

# **How Children Learn to Be Healthy**

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## **Mechanisms and Consequences of Socializing Children to Be Healthy**

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Heart disease and cancer are the first and second leading causes of death in the United States. Although great strides have been made in reducing deaths from heart disease in the past 20 years, due to improvements in treatment for hypertension and myocardial infarction and changes in diet, smoking levels, and exercise patterns, deaths from many cancers continue to increase. Cigarette smoking is the leading cause of lung cancer in both men and women. We know that 80% of smokers begin to smoke during adolescence and that attitudes learned in childhood and adolescence are the most powerful predictors of smoking in adulthood. Imagine how much additional reduction in the number of deaths caused by these two major killers could be achieved if children began to eat healthy diets in childhood, if they never started to smoke cigarettes, and if physical exercise was a natural part of every child's life.

There appears to be an inadequate U.S. national commitment to prevention and health promotion; our national investment in prevention is estimated at less than 5% of the total annual health cost (Stone et al., 2000), and without this orientation toward prevention, the prospects for children's health and functioning cannot be improved. Money is available to provide expensive hospital care for those with serious illnesses; thousands of preterm and otherwise sick infants are hospitalized for months at a time. But Americans make inadequate attempts to improve children's lives before they get sick, and many of today's children will reach adulthood unhealthy.

In order to understand the etiology of children's health status, it is important to review the historical and contemporary perspectives utilized

in portraying the dynamics of child health. Until recently, the dominant model of children's health has been biomedical, simultaneously emphasizing biological models of wellness and illness and disregarding social, psychological, and behavioral dimensions of health (Engel, 1977; Tinsley & Parke, 1984). However, the dominance of the strict biomedical model of disease is lessening, and a model incorporating concern with behavior and the whole person is much more prevalent in health research, in both academic and clinical settings.

Sameroff's (1989) transactional model of development suggests that two continua – a continuum of reproductive causality, which includes both genetic constitutional factors and birth-related trauma, and a continuum of caretaking causality, which includes the social, intellectual, and physical environments – are necessary for adequate prediction of developmental outcomes. Other models such as systems theory approaches similarly stress the necessity of considering the complex interplay between biological and experiential factors (Ramey, MacPhee, & Yeates, 1982; see also Sameroff, 1982). These shifts suggest that the traditional medical and developmental models have undergone modification, resulting in mutual movement to incorporate major tenets of each.

Other factors have also contributed to the emerging redefinition of the relation between traditional medical and developmental models of child health and development. Due to a decrease in child mortality and morbidity rates (brought about by the conquest of a number of major infectious diseases by biological medical science), pediatric medical science is also preoccupied with two major concerns: (1) the prevention of chronic diseases related to lifestyle and social environment later in life and (2) parents' requests for child-rearing advice (Doherty & Campbell, 1988; Tinsley & Parke, 1984).

Currently, medical science is significantly focused on illnesses caused by noninfectious processes (e.g., heart disease, cancer). Single microbiologic factors are not solely responsible for these types of diseases; lifestyle factors such as diet and smoking are considered to be significant contributors. Preventive measures, emphasizing lifestyle and behavior, are highly valued ways in which to maximize wellness. Health professionals increasingly target many of their efforts to influence children's lifestyle and behavior in the belief that health habits are formed early and persist throughout life. Considerable work has been accomplished utilizing a variety of methodologies and paradigms, which illustrate the importance of such nonbiological factors for children's health.

Secondly, parents' requests for childrearing advice are taking increasing amounts of pediatricians' professional time. Estimates of the extent to which pediatric primary care visits involve childrearing, behavior problems, or other psychological components vary from 37% to 50% (Duff, Rowe, & Anderson, 1973; Glascoe, 1999). Thus, pediatric medical professionals spend far less time ameliorating illnesses caused by infection and more time helping parents and children to shape health and other types of child behavior.

In summary, on the pediatric side, the traditional and formerly dominant medical model of disease, which conceptualizes disease as a deviation from normative biological functioning, is being replaced by medical models that address social, psychological, and behavioral dimensions of disease (Engel, 1977; Tinsley & Parke, 1984). In addition, developmentalists' past concentration on behavioral models that give little explicit recognition to biological factors is diminishing. Practitioners in the fields of both pediatrics and child psychology demonstrate concern with the effects on health and development of psychosocial and behavioral factors.

With the development of this new interest on the part of medical professionals in children's health attitudes and behavior, and of social scientists in child health, has come a substantial increase in research on children's health attitudes and behavior. For those who are interested in the factors influencing children's health (e.g., for preventive or ameliorative purposes), this emerging model will be useful for specifying nonbiological correlates and causes of children's wellness and illness.

### **Mechanisms**

The mechanisms of children's health-related attitudes, and of behavior acquisition and socialization, have been the focus of theoretical and empirical attention. Two issues have been explored. First, what familial or other social environmental conditions provide the opportunity for the acquisition of attitudes or behaviors that are necessary for child wellness? Second, what are the mechanisms that facilitate the acquisition and socialization of these attitudes and behaviors? As will be presented in this book, the research, to date has focused on several possible factors that may be involved in explaining childhood health socialization. In studies of child health attitudes and behavior, the explanatory burden has fallen on three categories of variables: (1) the child's background and characteristics (i.e., developmental status, demographics, personality variables,

and possibly gender), (2) extrafamilial agents (peers, schools, media), and (3) the parents' and family's relational and interaction variables.

The most common and well-researched way in which children learn about health is through familial relations. The research suggests that parents and families provide models of health attitudes and behavior, demonstrating, teaching, and reinforcing specific health attitudes and behavior, as influenced by background characteristics such as demographics and parents' personality variables (Garralda, 2000). Children are hypothesized to learn concepts of health and health skills as a result of repeated opportunities for practice of these behaviors in the home. Evidence suggests that these concepts and skills are utilized by children, as they get older, in other health behavior-eliciting situations, such as with friends and in school. Exposure to these alternative contexts serves to modify these health attitudes and behaviors. Nevertheless, the research indicates that children's health attitudes and behaviors appear to be more similar than dissimilar to those of their parents (Wiehl & Tinsley, 1999).