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PARADOXES IN WOMEN'S HEALTH PROTECTION PRACTICES

A thesis presented in partial
fulfilment of the requirements
for the degree of Master of Philosophy
in Nursing Studies at Massey University

SUBMITTED BY : AROHA EVELYN PAGE

YEAR : 1987

**DEDICATED TO THE MEMORY
OF THE ANZACS
AND ALL FOR THOSE NURSES WHO DARE TO CARE**

ABSTRACT

The study explored the basis of the relatively low uptake of cervical screening and practice of breast self-examination among New Zealand women. Consistent with an interpretative approach to social phenomena it was anticipated that part of the explanation would lie in the meanings which women attach to health in general and to these specific health-protection practices.

Theoretical sampling was effected by semi-structured interviews with 45 women. Transcripts of these interviews provided the substantive data which were then analysed by the process of constant comparative analysis and other grounded theory strategies for analysis.

The concept of a health-protection paradox centred around the core-variable 'vigilance-harmonizing' which was generated to reconcile the seeming inconsistencies within, and between, individual women and their health protection practices. This conceptualization was developed from the substantive data in order to provide a model designed to increase the effectiveness of nursing interventions for this area. The model, by illuminating processes from the client's perspective then can indicate those processes most suitable for incorporation in effective health education measures designed to promote the uptake of cervical screening and breast self-examination by women.

As an adjunct to the study, a breast cancer case history is presented which shows the theory-in-use. The use of this case-history lies in the fact that it shares the substantive area of inquiry which serves to accentuate the viability, relevance and applicability of the grounded theory.

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CHAPTER 1

THE SHAPE OF THINGS TO COME INTRODUCTION AND OVERVIEW

Perception and interpretation are as influential on health as the presence or absence of pathology.

- Weisensee (1986, p. 20)

1.1 INTRODUCTION

This study concerns the meanings that women give to health and health protection practices. Specifically it focuses on the health protection practices of cervical screening and breast self-examination. Attention to the meanings that women give to these practices is both timely, because sub-optimal uptake of the practices is reported (Rose, 1978; Skegg, 1985), and vital for women's health, since women in New Zealand are confronted with a potential cervical cancer epidemic (Skegg, 1985). Furthermore, the incidence for breast cancer remains constant among New Zealand women.

Nurses are in a key position to help redress this situation by promoting these health protection practices among women. Davison (1965) states that nurses have a mandate to undertake preventive education about cancer. However, nurses are not always able to fulfill this mandate. Blum (1982, p.41) contends that:

...interventions directed at increasing responses for risk-reduction, are not being fully developed because the explanatory base for specific behavioural responses is not yet sufficiently comprehensive.

The need to acquire such an 'explanatory base' is also indicated by an imbalance in the literature which shows a dominance of quantitative studies with designs limited in capacity for developing an explanatory base.

Grounded theory, a form of qualitative research, was selected for this study, as it has the capacity to generate a substantive theory for explanatory purposes. Development of a

theory based on the meanings women attach to health and health protection practices can help nurses in fulfilling their mandate more effectively.

1.2 OVERVIEW OF THE THESIS

Following this introduction, Chapter 2 - Background for the Study, provides the explanatory and contextual factors that led to the study's conception. In outlining the background and foundation for the study the following features are highlighted:

- The study plan which describes the potential fruitfulness of the grounded theory approach.
- Origins of the study including the researcher's interest in the area and the formulation of the research question.
- The significance of the study for nursing in which the nurse's role in prevention and health education is stressed within three sections that introduce concepts of i) health, ii) health protection, and iii) health education for cancer prevention.

Chapter 3 is in two sections covering the literature relevant for the Health Protection Practices (HPP) of cervical cancer screening and Breast Self Examination (BSE). Specifically, it reviews the literature that discusses factors thought to influence use of these practices.

Chapter 4 Gathering the Data - begins with a description of the grounded theory approach to data collection. The key concepts of "theoretical sampling" and "constant comparative analysis", both of which guided the interviewing phase, are discussed. The study sample is described, and ethical considerations of privacy, anonymity and consent are discussed, and the interviewing schedule outlined.

Chapter 5 Working the data - demonstrates the analysis of substantive data. It describes the processes involved in analysis such as memoing, coding, categorizing, and property-searching. These processes assist in the identification of a core-variable or concept which integrates the data. This core-variable is then described and linked with the development of the emergent theory. Approximations of the theory are made with extant theories.

In Chapter 6 a conceptual account of the theory Vigilance-Harmonizing is presented, drawing together findings referred to in Chapters 4 and 5. This presentation is separated into two parts. The first part comprises of two aspects. The first aspect describes the theory, the second, with a substantive example, gives a practical description showing the theory-as-process. Following this, Part II presents a breast cancer case-history showing the theory-in-use. Throughout this chapter, concepts from existing theories are again interwoven to highlight features of the emergent theory.

Chapter 7 Implications of the Study - are discussed as they apply to nursing practice, theory, and research.

Chapter 8, concludes the study.

DEFINITION OF TERMS

HEALTH PROTECTION PRACTICE (HPP)

The undertaking by women of the practice of routine cervical screening and breast self-examination, regardless of her perceived or actual health-status for the purpose of protecting health and/or detecting any deviation from normal findings (whether or not such practice is objectively effective toward that end).

The above definition is based on Harris and Guten's (1979, p. 18) typology for 'Health-Protective Behaviour'.

CERVICAL SCREENING

A health protection practice that is a systematic and standardized method for detection of cervical abnormalities from a smear taken from the cervix.

BREAST SELF-EXAMINATION (BSE)

A health protection practice which is a systematic method combining palpation and inspection of breasts, undertaken by a women herself as a detection measure for any abnormal changes of the breast.

CHAPTER 2

BACKGROUND FOR THE STUDY

2.1 OVERVIEW

This chapter extends selected aspects of the introduction, beginning with the study's purpose, and the study plan which focuses on grounded theory. It then goes on to examine the origins of the study from the researcher's perspective. Next, concepts of health, health protection incorporating aspects of secondary prevention, and health education are introduced and discussed with emphasis on their special significance for nursing.

2.2 PURPOSE OF THE STUDY

The purpose of this study is to examine the meanings that women associate with health and particularly for the health protection practices (henceforth referred to as HPP - see Definition of Terms) of cervical screening and breast self-examination (henceforth referred as BSE). This study arose in response to the puzzling question as to why some women adopt these practices and others do not. The answer may lie with the meanings which women actually give to these procedures.

Nurses, along with other health workers, tend to view women as "compliant" or "non-compliant" (Trotta, 1980), "acceptors" or "rejectors" (Hobbs, 1985) with respect to the HPP. Such a tendency can lead nurses to lose sight of accountability for their role within the community. Nurses need to relook at their espoused principle of client-focused care in relation to the outcomes of the health-related encounters with clients. Knowing in advance the meanings that women hold towards these practices may help to consolidate efforts towards their promotion and implementation.

In light of the above observation, the specific aims of the study translate into the following questions:

1. What meaning does health hold for women?
2. Do women perceive any action they take as a form of health-protection?

3. What meaning do women associate with the health-protection practice of BSE?
4. What meaning do women associate with the health-protection practice of cervical screening?

2.3 SYNOPSIS OF THE STUDY

Grounded theory, as stated in the introduction, was adopted as the approach to this study because of its potential for generating a theory that seeks to explain aspects of the phenomena under inquiry. Glaser and Strauss (1967 p. 1), exponents of grounded theory, define it as the "discovery of theory from data". It was the aim of the study to discover such a theory from the data given by women participants.

Application of grounded theory requires the researcher to "... enter the research setting with as few pre-determined hypotheses as possible". (Glaser, 1978, p. 3). While the researcher cannot totally abandon any pre-conceptions, the emphasis is placed on a detailed description of the features drawn from the data before making more general theoretical statements. Once a store of accurate descriptions for the study phenomena has accumulated, then the researcher can start to observe or hypothesize about relationships among them. These relationships may subsequently be checked for their viability by further samples of data for comparison.

From this gradual accumulation of data indicating relationships, the researcher generates, or "discovers", the grounded theory (i.e. theory grounded in data). This discovery is assisted by a rotating cycle of data collection and analysis guided by the characteristics of "... strategic decisions, instrumental actions, and analytic processes". (Schatzman and Strauss, 1973, p. 7). Grounded theory encourages the researcher to determine if the theory generated justifies itself by providing a detailed and carefully crafted account for the study.

Women themselves provided the data. They participated in the study by responding to semi-structured interviews. This method of interviewing generates a large store of data which accumulates in non-standard and unpredictable formats suitable for the grounded theory approach. This method of interviewing reinforces grounded theory's aim of expanding knowledge by encouraging (women) participants to respond with their own thoughts, ideas, and

views, at their own pace. This accommodation concurs with Reason & Rowan's (1981, p. XI) empathic assertion that:

Human inquiry is concerned with exploring and making sense of human actions and experience, requiring approaches that do justice to the humanness of those involved in the research endeavour.

2.4 RESEARCHER'S INTEREST IN THE AREA OF INQUIRY

The real voyage of discovery consists not in seeking new lands but in seeing with new eyes.

(Proust)

As a public health nurse (in Western Australia), one principle that I have learned is that of "relooking" at situations. Relooking means reflecting, seeing deeper and sharing the other person's perspective, going beyond the surface experience of situations rather than accepting the "status quo".

Translating this guiding principle to the area of inquiry, the following account is given. Firstly, from an empirical perspective, it appears that more younger women are developing cervical cancer. For those women screened for this cancer on a routine basis, carcinoma-in-situ, a pre-invasive stage of cancer, is more likely, if present, to be detected and subsequently effectively treated by medical intervention. In women who rarely attend screening, cancer, if present is more likely to progress to invasive cervical cancer, so reducing optimal chances of cure. Secondly, from an epidemiological perspective, statistical data reflects an alarming increase in all stages of cervical cancer among younger women. A projected epidemic appears imminent in the absence of a systematic cervical screening programme being provided for all women, along with steps to increase women's participation in such a programme.

In view of the above situation, I decided to relook at ways of increasing the uptake level of routine cervical screening for women in my local setting. Concerted efforts towards this goal of increasing levels of screening, whilst not completely successful, were rewarded with a significant rise in the screening acceptance by women over a two year period. The art and practice of relooking over time paid dividends in human terms. It revealed that women who had not yet accepted screening did possess health protection concepts and repertoires for other

health protection practices. This discovery suggested that the women had receptivity for the concept of cervical screening and its transformation into practice. Nursing could therefore concentrate on eliciting and identifying "cues" which represent this predisposition towards screening acceptance. Interpreting these cues led to the nurse having more effective health encounters with women.

The following vignette demonstrates a typical example of a health encounter with a young woman who had been referred by another health agency and labelled as 'non-compliant' and 'resistant'. During my entry stage of this encounter I noticed that this woman was spraying the kitchen to get rid of the flies, having first removed her infant to another room. This I took as evidence that she had some concept of health protection and so was able to build on this basis in discussing the need for cervical screening. (Previous information phrased in a technical language had been alien to her, resulting in fear and resistance.)

Concurrent with this interest in cervical screening was the phenomenon of BSE for early detection of breast cancer. BSE has the potential to reduce the mortality of women by up to 24% (Greenwald, 1978, p. 271). The tragic puzzle encountered here was that BSE practice was empirically low in my area. This was despite health education measures for promoting BSE, especially for women over 35 years who are considered more vulnerable candidates for breast cancer. Another aspect of this puzzle was that, among the minority of women who did practice this HPP on a regular basis, many delayed reporting signs of breast abnormalities they had detected. This seeming reluctance was puzzling since these women were conversant with the possible implication of these abnormalities as they relate to breast cancer. Likewise, they were aware that up to 90% of breast lumps were benign.

The researcher was qualified to implement the present study for the following academic and practical reasons. Firstly, the researcher had pre-existing knowledge concerning the epidemiology of cervical and breast cancer and screening and had organised, implemented and evaluated a pilot-project cervical screening programme and BSE programme. As well, the researcher had completed the coursework requirement for Master's in Health Science (Epidemiology) Curtin University.

Summarizing this section the following points are emphasized. Firstly, from a practice level there seemed no immediate formula for increasing the uptake of the specific HPP of cervical screening and BSE. Such a result required health education on a one-to-one basis over time. Even then, this method was not successful for all women. It may be that they required more time for sensitization to the HPP concepts, or that there are other impeding factors and processes not yet identified. The current situation of breast cancer, with its unrelenting strike rate among women, together with cervical cancer, and its potential for afflicting increasing numbers of younger women, need efforts for amelioration. This complex situation prompted the present study which provides a response to Gunter's (1972, p. 219) challenge that:

...unless researchers are willing to tackle significant problems, even though they are complex, it may be that we can anticipate little, if any improvement in client care.

2.4.1 MEANING OF HEALTH - SIGNIFICANCE FOR NURSING

In this study explorations of the "Meaning of Health" serve to provide a contextual frame for understanding self-defined responses concerning health protection. It seeks to find if health can be explained by reference to an overall health concept. Such an approach is a reversal of the traditional quantitative study-designs which tend to measure a single preventive behaviour in the hope that it may provide an adequate index for a more general health orientation.

Looking at individual or personal meanings of health is a relatively new approach. As a construct health is elusive and difficult to define (Dunn, 1969). According to Twaddle (1979, p. 1) there is no consensus about the criteria that determine health. As a concept, health is considered to be culturally bound, grounded in the norms, mores, and values of individual societies. According to Herzlich (1973) health is defined by each person individually. This reflects a quality of variance for its characteristics, rather than that of uniformity. McBride's (1982 p. 37) observation reflects this variance among women:

... women live out their lives embedded in a context that may be constantly in flux. As a result of this, no single point of view about women's health can be expected to emerge ... You cannot just differentiate women as a group, but have to analyze the experiences of individual women within the huge category of women. To generalize beyond the population under scrutiny may be destructive to an appreciation of other lived experiences.

Tillich (1961) in attempting to define health stated that the "meaning of health" is directly related to two key elements associated with the processes of living. These elements, Tillich described as "self-identity" and "self-alteration". Smith (1981) suggested on the basis of an extensive meta-analysis of the health literature that the many definitions of health can be categorized within four models of health; i) the clinical model, ii) role-performance model, iii) the adaptive model, and iv) the eudiamonistic model. Keller (1981) also conducted an extensive literature review to clarify the health concept, finding that writers tended to differentiate "total health" into "physical" and "mental" health functions. However, Ellis (1986, p. 412) suggests that health as a concept still remains undefined from a nursing perspective.

While nurses have rejected the view of health as the absence of disease, they have not solved the conceptual vacuum created by this move nor have they adequately provided empirical referents for the abstraction, health.

Individual's concepts and orientations of health are receiving increasing attention from health and nursing researchers' (Baumann, 1961; Laffrey, 1986; Suchman, 1966). Specifically Laffrey (1986, p. 107) states:

Discrepant definitions of health often lead ... to confusion and conflict ... For nursing, a discipline that aims to help promote higher levels of health, a multi-dimensional view of health probably is more suitable than a unidimensional view. Most important, however, is that we clarify the meaning of health for health professionals and for clients. The nature of nursing necessitates that client conceptions of health be assessed, as the basis for meaningful interventions.

Concerning health as the frame of reference to assist in understanding health protection practices Baumann's (1961, p. 39) comment finds relevance here with the recognition that a major problem in attempts to evaluate health attitudes stems from the fact that individuals perceive behaviour differentially as related to their concept of health;

Before evaluating an individual's attitude towards health, one must first ascertain the conception he holds of the term ... Conceivably, persons may fail to respond to measures designed to improve their health because they fail to perceive the measures as related to their conception of health.

Much earlier Nightingale equated the laws of health with the laws of nursing. If the goal of nursing is the individual's health, nurses must direct their research and practice toward clarifying perceptions of health and determining patterns of health-related behaviour.

2.4.2 CONCEPT OF HEALTH PROTECTION AND IT'S SIGNIFICANCE FOR NURSING

Health protection, the concept formalized by Harris & Guten (1979) is a focal concept in this study. This concept accommodates a synthesis between health promotion and illness-prevention which displaces the traditional disease-oriented focus on prevention by a health-oriented approach. Such a conceptual shift is in keeping with the trend pursued by other health and nursing researchers. (Pender, 1982; Terris, 1975).

Since health is specified as the pivotal point of nursing this conceptual shift to prevention has significance for nursing. Pender (1982, p. 1) has assisted the dissemination of this concept throughout nursing's theory of practice by saying that:

*...prevention is better described by the term 'health-protective behaviour'
...because of its emphasis on guarding or defending the body...*

Health protection as a theme is emphasised by Harris and Guten (1979, p. 29) who advise that:

Social Science can make a unique contribution to health protection by studying both activities that individuals perform to protect their health within their lifestyle contexts, and the compromises they reach while trying to balance health with other life goals.

Health protection operates as a "conceptual umbrella" subsuming the dimension of "preventive health care" identified by Harris and Guten (ibid) . This dimension likewise subsumes the concept of secondary prevention. Both cervical screening and BSE are examples of this level of prevention, since secondary prevention has as its aim early detection and prompt intervention to arrest the pathological process.

One specific finding concerning secondary prevention in Harris and Guten's classic study (1979, p. 23) was:

...that people who obtain preventive examinations ...are no more likely to perform other types of health-protective behaviour than are people who do not get them.

This finding has a direct bearing for the current study, in its search to understand why some women adopt the HPP and others do not. Pender (1982, p. 1) furthermore, acknowledges the complex interaction of factors that influence decision-making for health protection practices:

Gaps exist between early detection of disease and the public's utilisation of services ...many who appear to have adequate knowledge and favourable attitudes about prevention do not always put them into action.

It would appear from these researcher's statements that there are paradoxes concerning preventive behaviour. Further to this apparent paradox of health protection practice Harris and Guten (1979, p. 29) conclude from their study that "...measuring only preventive health care behaviours but then generalizing to a broader set of health behaviours is not empirically justified". This conclusion indicates that preventive behaviour may be multi-dimensional and independent, and that the pattern of the underlying dynamics of each preventive behaviour may be unrelated and independent to each other. Taking note of this conclusion the author of the current study places the specific HPP within a total health context, as is indicated by the broad question with which the study began.

Living is intrinsically risky and potential health threats have to be guarded against. Health-protection practices are behaviours that people believe they use to protect their health. In Harris and Guten's study (1979, p. 17), 97.5% of respondents indicated that they engaged in some form of these practices. These practices are a function of both perceived personal needs and the environmental resources, along with the interaction between these two factors. Women promote and protect their health in a variety of ways aimed at reducing vulnerability and increasing resistance to health threats by ensuring early detection and treatment of warning signs. Women themselves, in reference to the current study's HPP, are often the first

to identify needs by experiencing symptoms, (e.g. "itchiness" of the breast, and perceiving potential health problems, such as susceptibility to cervical cancer). Women engage in health protection with the goal of guarding their bodies in the hope of reducing their morbidity and mortality.

2.4.3 HEALTH - EDUCATION FOR CANCER PREVENTION: SIGNIFICANCE FOR NURSING

Nightingale envisioned the role of nurses as "guides and teachers of health" (1860, p. 1). Being a guide, in conjunction with "teacher", implies nurses assume a "mentorship" role for people and their health care needs. This role emphasises helping women to become aware of their own health needs, by education and through a process of self-discovery for decision-making. Part of this approach requires facilitating women's expression of their views and beliefs concerning aspects of health (for effective nursing interventions). Acknowledging both the initial role of the women as the decision-makers, and the contextual and personal factors involved in their decisions, could help nurses to understand the adoption or non-adoption of the cancer related HPP of cervical screening and BSE.

Referring specifically to cancer, Davison (1965, p. 24) and Hubbard (1978, p. 31) emphasise that nurses are expected, by society, to participate in public education. This finds endorsement in the New Zealand Nurses Association's Social Policy Statement (1985, pp. 6-7).

