test of the protective hypothesis, we divided the sample according to high and low family stress and general health. Con-
sistent with the multiple risk literature, a family health-stress risk score was generated (Seifer et al., 1996). The family health-life stress score was calculated according to the presence or absence of asthma, emergency room visits in the past year, school days missed in past year, family members perceptions of the child’s general health, and number of stressful life events endorsed on the PSI. Total scores ranged from 1 to 8. A median split was performed on health-life stress scores, consistent with previous analysis on ritual scores, resulting in two groups: one with high health-life stress and one with low health-life stress.

We found a significant interaction between mother’s report of family ritual meaning and health-life stress grouping (see Table IV). The interaction is depicted in Figure 1. In cases where there were elevated levels of health-life stress but mothers reported more meaning in their family rituals, children reported fewer anxiety symptoms.

Like the analysis conducted using presence of asthma as the grouping variable, there was a significant main effect for father’s report of family ritual routine in relation to child report of anxiety. The interaction between family health-life stress and father report of family rituals was not significant in predicting child report of anxiety.

Table IV. Analysis of Variance Predicting Child Anxiety From Family Health-Life Stress (High/Low) and Ritual Groups (High/Low)

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<tr>
<td><strong>Mother</strong></td>
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<td></td>
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<tr>
<td>Health-life stress</td>
<td>0.03</td>
<td>.87</td>
</tr>
<tr>
<td>Mother meaning</td>
<td>4.65</td>
<td>.03</td>
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<tr>
<td>Mother meaning × health</td>
<td>3.90</td>
<td>.05</td>
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<tr>
<td><strong>Stress</strong></td>
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<tr>
<td>Health-life stress</td>
<td>0.02</td>
<td>.88</td>
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<tr>
<td>Mother routine</td>
<td>1.99</td>
<td>.16</td>
</tr>
<tr>
<td>Mother routine × health</td>
<td>1.32</td>
<td>.25</td>
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<tr>
<td><strong>Father</strong></td>
<td></td>
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<tr>
<td>Health-life stress</td>
<td>0.02</td>
<td>.88</td>
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<tr>
<td>Father meaning</td>
<td>0.60</td>
<td>.44</td>
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<tr>
<td>Father meaning × health</td>
<td>2.24</td>
<td>.14</td>
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<tr>
<td><strong>Stress</strong></td>
<td></td>
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<tr>
<td>Health-life stress</td>
<td>0.01</td>
<td>.90</td>
</tr>
<tr>
<td>Father routine</td>
<td>4.38</td>
<td>.04</td>
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<tr>
<td>Father routine × health stress</td>
<td>1.45</td>
<td>.23</td>
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Figure 1. Child-reported anxiety by health-life stress risk and mother’s ritual meaning grouping.

**Exploratory Analysis Predicting Child Anxiety in Children With Asthma**

Because a child with asthma may experience different types of stressors than a healthy peer, we were interested in the degree to which child health, family stress, family health, and family rituals were related to child report of anxiety. We conducted a hierarchical multiple regression using four steps to predict child report of anxiety. The first variable to be entered in the analysis was child health. Child health variables included the number of asthma attacks, emergency room visits, school days missed, and hospitalizations, having ever needed mechanical ventilation, and medication (use of epinephrine or terbutaline). The child health variables accounted for 19% of the variance associated with child anxiety. When family perception of child asthma severity was added, an additional 7% of the variance was accounted for (total $R^2 = .27$). Family health variables (i.e., parents’ perceptions of their own health) accounted for an additional 32% of the variance associated with child anxiety (total $R^2 = .59$, $R^2$ change $= .33$, $p < .004$). Family rituals accounted for an additional 17% of the variance (total $R^2 = .76$, $R^2$ change $= .17$, $p < .01$). Taken together, measures of child health, family perceptions of child asthma severity, parent report of family health, and family rituals accounted for more than three-quarters of the variance associated with child report of anxiety in the asthmatic group.

**Discussion**

The purpose of this study was to examine the relation between family rituals and child report of anxiety in families with a child with asthma. We found little support for family rituals to operate any differ-
ently in families who have a child with asthma and those who do not. We did find, however, when multiple indicators of family health were considered, family rituals may protect children from anxiety. Our findings are consistent with the biopsychosocial model that points to the multidetermined nature of child adjustment (Wood, 1995). We begin our discussion by addressing the limitations of the study. We then consider the usefulness of multiple risk models in predicting child anxiety in pediatric populations, as well as the differential perception of family life by mothers and fathers. We conclude with clinical implications.

Several limitations of this study restrict the generalizability of results. Because our sample was primarily middle class and Caucasian, we do not know if similar results would be found in a more economic and ethnically diverse sample. This limitation may be compounded by our exclusion of single-parent families from the study. Because of the increased risks and poor outcome associated with pediatric asthma in low-income families (Clark et al., 1986), this study must be replicated before generalizations can be made.

Our method of recruitment may have also attracted highly motivated families. Families who were overwhelmed by the care of their child may have not participated in the study, thus skewing our results. We included variables identified as risk factors in medical assessment for severe exacerbation of asthma (Emond, Camargo, & Nowak, 1998); however, we did not collect objective measures of asthma severity such as peak flow readings or perception of individual attacks. Data collection was limited to parent and child report from questionnaires and was vulnerable to the usual report biases of self-report questionnaires. Parents of younger children were asked to read questions to children if necessary, which leaves potential for bias. However, recent evidence suggests that oral and written administration of some child measures may result in equivalent performance (Walters & Merrel, 1995).

