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Family Health Data Presentation

Families create environments that can protect children — what the science shows across 5 pillars

Evidence-based · Citation-Verified 2026 · Data current through March 2026



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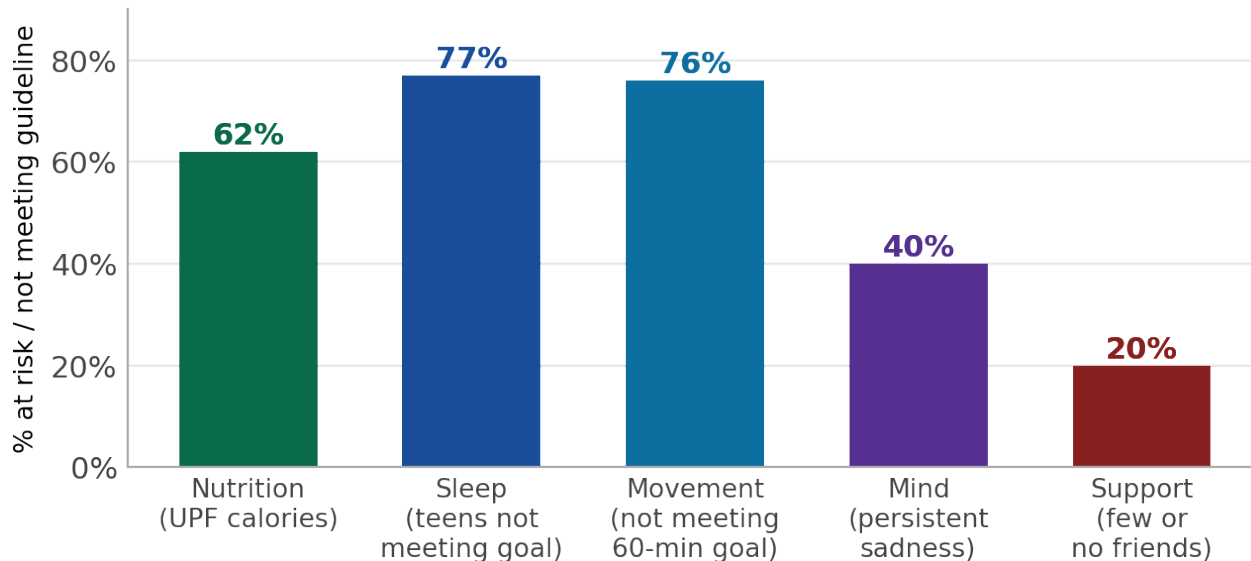
Overview — where American children stand today

Federal surveillance data and peer-reviewed sources · data current through March 2026



These challenges frequently cluster within the same families and communities. Across all five pillars, research consistently shows that family and parenting environments are among the most influential and modifiable **proximal** factors associated with child wellbeing — operating alongside broader structural determinants — and that small, consistent changes in family habits compound meaningfully over time.

Current U.S. child outcomes — % flagged as at risk or not meeting guidelines



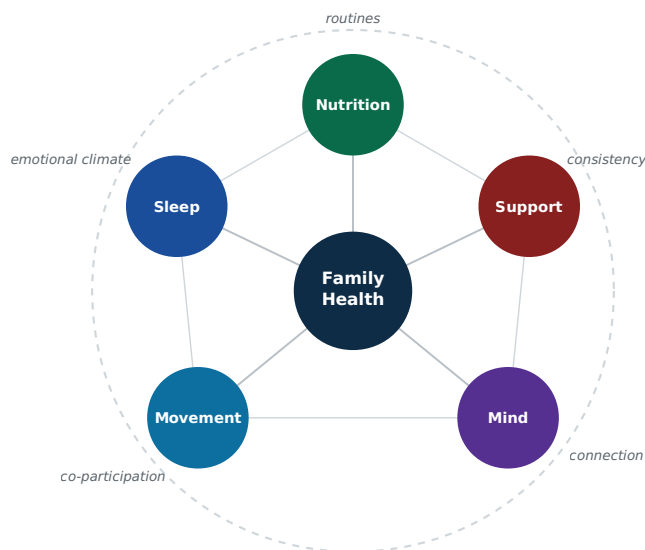
CDC surveillance Current U.S. child outcomes across 5 pillars — % not meeting guidelines or flagged at risk

CDC NHANES 2025 [1] · CDC YRBS 2023 [2] · PAA 2024 [3] · CDC/USAFacts 2024 [4] · Mott Poll 2024 [5]

The Family Health Ecosystem

Five pillars — interconnected, not independent

The five pillars are not a checklist. They are a system. Each pillar influences the others — poor sleep disrupts food choices, chronic stress reduces physical activity, social isolation amplifies anxiety. Family environments that support all five pillars simultaneously produce the most consistent and durable outcomes for children and parents alike.



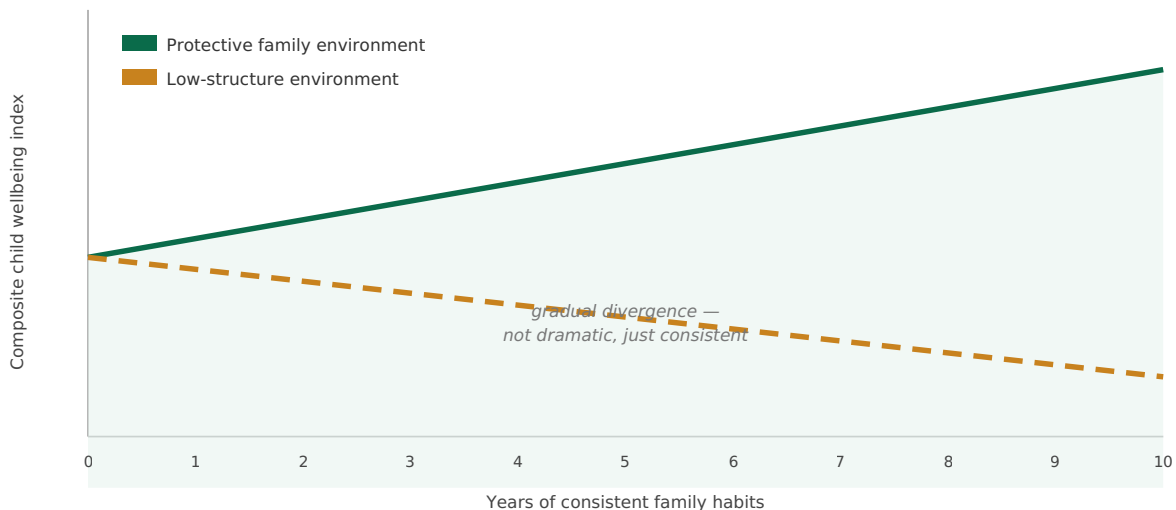
Illustrative The Family Health Ecosystem — five interconnected pillars surrounding family health

Structural model based on: Pellegrini et al. IJERPH 2025 [19] · Cross-pillar associations are observational; diagram is illustrative of systems relationships

Small family habits compound over time

Why consistency beats intensity

Protective family environments do not produce dramatic overnight change. They produce gradual, compounding divergence. The gap between a structured, connected family environment and a low-structure environment widens slowly — and that is exactly why consistent small habits matter more than occasional large interventions.