Nursing is an integral part of the society out of which it has grown and with which it continues to evolve. It is a profession concerned with health; it exists in response to the health needs of society.

Here then lies the mandate for nursing's role in health education for cancer prevention indicated in the introduction. Smith (1979) notes that the importance of nurses' health education function is receiving increased recognition within the profession. The current status of nurses' efforts for cancer prevention is however less than ideal. Information on cancer prevention is not being fully utilised or developed by nurses. This is reflected in Marino's (1981, p. 12) observation that "...nurses do not promote themselves as health educators for cancer prevention". Health education by nurses has great potential for reducing morbidity and mortality from cervical and breast cancer. However, for effective programmes, it is necessary

to have some knowledge about how, and under what conditions, women will take preventive actions related to cancer, something which the current study seeks to identify.

Currently, nurses seem to be absorbed with teaching techniques for BSE. This is reflected by the numerous studies (quantitative) concerning BSE. These studies tend to contract the professional practice perspective. There is a dearth of literature concerning other aspects related to BSE such as women's feelings, views, and meanings for this HPP. Lenrow (1978, p. 280) cautions that an emphasis on techniques is deleterious since:

These roles institutionalize a belief that competence in dealing with human problems lies in mastering of specialised technique considered in isolation from the personal meaning systems and in integrity of the people using the techniques, or affected by them.

Summarising this section, the following features are highlighted. Firstly, that traditionally, nurses have a function of health education in society. Secondly, that in relation to cancer education, this role is under-utilised. Thirdly, more information is needed regarding the processes involved in influencing women's participation in HPP. Fourthly, the potential impact nurses can have in reducing morbidity and mortality from cervical and breast cancer by promoting these HPP is considerable.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION AND OVERVIEW

This chapter reviews the literature that establishes known parameters for the study area and gives direction for further research. With grounded theory, the literature review does not feature to the extent that it does with other research methodologies. Swanson and Chenitz (1986, p. 149) emphasise this point:

...the literature review in a grounded theory project neither provides key concepts nor suggests hypotheses as it does in hypothetico-deductive research.

However, such a review can serve to show up limitations of previous research, such as gaps in knowledge and the incidence of systematic bias. Limitations of previous research are firstly, that no qualitative studies concerning the current study's area of inquiry were found and secondly, there is a dearth of research concerning factors that influence the women presenting or not presenting in cervical cancer screening. Limitations evident in the multi-disciplinary research concerning BSE are that only a few studies acknowledge the evidence that the value of BSE is debatable (Frank & Mai, 1985; Miller, 1985; Roberts, 1986; Skrabanek, 1985), and the persistent use of the health-belief model (Rosenstock, 1966) as the framework for their research (e.g. Trotta, 1980) restricts expansion and scope for yielding new knowledge. This model describes, briefly, some of the variables influencing an individual's decision to take health action for the purpose of preventing disease or detecting its presence in the early, asymptomatic stage. The approach of this model is based on a professional ideology rather than on individuals' stated beliefs. Harris and Guten (ibid, p. 17) point out this limitation as follows.

The dominant research strategy for studying health behaviour has been to select medically approved preventive health behaviours and then explore the effects of a set of explanatory variables on the performance of these behaviours.

In recent times the study of individual differences in health-related responses has attracted a growing interest from various disciplines. This search for patterns in individual

differences, their meanings, and implications, has been approached mostly from quantitative designs. Empirically, these quantitative studies have not yielded knowledge for application by nurses to increase the adoption of cervical screening and BSE. Specifically, the research findings fail to provide the coherence needed for formulating nursing interventions to promote these health protection practices. This review converges on identified factors that are currently thought to influence women in their adoption of cervical screening and BSE.

3.2 PART 1

CERVICAL SCREENING

The studies that relate to women and cervical screening practice or non-practice all use quantitative designs. Cervical cancer screening was introduced by Papanicolaou and Traut in 1943. The rationale for this technique was the hope that cervical neoplasia would be detected, preferably at a pre-cancerous stage and appropriately managed to reduce mortality from invasive cervical cancer. Such a reduction of invasive cervical cancer has been shown in areas with intensive cervical screening campaigns, for example Canada and Scandinavia (Mangus; 1982). No such reduction in incidence or mortality is seen in New Zealand, which currently does not have an intensive cervical screening programme. Maclean (1985, p. 756) cites that 250 women are diagnosed with cervical cancer each year, or 6% of the registered cancers for New Zealand women on an annual basis. This incidence indicates that many women are not being routinely screened. Many studies are epidemiological. Few, focus on factors affecting the response of women to cervical screening; although the literature shows increasing concern by health professionals about the low uptake of screening by women, indicating a need for further research.

One study that focuses on identifying such factors is that of Grace (1985, p. 139). In her study Grace conducted a survey to obtain information about women's attitudes, beliefs, and behaviours in relation to cervical cancer and screening. Grace's study was both exploratory and descriptive. Two hundred women were interviewed. The sample was designed as a stratified sample to include women from different social classes, as well as different ethnic and

age groupings. In relation to actual screening participation it was found that the following factors had a role (ibid, p. 139):

1. 'Middle class' women tended to have regular smear tests more often than 'working class' women.
2. Women in age-cohorts above 45 years tended to have been screened on a more sporadic basis compared with the younger age-cohorts.
3. Knowledge of the location of the cervix and knowledge of the actual screening process and its function appeared to be related to higher rates of screening.
4. Barriers to screening were measured in two ways. The first way was by rating certain specified barriers vis-a-vis; "dislike having it done; forgetting to have it done; fear what the results might show; cost; finding the time; children; no appropriate place close by; transport".

The results showed that for the majority of the women these barriers were not perceived as significant barriers to action. To account for the differences in screening participation, Grace concludes that they occur because of the different screening patterns initiated by the doctors, with compliance rates being higher for doctor initiated screening. The second way of measuring potential barriers to screening, 'past reactions to screening' were elicited from the women. In this instance, the majority categorized it as 'moderately negative'.

Finally, the factor of 'embarrassment' was examined. For 51% of the cases this was significant. In response to this Grace (ibid, p. 142) advocates that: "*Cervical screening should be accompanied by a full explanation of its purpose and the procedure in language easily understood by the recipient*".

Previous studies of the response of women to cervical screening show a fairly uniform pattern of over-representation of younger women and those in the higher socio-economic groups, and under-representation of older women, particularly those in the lower social groups. Among the more recent reports of this nature, for instance, Sansom, and Yule (1971) analysed sociological data concerning up to 35,000 women who had smears taken in the Manchester region (UK). They found that only 7.4% of all women screened were over 35 years old and

were identified as being in lower social class gradients. Kegeles (1965, p. 818) also found that social class and knowledge affected uptake of cervical screening.

In 1971 Davison and Clements (p. 329) followed up these findings with supplementary questions for a pilot social survey about cervical cytology. In response to the first supplementary question concerning "Beliefs about the purpose of the smear test", 46% of the women 'did not know' or 'never heard of it', while 54% saw it as cancer detection. For their second question concerning "Knowing where to go for a smear test", some 39% 'did not know'. For those that "did know", the majority were younger women. The final question simply asked if the women "had had the test yourself?" revealed that up to 63% of women 'had not'. Such gaps in screening participation in this survey show knowledge to be a significant factor affecting attendance.

Gerace and Sangster (1986, p. 566) investigated pap smear practice in relation to patterns of family physicians in Ontario. In this study the physicians were surveyed in order to compare the frequency of their screening with the 1982 Canadian Task Force recommendations. This study found that there was considerable variation between screening frequency and the recommendation for women in the 36-60 year age-cohort. Their study indicated that more uniformity was required by the physician's practice, for cervical screening programmes to achieve their maximum effectiveness. This concurs with Grace's finding, that 'provider's initiation' is a significant factor in influencing screening participation by women, a position also confirmed by Reid (1986, p. 5) in New Zealand.

Specifically, in relation to cervical screening there are studies that show the procedure to be associated with fear of discovering pathology. One such study for example was conducted by Smilkstein (1981). As well a study by Alexander and McCullough (1981) found that in a screening programme in Sweden, the non-participants reported that they perceived pelvic examinations as 'more unpleasant' than did participants. Skegg (1985, p. 638) also states that: "high priority should be given to research aimed at improving the delivery of screening and its social acceptability".

Eardley (1985, p. 955) suggests two different perspectives exist to explain low attendance for cervical screening. The first perspective focuses on the failure of the women to

attend and the second on the failure of the service to meet the needs of women, which highlights a dichotomy between "user-initiated" screening versus "provider-initiated" screening. Eardley's main finding was that the present screening service in the United Kingdom "impedes the maximum participation of at-risk women", and advocates that it should become 'provider-initiated' and 'user oriented'. This endorses McKinlay's (1972, p. 115) contention that the trend of research into the use of health services was to move away from an emphasis on the "personal pathologies of 'under-utilizers' towards a concentration on various types of organisational impediments". McCurtis (1979, p. 807) seems to have heeded this advice in his study which shows that:

...measures to increase periodic contact with physicians could influence women to obtain regular cytologic examinations ... if motivating programmes were directed towards this, a significant number of currently irregular or non-acceptors of cytological screening would obtain periodic screenings for cancer.

McCurtis (ibid) reviewing research into cervical screening participation, states that;

most of the previous research has produced little in the way of understanding and/or modifying the behaviour of the 'non-user' of cytological screening.

Social scientists have looked at 'acceptors' and Roberts (1986, p. 339) for example, found that forces such as mass media were useful in influencing them to be screened. McCurtis (ibid) examined the social contact factors responsible for 'use' and 'non-use' of cervical screening. He found that: i) mass media to impart knowledge failed to influence or reach the "target" population, and ii) that contributions of relatives and community members were important, but not enough to endorse them as factors which influence the 'users'.

In summary this review has focused on studies that show characteristic variables in relation to the use or non-use of cervical cancer screening. It tried to identify factors which influence the participation or non-use by women but was limited by the dearth of studies into this much needed area. Whilst epidemiological studies are in abundance, very few even touch on factors other than the 'doctor-related factor'. This then endorses the need for research on the phenomenon of cervical screening from the women's perspective. It would appear that studies concerning the generic screening incorporated into 'Pelvic Examinations' endorse Grace's finding that embarrassment may be one factor influencing screening participation.

Tentatively, this review shows that knowledge and belief in cancer detection are significant, but this is limited by variables of social class and age.

3.3 PART 2

BREAST SELF-EXAMINATION (BSE)

BSE has been recommended as an adjunct practice for early detection of breast cancer for over thirty years. In 1950 Haagensen stated that:

... from the point of view of the greatest gain in early diagnosis, teaching women how to examine their breasts is more important than teaching the technique of breast examination to physicians, for we must keep in mind the fact that at least 98% of the women who develop breast cancer discover the tumours themselves.

(Cited by Frank & Mai; 1985, p. 655)

Recently, the rationale for BSE has been demonstrated by Feldman (1981) and Foster (1986) in association with increased survival for women with subsequent diagnoses of breast cancer. Despite the potential BSE has for early detection of breast cancer it has not been universally accepted by women. Among New Zealand women, 1,000 new diagnoses of breast cancer were made annually and only 44% of women with diagnosed breast cancer reported at a stage when successful outcome was most favourable (Rose, 1979). In another study of New Zealand women, Maslowski (1985) found that only 19% of women surveyed practiced BSE on a regular basis. This rate of BSE practice is similar to studies conducted overseas. With this situation in mind, the World Health Organisation, (hitherto referred to as W.H.O.) has been prompted to advise:

When a method that is successful in persuading women to practice BSE regularly and to refer themselves when necessary has been devised, it should be applied to the appropriate target population.

(W.H.O. Memorandum, 1984, p. 863)

From a nursing perspective, Trotta (1980, p. 13) states that:

It is incumbent on health professionals, especially nurses, to promote this potentially life-prolonging practice. In order to do this effectively, we need to know more about women's present practices and attitudes and to identify the best way of teaching the procedure.

3.3.1 FACTORS THOUGHT TO INFLUENCE BSE PRACTICE

Nurses' and allied health professionals' concerns about motivational factors of women in relation to BSE practice are reflected in the number of studies and surveys they have conducted. Trotta's (1980) study was of a factor-relating design for investigating how frequently and thoroughly women practice BSE; how they learn about BSE and what influences their compliance. The theoretical framework for this study was based on the health belief model. Trotta's findings were presented by use of multiple regression analysis. This technique revealed that of all the study variables, the number of perceived barriers had the most significant influence on compliance. Women with high 'barrier' scores tended to be low compliers. Trotta, concludes that for BSE instruction to be most effective, it should be done by personal interaction and include use of individualized strategies to overcome barriers to regular practice. Chamberlain (1985 p. 182) states that there are "psychological and physical barriers affecting BSE". The psychological barriers described are:

fear that breast cancer is incurable, fear of mastectomy, fear of stigma, or even guilt of a cancer diagnosis, and fear of the effect of the illness on relationships and lifestyle.

The 'physical barriers' described are: "... finding the time and suitable place to do it, and remembering to do it at the recommended time". The effects of these various barriers to compliance are well illustrated in the work of Stillman (1977) who studied a well-educated group of American women and found that, although over 90% considered themselves vulnerable to breast cancer and believed that detection by BSE would improve their chance of cure, only 45 women out of her sample of 122 actually practiced this technique. Baines (1983, p. 256) on review of the BSE literature introduces a new view of factors influencing BSE practice. Baines questions whether living on guard against death is actually counter-productive:

that BSE is a 'defensive act' that for some becomes a 'ritual' and represents an obsession with measures to defer death and may, in so doing, diminish the quality of life.

Baines (ibid) questions whether it generates tensions that heighten the mind-body dichotomy, that the:

... act of distancing one's mind from one's physical being for a judgement can be a depersonalizing experience. It requires objectification of a body part that is associated with sensuous human experiences. With BSE, feeling seeks disease instead of producing pleasure.

Other researchers have also concentrated on identifying motivational factors associated with BSE as a 'cancer detection behaviour' (Schwoon & Schmoll, 1979; McCusker & Morrow, 1980). Schwoon and Schmoll's study (ibid, p. 283) they found that situational factors such as "finding spare time", or "obtaining baby-sitters", played a major role in preventing participation by women with lower socio-economic status. By contrast, McCusker and Morrow found that in a sample of middle-class professionals, with easy access to the health care system, a preventive orientation on the part of the physician was crucial in motivating women to participate in BSE. The results from these two studies suggest that social class, with all its associated cultural and economic factors, and women-physician bonding, need to be considered with respect to understanding the motivation of BSE practice.

Congruent with Trotta's study, Van Den Heuval (1978, p. 96) concludes that;

women who participate in breast-cancer detection are more likely than non-participants to view the disease as being serious, more likely to feel a susceptibility for it, and more likely to have a good knowledge of the disease.

This study, like Schwoon and McCusker's, shows also that other factors such as social-class gradient and age both influence participation. Manfredi (1977, p. 433) found that women's belief in the efficacy of early detection to reduce the danger from the disease was the strongest correlate for the ability to perform BSE. Hannan (1979) found that awareness of BSE was related to the use of other preventive health-behaviour measures, such as chest x-rays and cervical smears. As well, Hannan shows that women who practice BSE are more likely to view breast cancer as the "most worrying disease to which they are prone". Conversely, awareness of BSE appeared to bring with it a greater optimism about a cure.

Kelly (1979, p. 36) found that while 'examiners' and 'non-examiners' generally accepted the need for early detection of cancer, the difference between the two groups

appeared to be that: "examiners 'acknowledge', and non-examiners 'denied', that they were at risk of breast cancer". Over a quarter of the 'non-examiners' in this study were "too afraid to perform BSE". In other studies, the factor of fear has been shown to deter some individuals from following health regimes (Janis & Fesbach, 1953; Haefner, 1965).

Dickinson (1986, p. 235) studied BSE in relation to knowledge and attitudes of working women. In this sample it was found that younger women had less knowledge about breast cancer, and did not practice BSE as often as the older women. The older women were generally aware of the benefits of BSE and believed they could affect their health with regular BSE practice. The most frequently cited barrier to BSE practice was "too busy", followed by "I don't know how to". Of the respondents questioned, 62% indicated they would practice BSE if they were shown. With the use of stepwise multiple regression it was found that the factors of attitudes, knowledge and belief do influence the practice of BSE.

Howe (1981, p. 251) examined the "social factors" associated with BSE among "high risk women". The study was retrospective, and thus could not describe the causal relationships, although the researcher analysed the associations between the frequency of BSE practice and the following variables; age; education; detection; confidence; social influence; modesty; preventive health behaviours, and memory. Of interest also, since Howe defined BSE in the study as an autonomous preventive health behaviour, is that her study found that BSE frequency had a stronger association with 'medical preventive behaviour' than with 'autonomous preventive health behaviours'.

Stillman (ibid, p. 126) in her study of health beliefs and BSE found that religion was a significant factor. The Catholic group who had the lowest scores on 'breast cancer' and 'BSE beliefs' tended to have the highest average rate of practice. Fink (1972) and Gold (1964) however, found that Catholics were reluctant participants. Likewise, Stillman identified 'embarrassment' as a significant factor to detract from practice. This supports the health belief model thesis which states that negative aspects may outweigh the positive benefits in the individual's subjective world.

Hallal (1982, p. 137) studied the relationship of health beliefs, health locus of control, and self concept to the practice of BSE. This was a descriptive-correlational study to determine

if there were differences in these aspects between BSE 'practicers' and 'non-practicers'. The analysis of data revealed that there were differences. Specifically, the 'BSE-practicers' when compared to 'non-practicers' demonstrated higher levels of health beliefs about and perceived benefits and susceptibility to breast cancer of BSE self-concept, and tended to exhibit an 'internal locus of control'. This conflicts with Stillman's finding on her scale that 20% of 'non-practicers' had high beliefs also for perceived benefits of BSE and perceived susceptibility to breast cancer.

Margarey (1977) studied psycho-social factors in women with symptoms of breast disease and found that conscious factors, which included: fear of breast cancer; fear of breast loss or dying; knowledge about cancer; age; and education did not influence the practice of BSE. 'Unconscious factors', especially ego defences such as denial and depression were found to have a greater significance by relationship affecting health practices than conscious factors.

Schleuter (1982, p. 348) investigated the role of knowledge and beliefs about breast cancer and BSE between athletic and non-athletic women. Schleuter concluded that knowledge of breast cancer, beliefs about breast cancer and BSE, or engaging in regular physical exercise as a preventive health behaviour do not affect the uptake practice of BSE. Kelly (1979, p. 31) in her study found that BSE practicers had two main reasons for doing BSE. Firstly, that they had an awareness that it is desirable to detect breast cancer early. Secondly, that they had an awareness that it could successfully arrest breast cancer through early detection, while non-practicers tend to deny this possibility. Therefore, Kelly concludes, to become BSE practicers, women who are non-practicing may need to be convinced not only that early detection is effective, but also that they too are at risk of breast cancer.

Nurse researchers have also focused on nurses as a group of women in relation to BSE. Edgar (1984, p. 255) found that while there were significant differences in knowledge levels, as a factor influencing BSE, between the nurse and non-nurse group there was negligible difference between their frequency of practice. Turnbull (1978) found that of 90 masterate nursing students surveyed, 77 were regularly practicing BSE. Bayley (1980, p. 42) examined the frequency of BSE by student nurses and found that 76.6% practiced BSE. The

highest factor affecting this result was 'a wish to know you are healthy', followed by 'cancer fears', and 'mass media publicity'. Hirst (1986, p. 42) in her study found that 96% of nurses had practiced BSE within the last six months, but of these only 18.5% used the 'correct procedure'. Calnan (1984, p. 199) states in relation to studies of beliefs and BSE that they have a fundamental weakness in that they are correlated at the same time: "the best way to test if beliefs produce behaviour is to collect information about beliefs before the behaviour occurs".

