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Bonded Caring:
Health Care Choices of
Women with Dependent Children

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

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Abstract

The question for this study arose from the observation that health care often does not match the client's self-determined needs and desires, and hence is wasted care. As a result, the study proposed to discover what elements are involved when women with dependent children make health care choices and what they want in the way of health care.

The exploratory study was conducted using strategies of grounded theory. Fourteen indepth interviews, involving eleven women, were conducted. The selection of participants and of the questions for the interviews was based on theoretical sampling. Constant comparative analysis and integrative diagramming were used to analyse the data.

The theory that emerged from the data was Bonded Caring and its two essential categories; Interconnectedness and Caring. Bonded Caring requires an intimate and ongoing relationship in which there is development of indepth knowledge of the unique characteristics of the person(s) involved. It is characterised by a strong and enduring affective quality, and by concern, worry and serious attention to the needs of the person(s) involved. This concern necessitates the gathering of information about the nature of the needs, and making the best possible choices concerning their management.

During this search for knowledge and skills needed to carry out health care, women assess their own knowledge and experience; the level(s) of health care needed by each individual; the availability, competence and expected response of the resource person or health care consultant; the perception of risk associated with a health concern; and the family's culture and life style. The women considered these elements within a structural framework of finite material and personal resources. The women juggled the distribution of these resources in a way that allowed them to select the avenues of health care that provided the best degree of safety and protection of development within the context of their circumstances.

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Table of Contents

	<u>Page</u>
Abstract	i
Acknowledgements	ii
Table of Contents	iii
Part I: Background, Research Method and Procedure	1
Chapter 1: Introduction	2
1.1 Personal Reasons for the Research	2
1.2 Women and Health	4
1.3 Nursing	5
1.4 Research Question	6
1.5 Research Method	7
1.6 Thesis Format	7
Chapter 2: Context of the Study	9
2.1 Women and Health Care	9
2.2 Nursing's Ideological Shift	14
2.3 Related Research	18
2.4 Conclusion	22
Chapter 3: Research Method	25
3.1 Strategies of Grounded Theory	25
3.2 Sampling	30
3.2 Data Collection	33
3.3 Ethical Considerations	36
3.4 Conclusion	38
Chapter 4: Analytic Strategies and Procedure	39
4.1 Constant Comparative Analysis	39
4.2 Integrative Diagramming	48
4.3 Decision Trail	50
4.4 Conclusion	59

Part II:	Analysis and Theory Fit	60
Chapter 5:	Health and Illness Categories	61
5.1	Organisation of the Thesis	61
5.2	Health and Illness	62
5.3	Health Concerns	65
5.4	Evaluating Risk	68
5.5	Levels of Health Care	76
5.6	Conclusion	85
Chapter 6:	Context of Choice	86
6.1	Ways, Approaches and Lifestyles	86
6.2	Structural Influences	94
6.3	Personal Resources	101
6.4	Conclusion	104
Chapter 7:	Skills for Knowing	106
7.1	Being Aware	106
7.2	Finding Out	109
7.2.1	Taking Notice	110
7.2.2	Observing Signs	111
7.2.3	Interpreting and Integrating	118
7.3	Conclusion	128
Chapter 8:	Striving to Know What and Striving to Master	129
8.1	Striving to Know What	129
8.2	Striving to Master	134
8.3	Conclusion	145
Chapter 9:	Using Resources	146
9.1	Information Gathering	146
9.2	Impersonal Information Resources	147
9.3	Personal Information Resources	150
9.4	Conclusion	159
Chapter 10:	Consulting for Health Care	160
10.1	Chemists	161
10.2	Complementary Therapists	162
10.3	Doctors	167
10.4	Nurses	171
10.5	Conclusion	177