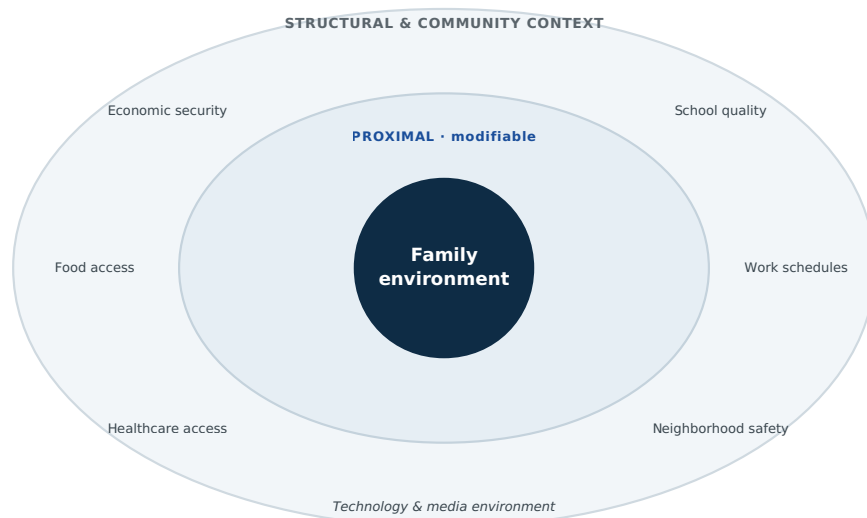


Illustrative Illustrative trajectories: composite child wellbeing index over 10 years — protective vs. low-structure family environment
Conceptual model based on developmental science literature · Trajectories are illustrative, not derived from a single study · Supported by: Laird et al. 2023 [6]; Pellegrini et al. 2025 [19]; CDC ACE literature

Families operate within larger systems

Why this is not about blaming parents

The five pillars describe what families can influence directly. But families do not act in isolation. Every household sits inside wider systems — economic, social, and structural — that powerfully shape what healthy routines are realistically achievable. **This deck focuses on proximal family factors precisely because they are modifiable — not because they are the only factors that matter.** Many determinants of child wellbeing lie largely outside any single family's control.



Equity matters. Single parents, low-income households, families of children with disabilities, and parents under chronic stress face real structural constraints. Effective family-health support meets families where they are — it does not assume every routine is equally available to everyone.

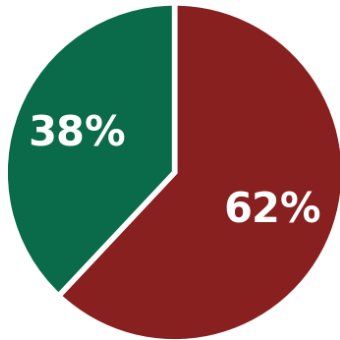
Illustrative Family environments nested within structural and community determinants of child wellbeing

Framing based on socio-ecological and biopsychosocial models · Bronfenbrenner ecological systems theory · diagram is illustrative

Pillar 1 · NUTRITION

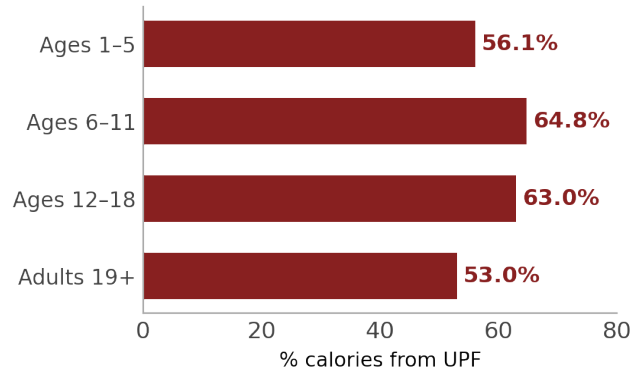
What families eat, when they eat, and who they eat with

The CDC's 2025 NHANES report — the first federal estimate of its kind — found youth ages 1–18 consume 61.9% of calories from ultra-processed foods (UPF). Ages 6–11 are highest at 64.8%. Childhood obesity reached a record 21.1% (2021–23). Families who eat together 5+ times per week show lower associated prevalence of substance use, depression, and obesity in adolescents across multiple longitudinal studies.



CDC surveillance Child calorie sources (ages 1–18)

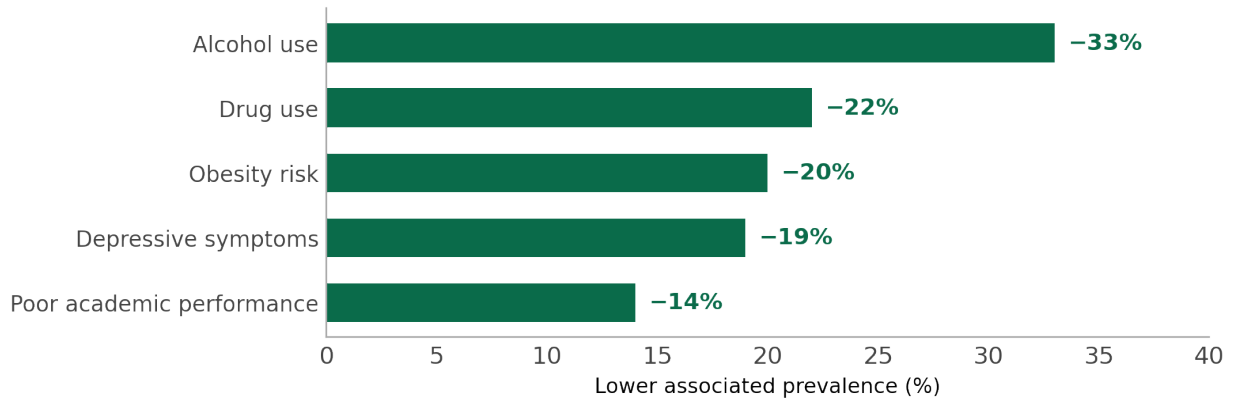
Williams et al. NCHS Data Brief 536, Aug 2025 [1]



CDC surveillance UPF calories by age group

CDC NHANES 2025, NCHS Data Brief 536 [1]