Combined, the reviews for both cervical screening and BSE show a clear need for qualitative research to generate new knowledge about potential factors influencing the uptake of these health protection practices. Overall, this review shows a need for clarification of why some women do and do not use BSE. A qualitative study, such as the present one may complement the reviewed quantitative studies shedding more light on this phenomenon.

In summary, this chapter has focused on reviewing studies concerning cervical screening and BSE and possible identified factors affecting their adoption. Validated factors have clearly not been identified to satisfactorily explain why some women get screened and do BSE, and others do not. The studies are limited in their quantitative design as they lack scope for other unknown possibilities and none are prospective. However, despite this, they are a concerted attempt to identify factors associated with the performance of these HPP.

CHAPTER 4

GATHERING THE DATA

4.1 INTRODUCTION AND OVERVIEW

According to Glaser and Strauss (1967, p. 159) grounded theory is used to "... discover what's going on rather than assuming what should be going on ...". This chapter focuses on the data-gathering phase of the study. It describes the process of interviewing specific to the grounded-theory approach in relation to the questions posed by the study. This approach sets out to grasp an understanding of the meanings for HPP from the data gathered from the interviews, and then to make them become accessible for subsequent interpretation and translation into the world of practice. As Swanson and Chenitz (1982, p. 245) state: "Qualitative research provides a way to construct meaning that is more reflective of the world of practice". Acquiring grounded meanings from women concerning health and HPP facilitates the discovery of answers to the study's questions.

Consistent with the grounded theory approach, women themselves were regarded as the 'experts' for inquiry, since Glaser (1978) advised that it is best to interview those people first who are considered the most likely source in providing responses for the study's inquiry.

The chapter is presented in the following format:

- the study sample,
- procedures,
- interview schedule,
- progress of interviewing

4.2 STUDY SAMPLE

With grounded theory, sample size is contingent upon the characteristics of the data thus negating any pre-planning. Glaser and Strauss (1967, p. 61) stress:

...the researcher cannot state at the outset of his research how many groups he will sample during the entire study; he can only count up the groups in the end.

At the end of this study there were four groups representing 'units of comparison' (Glaser & Strauss, *ibid*, p. 59) for assessing commonalities and differences indicated from the data. The sample size was governed by the twin strategies of 'theoretical sampling' and the 'constant comparative method'. The former is described by Glaser and Strauss (1967, p. 45) as:

... the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them in order to develop his theory as it emerges.

Since experts were required for the interview, the study sample, with groups of women representing 'units of comparison' can be described as a non-probability, purposive sample. Weisensee (1986, p. 19) claims: "... that the study of women's health is full of contradictions and nearly void of solid data findings". The data gathering for this study helps to start filling this void. A summary of the 'units of comparison' with their associated demographic data is presented in Table 1 (over page).

4.3 PROCEDURES

Once an initial group was established for the study, explanations of the purpose given, informed consent covering ethical issues of ensuring confidentiality, the right of the participants to withdraw at any stage, and permission for taping interviews was granted, dates and times were set for the participants' convenience, interviewing commenced. The same ethical procedures were applied to subsequent groups for the study. (Refer to Appendix No. 1).

Settings for the interviews were chosen by the participants and varied from home, work-place, to a community venue. Throughout the interview phase ethical criteria ensuring rights of privacy were fulfilled. Length of the interview ranged from 10 minutes to an hour. Transcripts were then made from the audio-taped interviews. Both tapes and transcripts were coded by group number and sequence of interviews, and kept locked in a safe to ensure

confidentiality and anonymity for participants. The researcher only, kept a master record of the coded names, addresses, and details of participants, and again this was kept locked.

Table 1

Description of Population Sampled - Type of Group, (Units of Comparison), Age, Ethnic Origin, and Marital Status

Group	No. of Women	Age-Range	Ethnic Origin	Marital Status
1. Mothers Suburban Group	16	30-40	All Caucasian NZ	All Married
2. Mothers Suburban Group	11	22-36	Maori = 1 Cauc- =10 asian	All Married
3. Mothers Rural Group	7	30-40	Samoan= 1 Cauc- = 6 asian	All Married
4. Single Working Women Urban Group	11	20-30	All Caucasian	All Single
Total	45			

The procedures of comparative analysis for the generation of theory are systematic and provide for empirical verification of the concepts and hypotheses developed during the research process. The research operations of planning and searching the literature, data-gathering, analysis, conceptual integration, go on simultaneously as opposed to the discrete stages associated with quantitative research which is designed to verify and validate rather than generate theory.

The advantage of constant comparative analysis is that it increases the potential for generality as Glaser and Strauss (ibid, p. 52) state: "The scope of a substantive theory can be carefully increased and controlled by such conscious choices of groups".

An interview-guide was developed to serve as a flexible reference for the interview sessions. This guide initially comprised the two major questions of the study concerning the meanings participants attach to health and HPP. As Pender (1982, p. 3) indicates:

In discussing the determinants of health behaviour within a humanistic context, perception emerges as a key concept. It is not the external event that directly affects behaviour but the meaning an individual gives to any object or event.

The women participants' interpretation of these HPP and what they mean is crucial for generating a substantive theory. The researcher as interviewer extends herself to grasp these meanings by encouraging and accommodating participants' responses. As Lofland (1971, p. 4) describes this aim:

The commitment is to get close, to be factual, descriptive and quotive constitutes a significant commitment to represent the participants in their own terms. This does not mean, that one becomes an apologist for them ... so that one's audience is not at least partially able to project themselves into the point of view of the people depicted.

Congruent with this aim of representing women's meanings to the fullest extent, the interview guide included reflexive phrases typical of a non-directive approach, e.g. "that's interesting ... can you tell me more about that please". The interview's function using this non-directive approach is primarily to serve as a catalyst to a comprehensive expression of the women's frame of reference within which personally constructed meanings are of significance. As stated additional questions were asked following the researcher's hunches from the initial interview. Formulating these hunches the following two questions arose:

1. Who initiates your cervical screening?
(e.g. self, Doctor, Nurse, significant other).
2. What do you think you would do if you notice something different about your breasts ... such as a lump?

These questions were posed only if they did not arise naturally during the interview. The first question was checking for a tentative emergent category of locus-of-control (with subsequent data-analysis this was developed as a property of categories). The second question was hypothetical in an attempt to further examine underlying processes of delay in reporting lumps

(mentioned in Chapter 2). It examined intention and meaning with respect to a projected HPP action.

As indicated in the study synopsis, Chapter 2, the selected method was the semi-structured interview. The advantage of this method, in conjunction with its formulated non-directive approach for open-ended questions is that it can elicit and accommodate the depth and breadth of the woman's meanings. At the completion of each interview, individual demographic data were recorded concerning age, marital-status, residence, and ethnicity. The operation of interviewing was contained within a time-frame and took two stages. The first three groups were interviewed during a three-month period. Following intensive data-analysis a fourth group was indicated by constant comparative analysis. Interviews took place seven months later and were completed within one month. The preliminary planning period for the interview phase occurred over a six month period. Since the researcher was new to the area, and from another country, a network was set up by her to facilitate implementing the study. This network composed of experts in the field of the study's inquiry and rapport was developed with the researcher. These field experts served as a passport for gaining access to the groups for interview purposes. This rapport was essential, as Dean (1954, p. 233) stresses: "Field contacts want to be reassured that the research worker is a 'good guy', and can be trusted".

The root source of "theoretical sensitivity" was the researcher. With an earnest and rigorous effort, the researcher attempted to be as objective as possible and data-oriented by trying not to impose ideas or other theoretical perspectives to confound valid interpretations of the interviews. As Glaser (*ibid*, p. 3) states, the researcher has a "... mandate to remain open to what is actually happening". Bias of direction of responses, while almost negligible, was present in a few interviews, and this was acknowledged as far as possible since the interviewer cannot assume the perfect ideal of an Archimedian neutral-point.

The questions used by the researcher, in the role of interviewer, were carefully phrased to minimize 'emotion-laden responses' such as those that might be prompted by the introduction of the word 'cancer'. Although the study was concerned with early detection for cervical and breast cancer, questions were phrased so that this specific word, and its

associated connotations, were not introduced by the interviewer. As Quint, a nurse, as noted (1963, p. 88)

"... the subject of cancer and its human response is emotion-laden". Burns (1985, p. 3), another nurse, also supports this observation. "Even the word 'cancer' elicits an immediate emotional response, which seems to have no relationship to rational thinking". Thus, the onus of making associations between the respective HPP of cervical screening and BSE with cancer was upon the participants.

Reactions to the second and third questions in their connections with cancer verified Quint and Burn's statements as there was a tendency to avoid the word 'cancer' by some of the participants as reflected by the use of alienating language such as; 'it', 'that one', and 'the other'.

The interviewer, then held a neutral role by phrasing the study's reflective questions as follows:

1. What is the meaning of health for you?
2. What things do you do to protect your health?
3. Do you or your doctor/nurse/others initiate your appointment for a cervical smear?
4. What would you do if you were examining your breasts and found something different ... such as a lump?

Reactions to the first question concerning health reflects its general elusive and abstract nature alluded to in chapter 2. Initial responses tended to acknowledge the difficulty and breadth of defining the meaning of health. For example:

"It's such a broad subject".

"I've never really thought about it, take it for granted".

"It's just your every day living ...".

Health, overall was the natural, normal accepted state of human existence placed in the context of women's everyday lives. The question was designed in recognition of the need to examine women's meanings and concepts of health, that were not necessarily dependent on

compliance with medical recommendations, or the health care system. Acquiring these meanings for analysis follows Rubin's (1981, p. 97) statement that:

We must bring to the surface the latent meanings that may lie outside the immediate awareness of the person who speaks them. And it's our task, too, to develop some system of ordering those words into a conceptual frame that permits a broader and deeper understanding than already exists.

Overall, the responses to this leading question about health revealed that it was an experiential concept, not just an analytical construct. These responses, while diverse, had commonalities that will be discussed further in Chapter 5.

4.4 PROGRESSION OF INTERVIEWS

This section briefly describes the rationale that governed the sample-size. By employing the grounded theory two-pronged strategies of 'theoretical sampling' and 'constant comparative method' the researcher was led to interview four distinct groups of women. The initial group was planned and provided preliminary data which were analysed concurrently. This analysis led to the need for another group, as a 'unit of comparison' for checking out emergent grounded processes. This second group, was from a different suburban location within a common urban area.

This group also comprised women of a younger age-cohort and lower socio-economic status than the former, for reasons of comparison (Refer to Table No. 1). Following data analysis, another group was further indicated. The characteristic of this third group was its rural location, again for data-comparison and examining the factor of accessibility for health care.

Further cumulative data-analysis led to the fourth group for further data-gathering. The main thrust determining this data search was that of opportunistic 'cues' for screening evidenced by ante and post-natal checks. During these checks, the doctor routinely implemented cervical screening. A group of either single young women, or post-menopausal women was indicated then, to examine cervical screening without these specific cues. The former was selected, and while the latter was relevant for the study, especially in regard to

breast and cervical cancer statistics, it was beyond the realities of the research time-frame. The 'cue' to cease interviewing is that of 'theoretical saturation'. This grounded theory term indicates a plateau whereby no new insights are generated. On completion of the fourth group theoretical saturation was deemed to have been reached.

This chapter has covered the description of the data gathering process. Specifically, it has focused on the interview as the vehicle for data-gathering. The sample size has been discussed, followed by a description of the special procedure involved in implementing the study by interviewing. The interview-guide developed for regulating the flow of data has been described. Finally, the progress of interviews, as directed by the grounded theory strategies of 'theoretical sampling' and 'constant comparative analysis' has been described. The actual processual-components of these strategies, such as category-development are described in the next chapter.

CHAPTER 5

WORKING THE DATA

5.1 INTRODUCTION AND OVERVIEW

Reference in the previous chapters to the alternating cycle of data-collection and analysis, specifically the twin strategies of theoretical sampling and constant comparative analysis tend to make this chapter heading appear a misnomer. In practical terms collection and analysis are simultaneous, interdependent processes that defy rigid separation and sequential representation. The operationalization of these processes are both cyclical and iterative, for example, discoveries in one area can affect discoveries in another area. For the purposes of the thesis, however, such an artificial distinction and representation is made (with awareness of the above statements) in order to explicate the 'working of the data' (Glaser and Strauss, 1967, p. 3).

The rationale that governs this chapter is the result of the researcher's critical review of the 37 published articles concerning nursing and grounded theories which were located. Generally the articles reviewed were lacking in descriptions of the actual data-analysis. The reports tended to concentrate on the findings and conclusions with only (token), superficial coverage of analysis. This leaves readers to assess the findings based on the quality of the arguments presented rather than on the methodological processes which is characteristic of the grounded theory approach. The theory is not independent of the processes of generation. As Glaser and Strauss (1967, p. 5) indicate "... one canon for judging the usefulness of a theory is how it was generated ..."

This chapter then seeks to give an explicit didactic account of the data-analysis from a theoretical and substantive perspective covering the grounded theory processes of: coding, memoing, category and property-generation. From examining the links and relationships that are created in these processes, movement is made towards the development of a core-variable. This then leads on to the generation of the emergent theory, which is discussed in

depth in the following chapter. The process of property identification is described fully towards the end of the chapter.

5.2 CODING

Grounded theory is a systematic way of dealing with the non-standardized data derived from the interviews described in the previous chapter. This analysis starts at the outset of the first interview. Following this interview additional refined and relevant questions were added, expanding the data supply. These data were initially organised by the pragmatic step of "open coding". (Referred also to as "in-vivo" by Glaser). Basically this involved a survey of the contents and then breaking the in-vivo data into meaningful working units for a foundation of further analysis. These units of in-vivo data were then transcribed on to cards for the subsequent step of sorting as shown in Table 2 (overpage).

Concurrent with open coding is the complementary process of theoretical coding. Whilst open coding concerned conceptualizing the empirical data within the format of the transcript, theoretical coding extends this step by conceptualizing how the substantive codes relate to each other for tentative formulations that subsequently become integrated into the theory.

Together, these codes facilitate references for further more complex analysis. They are an essential starting place and as Glaser (1978, p. 16) stresses: "... no step in the process can be missed". In other words, there are no short cuts for the data analysis as each 'step' is contingent upon and impinges upon the other within both hierarchical and lateral dimensions. (An apparent contradiction here is that whilst Glaser insists his method is non-linear, he chooses the term "step" rather than "phase" which would be more in keeping with the cyclical nature of analysis). This process of coding occurs throughout the interviewing period with established incidents noted, adding only new incidents as they arise to the transcripts until 'theoretical saturation' is reached.

TABLE 2 **EXAMPLES OF CARDS FOR SORTING****FROM IN VIVO DATA**

2.2AB Very stressful situation so that when I started accepting home help.	2.2AE I think my health is so vital to the family.	2.2AH My new G.P. does and I've always - my children have been 2 years apart - proper intervals (regular PS).
2.2AG It's up to your family to help you.	2.2AF I do have the smear test done.	2.2AI (BSE) I probably do it about 2 months. I know you should do it about every month.
2.2AD Plunket stepped in. Thank goodness for home help.	2.2AG I think about the breast one ... am conscious of any sort of lumps and bumps.	2.2AJ Yes, sometimes they've been a bit tender and I've wondered if that was because of my cycle.
2.2S Try not to carry extra weight.	2.2V ... time away from total responsibility-	2.2Y Holidays away from children regularly - my husband and I - to maintain the relationship.
2.2T Health I'm conscious of it.	2.2W More conscious than the average mother of time away.	2.2Z Now, how I'm going to survive this 1. Keep your health. 2. Keep your fitness. 3. Keep your state of mind. 4. Treat yourself as person.
2.2U I work 6 months of the year.	2.2X And restoring yourself.	2.2AA Husband's health/ infection cycle.

5.3 MEMOING

The complementary process for coding is "memoing". Memoing is a device that highlights certain aspects of the data relevant to the study's purpose and is essential for subsequent generation and shaping of the theory. Glaser (1978, p. 83) describes memoing as follows:

... the core stage is the process of generating theory, the bedrock of theory generation, its true product is the writing of theoretical memos ... Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst whilst coding ... Memoing is a constant process that begins when first coding data ...

Thus memoing can be seen to selectively subsume the coding component. The emphasis on 'constant process' is stressed by Glaser as he states that memoing does not finish until completion of the writing up of the research. In practice memoing tends to peak with theoretical saturation. However, retrospective ideas, insights, or connections with the extant literature can be added at any stage. In this sense, memoing can be regarded as a source of secondary data for the study.

Glaser (ibid) encourages the researcher to also write whatever comes to mind, and this facilitates the mental process of free association, intuitive feelings or hunches, and use of abductive processes. These mental processes are difficult and at times elusive to describe. Glaser (ibid, p. 88) states in relation to memoing that:

... The fruitful paradox of constant memoing is that while they force selection, focus, delimitation, and emerging frameworks, they also continually keep the analyst open to new possibilities of research in related substantive and conceptual areas.

Experientially, memoing becomes an art as the researcher, immersed in the data quickly progresses from an initial novice stage to that of an expert. Memos themselves, on reflection, have the (innate) capacity to generate further memos. The art of memoing is facilitated by constantly re-reading the data and/or listening to the taped interviews and comparing each incident and "slice of data" (Glaser and Strauss, 1967, p. 65). This is in conjunction with flashes of insight that occur during or between the reading of the data. (See Table 3, 4)

The art is for the researcher to play second-fiddle, letting the data represent themselves. In this way ideas will confront the researcher rather than the researcher imposing ideas a priori upon the data in ventriloquist vein. Memoing notes were made recording recurrent themes such as "health orientation", "balancing", and others. As well, there were references corresponding to aspects of extant concepts such as "locus of control". The selection of these conceptual labels, as indicated from the data are arbitrary and are produced as the result of the researcher's sensitive analysis with the aim of representing conceptually what the corresponding data reflect empirically. As Stern (1980, p. 21) a nurse researcher states:

While ideational, memos are sparked by the data, and in this way they are grounded in the data ... memos contain the conceptual groundwork for generating the data.

In developing the theoretical substance of a concept several themes may emerge that are not definite parts of the concept but emphasise the conditions or dimensions within which it occurs. For example, the researcher's memo fund shows the concept of (self-relating) "intimacy/alienation" in relation to the thought and/or word "cancer", and this example is an antecedent condition of the health protective practice of BSE. Memoing crystalizes the explicit relationships, both manifest and latent, between emergent concepts and the related empirical incidents. As this process proceeds the memo's title or label undergoes refinement. For instance, whereas initially, with limited data during the first unit of comparison, "functional" e.g. mental, physical, spiritual and emotional health, was recorded for some aspects of the meaning of health, subsequent data-collection and analysis extended this label to become "health maintenance", orientation, e.g. "I look after"; "I take care"; "I do jogging regularly".

TABLE 3
EXAMPLE OF MEMOING
INTEGRATING EMERGENT THEMES

PROPOSITIONS

1. Women who tend to alienate parts of their bodies as shown by language use (or reflect this by description, 'it', 'that one' etc) also tend to exhibit ELC in relation to cervical screening, conversely other women relate intimately e.g. 'my pap smear' / 'I do that') tend to exhibit an ILC.
2. Women who display ILC in relation to general health issues may then exhibit ELC when having cervical smears and vice versa.
3. If a woman perceives the level of uncertainty as high, on finding suspect/a breast lump she will refer to the Dr. Most would refer to a Dr. if they suspected a lump.
4. Few women are dominant illness-oriented in their meaning/concept of health.
5. The majority of women initiate cervical smears. Doctors tend to do them only when A/N, IUD, thrush, O/C. Women are mostly passive partners during this procedure as ascertained from their descriptions.