Consistent with previous research (Bennett et al., 1988; Fiese, 1992), we found an inverse relationship between meaningful family rituals and child anxiety. Children raised in households marked by deliberate and meaningful family rituals report fewer symptoms of anxiety, including worry and physical symptomatology. This study expands the previous literature by examining family rituals in the context of childhood chronic illness and including reports by mothers and fathers. We did not find overall differences in the report of family rituals for families with and without a child with asthma. Thus, our findings support the contention that the presence of asthma alone does not necessarily result in differences in family organization. Our findings do suggest, however, that the relation between family factors and child outcome must be considered in the context of multiple risks.

When life stress, family health, and child health were considered simultaneously, we found a more complete picture of the potential for family rituals to protect children from anxiety. For mothers, the meaning associated with family rituals was related to lower levels of anxiety in the context of multiple family life stress and health risks. Under conditions of multiple stressors, family rituals may offer one avenue for families to stabilize their lives and provide a sense of belonging. Families who are able to create meaningful family rituals in the first place may be better equipped to respond to multiple stressors. Longitudinal and intervention studies are warranted to examine this relation.

Consistent with the multiple risk literature, more child anxiety was accounted for in this study when we considered a greater number of asthmatic severity variables. For asthma, it may be the highly specific daily hassles involved around care of the child (e.g., administering medication, driving the child to the doctor, etc.) combined with health-related events that account for more distress (Pillow, Zaytram, & Sandler, 1996). Although this study did not address the additive effect of the numerous health stressors identified by families, the results do support the importance of considering a larger domain of health and life stress variables. The routine medical intervention involved with a chronically ill child may be perceived as additional stress or daily hassle, which in turn may result in negative attitudes toward care of the child. This study is consistent with the multiple risk literature and the importance of multiple indicators of stress, but it also demonstrates that rituals add something (adaptive) beyond the risks of the child’s health, life events, or parent stress levels in predicting child outcome. Whereas it has been established that family conflict disrupts family life when a child with asthma is involved, (Wamboldt et al., 1996), this study points to ways in which family life may be organized to foster child adjustment.

The results from this study also suggest gender differences in the family and the degree to which rituals are important. Primarily the mother’s per-
ception of meaning, but the father’s perception of routine, was most important when health is considered as the predominant stressor. This has important implications for the family with an asthmatic member. Mothers more often feel responsible for managing the child’s asthma on a daily basis and possibly in emergency situations. If the mother can get beyond daily difficulties and find meaning in family rituals, this may be protective for the child. For fathers, however, predictability of roles and routines was associated with lower levels of child-reported anxiety. Gender differences are often overlooked in family systems research but may have important implications for understanding the diverse roles that mothers and fathers may play.

The relative importance of rituals to family life and the delegation of roles may affect family members in different ways. For example, in a study of family coping and chronic pain, more positive family outcomes were associated with patients’ reports of higher routines; but for the spouses, meaning of rituals was important (Bush & Pargament, 1997). Although the family may be considered an organized group, individual members may hold different perceptions about what is important and meaningful in family life. For the mother whose daily routines include heavy involvement with a child’s health care, the importance of family rituals may reside in distinguishing some aspects of family life from illness and health care routines. On the other hand, the assignment of roles may be important to fathers because they provide stability in an environment potentially disrupted by illness. Routines may not only provide the father with a predictable way of interacting with the family, but they also provide him roles of importance in family functions by assigning specific duties related to regular routines.

Family rituals have been used as a therapeutic tool to address issues related to grief, alcoholism, remarriage, and separation (Imber-Black, Roberts, & Whiting, 1988). Findings from this study suggest that family rituals may be related to adjustment in children with a chronic illness such as asthma. On one hand, family rituals may play an important role in stabilizing the family and providing meaning in the face of life events and daily stressors involved in the management of chronic illness. Family rituals may also serve as a guide for families in tackling the challenges of disease management. Families that have already organized their lives around daily routines may be better equipped to integrate disease management in their lives. Families that experience more chaos in their lives may also find the implementation of daily routines one avenue to stabilize their lives. It would be premature to assume that family rituals directly affect child adjustment. They are correlates at best. We do believe however, that family rituals may be one avenue of intervention that can be crafted to the individual needs of each family. We do not propose that family rituals are necessarily distinct from other aspects of family life that contribute to child well-being, such as warmth, responsive parenting, and positive affect. However, routines and rituals are something that parents understand and are able to articulate. In this regard, healthy routines may offer an avenue of intervention that makes sense to families.

We offer a final caveat to our findings. This preliminary study aimed at examining the relation between family rituals and anxiety in children with asthma. Our findings are consistent with a protective hypothesis whereby family rituals may protect children from risks associated with family life and health stress. However, until we can either follow this process over time or implement ritual interventions, we cannot claim that rituals themselves protect children. Likely, family rituals are only one component of the complex system of family effects on child adjustment.

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References


Salvatore Minuchin, M.D. (left) in a 1969 family therapy session at the Philadelphia Child Guidance Clinic. Photograph from Pediatric Pioneering—The Children’s Hospital: Community Child Care, The Child Guidance Clinic, reprinted with permission ©The Children's Hospital of Philadelphia.