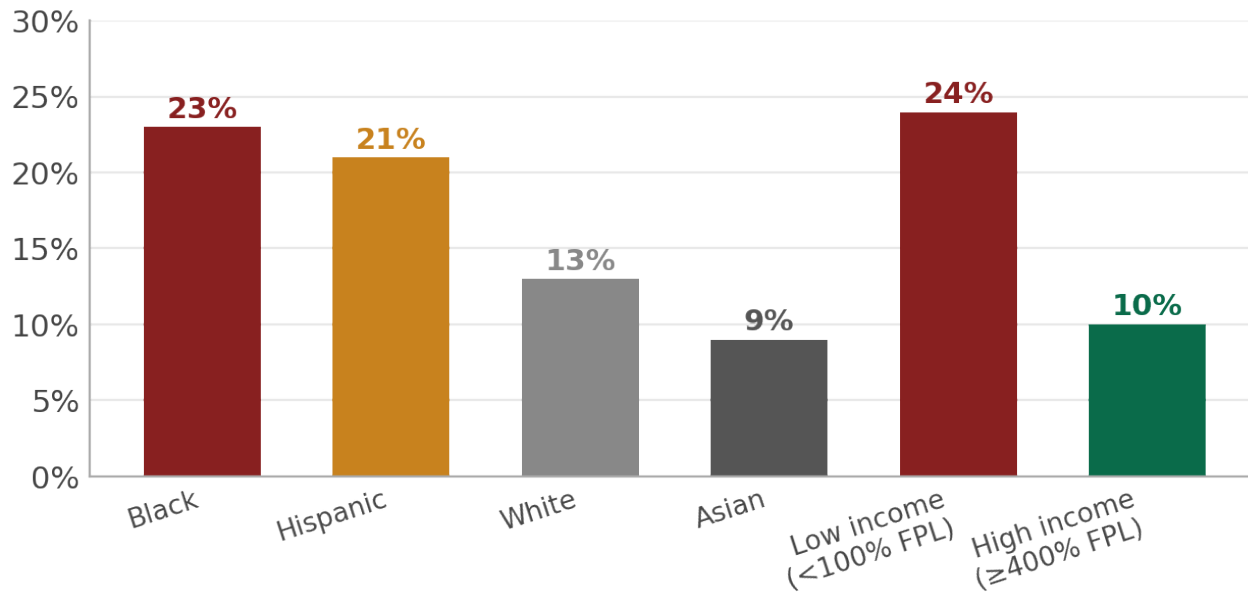
Family meal frequency — lower associated prevalence of risk outcomes (5+ meals/week vs. fewer than 3)



Longitudinal cohort Lower associated prevalence of risk outcomes in adolescents eating 5+ family meals/week

CASA longitudinal series via Laird et al. umbrella review 2023 [6] · Eisenberg et al. 2004 [7] · Observational — lower associated prevalence, not proven causal reduction

Childhood obesity by race/ethnicity and income (NSCH 2023–24)



CDC surveillance % with obesity by demographic group — ages 6–17

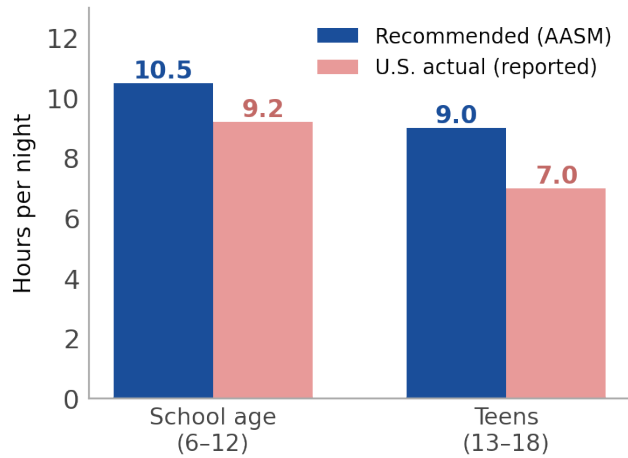
RWJF / State of Childhood Obesity — NSCH 2023–24 [8] · CDC NCHS Health E-Stat 112, 2025 [9]

Reading this with a systems lens. The roughly 2.5× gap between low-income and high-income children reflects differences in food access, neighborhood resources, and economic security — structural factors documented on the previous page — not differences in family effort or care.

Pillar 2 · SLEEP

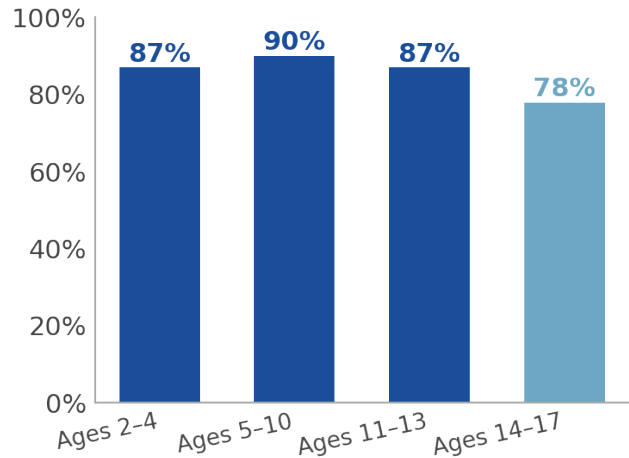
The most under-prioritised biological necessity in the household

AASM recommends 9–12 hours for children ages 6–12 and 8–10 hours for teenagers. The CDC's March 2026 NCHS Data Brief 551 found 85.6% of children have a regular bedtime — dropping to 77.5% for teens ages 14–17. About 8.1% of all children complain of daily daytime tiredness; children with disabilities are over three times more likely to report tiredness (22.0% vs. 6.3%). Family and parenting environments are among the most influential and modifiable **proximal** factors associated with children's sleep consistency.



CDC surveillance Recommended vs. actual sleep hours by age

AASM 2016; CDC/USAFacts 2024; NCHS Data Brief 437 [4]



CDC surveillance % of children with regular bedtime by age group

Black et al. — NCHS Data Brief 551, March 2026 [10]