<u>CODE</u>	P/S	=	Pap Smear
	ILC	=	Internal locus of control
	ELC	=	External locus of control
	A/N	=	Ante-natal
	IUD	=	Intrauterine device
	O/C	=	Oral Contraception

TABLE 4 **EXAMPLE OF MEMOING**

Categories/Themes Emerging from Datas

- Role in family - some look after 'self' to look after family - some put family first.
- Care-seeking behaviours - most watch diet, exercise etc.
- About 11% do breast self-examination, but most know about it.
- Meaning of Health was living life in balance guarding against health threats and knowing/pacing self/moderation of things - relative.
- Meaning of Health comprised of emotional/mental/spiritual and physical aspects. Most saw need for supportive network.
- Need for doctor to remind them when due pap smear - encourage pap smear/BSE. Most women initiate appointments (except during opportunistic screening - ante/post natal check).
- Orientation towards modern medicine - many partake in complementary health care for health-protective behaviour - chiropractor, naturopath, hypnotist.
- Most would refer to GP if found/suspected a lump (anxiety-reduction).
- Most emphasize need to 'talk out problems' - emphasize stress-reduction.
- Most view health as a commitment - active participators to maintain it.
- Most know, or know of, someone who has had cancer or benign lump of breast.
- Some equate health with well-being and awareness of what impinges on it and enhances it.
- Health - attitudes, values, beliefs transmitted to children and significant others.
- Mother/wife role as agent for health-socialization.
- Health - need to share/interact with others and natural environment to maintain.
- Awareness of family history.
- Need for space and time-out recognised for health.

5.4 SORTING

Concurrent with coding and memoing, as indicated, (refer Table 2) was the process of sorting cards with the transcribed data units. The rationale, from an experiential level, for sorting cards was that it facilitated moving across higher levels of abstraction in a data-based, 'hands-on' concrete fashion.

During the phases of joint data-collection and analysis, the data were systematically scanned for its relevance to the area of inquiry by the researcher. This onus for discernment of theoretically relevant data emphasizes the role of the researcher-as-instrument as she became the active sampler of the data. Using loosely, semi-structured interviews invites a harvest of data, some of which becomes redundant with the shaping of the emergent theory. Such data following the sorting phase were discarded as unassigned data for the purposes of the study. This process of discernment by the researcher became easier with experience as the study progressed. After each interview the researcher transcribed them for immediate scrutiny then for analysis comparing the content with previous data and in view of the shape and direction of the guiding analysis for theoretical relevance.

In this process of sorting, the researcher sets out to discover or identify a higher level of abstraction, that is higher than the data themselves, that can be recognised by an overall thematic label. Similarities and differences of data are sorted into gradually coherent configurations and the incidents recorded in the data are grouped under the emergent concept label. With some incidents there are similarities and overlap with other developing concept labels. Using the cards and sorting in conjunction with coding and memoing, assisted the researcher to develop categories, and the core variable by differentiation and abstraction. Glaser and Strauss (ibid) note that concepts emerge fairly quickly, particularly core concepts (Glaser, ibid) and that they are reversible if need be.

5.5 SELECTIVE CODING

While this process of sorting was important initially for category generation, it also involved a more refined process for the resultant the core-variable of 'vigilance-harmonizing'.

This process is referred to as 'selective coding' (which facilitates focusing by the researcher).

Glaser (1978, p. 61) describes this:

To selectively code for a core-variable, means that the analyst delimits his coding to only those variables that relate to the core-variable in sufficiently significant ways to be used in a parsimonious theory. The core-variable becomes a guide to further data-collection and theoretical sampling. The analyst looks for the conditions and consequences as they relate to the core process. Its analysis is guided by the core-variable. Selective coding significantly delimits his work from open-coding, while he sees his focus within the total context he developed during open-coding.

Focusing by use of selective coding for the core-variable does not mean that there are no other core-variables, it means that one is exploited to a higher level for theory generation. The identification of a core-variable is then subject to a process of what Glaser (ibid, p. 64) terms 'concept specification'. Glaser makes a point of differentiating this term from the more traditionally accepted term 'concept definition' set by Hempel(1952) because the concepts discovered using grounded theory remain in suspended animation, that is, the ongoing discovery of new incidents tend to modify a concept definition thus leaving room for subsequent adjustment as no item is regarded as static or irreversible. Hence, the study's core-variable that was initially labelled 'vigilance-balancing', was later modified to become 'vigilance-harmonizing', as it represented more fully the clusters of behaviour involved for the HPP by further clarification by new data and analysis. Such scope for modification is indicated by Glaser (ibid, p. 64) as "... changing the applicable distinctions and thus the concept's meanings ... as the theory emerges".

5.6 THEMATIC LABELLING

In preparing labels for the emergent concepts (i.e. categories and properties), the initial objective is to elicit a level of abstraction high enough to avoid devising a separate level for every incident or fact observed in the data, but at the same time striking the medium of being low enough to ensure that the emergent concept relates explicitly to the substantive phenomena under inquiry. Achieving such criteria as described for concept labelling requires discernment, diligence and tenacity as (at times), this is a time-consuming, tedious task. Confronted by the vast 'mountain' of accrued data cards, the researcher can be disheartened

by the seemingly insurmountable task of analysis, but the discoveries incurred compensate for the tedium.

When a label is insufficiently abstract or general, too few incidents will fall into that category. In such instances, the label merely re-phrases the data. To 'work', a conceptual label must occupy a higher level of abstraction than the incidents (i.e. facts and perceptions) it is intended to classify. If the concept is too abstract, however, too much information will fall in that category. For example, a concept card labelled 'health' or 'health behaviour' is so broad it might include all the data. Distinctions regarding forms and types of specific health behaviour, and the substance of the action would be overlooked. To develop a substantive theory relevant to health-protection practice, the researcher needs to devise such labels clearly relevant to that concept. This requires constant reviewing and revision of the data, particularly of the established categories. If, initially, the concept is too specific items may be into more general categories, (as shown in Table No. 5). If, on the other hand, the concept is too general it can be broken down into categories with more specific dimensions or aspects. Glaser and Strauss (ibid, p. 37) describe the process of refining the development of a category:

As they are emerging, their fullest possible generality and meaning are continually being developed and checked for relevance ...

The order in which concepts are defined or developed is arbitrary. The more useful concepts for categories will persist and the less useful ones will be discarded as the theory matures. Category development ceases with theoretical saturation, (as described in the previous chapter in relation to ceasing data-collection). Glaser and Strauss (ibid, p. 61) describe this phenomenon thus: "As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated". As well, a category is affirmed when it is congruent, consistent and pervasive when compared with the data pervading the substantive data.

TABLE 5
CATEGORIES SUBSUMED FOR

CORE-VARIABLE - VIGILANCE-HARMONIZING

VIGILANCE	HARMONIZING
Guarding behaviour for health	Health-as-coping
Visual + experiential vigilance for health	Health - keeping
Subsceptibility impinging on health	Health - as experience
Role of fear HPP	Health - as object
Insight & awareness HPP	Health-as-fluctuating-patterns
Fads in Health	Role-of-support for Health
Avoiding hazards for health	Role of stress
Women-as-having-specific health conditions	Health-as-everyday-living
Worrying for Health	Sickness-orientation
'Making sure' for health-protection practice	Health-as-capacity for resilience
Health-as-hygiene	The natural things (as resource for health - enhancement)
Role of age as affecting health health-perceptions	Health-as-sound-of-mind
Things within your control for health	Strategies for health
Things beyond your control for health	Choices for health care
Cancer as association with HPP	Role of Mother as Health Mentor
Selectivity & differentiating for health	Needs for health
	Beliefs/spiritual capacity for health
	Health as the art of balance
	Looking after as health maintenance
	Health as energy/life force
	Health as instrumental
	Role of "having things" for health
	Hedonistic view to health

- *Body image in relation to health
- *Time in relation to health (largest category.)
- *Illness episodes influencing concept of health
- *Doing things regularly for health
- *Mother as F/Health Manager
- *When 'something wrong'
- *Feelings - impinging on health
- *Relative capacity for health
- *Pacing self for health

- *Health as factor for transmission
- *Conforming for health
- *Comparing self with others
- *Health care seeking patterns

* These statements represent both vigilance and harmonizing.

5.7 CORE-VARIABLE

Establishing core-variables is critical for theory generation and their role is both to account for the variation in processes and to represent the substantive data. As Glaser and Strauss (1967, p. 37) intended:

... we believe that the generation of theory aims at achieving much diversity in emergent categories, synthesized at as many levels of conceptual and hypothetical generalization as possible. The synthesis provides readily apparent connections between data and lower and higher level conceptual abstractions of categories and properties.

The example that was given in Table 5 shows the range of variation among the categories, all of which are linked and then subsumed under the core-variable of vigilance-harmonizing which is described below.

Vigilance is reflected in the categories that signify a state of alert watchfulness. Examples of these are as follows: "Guarding behaviour for Health"; "Visual vigilance"; "Susceptibility"; "Insight and awareness"; "When something is wrong"; "Avoiding hazards"; "Keep a check"; "Choices for health care"; "Worrying for Health"; "Looking after"; "Making sure"; "Things within your control for health" and others as listed in the same table.

Harmonizing is reflected in the categories that keep the role of vigilance in check. It serves a balancing, compensating, stabilizing role, as well as reflecting clusters of harmonizing behaviours. Harmonizing is reflected from the categories as shown also in Table (No. 3). Examples of these categories are "Health as the art-of-balance"; "Health as coping"; "Health as everyday living"; "Health as the capacity for resilience"; "Health as soundness of mind"; "Relative capacity for health"; "The natural things ..."; "Strategies for health"; "Pacing self for health" and others. Examples of substantive data that reflect these categories are: "I try to cut down on smoking"; "I'm learning to pace myself - it's a whole slowing down"; "You need your own time out, a woman does"; "let nature's own thing do the healing"; "If I've had a heavy day

at work it's quite neat to go out for a run and forget everything"; "You can't expect to keep away from disease by just going on a course of vitamins, it's a life long thing".

Vigilance-harmonizing is likewise reflected in the substantive data. Examples from these are as follows:

Vigilance = "being aware" of any changes just in your normal way of functioning and Harmonizing = taking steps to rectify things".

"Consciously being aware (= vigilance) of stress-related illnesses and measures to counteract these (= harmonizing)".

"... and being aware (vigilance) of a normal or good state of health, and trying to maintain that through whatever way you can think of or is suggested to you". (= harmonizing).

"I've got to be careful as it lowers my body's resistance (vigilance), although I am building up an immunity (harmonizing)".

The viability of this core-variable from a grounded theory perspective lies in its capacity for usefulness, 'grab' and 'fit' with empirical reality. As Myrdal (1961, p. 273) states: "... concepts are spaces into which reality is fitted by analysis". This contrasts with the precise statistical measures of validity such as 'goodness of fit' in quantitative designs, although both share common ground in supplying evidence from the data. So, it can be said that grounded theory concepts are checked by congruency with the data for their viability. Actual 'proof' of validity in grounded theory, as with other qualitative research is confounded by what the philosophers of science have called the 'paradox of categorization' (Holsti, 1969). The concepts described in this chapter arose as a mediation between the emergent theory and the data from the researcher's intuitive and interpretive process, and this is hard to justify in objective terms. The paradox of categorization is a circular argument which basically questions the origin of concepts and verification by independent observation. However, Glaser and Strauss (ibid, p. 30) insist that:

... accurate evidence is not so crucial for generating theory ... not to provide a perfect description of an area, but to develop a theory that accounts for much of the relevant behaviour.

Next, property development will be described in depth with substantive examples highlighting how the data were 'worked'. The rationale for this description is that of practicality, there are only a few identified properties compared to categories.

5.8 EXPLICATION OF PROPERTIES

The properties have an important influence for operationalizing the core-variable. Properties are similar to indicators, latent at first, they manifest following hours and hours of systematic analysis. Once identified, they are checked for their viability and constancy with the subsequent data (as for category identification) derived from constant comparative analysis.

The specific properties that emerged for identification in this study are as listed:

- . Time - patterning and orientation (past, present, future)
- . Locus of Control (internal or external)
- . Valuing (relative)
- . Self-relating (intimacy or alienating)
- . Self-positioning (first or last in family for health needs)
- . Health-orientation (health-promotive, health-maintenance, health-protective, health-depletion)

These identified properties will be described in relation to the substantive data.

. Time - this pervades the data in two ways, linear and as a pattern. In the former a woman may have all, or some of these orientations toward HPP past, present and/or future.

'Past' Time-orientation is reflected thus:

(BSE) "No - I should, my mother has actually had a breast remove for cancer ... I did around the time my mother was in hospital ..."

(Cervical Screening) "No, he's (the doctor) put me off those ... well, the first one I had, I had to force them to have it. I was 20 years old and he didn't think I was old enough and then he 'clipped me'. It's put me off".

'Present' Time-orientation is depicted here:

"I don't hesitate if I'm worried, I'll go to the Doctor!"

"Oh, help I'd get it done straight away (BSE/Lump)".

"I don't have any qualms about Doctors. I would actually have myself dead within a week if I sat around thinking about it".

'Future' Time-orientation is reflected directly from the data thus:

"I used to think that the pill was marvellous, but thought it was better to be in control of things, I plan to have children later, 5 years or so, get everything cycling now. I'll have more chance later".

"I dread false-teeth, so I go the dentist every 6 months".

Time, as a property, also emerges as a "pattern-orientation". Such patterns identified from the data are as follows:

- Impulsive - "straight away"
- Delaying, deferring - "putting off", "hesitating"
- Not enough time to do BSE (time as a commodity)
- Time-out - "rest", "sleep"
- Anticipate "waiting for next appointment ... results".
- Reflect "I think about BSE ... lumps".

The descriptive role of time as a property will be followed up in the next chapter in relation to the theory.

. Locus of Control

The next property that surfaced was that of locus of control. This has significant input towards generating the theory. Putting locus of control in the study's perspective, it is one of many ways that help explain why some women adopt the health protective practice and others do not. Arakalian (1980, p. 25) has suggested that:

Locus of control is associated with mastery of health information, motivation, latent effective problem solving, sense of responsibility, desire for active participation in health care, and the ability to defer gratification.

From the literature, locus of control would appear to be a mediating factor rather than a casual one. Arakalian (ibid, p. 28) goes on to specify that locus of control a "stable personality factor that exists on a continuum, but can be modified through new experiences". The role of this property will also be taken up later in relation to the substantive theory explication.

Locus of control as a concept was originated by Rotter (1954) in his 'Social Learning Theory'. Rotter developed the theory and concept of locus of control to differentiate people who have a general expectancy that rewards are based on internal resources such as effort

from those who expect that rewards are externally related to things like luck, chance, fate or powerful others.

The substantive data concerning this property will be outlined. Basically the language used by participants tended towards a theme of control by showing their attributes of cause. The researcher found that this control exhibited by women was external or internal in locus. Substantive data that directly reflects the external property is shown here:

External Locus of Control

"It's just 'conditioning' from school, parents and community".

"I'm sure if there was more of a scare made of it, one would be conscious of it". (Cervical Cancer)

(Breast cancer) "What ever happens, we believe is meant to be".

(Cancer, BSE and Cervical Screening) "I find that I'm well catered for there as I've got a caring Doctor. So that has no concern for me".

(Cancer) "Also hereditary 'things' play a part".

(Cancer) "There are 'things' that you just can't control, something in your past ... so, therefore you have no control over it".

(Cancer) "I still believe in God's timing and his will, so I'm not really too worried about it".

(Breast Cancer) "I'm pretty lucky, I have a faith and believe in faith healing".

(Cancer) "The prevalent thing in the community is 'Oh well, there must be a pill to fix it".

(Health) "I've been lucky, I've never had anything".

(Health) "I don't really think of my health, just take it for granted".

(Health) "I'm very easily led by the health-food people".

Internal Locus of Control as a property is reflected in the following examples of the substantive data:

(Health) "I think a woman is responsible for her own health ...".

(Cervical Screening) "I used to think the Doctor was God, but now I ask the questions".

(Cervical Screening) "... I'll say right it's time, we'll go ahead ... yes you've got to do it".

(Cervical Screening) "I myself, I make up my mind to go and do it. He doesn't mention it actually".

(Cervical Screening) *"I think later I'll have to initiate it as I don't intend seeing the Doctor often now".*

(Health Protection) *"I think personally that, to a large extent you are responsible for your own health".*

(Health Protection) *"Especially when you've got an I.U.D. you like it to be checked to make sure it's not doing anything it's not supposed to do".*

(Health Protection) *"I learnt that natural method ... knowing your own body ...".*

. Valuing is a property pervading the substantive data. Valuing as a process can be seen as the interfacing of (personal) judgements with relevant values and beliefs. Valuing is a relative art of assigning priority, goals, ratings, beliefs, comparisons, views, preferences and importance placed on health and HPP.

The following examples given here reflect women's levels of assigning worth for health and the value of engaging in the HPP.

"I like having fresh vegetables, they feel good to eat, rather than just ordinary spuds, frozen vegetables ... I don't eat much meat now".

"Well, eat the right sort of foods ..."

"I've got to try and keep my health up, it's important and not let other aspects of women's health drop".

"I've never considered myself as healthy as other people".

"I am basically unhealthy - as far as my smoking and drinking goes".

"I always do BSE" (i.e. priority of importance in relation to other activities).

"I do believe in the cervical smear ..." (Valuing by beliefs)

"I must admit I have to force myself every 18 months to make that doctor's appointment because cancer is on the increase". (Valuing by belief in prevention)

"Yes, I have a pap smear every 6 months ... I'm aware of the importance for regular checks". (Valuing by placing time/importance)

"Oh, well, only when I've had my kids - I don't make a regular practice of cervical screening ..." (Valuing - not valued as a routine HPP)

"I realise the need for yearly smears and breast checks". (Valuing - HPP routine accepted)

"I have that ... I go myself. But what's interesting is that I presumed it was to be every 2 years ... when I went to have one done, 'no, every 3 years will do' the doctor said. And I went to have one and they didn't do it ... should you insist? I don't like having it done ... but I have it done". (Valuing - high valuing shown by interest in frequency and worth outweighing dislike of procedure)

Hubbard (1978, p. 31) states that: "*The real dilemma is the contest between the value assigned to competing activities which may be antagonistic to health*". This interpretation echoes also from the grounded data, as shown:

"... but you can't have physical health if you don't have emotional health ..."

"Sometimes I used to collapse because I would try to do a lot of things, but I didn't have my own outlet ..."

"Sometimes I think I'm my own worst enemy, that I have to do this and that, that really could be left and then I could do something for myself first".

"Exercise - I think people today can over do it".

"I don't enjoy sports because of my eyesight".

Valuing as with the other properties discussed, will be shown in relation to the theory in the next chapter.

Self-Relating

This was another property that emerged for identification. This property was in a sense "deductively" arrived at, from the language as well as from the inductive approach of using Grounded Theory. Basically, self-relating from the data refers to intimacy and alienation, or detaching one's self from one's body and/or parts. As well, it refers to the degree that one feels comfortable about using certain terms that they identified with such as: 'cancer', 'it', 'that one', or 'the other!'. It was interesting to note that when the researcher, on seeking clarification said "do you mean cancer?", this legitimized adoption of the word by the women. This same approach occurred in relation to mentioning specific body parts, some women felt comfortable introducing such terms as cervix and breast, whilst others described them also as 'it', 'they are', 'that one', 'the other'. Further grounded examples concerning cervical screening and BSE are provided below of the property of self relating, that is, intimacy and alienation:

TABLE 6
EXAMPLE OF PROPERTY SELF-RELATING
(INTIMACY/ALIENATION)

CERVICAL SCREENING AND BSE

INTIMACY

ALIENATION

"I like to go every two years to have a complete check-up when I have my cancer smear ... I do believe in the breast check for cancer also".
= Intimacy

"I do ... well, just to make sure I haven't got cancer".
= Intimacy

"Perhaps cervical cancer - there again that could be beyond your control also, but by going to your doctor and having checks ... because cancer is on the increase".
= Intimacy

"The hysterectomy thing in itself was strange for me".
= Alienation

I've just had one ... I go to my gynecologist every two years to have the I.U.D. checked ... but I like to go every 2 years and he does a smear and physical and all that type of thing. They've always come back negative - thank goodness".
= Alienation

"Yes, I get that done ... you're supposed to get that done every 2 years. Well, I've had that done when I had this one (referring to her child) ..."
= Alienation

This property of self-relating was a constant one, that again pervaded the substantive data. The implications of the role of this property again, will be shown in the next chapter. The next major property to be described is that of:

Self-Positioning

Self-positioning is essentially the place that women assign themselves in relation to health practices. That is, whether they put family members health needs first and their own last, or not at all, or put their health needs first. This property resembles the concept of "relational orientation" (Kluchohn and Strodtbeck 1961). This concept reflects how closely an individual is 'bound' to others, i.e. family. This commitment to respond to family first can interfere with a woman's ability to engage in the HPP. Examples of this property are as follows:

Self-first "I think, probably, very selfishly, although I think of myself - I've got a family and I do think about family, but initially, I would have to be selfish and think of myself".