Chapter 11:	Sharing Concern	178
11.1	Affirming	178
11.2	Efficient	186
11.3	Tolerable	188
11.4	Undermining	189
11.5	Conclusion	196
Part III:	Bonded Caring and Conclusion	198
Chapter 12:	Bonded Caring	199
12.1	Bonded Caring	199
12.2	Basic Social Process	206
12.3	Conclusion	209
Chapter 13:	Standards of Rigor, Implications, and Conclusion	210
13.1	Strengths and Limitations	210
13.2	Implications for Theory, Research and Practice	214
13.3	Summary	220
Appendices:		
1.	Consent to Request Volunteers	226
2.	Consent to be Interviewed	227
3.	Request for Volunteers	228
4.	Cover letter to Rough Draft of the Analysis	229
5.	Consent to use Data Professionally	230
6.	Summary of the Report sent to Participants and Clinic Manager	231
References		239
List of Figures		
1.	Stages of Knowing	107
2.	Stages of Striving to Know What and Striving to Master	135
Lists of Tables:		
1.	Example of Analysis	42
2.	Examples of Memos	49
3.	Characteristics of the Sample	55

PART I: BACKGROUND, RESEARCH METHOD AND PROCEDURE

Chapter 1: Introduction

The desire to understand what is happening when clients make health care choices is a professional concern arising from personal experience. An experience early in my career as a community health nurse which remains as a vivid memory precipitated this concern.

An elderly couple, referred to a community health agency, was visited by me and my supervisor, who was evaluating my work. The couple's home, which they owned, was filled with papers, garbage, and cats. The lady had congestive heart failure, and the man was blind and arthritic. They had little support from relatives and wanted to stay in their own home.

A regular routine of visits was initiated and a good relationship with the couple grew. Records were kept of blood pressure, pulse and respiration. Medicines were reviewed with a physician whom the couple had not seen in months. Toenails were manicured. Life review stories, and their present situation were discussed. In short, the nursing process was used: assessments were made and interventions planned and carried out.

An administrative protocol required that the health department be called because the garbage was a health hazard. The couple's home was inspected and they were told that the house would be condemned unless the garbage was cleaned up. This created havoc for the couple.

One evening, during the time that this problem was being dealt with, the woman died of heart failure. Her husband called an emergency number which had been left for just such a situation. The ambulance arrived and CPR was administered. The whole experience was very traumatic for her husband.

This experience was for me what Benner (1985,p.10) refers to as an exemplar because in response to it, I began a search to understand what had happened. I had used the nursing process to gather information, make assessments,

define nursing goals and interventions with traumatic results. I wanted to know why and began to look at other situations in which clients were unhappy or frustrated with nursing care. I now suspect that a tentative answer may be found within the nurse-client relationship. Referring to the exemplar, had I heard the couple's wish about the context in which they wanted health care, or did I hear my nursing ideals and administrative rules? Had the couple been heard, housekeeping and hospice support that suited the couple's needs might have been investigated and initiated. In fact, certain health care measures, which did not match the clients' health goals, contributed to the couple's problems. What health care a client wants and needs is a vital question. If health care does not suit the client's concept of need, it is wasted.

Later, personal experience reinforced the idea of wasted health care. As a mother of young children, I have been a health care client in the United States and New Zealand. In both countries I have experienced thorough and effective health care. I have also received wasted health care when my health concerns were minimized, or I had been told there is "nothing wrong". Attempts to seek further care or to monitor the health concern as a client resulted in being labelled a "worried" mother.

In New Zealand, access to complementary therapies provides an additional health care choice not readily available in the United States (Ehrenreich, J. 1978 in Allan and Hall 1988,p.30). Leibrich, Hickling and Pitt (1987,p.1) provide a definition for complementary therapies.

Complementary therapies are those diagnostic healing or health promoting techniques not usually offered within the Western orthodox health care system (i.e. that care provided by statutorily registered health professionals which include medical practitioners, nurses, physiotherapists, dentists, psychologists and chiropractors).

My curiosity aroused, an indepth interview of a woman with children who had used complementary therapies was conducted

and analysed using strategies of grounded theory. (The case study was done in partial fulfillment of requirements for a course on Nursing Research.) The woman, based on her observations, decided her child might have a hearing problem. However, her doctor, after examination, decided the child did not have a hearing problem. At home the problem continued. The woman then decided to try complementary therapy, and was told the child could have a hearing problem. Based on this, she had her child's hearing tested independently, and armed with proof of a hearing deficit, returned to the doctor. He referred her to an ear, nose and throat specialist.