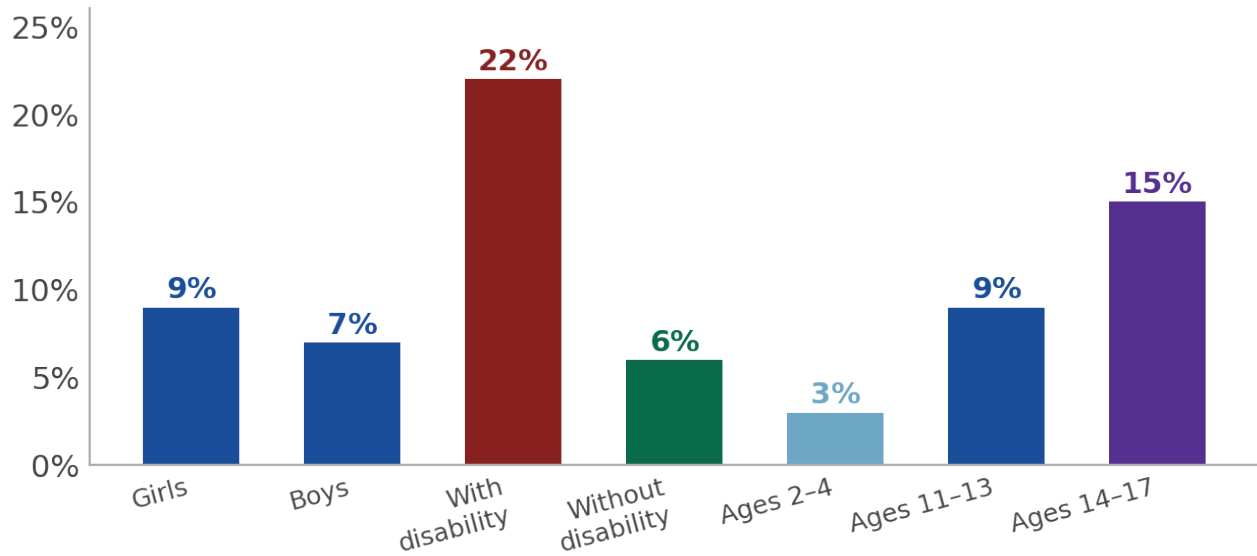
Teen sleep deprivation trend 2009–2023



CDC surveillance % of U.S. high school students not meeting AASM sleep recommendations — CDC YRBS biennial series

CDC YRBS 2009–2023 series; CDC/USAFacts 2024 [4]

Daytime tiredness — who is most affected (NCHS Data Brief 551, 2026)



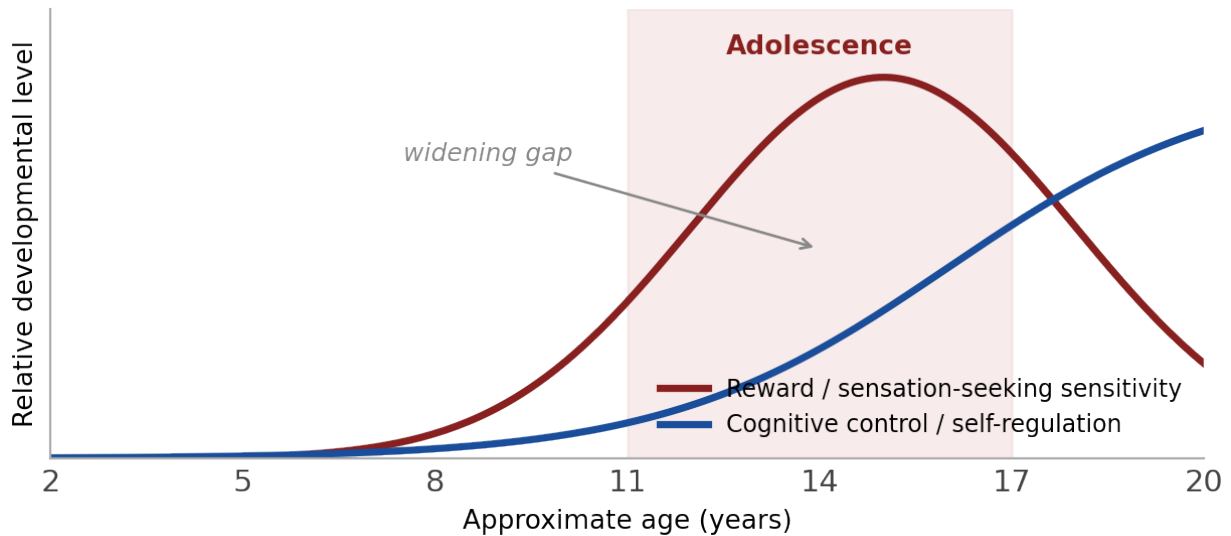
CDC surveillance % of children reporting daily daytime tiredness by subgroup (NHIS 2024 data)

Black et al. — NCHS Data Brief 551, March 2026 [10] · Overall rate: 8.1%

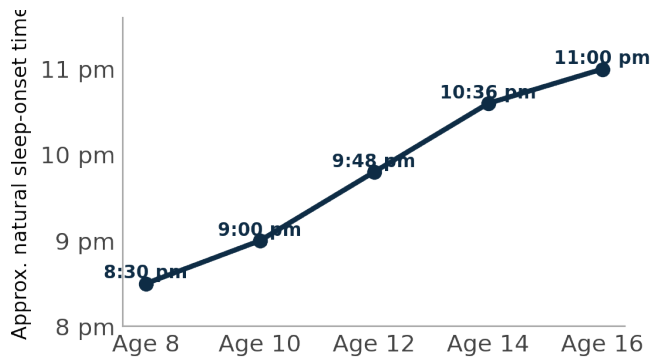
Why adolescence is uniquely vulnerable

Developmental timing and sensitive periods

Risk is not evenly distributed across childhood. Adolescence is a sensitive period in which the brain's reward and sensation-seeking systems mature earlier than the systems governing self-regulation and impulse control. This temporary imbalance — well documented in developmental neuroscience — helps explain why several pillar indicators (sleep loss, persistent sadness, risk-taking) worsen sharply in the teen years.



Developmental neuroscience Illustrative timing of reward sensitivity vs. cognitive control across development
Conceptual model after dual-systems / maturational-imbalance frameworks (e.g., Steinberg; Casey) · curves are illustrative, not from a single dataset



Why this matters for families. A teenager who cannot fall asleep at 9 pm is often experiencing a real biological phase shift, not defiance. Family routines that work at age 8 may need to adapt by age 14 — earlier screens-off, consistent wake times, and protected morning light.

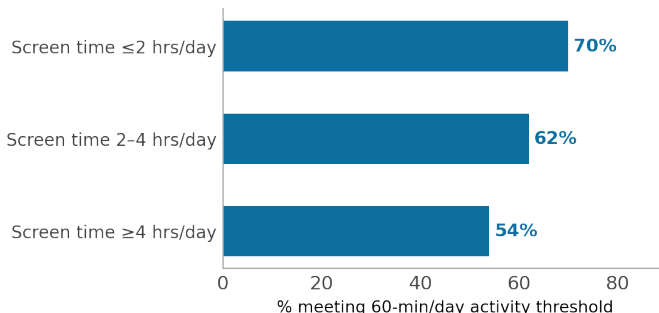
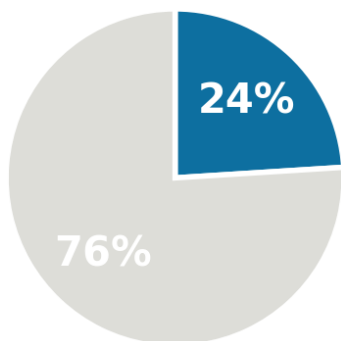
Developmental biology Puberty-linked delay in natural sleep-onset timing

Illustrative of circadian phase delay at puberty (melatonin-onset shift) · supports later natural bedtimes in teens

Pillar 3 · MOVEMENT

American children earned a D- on the national physical activity report card — twice running

The U.S. Physical Activity Guidelines recommend 60 minutes of moderate-to-vigorous activity (MVPA) daily for ages 6–17. The 2024 Physical Activity Alliance Report Card found only 20–28% of children meet this on objective NHANES accelerometer data. A 2015 meta-analysis (Yao & Rhodes, 115 studies) found that parental SUPPORT — logistical help, encouragement, co-participation — shows a moderate association with child PA ($r=0.38$), while parental modeling alone is only weakly associated ($r=0.16$). Supporting your child's activity directly matters more than simply being active yourself.