"Mothers ... who is going to look after you if you're sick, so I look after my health".

"I think my health is so vital for the family".

"I think it's important that I look after and maintain my own health".

"... that means looking after yourself as a person".

"The first thing I would think of is myself".

Self-Last "So, whatever you do for yourself, it's fitting it in over and above what everyone else wants".

"I guess I don't do as much for myself as I would like to".

"It is hard, because you tend to put yourself last in the family really".

"Now, I'm feeling better in that respect because I'm getting more time to myself, I can consider myself a little bit more now".

"So health to me is my kids, I don't really think of myself".

"Sometimes ... I think I could do something for myself first, but I guess a lot of women put themselves in that situation".

"Well, the kids go to the dentist - I make sure".

"I probably take more notice of my kids health than my own".

"I've had my ration (sport when young) - it's hard to fit in my own sports".

The last property to be considered as an essential part towards the generated theory is that of health orientation.

Health Orientation

This property shares a similar derivation from analysis with time-orientation. It is the result of fine-tooth combed analyses that led to surfacing of a latent theme and, like time, presented as an identifiable pattern. Again, with constant comparative analysis, it was found to be all-pervasive. Health orientation comprises four distinct dimensions: health-promotive; health-maintenance; health-protective; and health-depletive.

The substantive data revealed that women with a dominant general health orientation of health-depletion, actually performed the most HPP and health-procedures. Women in the study had at least one of these dimensions. As well, it was found that health orientation, like time orientation, was not static having a shifting capacity as different dimensions were used towards the respective HPP of BSE and cervical screening. Women who had experienced health-depletion and introjected this as an orientation, tended to have a greater repertoire of other health-orientations.

The health orientation property then plays a key role in the theory. (The most salient property that emerged "body-perception", will be within the theoretical context of the next chapter.) Substantive data in relation to the differentiation by semantics is presented at this stage:

- Health-Promotive: *"... it's just a better feeling, I think in yourself that you are doing something in the right direction".*
- Health-Maintenance: *"Look after your teeth and you won't have any fillings".*
- Health-Protective: *(BSE) "Yes, I keep a fairly careful check ... because of cancer. I make sure that ..."*
- Health-Depletive: *(BSE) "Well, I had an experience with that sort of thing ... I had a lump ..."*

The health orientation property pervaded responses to the meanings of health and HPP. The former was regarded as a general health-orientation while the latter was HPP-specific. Again, holding a dominant general health-orientation was not an indication of an approach to the respective HPP. Whilst the four orientations are listed in sequence, they do not represent a scale of lower to higher order, the list is arbitrary and gives an evolutionary perspective on the theoretical notions of health orientation.

This chapter described the analysis in relation to generating a theory by 'working the data'. It has demonstrated the processes involved in establishing a core-variable. These processes, in summary, were: coding, memoing, sorting, selective coding, thematic labelling, development of categories and properties which combined led to the core-variable which

integrates these processes for viability and theoretical utility. The analysis presented in this chapter serves as the foundation for the theory described in the next chapter. The explication of processes used for analysis are essential for understanding the theory, and the interaction of categories, properties, and core-variable which impinge and operationalize the theory with respect to women's HPP. Extant theories will also be interwoven amongst the substantive theory in the next chapter as applicable.

CHAPTER 6

PART I

CONCEPTUAL ACCOUNT OF THE GROUNDED THEORY

6.1 INTRODUCTION AND OVERVIEW

This chapter integrates the (generated) theoretical processes that were described in the previous chapter. Salient features of the emergent theory, 'Paradoxes in Vigilance - Harmonizing for Women's Health-Protection Practices', are described within the format of an ongoing commentary that provides a conceptual account of the relationship between the core-variable and the properties, along with their respective dimensions. An advantage of this format lies in its capacity to enhance the "theory-as-process ... as an ever-developing entity ... rather than the theory-as-product". (Glaser and Strauss, *ibid*, p. 32).

The underpinning of all research is the theory which guides scientific inquiry and serves to produce explanatory and/or predictive statements about the phenomena under study. The cue for readiness in presenting a theory is suggested by Glaser and Strauss (*ibid*, pp. 224-225) as: "When the researcher is convinced that his conceptual framework forms a systematic theory, that it is a reasonably accurate statement of the matters studied ...". The current theory emerged following the exhaustive systematic analysis of a set of related concepts. The main role of the theory is to elaborate and to clarify these concepts as they relate to the area of inquiry.

The functional purpose of this substantive theory is to account for the phenomena within the area of inquiry, and to represent the individual grounded meanings of the health-protection practices. This theoretical account is presented in two parts. Part I gives a formal description of the theory which is complemented by a practical description that demonstrates the theory-as-process. Part II emphasizes the scope and utility of the "theory-in-use", by drawing on the theoretical processes of a retrospective breast cancer case-history. Demonstrating the theory's capacity for application is one criterion for a successful grounded theory:

... it must be sufficiently general to be applicable to a multitude of diverse situations within the substantive area, not just a specific situation.

(Glaser and Strauss; 1967, p. 237)

As shown in the previous chapters, the data reflected a mutual association between breast cancer and the 'substantive area' of BSE.

Parallels between extant theories and aspects of the theory that has been developed here will be drawn during the commentaries of both Part I and Part II. This is done not so much for a validation of the grounded theory, but rather as an explanation of the extent to which the different developments mutually inform each other.

6.2 THE THEORY

The central feature of the theory derives from the dynamic process of the core-variable - vigilance-harmonizing. Establishing the core-variable was critical as it is the core variable that underpins and integrates the theory so enabling it to "... differentiate and account for the variations in the problematic pattern of behaviour". (Glaser, *ibid*, pp. 96-97). Since vigilance-harmonizing arose from the data it is logical that the core-variable itself is also a dimension of the problematic area of inquiry and the main concern or problem for women in the study.

Grounded theory places an emphasis on the analysis by which personal meanings account for behavioural patterns. The behavioural patterns that vigilance-harmonizing represents and accounts for are those differentiated in the introductory chapter, restated here as:

1. Why some women adopt both the HPP of cervical screening and BSE?
2. Why some women adopt one of the HPP, but not the other HPP?
3. Why some women do not adopt either of the HPP?

The following situational determinants affected the theory: firstly, at least seven of the women participants had had hysterectomies. These women were not all sure whether they were still eligible for cervical screening, that is to say, they were unclear as to whether they had total or partial hysterectomies, whether their cervixes were still intact or not. The following example represents this confounding dimension to the study:

I've had a hysterectomy - I'm not sure ... the doctor never said I needed a smear ... I'm not sure if I need to ... I must ask him next time I see him.

As well, these women lacked the cue of menstruation for the optimal time to do BSE. Secondly, a few women were daughters, grand-daughters, or nieces of women who had had breast cancer, and thus constitute an 'at-risk' group since family history is generally recognised as an associated factor for breast cancer. The behavioural paradox that emerged was that this personal experience of knowing a close relative with breast cancer by these particular women corresponded with their action of not practicing BSE and indicating they would delay reporting a lump, though they were aware of their at risk status. Thirdly, the study revealed that many of the doctors tended to offer 'opportunistic' screening rather than systematic screening as a routine HPP. This meant that women were screened during the course of their ante and post-natal visits without plans for their next schedule of cervical screening. As a result of this phenomenon, the onus for screening tended, overall, to be accepted and initiated by the women. Fourthly, for a minority of women, conditioning by the experience of their first cervical screening appointment appeared a salient factor for continued practice. If women had found the initial screening unpleasant or painful they showed a reluctance to engage in systematic screening. Lastly, as indicated in Chapter 2, cervical screening and BSE involve different behavioural dynamics. For instance, screening generally involves a medical practitioner taking a cervical smear, whilst BSE involves the woman herself.

In this study a few women requested the medical practitioner or practice nurse to examine their breasts rather than doing it themselves, or to check and confirm that they were alright. With respect to BSE, less than a quarter of the women practiced this, confirming the findings (as presented in Chapter 3) of previous studies that this is not a universally accepted practice. The role of the theory, vigilance-harmonizing accommodates all these stated variations in behaviour.

6.2.1 VIGILANCE-HARMONIZING

The meanings of HPP for women culminates in the core-variable. Some women showed the dimensions of vigilance-harmonizing with of a 'hypo'-vigilance-harmonizing, or 'hyper'-vigilance-harmonizing. In practical terms, the former dimension of 'hypo-vigilance' refers to women who showed a tendency to avoid one or both of the HPP. Reasons for this range from fear-arousal, to lack of knowledge concerning the respective HPP:

BSE No! lump ... yes I would be scared ... because we are taught to be scared of cancer.

BSE No! I think I would scare myself silly doing that ... I think we all have a fear of cancer.

BSE I don't know how ... never been shown.

Cervical Screening No way ... the doctors put me off those ... he clipped me.

I've never had a smear ... it's just one of those things ... put off ... embarrassing.

BSE No I don't ... I don't know whether ...

I would be able to feel the lumps ... I haven't got a mania for having something wrong with me.

I have to psyche myself up for that (screening) appointment.

I have to force myself to go for a smear ... because cancer is on the increase.

The complementary dimension of the core-variable is 'hyper-vigilance-harmonizing'. This dimension represents a 'high' level of vigilance-harmonizing that manifests itself by a heightened state of alertness, arousal, and a searching for information concerning the HPP and their rationale. Hyper-vigilance harmonizing is reflected in the following examples from the data:

... you just watch and keep examining your breasts ...

... I have a pap-smear 6 monthly (i.e. greater than recommended frequency)

Well, I have my smears. I would have them more often ...

The core-variable qualifies as a 'basic social process' as it has "two or more stages" and refers to a "... social structure in process ..." (Glaser, *ibid*, p. 102). Vigilance and harmonizing represent two distinct stages as shown in the previous chapter. For presentational

consistency, however, the term core-variable is maintained while acknowledging this qualification.

Following this general introductory description the dynamic nature of the core-variable will be described. Vigilance-harmonizing is dependent upon the interaction with the properties as a mechanism or frame of reference used for approaching the HPP. These properties will be described with an emphasis on those that are designated as 'orientation properties' since they are the salient features for explicating the theory-as-process.

6.2.2 BODY PERCEPTION

This salient property also displays two main dimensions that were grounded distinctions. These dimensions are designated as 'interior' and 'exterior' body-perception. Body-perception then is an orientation-property that takes the form of two distinct ways of viewing the body, an interior or an exterior view. Together, this property with its two dimensions represent the emergent 'pre-behavioural' pattern of actualizing or motivating factor that results in either engaging, or not engaging in the specific HPP.

The first dimension to be considered is that of the interior dimension. This dimension demonstrates a perception that is guided by a dominant concern with the state of the inner body, for example these women who reflected this dimension tended to emphasize 'being' or 'feeling good inside', contrasting with women who held an exterior perception that manifested in statements that emphasized a concern for 'looking good ... looking healthy and fit'. Women who displayed an interior concern tended to be concerned about disease or non-disease status of their bodies. They also reflected this concern by qualifying their responses to the question concerning HPP with the respective cancers that they associated with them. This cancer related concern of interior body-perception toward approaching the HPP, serves as both a motivating factor and guiding frame of reference for engaging, or not engaging in the HPP, by exerting influences upon vigilance-harmonizing.

Next, the complementary dimension of this property is considered. Exterior body-perception as a dimension was reflected by the substantive data that showed a dominant concern with body-image as related to the HPP. Likewise, this image related concern also

serves as a motivating factor and guiding frame of reference for exerting influence impinging on the operationalization of vigilance-harmonizing for the HPP. Glaser (ibid, p. 31) states:

When the theory seems sufficiently grounded and developed, then we review the literature in the field and relate the theory to it through integration of ideas.

In this instance body-perception parallels the concept of body image as representing the 'somatic ego' (Norris, 1978); it is the frame of reference through which each person perceives herself.

This salient property of body-perception constitutes the grounded theory distinction of a 'typology'. According to Glaser (1978, p. 65) a typology may be; 'internal to a concept and take the forms of its dimensions ... they are grounded distinctions ...' In this study then, both 'interior' and 'exterior' quality are two distinctive dimensions within this typology that represent the two major patterns of perception affecting behaviour reflected by the majority of women who participated in the study. The few women who did not overtly express this property representing the above patterns can be described within two further additional categories. These categories are firstly a 'mixed', one that is a combination of both the interior and exterior dimension with either one being dominant. The second of these adjunct categories is that of 'idiosyncratic' whereby responses did not provide enough tacit cues either way to lead to classification within the overall typology. The significance of this typology is that it represents distinct patterns of perceptions that influence decision-making for HPP.

The theme of body-perception pervaded the data providing consistency and was found to be stable and constant. Specifically, in relation to the question concerning protecting your health, many described visiting the dentist and it was from these responses that the cue for this property emerged. In the case of the interior typology the given rationale by the respective women was for purposes of prevention and detection of early signs of decay and gum disease. Conversely, women who displayed an exterior typology tended to give a rationale that indicated overt concern that was cosmetic and body-image oriented. Examples of these women's exterior body-perception are demonstrated here, as taken from the data:

That's one thing I dread ... false teeth!

I know they can make false teeth but it would be knowing that they're not mine and I would have to pull them out!!

I go regularly, every six months to get them polished ... to have a nice smile.

... I go because I hate the thought of my teeth falling out ... ugly!

I would hate to have to wear glasses ...

This body image concern then translates for BSE as follows:

I think a lot of women are frightened ... their figure.

You feel very womanly with the breast and I think if you lost one you'd feel inadequate and disfigured!

BSE ... because I don't want a mastectomy.

I think the hardest thing for me, even if I did lose a breast would be to put the prosthesis in and fiddle with it more than the cancer. I'd rather go without.

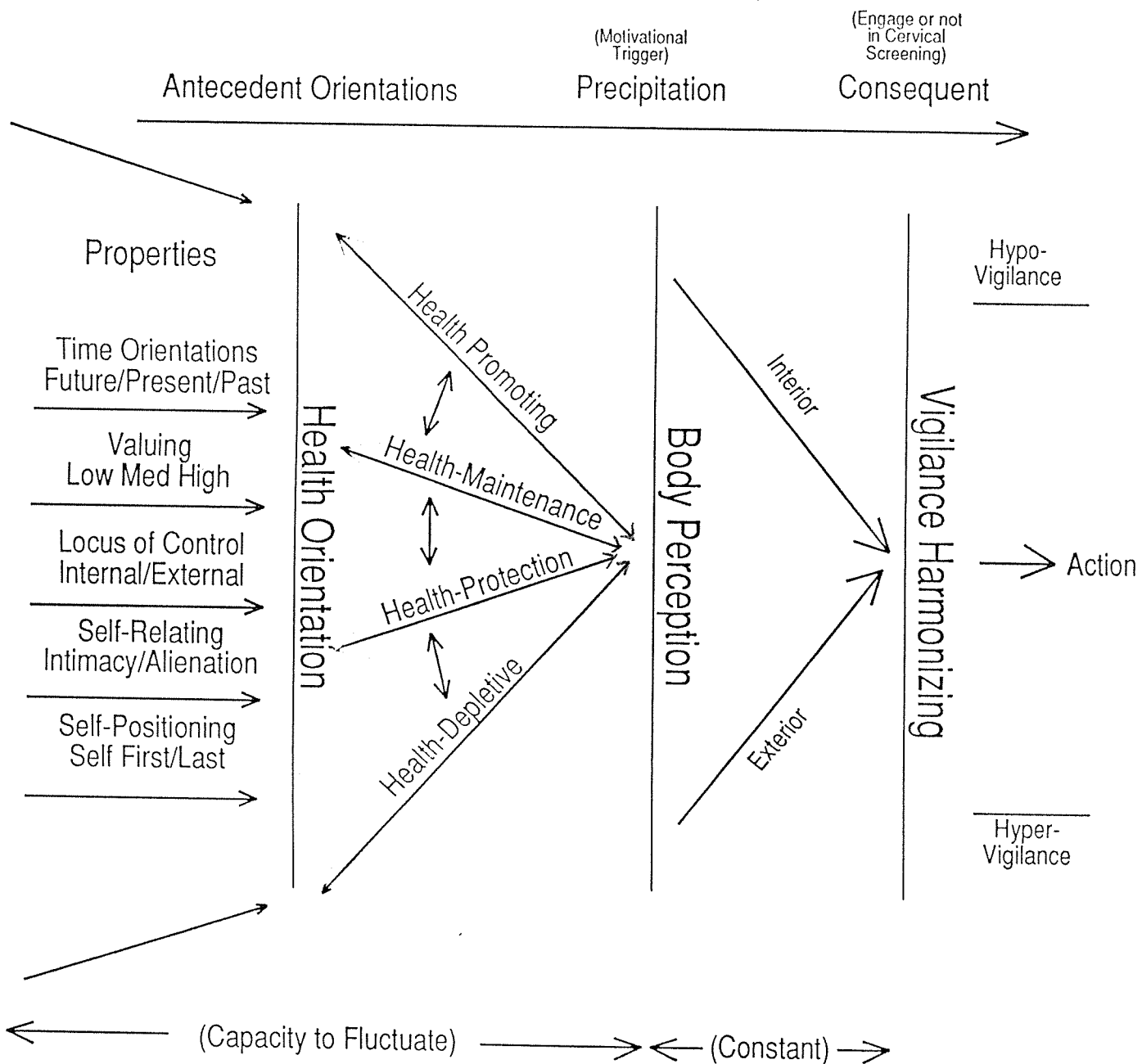
Think, losing a breast ... my husband would think I'm not a full woman.

In regard to cervical screening, the interior oriented women maintained a cancer-related association. Women with an exterior body-perception tended to describe the externality of the screening procedure and event. The women tended to describe whether it was painful, whether the speculum was cold or not, or embarrassing. As the cervix is not an obviously external organ, the external events replaced the direct body-image that was reflected with BSE in relation to the theory. Whilst the behavioural dynamics are different concerning the HPP of BSE and cervical screening, the theory accounts for this difference.

To summarise this discussion of the most salient property body-perception that actualizes vigilance-harmonizing by subsuming the other properties with their dimensions, Model 1 (overpage) is provided for explanatory purposes. Every conceptual model requires a cognitive construct - such as 'vigilance-harmonizing', around which to organise thinking and inquiry.

The model shows that both patterns of behavioural motivation - interior and exterior - achieve the same purpose - engaging or not engaging in the HPP, but from a different emphasis. Thus, while the meanings and perceptions from women differ or vary in their structuredness, they are able to engage in the HPP by influencing a different pattern of

Model:1 (Page:1987)
 Vigilance-Harmonizing for Cervical Screening and B.S.E.



dynamics between the other properties and their capacity for vigilance-harmonizing as an antecedent.

With respect to this theme of perception for actualizing vigilance-harmonizing, meaning and behaviour can be paralleled with the extant 'Perceptual Theory of Behaviour'. Perceptual theory draws from cognitive psychology and focuses on individuals and how they behave in response to meanings that they attach to situations, rather than the objective situations themselves, determining behaviour. Perceptions, then, have been equated with the personal meanings that govern or determine behaviour, such as, in this case, the engaging or not engaging in health-protection practices. Women are individuals with unique perceptions. Many factors can influence these perceptions, such as the properties that were identified in the previous chapter.

Another extant theory that relates to the substantive theory features of vigilance-harmonizing and body-perception is that of 'Decision Making theory'. With the decision making process there has been shown to be two distinct phases involved. Specifically, in relation to the substantive theory is the initial phase which involves adopting a decision frame. Tversky (1969, p. 35) describes decision frame as "... the decision maker's conception of acts, outcomes and contingencies associated with a particular choice". The particular frame adopted is critical for determining the subsequent phase, i.e. vigilance-harmonizing, in which alternatives such as engaging or not engaging in each respective HPP, and consideration of their specific purposes and rationale are assessed. This phase of an initial decision-frame is also similar to the theory's contingent property of health-orientations towards HPP. Whilst body-perception and health-orientations together as antecedents represent the stated aspects of perceptual field theory and decision-frame, the act of vigilance-harmonizing in HPP represents an empirical referent. Empirical referents are observable behaviours that demonstrate whether the concept has occurred. In the case of the concept vigilance-harmonizing the empirical referents are that HPP have been engaged in or not engaged in.

6.2.3 HEALTH ORIENTATION

The other salient property, health orientation that was mentioned in relation to the above extant theories will next be considered. This property also exerts a major influence and direction for vigilance-harmonizing. Health orientation will be described for its role in the theory since the previous chapter introduced it in conceptual and substantive terms. A health orientation is not fixed or universal. It consists of four distinctive patterns for appraising health and the respective HPP. These four patterns have a propensity to shift in approaching each HPP. That is to say, that a woman may hold a health protective dimension towards cervical screening and then adopt a health-maintenance dimension for BSE. This tendency to shift from one dimension of the health orientation mode to another is congruent with Beach and Mitchell's (1978) theoretical formulation for decision making that suggests a choice is made according to the characteristics of both the decision-maker and the specific task.

This capacity for shifting health orientation dimensions may be one way to account for some of the paradoxes concerning HPP presented in the data. The notion of paradox reflects a contradiction between stated views, beliefs, intentions and subsequent specific or related actions. An example of this is when one woman went to all the trouble to practice the natural rhythm method for contraception but declined to do BSE as she equated this with breast cancer and fate. So, for this woman protection from an unplanned pregnancy was important but doing BSE for early cancer detection was not, as she was fatalistic in this area. Such an example of a paradox is shown in Table 7 (overpage).

This capacity for 'shifting' health orientation dimensions draws a parallel with the extant theory of "Symbolic Interactionism" (Blumer, 1969). Briefly this theory conceptualizes the individual as comprised of several identities that take reciprocal turns of being manifest and latent. These identities are not fixed or immutable, rather, they are in flux, constantly displacing each other in response to changing situations and varying circumstances. This capacity for shifting health orientation dimensions assists in the theoretical account of the area of inquiry by giving an explanatory scheme for the empirical dissonance between intention and action that constitute the paradoxes in HPP.

TABLE 7**EXAMPLES OF PARADOXES IN WOMEN'S HEALTH****PROTECTION PRACTICES**

- i) Women with a family history of breast cancers, and thus considered as potential candidates also for breast cancer tended to be hypovigilant by not doing BSE and indicated that they would delay reporting a lump in their breast.
- ii) Women who do BSE indicate that they would, initially, delay in the reporting of finding a breast lump.
- iii) Women who displayed a dominant health-depletive orientation tended to engage in a greater number of general health-protection practices and a high uptake of the study's specific HPP.
- iv) Contrasting with the extant literature that equates health promotion-orientation with self-actualization and suggests people with this orientation tend to be more motivated in engaging in HPP this study did not support this popular contention (e.g. Laffrey, 1985; Smith 1978, p. 5).
- v) Many women received opportunistic cervical screening from doctors and initiated screening themselves rather than wait for an invitation by a doctor.
- vi) Numerous miscellaneous, paradoxes pervaded at the individual level concerning health protection in general. An example of this is from a woman who undertook the complex process of the natural method for contraception and yet did not do BSE because "if you're meant to get cancer, you're meant to ... I believe in faith healing".
- vii) Some women in their role as mothers and spouses ensure their family health needs to the detriment of their own. Other women look after their health needs first as they consider the family dependent on their healthy functioning.
- viii) An individual woman may have a repertoire of four distinct dimensions of health-orientation that have the capacity to 'shift' in relation to the HPP contrasting with extant literature.
- ix) Many women do not do BSE yet they engage in cervical screening (whether opportunistic or systematic) for cancer detection. The paradox here is that women have a far greater statistical potential for developing breast cancer than cervical cancer.

Grounded theory, a form of interpretive research-methodology, has its roots in the theoretical perspective of symbolic interactionism. A fundamental premise of symbolic interactionism is that persons construct meanings for phenomena based on their interpretations that they have with other people within a social context. Central to symbolic interaction theory is the concept of 'emergence'.

Emergence refers to a process whereby meanings are created through symbolic interaction. What is distinctive about the interactionist view of meaning is its stress on conscious interpretation. An event such as HPP has meaning for the woman at the point when she consciously thinks about or interprets the event. This process of handling meanings becomes an internal dialogue as Blumer, who first coined the term of symbolic interactionism states (ibid, p. 5):

The actor selects, checks, suspends, regroupes and transforms the meanings in light of the situation in which he is placed and the direction of his action.

In fact, this reflects one of Blumer's premises (ibid, p. 2) for symbolic interactionism:

... these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.

Vigilance-harmonizing is contingent upon this role of the health-orientation property. The same processes involved for body-perception in actualizing vigilance-harmonizing apply also with the health-orientation property. The latter property also has a guiding, steering influence which it exerts upon vigilance-harmonizing as an auxiliary force or 'back-up' to body-perception as it actualizes and operationalizes vigilance-harmonizing for the HPP. Health orientation is also contingent upon the interaction with the other identified properties and their dimensions and conditions as was shown in Model 1.

Other properties, viz.: locus of control, time-orientation, valuing, self-relating, self-positioning, affects both health-orientation and body-perception. For the empirical manifestation of the dimensions of these properties as they interact with the more salient property of health-orientation a process is set into action. This process operates like a series of interlocking processes in synchrony that together impact upon health-orientation and subsequently body-perception for activating vigilance-harmonizing. The function of these

interacting properties that impinge upon vigilance-harmonizing are illustrated next within a substantive context that emphasizes the theory-as-process.

EXAMPLE:

"Yes, I always ring up for that appointment. I have my smear every two years ... to make sure I haven't got cancer. They always come back negative - thank goodness".

Body perception

Concerning the HPP of cervical screening - the substantive criteria would place this response as an 'interior' typology since it conveys an emphasis on cancer-related behaviour.

Health orientation

The example illustrates a health-protective orientation by the substantive cue of 'make sure I haven't got cancer'. As well, the fact that this woman engages in screening 'every two years' reflects a health-maintenance capacity by the routine of screening. However, this is implied or inferred, the dominant language constitutes the substantive criteria for health-protection.

Locus of control

The locus represented in this example is classified as internality. This selection is decided and indicated by the data that emphasize self-initiated screening; "I always ring up ... I have my smear".

Time-orientation

This is described as future-oriented as reflected by; "every two years" which shows a planning component. As well time patterns of anticipation and regularity are reflected by "always come back negative" and "I always ring up".

Valuing

The example illustrates a high level of valuing screening as represented by the word 'always' which reflects a priority within the participant's scheme of living. As well, valuing i.e. appreciation of the rationale for screening is shown by "... they always seem to come back negative - thank goodness". This monitoring of results infers a level of valuing.

Self-relating

This is described as 'intimate' and is indicated by the words 'I', 'my cervical smear'. Together these words indicate by expression that the participant relates and acknowledges herself in relation to body parts and screening.

Self-positioning

Contrary to most of the married women who displayed the latter dimension, and the women who received opportunistic screening during ante/post-natal checks or secondary intention during a doctor's visit with appointments for children's sicknesses, this woman put herself first and practised systematic screening by making the appointment every two years.

Vigilance-harmonizing

The properties and their dimensions specifically shown in the example exert influence for actualizing vigilance-harmonizing in its 'normal' operant stage i.e. the example does not reflect the dimension of hypo or hyper-vigilance-harmonizing.

Specifically, it was operationalized by an 'internal' body-perception typology and 'health-protective' health-orientation. These salient properties in turn were then interacted upon by other properties and the influence of their specific dimensions. (Paradoxically, the interview from which this example is drawn showed a 'non-practice' of BSE). Vigilance-harmonizing was reflected by the participant engaging in cervical screening every two years and also by monitoring the results from her smears. The specific categories represented in this short example are those of 'making sure for health' and 'cancer as associated with HPP'.

This section has focused on the theoretical explanation within the framework of a discussion on the conceptual categories and properties. Since the core-variable represents a confluence of the categories it was the main focus for discussing the theory in relation to the properties. The notion of paradox was introduced in relation to engaging the variations for engaging in the HPP and the shifting nature of health orientations for dominance. The salient properties of body-perception which also earned the grounded distinction of a typology and health orientation were shown for their significant role in effecting vigilance-harmonizing. The remaining properties were then shown, by a substantive example to have an interacting role of

influence upon the salient properties and subsequently upon activating vigilance-harmonizing for HPP.

The theory has been presented to show its versatile role in accommodating the diverse meanings of the HPP given by the women participants and as an approximation to the substantive data. It is an account that seeks to explain the study's area of inquiry and shows the different pathways to engaging or not engaging in HPP. Vigilance-harmonizing appears as a pragmatic correlate for the health protection concept, with its dimensions of hypo and hyper-vigilance dimensions affecting the stabilizing aspect of harmonizing simultaneously in response to HPP. As outlined at the beginning of the chapter several extant theories are presented next prior to the discussion of a breast cancer case history in relation to the substantive theory.

While the conceptual properties used such as 'locus of control' and 'health orientation' arose naturally from the data the terms are already in use (e.g. Rotter 1954; Suchman 1966; Baumann 1961; Smith 1981; Laffrey 1986). Glaser and Strauss (1967, p. 6) acknowledge that such parallels will occur:

... the source of certain ideas, or even 'models' can come from sources other than the data. The biographies of scientists are replete with stories of ... seminal ideas ... garnered from sources outside the data ... no one is a tabula rasa ...

6.2.4 EXTANT VIGILANCE THEORIES

Grounded theory has the capacity to accommodate and transcend extant theories. This section presents a comparison of the substantive theory with related extant theoretical concepts, specifically, those concerning vigilance.

Mackworth (1959) is responsible for much of the research concerning vigilance in relating to monitoring tasks of which this study's concept of vigilance and health-protection practice is an example. Mackworth (Ibid, p. 389) defines his concept of the term 'vigilance' as follows:

... a state of readiness to detect and respond to certain specified small changes occurring in the environment at random intervals of time.

In the present study, 'environment' can be interpreted as representing the human body in relation to the self-monitoring tasks of the HPP of BSE and cervical smears.

Another theoretical perspective is provided by Janis and Mann (1977) concerning vigilance. These psychologists identified five basic patterns of coping with realistic threats. In this study, the latter would be presence of breast and cervical cancer. Vigilance is described by Janis and Mann (ibid) as constituting the fifth coping pattern: "...The decision-maker searches painstakingly for relevant information, assimilates it in an unbiased manner and appraises alternatives carefully before making a choice". This pattern, they conclude, generally leads to decisions of the best quality. This coping pattern is contingent upon the presence of the following three conditions:

1. Awareness of serious risks for whichever alternative is chosen (i.e. arousal of conflict) and (radiotherapy or mastectomy) for breast cancer.
2. Hope of finding a better alternative (e.g. lumpectomy rather than a mastectomy).
3. Belief that there is adequate time to search and deliberate before a decision is required (e.g. engaging in HPP and delay in reporting a lump).

Rogers (1975) another psychologist extends vigilance theory into his 'Protection Motivation Theory'. Briefly summarized, this theory predicts that people will be most likely to accept advice on how to protect themselves from a health threat when they can be convinced of the threat's seriousness and their susceptibility to it, as well as be persuaded that by following the recommended actions they will be able to control or avoid the health threat. The recommended actions in this study are the HPP of BSE and cervical screening. Combined, all three aspects of vigilance theory have been shown to have similarities with the substantive data and theory.

PART II

6.3 BREAST CANCER - A CASE HISTORY

This section discusses a case history that concerns a participant's account of her finding a breast lump and her subsequent referral for diagnosis. The participant describes the stages that she identified that led towards self-referral. The processes involved in this time prior to referral are examined in the immediate light of the substantive theory and the properties.

While there is no definite template for the presentation of a case-history, the organising scheme used here places emphasis on the theoretical (analytical) interpretive level to relate the substantive data to abstract theoretical considerations.

Firstly, the case-history revealed a consistent 'interior' body-perception. Secondly, consideration is given to the general health-orientation. The dominant orientation in the response to the meaning of health is health-promotive, as reflected here: "Meaning of health is being well ... being mentally happy". The emphasis on 'being' and the feeling state of being 'mentally happy' are examples of the study's substantive language of a health-promotive orientation. This participant, as with many others, displayed versatility in her repertoire of meanings for health. Thus, a health-maintenance orientation was also identified as a general health-orientation, although it was not dominant: "... looking after myself and family". This same phrase also indicates the property of self-positioning whereby the participant puts herself first and family last.

Secondly, in regard to the participant's response to the question "What things do you do to protect your health?" the dominant orientation is that of health protective. This is shown in the following excerpt.

There are all sorts of preventive things, well, diet is an obvious one, getting plenty of exercise, prevention, - health screening, - such as learning to do BSE the correct way - having regular cervical smears ... As well, this participant observed in relation to cervical smears, they all knew they had them but thought it was because they were on the pill - not because they were sexually active.

This reflects the conceptual gaps, paradoxical construing and deficiencies in imparting health-education measures.

This participant also displayed an initial dominant 'intimate' language in respect to the property of self-relating. This persistent language was post-mastectomy, which is significant since this language was present in the hypothetical question: "What do you think you would do if you noticed something different about your breasts, e.g. a lump?" and, while it cannot be generalized it does indicate the property's pervasiveness in a post-mastectomy account.

That then changes to an 'alienating' language which is shown by the following excerpt. Concerning BSE "... I am sure if people get to know their own geography, they're more likely to recognise something when it happens - and hopefully do something about it ..." Here, the use of 'people' presents 'woman'; 'geography' represents body and breasts; 'it' represents 'lump' that may be cancer related. The effect of this language is one of detachment and alienation, it also reflects a mind-body dichotomy congruent with the self-relating property, previously discussed.

This following section describes the phenomenon of finding a breast change: "Over the years I've been reasonably vigilant ..." This indicates that the participant has engaged in self-monitoring of her breasts. As well, it epitomizes the core-variable of vigilance-harmonizing, vigilant is qualified by the use of the word 'reasonable'. This qualification reflects the regulatory capacity of harmonizing by its moderating influence rather than being hyper-vigilant or hypo-vigilant. The participant then goes on to say:

... so myself when I found an irregularity in the shower I didn't relate it to myself - 'it couldn't happen to me'. I thought 'it couldn't be' and shrugged my shoulders, went to sleep and forgot about it. The next day it was still there and I did 'stew about it' for a couple of days before I did anything about it because I didn't want to think about it being 'related' to me ... and it was going to be a nuisance because I had all sorts of things planned and I did not have 'time' for anything like 'that'.

Here the participant reflects her use of vigilance 'found an irregularity'. Then the property of intimacy/alienation, body-relating, reflected in the objectification, 'I didn't relate it to myself' as well as 'an irregularity', with no mention of breast. This not being able to 'relate it to myself' again reflects a mind-body dichotomy as well as shock or disbelief. The paradox revealed here is that while the woman engaged in the HPP of BSE and was reasonably vigilant, when she did find a lump, she was unable to relate it to herself.

The theme of alienation continues and leads towards an initial stage of denial and rationalization - 'it couldn't happen to me ... I thought it couldn't be' and shrugged my shoulders went off to sleep and forgot about it. Here the use of 'happen' indicates a switch from internal to external locus of control as reflected by the phrase "happen to me". The participant's reality shock continues as she says:

The next day it was still there and I did 'stew' about it for a couple of days before I did anything about it because I didn't want to think about it being 'related' to me.

This theme of delay in reporting the 'irregularity' is consistent with the extant literature (Margarey 1977). While the inexorable fact of the 'irregularity' is confirmed by being 'still there'. The participant then qualifies her cognitive organizing scheme of her life as part of the reason for delaying.

... and it was going to be a 'nuisance' because I had all sorts of things planned and I did not have 'time' for anything like that.

This verifies Harris and Guten's (op.cit) contention regarding the 'compromises they reach while trying to balance health with other goals'. This 'time' was 'valued' highly. Here, the participant reflects her absorption with life and a future time-orientation 'planned', 'didn't have time'. Her 'lump' represented a 'time' problem by being a 'nuisance' factor. Being future time-oriented paradoxically made it difficult for the participant to adjust her world of reality to accommodate an immediate, present event. Again the paradox pervades since BSE is a longitudinal practice for detecting 'an irregularity' at an early stage for referral based on the assumption that early detection may have a more favourable outcome from measures of intervention. When the aim of BSE is realised the immediate result of recognition of potential warning signs of an 'irregularity' is shown by delay and hesitancy in self-referral paradoxically almost negates the purpose of BSE.

The participant then goes on to describe the events that progressed towards an admission of 'denial' in relation to the fact that the 'irregularity' was still there and the eventual choices that confronted her regarding the diagnostic outcome of her self-referral. The first step of her referral was a biopsy. During the waiting period of a week for the results the participant

juggled with the facts she had learned about 'lumps' in the breast. These facts are reflected here:

... I was a bit ambivalent about that because 9 out of 10 lumps are benign and I'd been to a seminar a few weeks ago where the figure one in fifteen was given for woman of my age group for breast cancer. I sort of ... I've never won a raffle or anything ... how could I be that one in fifteen? ... I was still denying it.

In this description of reactions following a biopsy and anticipation of the results, the participant shows how she juggled with the knowledge that she had about breast 'lumps'. The emphasis on 9 out of 10 lumps are benign, offers some reassurance and hope but this is then countered by '1 in 15 ... for breast cancer'. Here, the participant makes an acknowledgement of 'breast' and 'cancer'. This change or shift from an alienating approach to more intimate relating is transient and introduced in a formal capacity as she repeats what she heard at the seminar which appears to 'legitimize' her usage of the description 'breast cancer'. Thus, repeating the talk at the seminar serves still to detach the woman from reality of her situation.

The juggling with facts concerning breast lumps continues as the participant shows she has switched to an external locus of control again: "I sort of ... I've never won a raffle or anything ... how could I be that 1-in-15?..." Comparing herself with the statistical fact of 'one in fifteen' of women having breast cancer the participant appeals to fate and chance as reflected by the language 'never won a raffle ...' therefore she could not readily accept that she may be 'that one in fifteen', since statistically she had never been selected, implying luck, chance and fate. Following this juggling of the facts as they relate to her potential diagnosis the participant, in retrospect, observes and admits '... so I was still denying it'.

The results of the biopsy are then discussed.

It wasn't until I had a phone call a week later that the biopsy wasn't so good that the 'horror' of the fact that I was going to lose a breast dawned on me...yet I still felt 'it couldn't happen to me' until then ... quite traumatic. I was sad about it.