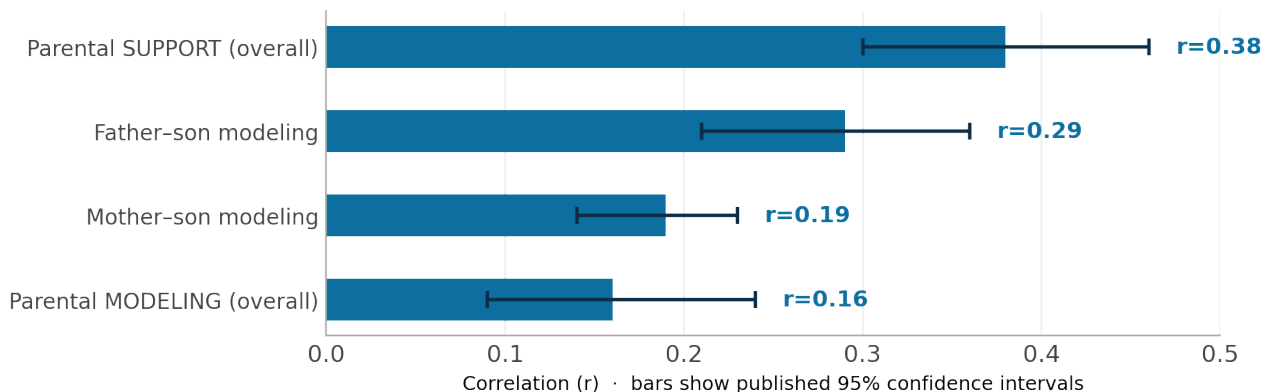
CDC surveillance Screen time vs. activity rate (teens 12–17)

Black, Ng & Zablotsky — *MMWR* 2024;73(44) [11]

CDC surveillance Children ages 6–17 meeting 60-min/day goal

Physical Activity Alliance Report Card 2024 [3]

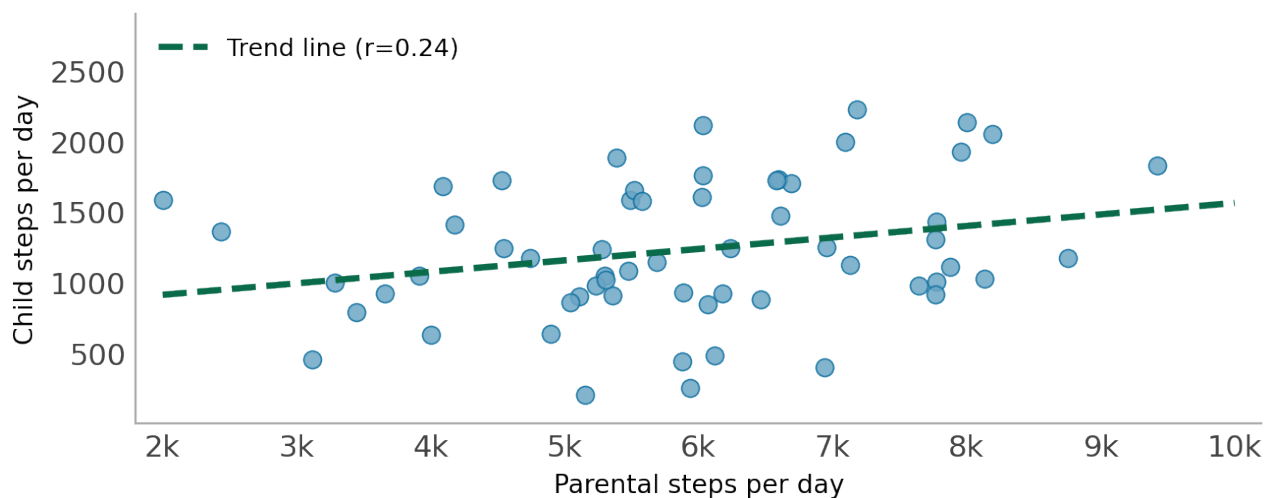
Parental influence on child physical activity — effect sizes (Yao & Rhodes 2015, n=115 studies)



Meta-analysis Support $r=0.38$, 95% CI 0.30–0.46 (moderate) · Modeling $r=0.16$, 95% CI 0.09–0.24 (weak) · Father–son $r=0.29$ (0.21–0.36) · Mother–son $r=0.19$ (0.14–0.23)

Yao & Rhodes — *Int J Behav Nutr Phys Act* 2015;12:10 · PMC4363182 [12] · Error bars are the random-effects 95% CIs reported in the paper · substantial between-study heterogeneity noted by the authors

The steps effect — parental steps predict child steps



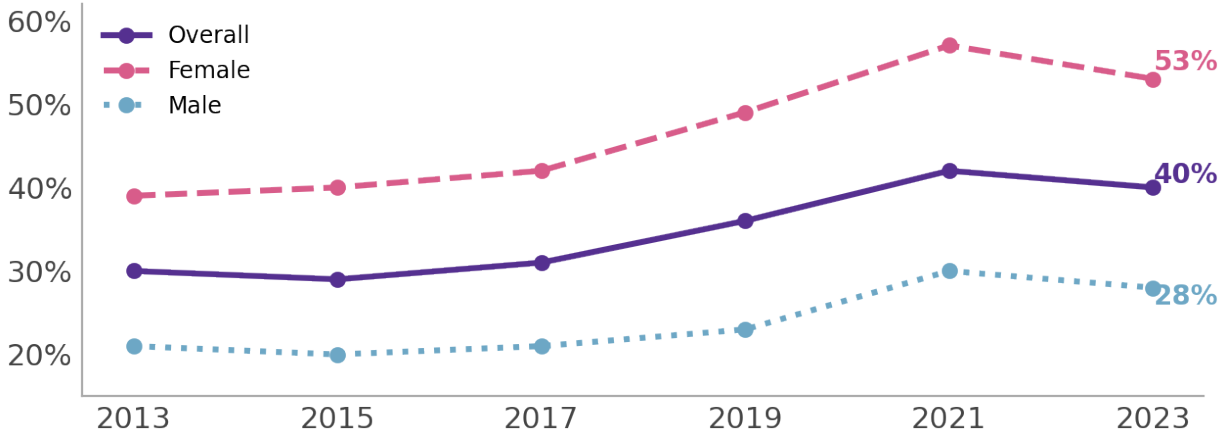
Illustrative Illustrative scatter at the reported partial correlation $r=0.24$ (Schoeppe et al. 2016); the study reports approx. +260 child steps/day per +1,000 parental steps

Schoeppe et al. — *BMC Public Health* 2016 [13] · Points are simulated to reflect the published correlation; the trend line shows the $r=0.24$ association, not a fitted study slope

Pillar 4 · MIND

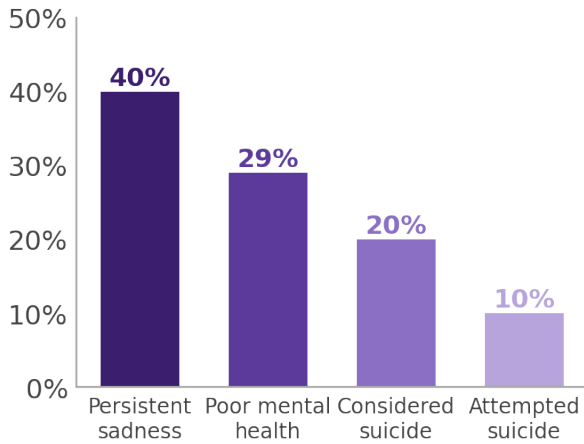
Family environments are among the most influential proximal factors for child mental health

The CDC's 2023 YRBS found 40% of high school students report persistent sadness or hopelessness — up from 30% in 2013. Female students: 53%. Male: 28%. A 2023 meta-analysis (Stracke et al., 83 articles, 80,000+ families, data collected during COVID-19) found associations ($r=0.19-0.46$) between parental mental health and child mental health outcomes — parenting stress showing the largest effects. All measured protective factors — family, school, community — were associated with lower prevalence of mental health risk indicators.



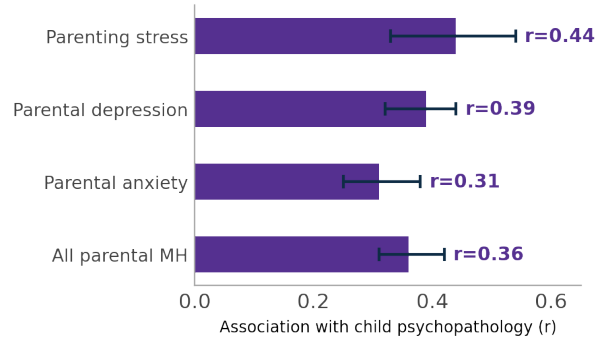
CDC surveillance Teen persistent sadness or hopelessness 2013–2023 — % by gender (CDC YRBS biennial)

CDC 2023 YRBS; Verlenden et al. — MMWR Suppl 2024;73(4) [2] · Unadjusted national prevalence



CDC surveillance High school mental health indicators 2023 (% of students)

Verlenden et al. — MMWR Suppl 2024;73(4) [2]



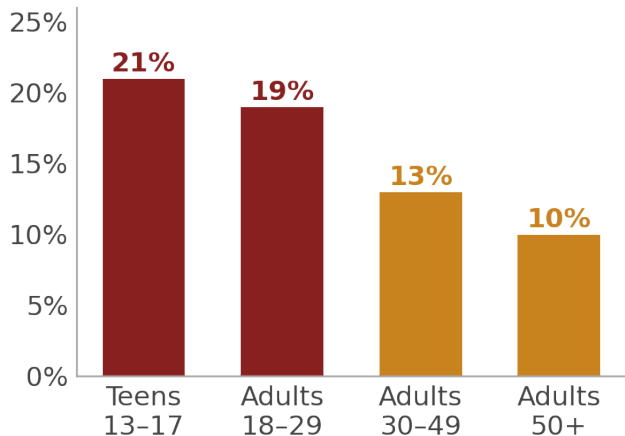
Meta-analysis Parental factor → child psychopathology (r, published 95% CI): parenting stress 0.44 (0.33–0.54); depression 0.39 (0.32–0.44); anxiety 0.31 (0.25–0.38); any psychopathology 0.36 (0.31–0.42)

Stracke et al. — IJERPH 2023;20(5):4485 · COVID-19 context, 83 articles [14] · Observational; high heterogeneity (I^2 up to ~89%)

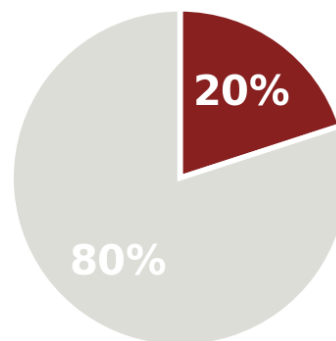
Pillar 5 · SUPPORT

Among the highest reported loneliness rates globally — and families are a strongly protective factor

The WHO's 2025 Commission on Social Connection found teens ages 13–17 report loneliness at the highest rate of any age group (20.9%). A 2024 Mott Poll found 1 in 5 parents of children ages 6–12 report their child has few or no close friends. A rapid systematic review of 80 studies (~51,500 children and adolescents) found that childhood social isolation and loneliness were associated with higher rates of depression — and probably anxiety — both at the time and up to nine years later [21]. Secure parent–child attachment is among the most robust protective factors for social and emotional wellbeing across the lifespan.



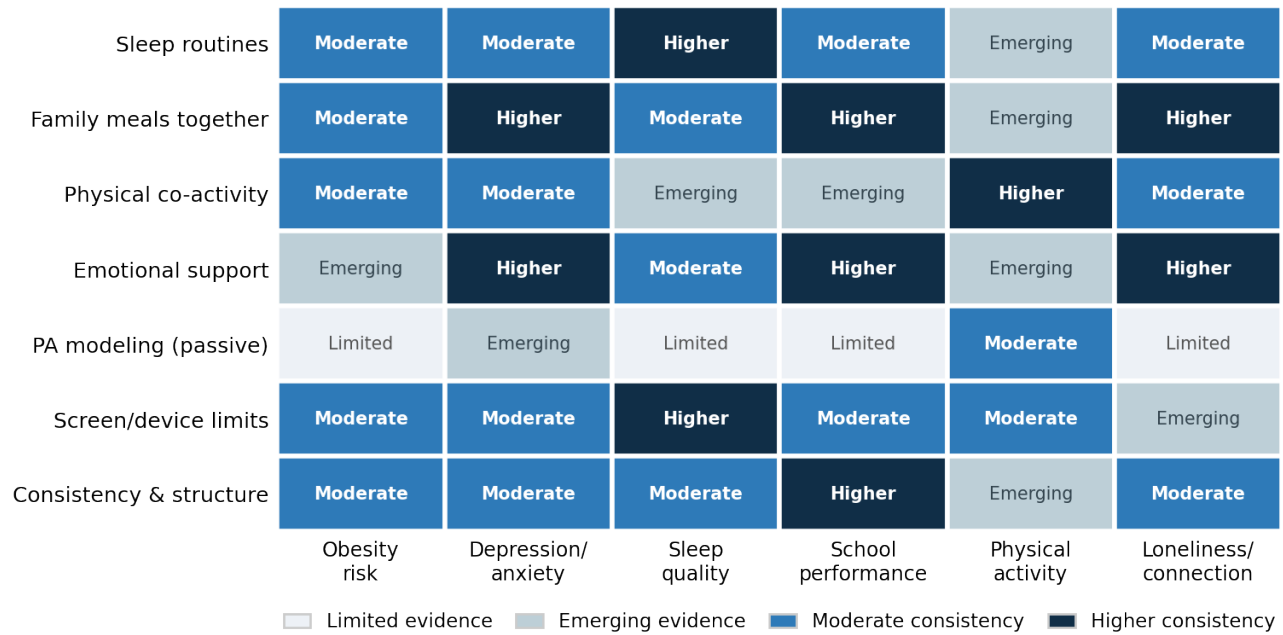
Systematic review Youth loneliness by age — % reporting loneliness, highest of any age group (global)
 WHO Commission on Social Connection 2025 [15]