This description of events shows that the participant's reaction to the biopsy results was still influenced by an external locus of control. As well, the reality shock is still evident 'horror of the fact', 'traumatic' and 'couldn't happen to me'. This shock phase of denial gradually leads to acceptance and sensitization of the reality of her biopsy results ..."I was sad about it" which indicates the need to "lose a breast". Here, the participant associates with her body with intimacy.

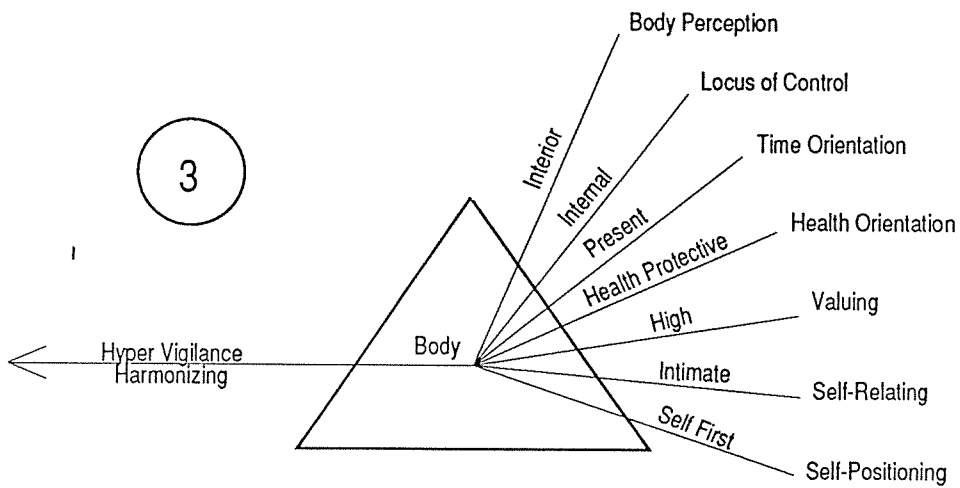
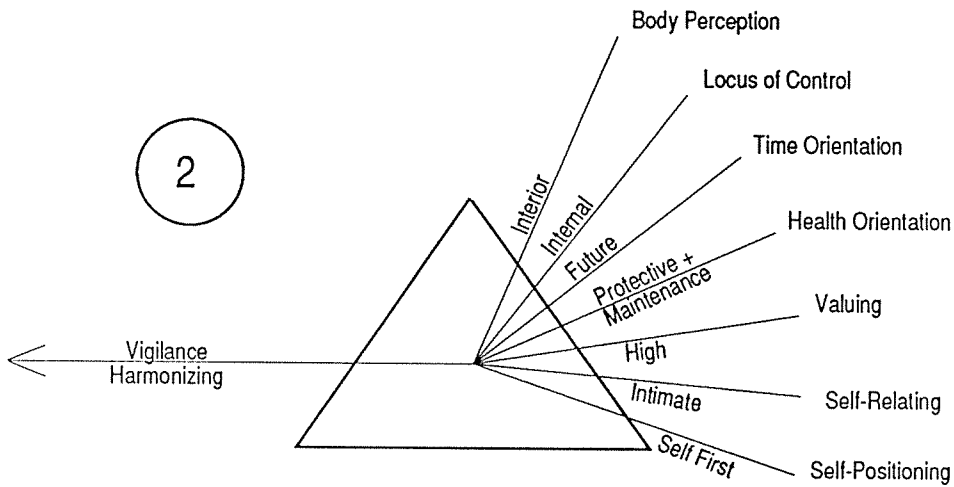
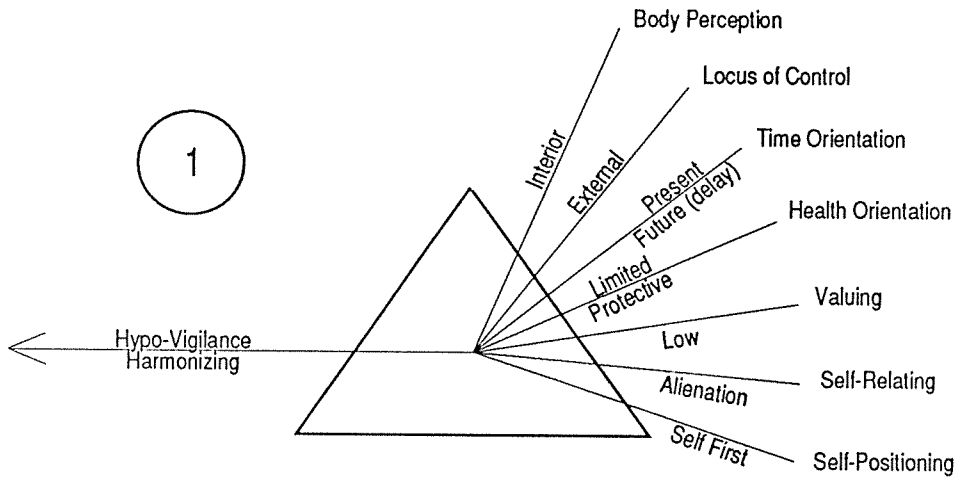
Following the phase of receiving the biopsy result the participant then describes the contingent phase of decision-making in response to the result.

I was given a choice. The surgeon said it was 'two tiny pieces', one was malignant - one was benign and that I'd probably be a good candidate for radiotherapy but that was my choice ... he went on to explain that if he did a mastectomy he'd take the glands out in case they were affected - whether or not they were - in case they were - whether it was the right decision or not - I felt I couldn't bear not knowing and that radiotherapy wouldn't be as final for me and I still feel like that - but someone else might feel differently about that.

Confronted by the choice of conservative treatment in the form of radiotherapy and the more aggressive treatment of radical mastectomy the participant chooses the latter. Within three days surgical intervention took place in the form of a radical mastectomy. This prompt decision-making consolidated by the respective action in a very short time-span reflects three main events. Firstly, locus of control fluctuates back to an internality mode as reflected by choosing. Secondly, time-orientation changes to a present-orientation and reflects a somewhat spontaneous, even impulsive attitude under the threat of malignancy. Thus while delay and defer/refer was the time-pattern prior to acceptance of the reality of 'finding an irregularity', once referral occurred and biopsy results were to hand, the concrete fact of malignancy presence resulted in time contracting and accelerating actions. Thirdly, this reflects a shift in vigilance-harmonizing, as influenced by the properties of 'present' time orientation, 'internal' locus of control', more intimate self-relating, self first, self-positioning, and high level of valuing, towards a hyper-vigilance-harmonizing level. This again contrasts to the initial phase of BSE reflecting a moderate or 'reasonable' level of vigilance-harmonizing and the subsequent phase on and after 'finding' the irregularity which resulted in a transient fluctuation of hypo-vigilance-harmonizing as already described. These operating factors in regard to the theory are shown in Model 2 (refer overpage).

The conclusion of this decision making process reflects the hyper-vigilance-harmonizing phase whereby the participant chooses the radical, if not extreme treatment rather than take the risk of the more conservative treatment in removing the malignancy and the potential that it may have disseminated systemically into the axillary glands. This decision was guided by uncertainty 'I felt I couldn't bear not knowing' and that 'radiotherapy would be less final for me'. Balancing the options for effective cancer eradication and using tolerating

Model:2 (Page:1987) Patterns of Vigilance-Harmonizing



strategies to cope with the decision making, such as anxiety or uncertainty reduction reflect vigilance-harmonizing as a theory in process.

The discussion progresses towards the conclusion of events as the participant considers the operation results and subsequent reactions to her operation of radical mastectomy:

Once confirmed by the biopsy I had my surgery on Monday and the results came back on Friday and there was no cancer in the glands as it happens and that was a relief. In hindsight it would have been okay to have the radiotherapy. I'm still not sorry - I don't regret that choice - that was my reason - cancer spreading.

Here, the participant reflects a more intimate self-relating as evidenced by 'my surgery ... no cancer'. The hyper-vigilance-harmonizing mode resulted in 'relief' when the glands biopsy result showed 'no cancer'. Retrospectively the participant realises and acknowledges the consequence of her choice of treatment. As it eventuated, the more conservative treatment would have been appropriate and effective since there was no axillary node involvement. However, consistent with her internal locus of control in hyper-vigilance-harmonizing the participant accepts the responsibility of her action: "... I don't regret that choice ... that was my reason". As well it indicates that a stage of conflict-resolution has occurred, ending the shock phase. However, a glimpse of external locus of control is still evidenced by the qualification "there was no cancer ... as it happens", referring again to chance/fate.

The adjustments following surgery are next described, and while exterior body-perception is evidenced, interior (i.e. cancer related) dominates:

I didn't worry about people staring at me - saying "she's only got one breast" only once did I think I'd have a post-op reconstruction but I was so sick after the anaesthetic I've sort of gone off that now. There's no plastic surgeon here to do it ... I don't feel strongly about it now - all the hassles. My one ambition was to get well enough to get back to work. I think I'm fairly lucky as I had a small bust, but someone with a bigger bust may feel lop-sided at first until used to it. The only things that have happened - I find when I do the garden and bend right over - it falls out of my bra! - my husband had to make some adjustments and when in hospital it was a shock but he was marvellous. When I had the biopsy the same day - the other lady with me - hers was O.K. I had to know but I didn't want to know if it was cancer - if benign - yes - otherwise it would be inconvenient.

This account firstly refers to the adjustments in body-image which reflects optimal level of adjustment. Self-consciousness was not a problem to contend with as evidenced by 'I didn't worry about people staring at me - saying "she's only got one breast" ... only once did I think

about post-op reconstruction'. Having a small bust, the participant considered was an advantage for wearing a prosthesis and facilitated its use (except when gardening). This also shows intimate body-relating and exterior body perception. The participant acknowledges the adjustments her husband 'had to make' but these are not specified. Next, the time this took was considered 'inconvenient' again. Finally, the participant repeats her earlier sense of ambivalence "I had to know but didn't want to know if it was cancer - if benign 'yes'". This ambivalence is characteristic with stages of coming to terms with reality such as in shock and bereavement (loss of breast) as was the stage of denial shown earlier. As well it confirms and reinforces the theory of 'the paradox of vigilance-harmonizing by women for health-protection practices'.

Summarising this breast cancer case history the following synoptic comments are made. The 'concrete' substantive data were matched and 'related' with 'theoretical abstraction' to the substantive 'theory'. This theoretical abstraction served to reinforce the utility and generalizability of the theory as it reflected paradoxes in vigilance-harmonizing towards finding an 'irregularity' by doing BSE over the years. The processes experienced by the participant are congruent with other participants interviewed in relating to the responses of the hypothetical question concerning reactions to finding an irregularity of the breasts. The study showed three different levels of vigilance-harmonizing the other two being hypo-vigilance-harmonizing and hyper-vigilance-harmonizing. This changeability reflects the dynamic nature of the theory both as a process and theory in use. Certain circumstances, such as finding an irregularity, can cause a new set of conditions which in turn influence the capacity of vigilance-harmonizing to lower and higher levels as the properties change in response to a perceived threat.

Corresponding with the shifts of levels of vigilance-harmonizing were the phases commonly associated with shock and bereavement (i.e. in this case loss of a breast). The shock that resulted from the discovery of detecting and registering an "irregularity" at the cognitive-affective dimensions shows the difficulty in mobilizing resources for immediate decision making in referral for subsequent diagnostic purposes. In this case, the actual delaying period was short - three days - however it does help to explain the processes involved

in delay, a common feature in women presenting at a later stage from initial recognition of an irregularity.

In a sense, this case history represents an application of the theory, 'paradoxes in vigilance-harmonizing for women's health protection practices'. Glaser and Strauss (ibid, p. 237) pointed out four inter-related properties of a grounded theory that are requisite for its successful application:

The first ... is that the theory must closely fit the substantive area in which it will be used. Secondly, it must be readily understandable by layman concerned with the area. Thirdly, it must be sufficiently general to be applicable to a multitude of diverse daily situations within the substantive area, not just a specific type of situation. Fourth, it must allow the user partial control over the structure and process of daily situations as they change through time.

The first and third criteria for application of theory were able to be demonstrated in this case history that was recorded during the interview or data gathering phase of the study. The remaining criteria await future research and development for application.

6.4 SUMMARY

The emergent theory was approached from three different 'vantage points', for purposes of 'putting the substantive theory into relief' (Glaser; ibid, p. 131). From the first vantage point, focus was placed upon the theory's integrative processes as an 'ever-developing entity'. Emphasis was placed on the function of the core-variable (which arose from the categories) vigilance-harmonizing and the interaction of the subsumed properties, especially the salient property of body-perception.

Body-perception was shown to be a generative mechanism for the processes involved for vigilance-harmonizing in HPP. Body-perception emerged as the motivating trigger giving impetus and shaping self-direction for vigilance-harmonizing. Vigilance-harmonizing represented the meaning ascribed to the HPP by women, which directs action related to the HPP. The second vantage point demonstrated the theory-as-process by describing how an example from the substantive data matches the theory. The third vantage point demonstrates the theory- in-use with a breast cancer case history. The rationale for inclusion of this case history lies in the fact that it shares the mutual substantive area of the study and that it shows

the different patterns of vigilance-harmonizing (i.e. hypo and hyper). Combined, all three vantage points contribute towards the criteria for a 'successful' grounded theory:

... it must fit the situation being researched and work when put into use. By 'fit' we mean that the categories must be readily applicable to and indicated by the data under study; by 'work' we mean that they must be meaningfully relevant to and be able to explain the behaviour under study.

(Glaser and Strauss; ibid, p. 3)

Emphasis on 'fit' and 'work' then are essential criteria for judging whether the theory presented in this chapter can be considered successfully grounded.

CHAPTER 7

IMPLICATIONS OF THE STUDY

7.1 INTRODUCTION AND OVERVIEW

This chapter draws together relevant aspects of the theory described in the previous chapter and discusses their implications for nursing in general, then specifically for nursing research, theory and practice.

7.1.1 IMPLICATIONS FOR NURSING IN GENERAL

The study places a health oriented emphasis upon individual women and HPP rather than on the respective diseases represented by the HPP. Traditionally, nurses have tended to view preventive behaviour from a disease perspective. Refocusing secondary prevention for cancer within a health protection perspective involves a subsequent shift within nursing's philosophical tenets. This shift in emphasis is congruent with nursing's goals since the professions' metaparadigm incorporates nursing transactions between women and health.

The study's health protection model of vigilance-harmonizing follows a new line of inquiry that attempts to build a conceptual framework based on the deep-rooted practice wisdom of the nursing profession. A wisdom that has sustained nursing's adherence to humanistic principles. The study's refocus on the guiding principles of nursing (i.e. defining meanings of health and HPP from individual women) entails upending the process of inquiry upon which nursing has traditionally been based. This process of inquiry is described by Doerr and Hutchins (1982, p. 299):

The key to our major strides in health care may no longer be the high cost, high technology of secondary and tertiary care, but in changing definitions of health and in interventions that occur much earlier in the natural history of disease. As these perspectives have evolved, there has been parallel development in the philosophical underpinnings of nursing, particularly related to the concepts of health and self-care.

The study then is epistemological since it highlights the most fundamental aspects of nursing's beliefs and critically examines nursing assumptions about why some women adopt the HPP and others do not.

Looking, from the women's perspective, at the HPP as part of nursing's practice repertoire is timely when superimposed on the morbidity and mortality statistics for cervical and breast cancers. The theory generated by this study represents the substantiated knowledge of women for subsequent interpretation by nurses to consider for incorporation within their practice. Nursing exists by a societal mandate with a commitment to provide care for individuals. This commitment involves examining nursing practice from the client's perspective in an attempt to prevent nursing becoming entropic, as advocated by Tinkle and Beaton (1983, p. 31):

If the concerns and perceptions of the recipients of nursing services are considered unimportant factors in nursing research, then nurses may indeed be providing nursing care that is more meaningful to themselves than to patients.

This study has demonstrated the value of ascertaining women's meanings as a basis for providing more 'meaningful' nursing care.

7.1.2 NURSING PRACTICE

As mentioned earlier, the thrust of nursing research is gathering momentum within the practice arena. Nevertheless the theoretical and research base for the literature in public health nursing remains underdeveloped with regard to emphasizing the importance of orienting health care to both the individual and the aggregate community. The study, with its theoretical account for HPP is an attempt to meet this need. By focusing first on where the client is in relation to the HPP, (i.e. the meanings HPP represent to them) subsequent transactions by the nurse to facilitate clients engaging in the HPP can then be planned more effectively with anticipatory guidance.

Planning nursing action in partnership with the client by individualizing communication in response to language style used by the client during assessment has the potential for making nursing transactions more congruent for the clients' action (thus reducing the

dissonance between clients' interpretation of the HPP and subsequent action referred to by Laffrey (1985) in Chapter 2). Smitherman (1981, p. 4) observes that:

It is through the use of therapeutic individualised communication that a nurse has the greatest potential for influencing the health and well-being of clients.

The nursing assessment is dependent on the nurses' eliciting data for cognitive and analytical review of the inventory of data and cues provided by the clients. These data are then systematically sorted, labelled and condensed within a recognizable, emergent pattern of relating and behaviour that can be understood specifically in relation to a client's capacity for vigilance-harmonizing leading to subsequent nursing intervention and planning for promoting the HPP. In a sense then nursing assessment is a process of value-clarification with the client and can include an identification of the factors involved for the mechanism of vigilance-harmonizing concerning the HPP. Stern (1980, p. 200) draws a parallel between the nursing process and grounded theory as follows;

Grounded theory research methodology and the process of nursing are intrinsically linked ... The nursing process ... occurs in a natural rather than a controlled setting ... and involves a constant comparison of collected and coded data, hypothesis generation, use of the literature as data, and collection of additional data to verify or reject hypotheses.

Implicit in the health education function of the nurse is the agenda for facilitating the client to effect her own personal health care needs (such as the HPP). Using the conceptual model of vigilance-harmonizing as a strategy for use during the assessment phase can help to locate where the client is in relation to this construct in order to assist her in mobilizing her own resources towards engaging in the HPP.

To use the nursing process successfully in the area of health education, nurses have to accurately assess the meanings which HPP have for clients to enable them to anticipate the context of language usage to match the clients. Intervention in the form of health education strategies can then be devised from this initial nursing assessment that is congruent with the client's perspective. The essence of the particular health-education strategy indicated by the theory lies in letting the clients speak the words first. Then the nurse can use these words for a theoretical scaffold, building upon them with new strategies devised for matching the words. Eliciting the language within the theory's framework, from the client first for subsequent

implementation of a nursing strategy finds congruence with Cox's (1984, p. 173) observation that:

Searching for clusters of both client and contextual factors in advance that influence the client's adoption of a course of action will help providers use of implementation such as a nursing care plan to promote a client engaging in a risk-reduction approach that is consistent with public health philosophy.

New and more congruent health education messages could be devised that match specifically the expressed properties of vigilance-harmonizing by the client. The main properties involved would be those of health orientation and body-perception with the other properties still being pertinent.

The aim of health education has been defined as helping people to achieve health by their own actions and efforts (Gatherer, 1979) as well Jaccard (1975, p. 152) states that:

Health education, or at least aspects of it, may thus be construed as the study of those factors that influence an individual's behaviour i.e. his health-related actions.

Following the explication of these properties in the previous chapter within a substantive context, tentative health education messages formulated from the substantive data will be discussed. The theory of vigilance-harmonizing presents a theoretical and conceptual analysis of selected properties (or variables) related to HPP and delineates methodological issues relevant to the study of HPP.

Once the dominant dimension of the typology body-image perception has been elicited, (i.e. exterior or interior) messages can be made that reinforce and accentuate this dimension. This formulation could also take the form of a picture for instance that highlights an 'exterior-oriented' woman with visual descriptions of the steps involved in taking a cervical smear and BSE. Alternately, an interior-oriented woman may (on testing) respond more to written descriptions of interior bodily concerns and status (e.g. normal feature of breasts, early signs, symptoms of potential disease).

Health orientation also can be used to design more effective health education strategies. Four distinct patterns of health orientation emerged from the data that are dynamic and capable of shifting in relation to each specific HPP. For this reason, the educational

message would necessitate a multi-dimensional approach incorporating all of these patterns. A tentative example is given as follows:

- Health-promotive Be healthy and feel good -
have your cervical smear
- Health-maintenance Look after your breasts
Keeping a check on cervical
smears
- Health-protective Make sure you have a cervical
smear/breast checks
- Health-depletive Feeling susceptible to breast
cancer - then check your
breasts and/or go to the
doctor and get them
examined regularly.
Prevent unnecessary sickness
have a cervical smear
regularly.

Further exploration may show that language that represents the other properties (for instance 'self first/last' - when taking your child to the doctor ask for a cervical smear at the same time) may also provide useful cues for design of health education messages which will reach their target. As well as this aspect of health education messages the data shows a need for reinforcement of having a cervical smear, many women indicated that they did not know what the result was. Some stated that the doctor would notify them only if their smear was abnormal. However, knowing, in concrete terms the result, if it is negative can bring peace of mind to the woman as well as reinforce her systematic practice of engaging in cervical screening. Nurses could liaise with doctors to make clients conversant with their results, otherwise it can be construed that a positive smear is the doctor's reward rather than a negative smear being an incentive or 'reward' for the screened woman.

Overall the study's implications for nursing practice involve taking time with the client during the assessment phase. This step will enable the nurse to gain more understanding of the client for promoting the HPP more effectively. Paradoxes that emerge from the clients' responses within a total health protection context in relation to the HPP may be resolved with appropriate counselling. The 'non-compliant' client (Trotta, 1980) referred to in Chapter 2 may be the result of ineffective nursing interactions for HPP. Glitterman (1983, p. 127) supports this view:

Labelling a client's behaviour as 'resistance' often enables workers to avoid confronting deficiencies in their agencies or themselves.

With further development of health education strategies the nurse when confronted with a woman who does not overtly respond to engaging in the HPP may be able to use a repertoire of strategies designed to increase the likelihood for uptake of HPP by individual women. The study, in relation to nursing practice and the HPP has substantiated Weisensee's contention (op cit) that: *perception and interpretation are as influential on health as the presence or absence of pathology.*

Limitations of the study as they affect nursing practice are as listed:

- i) Women over 40 years (and post-menopausal women) were not represented.
- ii) Theoretical sampling did not represent Maori or Pacific Islander women.
- iii) 15% of the women in the study's population had had hysterectomies, thus affecting optimal responses concerning cervical screening (some of these women did not know if they still had a cervix or not).

7.1.3 NURSING THEORY

Introduction of the concept of health protection served as a guiding framework for the study. Using existing concepts is in line with the grounded theory approach, as Glaser and Strauss (ibid, p. 45) indicate, the researcher utilises only a general orientation for highlighting the "*... principal or gross features of the structure and processes in the situations that he will study*". The interpreted meanings given by women for health and health-protection resulted in the emergent core-variable of vigilance-harmonizing that led to the subsequent grounded theory.

Vigilance-harmonizing involves a complex interacting process of properties. Combined, these properties and their dimensions show that vigilance-harmonizing is the frame of reference that directs women in the choice-point for engaging in the HPP. The critical operationalization factor for activating this frame of reference for HPP was identified as the property/typology of body-perception. This factor subsumes the other relevant properties for

action. This action equates with the extant health protective concept espoused by Harris and Guten (ibid) and represents a simultaneous, synergistic expression of vigilance and harmonizing. Women's patterns of vigilance-harmonizing represent a stabilizing tendency directed towards reducing an individual's appraised susceptibility of encountering cervical and breast cancer. As such, the emergent theory can be construed as a paradigm for explaining health protection practice at the level of identifying the processes involved (i.e. not predictive).

The value of this theory lies in the ability it has to 'fit' and 'work' in practice by the explication of these processes as a guide for nursing encounters with clients as discussed in the previous section. As a practice profession serving society nursing needs to develop knowledge that is required for its specific function in society. New knowledge for nursing's theoretical orientation arrives from the generation of research which is accretive in nature. That is to say, new knowledge develops from previous work since, as indicated, most studies, including this, rest on some assumptions accepted as a priori for the area of inquiry, in this case, health and health protection.

Vigilance-harmonizing has relevance for nurses in their health care endeavours as it extends nursing's knowledge base. Bilitski (1981, p. 20) notes that: "... *nursing is concerned with all variables affecting health behaviour and ways to facilitate client's health*". As well, Antonovsky (1976 p. 75) suggests that "... anxiety, knowledge about personal experience with cancer ... are intervening variables that may affect health actions". The theory identified the properties influencing HPP. These properties can be equated with variables that affect health behaviour (such as locus of control and others discussed in Chapters 5 and 6). The theory accounts for the patterns of variance and paradoxes in women concerning HPP. For instance, associations by women with experience of relatives with breast cancer, tended not to engage in BSE and indicated that they would delay reporting suspicious breast lumps. This finding is consistent with Antonovsky's suggestion.

The concept of health is evolving over time. Currently, from a nursing perspective Ellis (op. cit.) has referred to the 'conceptual vacuum' and lack of 'empirical referents' for this concept. Vigilance-harmonizing represents both health as a concept and health as a practice explicating the needed empirical referents. As a concept it is in flux, having the propensity to

shift according to specific HPP and experience. Viewing this theory upon nursing's theoretical landscape, the nearest approximation that could be made is that between the health orientation and its dimensions and Smith's (op.cit.) 'Idea of Health' which also comprises of four distinct views of health. Of these four views of health that Smith summarised from the literature, the 'eudiamonistic' view corresponds with the theory's health-promotive orientation. However, the major difference is that Smith's view of health is more along the lines of a continuum mode with 'fixed' models whereas the present theory is represented as more fluid, holistic and dynamic.

Each property identified in the theory has significance for nursing theory. For instance, the property of time-orientation arose from the meanings given by women. The inclusion of this salient property is significant for nursing theory according to Ellis (ibid) and Stevens (1984, p. 280). Stevens states that the *"key to nursing rests in the concept of time ... it must be significant in nursing theory"*. The scope and utility of this theoretical component, as with other aspects of the theory lies in the application for nursing practice.

The theory then shows a multivariate determination involved for HPP. Since the inception of this study Lau, Hartman and Ware (1986, p. 43) have found that both 'non health related' and 'health related variables' may interact in a complex mode to determine health behaviour. The theory includes such items that could be classified as seemingly 'non health related' such as the properties of valuing, self-relational, self-positioning, locus of control, and time-orientation.

The model in entirety casts a view that moves away from the traditional, static, causal linear relationships (e.g. health belief model) towards a more fluid field of interacting, multi-dimensional factors for explaining HPP. It is one small but significant extension for nursing's theoretical base. It can complement other nursing theories concerning health behaviour. It may play a part in a system of nursing theory development adding important insights from a new vantage point for the overall conceptual development of nursing practice.

Many theories ignore meaning completely, and others place it in the general subordinate category of 'antecedent factors'. This grounded theory, rooted in symbolic interactionism, places meaning within a central focus for the individual processes affecting HPP by its stress on conscious interpretation by women.

7.1.4 NURSING RESEARCH

The ultimate aim of research for nursing practice is improvement in the quality and relevance of care with clients. Data expand and clarify the knowledge base which, in turn, is applied in practice for the benefit of clients. This aim for research endeavours is reflected in the New Zealand Nurses' Association Social Policy Statement (ibid, p. 9):

Effective nursing practice is dependent on a broad knowledge base. Nursing knowledge is derived from ... the substantiated knowledge of nursing itself. Conceptual models unique to nursing develop from this base, from research arising from nursing practice.

The study's area of inquiry arose from nursing practice. The conceptual model generated by the study makes a contribution to nursing knowledge. A conceptual model is a construct that makes knowledge coherent explicit. Engel (1977, p. 29) states that:

... broadly defined, a model is nothing more than a belief system, utilized to explain natural phenomena, to make sense out of what is puzzling.

The conceptual model, vigilance-harmonizing, derived from the puzzling question of why some women undertake the HPP and others do not. Thus, there is an interactive flowing process from practice to reality-based research translated back again into practice.

Another implication for nursing research lies in the potential it offers for generating further research. As stated, the theory is an 'ever-developing entity' and as such offers scope for extension and modification. Further qualitative research could be undertaken for language use in order to formulate more specific health education messages concerning the specific HPP. A complementary study is indicated whereby nurses and doctors are subject to interviewing concerning their meanings of the HPP, especially since the data showed that some doctors are not, overtly, recommending systematic cervical screening and many of the women participants initiated their own screening appointment. As well the data that mentioned 'nurses', by content analysis, revealed that reference to nurses in respect to the associations with the HPP were very conspicuous by their absence. This confirms the need for nurses to relook at their mandate for education in cancer prevention with clients.

A substantive theory has an innate capacity for subsequent refinement and extension into a 'formal' grounded theory:

Substantive theories have important general implications and relevance, and become almost automatically a springboard or stepping stone to the development of a grounded formal theory.

(Glaser and Strauss, ibid, p. 79)

This theory could be developed for a formal theory status. The explanatory proposition concerning the process of vigilance-harmonizing could be further researched and even tested to enhance the theory's utility, since Glaser (ibid, p. 157) goes on to elaborate:

An applied use for grounded theory exists, especially one based on a basic social process. This is based on the fact that it is not generalized to other populations but generalized to the basic social processes that underlie the issues and problems of diverse substantive areas.

The rationale and utility for developing this theory into a formal theory would be the potential it has for extending nursing knowledge specific to nursing practice aspects of assessing, negotiating, educating and counselling women in regard to the HPP.

Other forms of qualitative research could also extend from the 'springboard' that this theory presents. For example, an ethnographic study could adjust the theory's focus on to cross-cultural comparisons for the representiveness and generalizability. (However, it must be emphasised that whilst the study did not involve a cultural contrast, this is not a limitation of the study since the nature of theoretical sampling - as explained in Chapter 4 deems such a limitation redundant and as Glaser (op. cit) emphasizes it is '... not generalised to other populations but to the basic social processes ...' Another approach that could be taken is that of a phenomenological study. This approach could extract added information concerning the meanings of the HPP.

7.2 SUMMARY

This chapter has reviewed the salient emergent issues from the study. Specifically this review has highlighted the implications of the theory as they translate for potential impact upon the nursing domains of practice, theory and research. Emphasis was placed on considering the theory as an applied grounded theory for practice. The specific implication for nursing

practice concerned the areas of the nursing assessment phase of the nursing process. Showing the scope and utility of the theory for nurses with an emphasis on tailoring their transactions to suit individual clients. Nurses, relooking at their assessments with clients using the cues alluded to concerning language can 'plot' where the client is with respect to vigilance-harmonizing and then adapt their health education messages to match this for congruence and subsequent planning if indicated to guide the client towards engaging in the HPP. More research is indicated for refining and designing health education messages and strategies for use by nurses in practice concerning their promotion of the HPP. The theoretical relevance of the study was then considered. Acquiring the meaning of health and health protection were considered for their implications upon nursing's theoretical orientation. Vigilance-harmonizing sheds light on the variables involved for women's HPP and thus extends nursing's theoretical base (and simultaneously nursing knowledge). The theory's basic social process (shown in Chapter 6 by the case history) is generalizable for other aspects within the substantive area.

CHAPTER 8

CONCLUSION

8.1 OVERVIEW

This final chapter summarizes the significant phases and features of the study. Tracing the events from the origin and purpose of the study to the emergent issues, the following areas are covered: area of inquiry; data-generation which focuses on the study sample and aspects of the interview; data analysis; the emergent theory; and implications arising from the study for nursing.

8.2 REFLECTIONS ON THE ORIGINS OF THE STUDY

The study began by noting that measures for promoting the health-protective practices of cervical screening and breast self-examination for early detection and referral purposes need to be developed and instituted (Rose, 1978; Skegg, 1985). These measures assume urgency when placed against the current morbidity and mortality statistics for New Zealand women from cancers of the cervix and breast, and a predicted cervical cancer epidemic for the younger age-cohort groups in the absence of a systematic cervical screening programme. The relevance and associated meanings that women hold towards these HPP needed to be considered if appropriate and optimally effective promotive measures are to be devised.

Conscious of the pressing need to develop such promoting measures, this study, with its qualitative approach is timely since it offers just such insight into meanings women give to specific HPPs. The approach that was adopted to access these meanings was that of grounded theory. Summarising this approach, grounded theory is a perspective on both data and theory. It contends that there is much value in the conceptualizing and organising of research data into a body of theory.

The empirical trigger that led the researcher to pursue this area of inquiry was a puzzling situation whereby many women did not engage in these specific HPP. Through an extensive review of the related literature this empirical need was also affirmed.

The review revealed mainly quantitative studies. These studies displayed replication with a limitation of scope for providing a sufficient account of the factors involved for the adoption of the HPP by women. This review underlined the need for more indepth study by qualitative and complementary research for the purposes of explanation and clarification in this area.

8.3 PURPOSE OF THE STUDY

The stated purpose of the study was to gain an understanding into the meanings that the specifically described health protection practices of cervical screening and breast self-examination hold for women. The specific purpose of the study translated into four main questions (as listed in Chapter 1). It was anticipated that answers to guiding questions might offer coherence to the stated puzzling situation.

8.4 DATA GENERATION

The grounded theory strategy for data generation was guided by application of the inter-related processes of theoretical sampling and constant comparative analysis which provided an effective medium for systematizing and co-ordinating the gathering of data for concurrent analysis.

8.4.1 STUDY SAMPLE

Access to an initial group of women for interviewing through a network comprising people with cancer prevention interest, which the researcher set up. Directed by the two grounded theory processes (described above) the sample was extended to include a total of 45 women with an age range 20-40 years. Three groups were from a suburban location and one group from a rural location. All members of the groups volunteered to participate in the study. Interviewing ceased when theoretical saturation was reached.

8.4.2 INTERVIEW SCHEDULE AND PROCEDURES

The interviews were semi-structured and this method facilitated the gathering of data. There was no time limit set for the length of interviews. The major questions for the interview were: 1) What is the meaning of health for you?, and 2) What things do you do to protect your health? A third question arose asking "Who initiates your cervical screening?" A fourth question also developed. "What would you do if you found a breast irregularity?" Whilst the second question was the more direct for achieving the study's purpose, the first question was important in setting the context and so potentiating the responses concerning the second question. The implementation of the interviews followed the ethical requirements of informed consent, anonymity and permission to be taped.

8.4.3 DATA-ANALYSIS

Concurrent with the data-generation for the study, the grounded theory processes of analysis were applied. The main processes involved were coding, memoing and sorting. From these processes, the specific components of grounded theory such as categories, properties, and core variable were identified and developed. Categories were developed along with the properties. Together these led to the development of the core variable "Vigilance-harmonizing" which in turn, led to the emergent theory.

8.5 THE EMERGENT THEORY

The theory was presented as a process and then in use with a breast cancer case history. The theory that emerged from the processes involved in the data generation and analysis was that of the 'Paradoxes in Vigilance-Harmonizing for Women's Health Protection Practices'. The theory is an account for the area of inquiry. As stated, it is contingent upon the core-variable and properties for this explanatory account. All women exhibited degrees of

vigilance-harmonizing towards the HPP. The theoretical account shows the dynamic nature of the theory with its emphasis on the salient properties of body-perception and health orientation as they impinge on the core variable.

Paradoxical behaviour and intention in relation to HPP pervaded the data to the extent that it could be considered a 'norm' something that nurses need to acknowledge and accommodate in their client focused care, rather than expecting general conformity.

8.6 IMPLICATIONS FROM THE STUDY FOR NURSING PRACTICE, THEORY AND RESEARCH

The main value of the findings from the study lie in the potential for improving nursing assessments, so leading to more appropriate interventions with clients. As well the theory has a contributory role for the subsequent development of nursing health knowledge as it provides a new perspective and identifies factors that are involved for HPP. This also has critical relevance for designing of future health education programs specifically directed at HPP.

Acquiring extensive information during the assessment process is critical to the subsequent stages of planning and implementation of the nursing process. Increased awareness of data-gathering between nurses and clients can be promoted by recognition of cues for pattern recognition from the clients language pattern of health orientations, body-perception dimensions and the other contingent properties that influence their capacity of vigilance-harmonizing for HPP. This in turn could lead to congruent planning, implementation and improved outcomes.

The theory has practical significance for nursing knowledge concerning health education for prevention purposes. It sheds light on factors that may be useful for understanding the dynamics involved in practising health-protection. This has critical relevance for designing future health education programmes specifically directed at HPP.

Cancer education and prevention is a unique category of health education. As stated in the introductory chapter 2, cancer related messages are surrounded by a certain mystique and fear and can hinder engaging in HPP (i.e. except for women with a health-depletive orientation). Rather than reinforce their associated aspects, messages could be devised aimed

at minimizing this fear whilst not detracting from the seriousness it requires. The language set of the health-orientations that emerged from the study then is a 'cue' for more congruent health education messages.

8.7 SUMMARY AND INTERPRETATION

This study has explored the meaning of health protection practice, viewing specifically the HPP of cervical screening and BSE with a grounded theory approach. Previous researchers have examined a variety of variables thought to influence the uptake of these HPP. All have been of quantitative design and have reached a plateau whereby no new insights are being yielded for practical use. The responses by the study's sample of women resulted in the emergent theory.

The paradoxes of vigilance-harmonizing for women's health protection practices are of a multi-dimensional nature. The implications of this study for the explication of the HPP meanings for women are threefold. Firstly, the dimension of language-sets used by women could extend nursing assessments as a basis for planning intervention to facilitate engaging in HPP. Secondly, the language-set could be a basis and strategy for designing health education messages with more efficacy in increasing the likelihood for women to engage in HPP. Thirdly, the identified variables involved in HPP expand nursing knowledge related to health and health protection. This in turn may lead to a contracting of the gap that Pender (op.cit) noted existing between early detection of disease and utilization of services. The theory, in its nascency invites and challenges further development and application by nurses.

Massey University

PALMERSTON NORTH, NEW ZEALAND
DEPARTMENT OF NURSING STUDIES

TELEPHONES, 69-079, 69-089, 69-099.

In reply please quote:

20th September, 1985

TO WHOM IT MAY CONCERN

This introduces AROHA PAGE, a registered nurse from Western Australia, who is undertaking graduate studies in nursing at Massey University.

Her research, conducted under the supervision of staff from the Department of Nursing Studies, requires that she interviews women about aspects of their health.

Norma Chick

Norma Chick, PhD.,
Supervisor,
DEPARTMENT OF NURSING STUDIES.

Massey University

PALMERSTON NORTH, NEW ZEALAND

TELEPHONES, 69-079, 69-089, 69-099.

In reply please quote:

TO WHOM IT MAY CONCERN

My name is Aroha Page. I am a Masterate student and a nurse from Western Australia, researching aspects of women's health. At your convenience I would like to talk to you about this topic in an interview which will take from a half to three-quarters of an hour. If you are agreeable the interview will be tape recorded. Otherwise I will need to take notes.

Only a number will be used to identify you as the person being interviewed and your name would not appear on the tape. The tape will be wiped after I have taken notes from it. If you do decide to participate, you are free still to withdraw from the study whenever you wish. I may need to re-interview you at a later stage, if you would be willing.

When I write up this research-project, no-one will be identifiable by name or in any way. Anything you say will be treated as confidential to this study and will not be used in any other way.

Although there may not be any immediate gain for you, I expect that in the long term, women in New Zealand will benefit through the potential which the results of the study will have for influencing health-care agencies.

Thanking you in anticipation for your assistance.

Aroha Page

Aroha Page.

Please sign below:

I have read the above information and consent to being interviewed.

Signature.....

Date.....

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