Cross-sectional Children ages 6–12 reported to have few or no close friends
 C.S. Mott Children's Hospital National Poll 2024 [5]

Parental influence heatmap — family behaviors vs. child outcomes

Evidence consistency across seven family behaviors and six child outcome domains. **'Higher consistency'** = multiple meta-analyses or longitudinal RCTs converge. **'Moderate consistency'** = longitudinal observational studies. **'Emerging evidence'** = cross-sectional or limited cohort data. **'Limited evidence'** = insufficient or inconsistent findings. Labels describe how consistent the evidence is, not the size of any causal effect.



Meta-analysis Parental behavior vs. child outcome — evidence-consistency heatmap

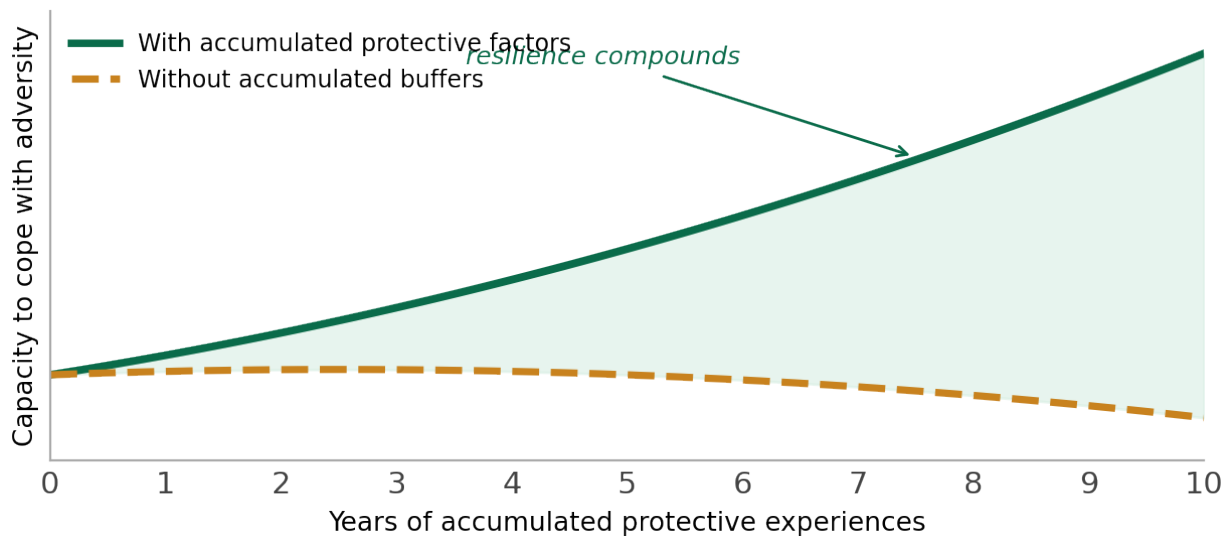
Synthesized from: Pellegrini et al. IJERPH 2025 [19] · Laird et al. 2023 [6] · Verlenden et al. 2024 [2] · Stracke et al. 2023 [14] · Yao & Rhodes 2015 [12] · Holt-Lunstad et al. 2010 [17] · Ratings reflect the author's synthesis of published evidence and describe evidence consistency, not effect magnitude; not a formal systematic review

How to read the scale. A cell rated 'Higher consistency' means independent high-quality studies tend to agree that a relationship exists — it does not quantify how large that relationship is, and most associations shown are observational rather than proven causal.

Resilience accumulates

Balancing risk with what builds children up

Most surveillance data describes risk. But the same body of developmental science shows that protective experiences accumulate into resilience — a buffer that helps children cope with adversity they will inevitably face. Resilience is not a fixed trait; it is built repeatedly through everyday interactions, and small protective experiences compound much like the habit trajectories shown earlier.



Illustrative Illustrative accumulation of coping capacity with vs. without sustained protective experiences
Conceptual model based on resilience and developmental-systems literature · trajectories are illustrative

Secure attachment
 Responsive, predictable caregiving is among the most robust buffers across the lifespan.

Co-regulation
 Calm adult presence during distress teaches children to regulate their own stress response.

Belonging & routine
 Reliable rituals and a sense of belonging stabilise mood, sleep, and behaviour over time.

What families can realistically do

Small, low-cost, evidence-aligned starting points — adapt to your circumstances

The science points toward consistency over intensity. None of the steps below require money or special expertise, and families facing structural constraints should treat them as a menu, not a checklist. Even partial, imperfect routines move the needle when sustained.

Nutrition

Aim for a few shared meals each week — even quick ones. Keep one easy default vegetable on hand. Eat together without screens when you can.

Sleep

Pick a consistent wake time first; bedtime follows. Screens off 30–60 min before bed. Protect morning light, especially for teens.

Movement

Support beats modeling: offer rides, encouragement, and co-activity. A 10-minute after-dinner walk together counts.

Mind

Build one daily low-pressure check-in (car rides and bedtime work well). Name emotions calmly. Manage your own stress — it is contagious in both directions.

Support

Protect time for friendships: facilitate playdates and group activities. Keep one predictable family ritual. Stay warm and available rather than perfect.

The 5-minute principle. Research on family habits favours small repeated behaviours over occasional large interventions. A consistent five minutes — a check-in, a walk, a shared breakfast — sustained over months tends to matter more than a rare ambitious effort.

General, non-clinical guidance synthesised from the sources cited throughout this deck. Not medical advice; families with specific health concerns should consult a qualified professional.

Citations & Scientific Sources

All statistics verified against primary sources — data current through March 2026

Verification notes: (1) UPF 61.9% from NCHS Data Brief 536 (Aug 2025) — first federal estimate. (2) Teen sadness 40%: unadjusted 2023 YRBS national prevalence. (3) Yao & Rhodes 2015: SUPPORT $r=0.38$ (95% CI 0.30–0.46, moderate); MODELING $r=0.16$ (95% CI 0.09–0.24, weak) — key distinction; effect-size charts show the random-effects 95% confidence intervals reported in the source papers (Yao & Rhodes 2015; Stracke et al. 2023, Table 1, parental factor → child psychopathology). (4) NCHS Data Brief 551 (2026): 8.1% overall daily tiredness; disability 22.0% vs. 6.3%. (5) The earlier social-isolation "mortality risk comparable to smoking" framing (Holt-Lunstad 2010) has been removed: it derives from adult mortality data and is a population mismatch for a child-focused synthesis. The child loneliness claim is now anchored on Loades et al. 2020 [21], an 80-study systematic review specific to children and adolescents. (6) Stracke 2023: COVID-19 context, observational. (7) BMJ 2024 UPF risk figures are from adult populations. (8) All cross-pillar associations are observational. (9) Heatmap relabelled to describe *evidence consistency* (Higher / Moderate / Emerging / Limited) rather than effect strength; cells verified against primary sources: sleep/obesity Emerging (BMC 2024 found no significant RCT effect); PA modeling Limited/Emerging (Yao & Rhodes 2015, $r=0.16$); family meals school/depression Higher (Laird 2023; Harrison 2015); emotional support depression/anxiety/loneliness Higher (Zimmer-Gembeck 2022; England-Mason 2023). Not a formal systematic review. (10) Ecosystem, systems-context, compounding, adolescence, and resilience visuals are illustrative conceptual models, not single-study reproductions. (11) 'Risk reduction' language replaced throughout with 'lower associated prevalence' to reflect observational evidence. (12) 'Proximal' added to family-influence claims, and a structural-determinants page added, to situate family factors within broader systems. (13) Implementation guidance is general and non-clinical. (14) Mott Poll figure corrected from "Gen Alpha" to its actual sample, parents of children ages 6–12; WHO loneliness wording aligned to source ("report loneliness — highest of any age group"). (15) Updated to Citation-Verified 2026, data current through March 2026.

- [1] Williams AM, Couch CA, Emmerich SD, Ogburn DF. Ultra-processed Food Consumption in Youth and Adults: United States, August 2021–August 2023. NCHS Data Brief No. 536, August 2025. DOI:10.15620/cdc/174612. Youth ages 1–18: 61.9%. Ages 6–11 highest at 64.8%.
- [2] Verlenden JV, et al. Mental Health and Suicide Risk Among High School Students — YRBS United States, 2023. MMWR Suppl 2024;73(Suppl-4):79–86. PMC11559681. 40% persistent sadness (national unadjusted).
- [3] Physical Activity Alliance. 2024 United States Report Card on Physical Activity for Children and Youth. D– grade. 20–28% of ages 6–17 meet 60-min/day on objective data. paamovewithus.org. JPAH 2025;23. DOI:10.1123/jpah.2024-0872.
- [4] Black LI, Ng AE, Adjaye-Gbewonyo D. Regular Bedtimes Among Children Ages 5–17: United States, 2020. NCHS Data Brief No. 437, CDC 2022. USAFacts (2024): 77.3% of high schoolers sleep-deprived.
- [5] C.S. Mott Children's Hospital. Facilitating Friendships: Parents' Role. Mott Poll Report, 2024. mottpoll.org. 1 in 5 parents of children ages 6–12 report their child has few or no close friends.
- [6] Laird Y, et al. Family Mealtimes: A Systematic Umbrella Review. Nutrients 2023. PMC10346164. 41 systematic reviews.
- [7] Eisenberg ME, et al. Correlations between Family Meals and Psychosocial Well-being among Adolescents. Arch Pediatr Adolesc Med. 2004;158(8):792–796.
- [8] RWJF / State of Childhood Obesity. NSCH 2023–24: Black 23.0%, Hispanic 20.6%, White 12.8%, Asian 9.3% obese. stateofchildhoodobesity.org
- [9] Emmerich SD, et al. Prevalence of Overweight, Obesity: Children 2–19. NCHS Health E-Stat No. 112, 2025. Record 21.1% obese (2021–23).
- [10] Black LI, Ng AE, Adjaye-Gbewonyo D. Sleep Routines and Tiredness Among Children Ages 2–17: United States, 2024. NCHS Data Brief No. 551, March 2026. DOI:10.15620/cdc/174647.
- [11] Black LI, Ng AE, Zablotsky B. Physical Activity Among Children 12–17 by Screen Time — US, 2021–2023. MMWR 2024;73(44). DOI:10.15585/mmwr.mm7344a5.
- [12] Yao CA, Rhodes RE. Parental correlates in child and adolescent physical activity: meta-analysis. Int J Behav Nutr Phys Act 2015;12:10. PMC4363182. n=115 studies.
- [13] Schoeppe S, et al. Cross-sectional study: parents' and children's physical activity. BMC Public Health 2016. PMC5086053.
- [14] Stracke M, et al. Mental Health Is a Family Affair — COVID-19 Meta-Analysis. IJERPH 2023;20(5):4485. PMC10001622. 83 articles, >80,000 families.
- [15] WHO Commission on Social Connection, 2025. Teens 13–17 among the highest reported loneliness rates globally (20.9%).
- [16] CDC/NCHS. Social and Emotional Support Among Teenagers 12–17: US, Jul 2021–Dec 2022. NHSR No. 206, July 2024.
- [17] U.S. Surgeon General. Our Epidemic of Loneliness and Isolation. HHS Advisory, 2023. (Adult-population mortality data: Holt-Lunstad J, Smith TB, Layton JB. PLOS Med 2010;7(7):e1000316.)
- [18] Lane MM, et al. Ultra-processed food and adverse health outcomes: umbrella review. BMJ 2024;384:e077310. 45 pooled analyses, ~9.9M participants. Adult populations.
- [19] Pellegrini G, et al. Impact of Parental Behaviors on Children's Lifestyle, Dietary Habits, Sleep, Mental Health, and BMI: Scoping Review. IJERPH Feb 2025. PMC11854690. 26 studies 2004–2024.
- [20] Felix A, Candeias A. Sleep as a Developmental Process: Systematic Review. Clocks & Sleep 2025;7(4):66. PMC12641626. 20 studies (2019–2024), children ages 6–12.
- [21] Loades ME, Chatburn E, Higson-Sweeney N, et al. Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19. J Am Acad Child Adolesc Psychiatry 2020;59(11):1218–1239. 80 studies, ~51,576 children/adolescents.