A basic social process, Finding Out, in which the woman's activities were directed towards finding out what was wrong and what to do about it, was generated. Part of this process showed the woman engaged in observational and interpretative activities prior to contacting the physician. She did not come to the consultation empty handed.

Women and Health Care

Historical evidence, from prehistoric time to the present, indicates that women's activities include health care. During the Pleistocene era (one million years back), Hominids became hunter-gatherers and established camp sites. Thus, women gained a new role, that of nurse (Boulding 1976,p.72). Later when humankind became planters and entered the agricultural era, one of the arts passed on to young girls was herbal medicine lore (Boulding 1976,p.133). Nightingale, in 1860, observed:

Every woman, or at least almost every woman in England has, at one time or another of life, charge of the personal health of somebody, whether child or invalid (Nightingale 1860,p.3).

This observation has been restated, over one hundred years later. Mechanic (1966 in Jaco 1972,p.121) acknowledges

maternal attitudes are important in "determining whether medical aid will be sought for the child when ill." Assertions that women take care of their own health and the health of their families have increased in the 1980's (Finch and Groves 1983,p.22; Graham 1984,p.61; Locker 1981,p.24). In New Zealand, where women aged 15-64 are 32.1% of the population (New Zealand Yearbook 1987-1988,p.127), the Royal Commission on Social Policy (1988,Vol.II,p.239) states:

Because it is predominantly women who take care of the dependents (the young, the old and the disabled), women are often responsible for the health care needs of others in their households.

'Doing' health care requires that decisions and choices be made as to how and what form the health care will take. Findings of the report of the Royal Commission on Social Policy (1988,Vol.II,p.244) stated that women make "decisions about their health care needs and the needs of those for whom they care." Embedded within health care choices are the purpose(s) for the decision and the expectation that the chosen actions and methods will have a desired effect.

Nursing

The work of nursing takes place within a cultural, social and economic environment (Butterfield 1990,p.2; Leininger 1978,p.60-61) and involves a nurse, a client, a health concern and an interaction. Nurses bring to the interaction nursing skills and knowledge. As implied in earlier examples, the client brings a health concern, background knowledge and ideas about a desired outcome. As the nurse and client exchange information, the nurse acquires knowledge that enables her to assist and support the client's health care choices.

Referring to the ideal characteristic of the nurse-client interaction, the New Zealand Nurses' Association Social

Policy infers a close working relationship:

The standards reflect a therapeutic alliance between the nurse and the persons for whom he/she provides care, making use of the nursing process (NZNA 1985,p.10).

From this it may be surmised that the intention of the New Zealand Nurses' Association is to promote nurse-client relationships in which the client actively participates in the processes of nursing care. The fact that this ideal is stated, but not yet consistently practised, is suggested by Sherrard:

Health care is changing in New Zealand. We read of Quality Assurance Programmes, yet I constantly hear horror stories of human experience which affect the lives of people. The tales of woe indicate to me that health care is still dominated by sickness care and nursing is essentially task oriented and medically based (1988,p.33).

This situation is not peculiar to New Zealand but is found throughout the world in the nursing profession. Nurse theorists advocate client participation in health care planning (Newman 1986,p.68; Orlando 1961,p.36-56; Peplau 1952,p.239; Roy 1984,p.50). It is an ideal which sometimes does not find its way into practice. It must be acknowledged that nurses often work in environments which do not support them to encourage clients to participate in health care decisions (Parker 1990,p.20-22; Dixon 1990,p.9; Perry 1987,p.11). In spite of these difficulties, there are many instances when nursing care does demonstrate these ideals (Christensen 1990,p.205) and it is an assumption of this thesis that the development of an understanding and sensitivity to what clients need and want from health care services is a skill which nurses can use as they strive to translate the theoretical ideals of nursing into the reality of practice.

Research Question

Embedded within the decision to use a particular health care service is the purpose(s) for the choice, and the

expectation that the health care consultant will respond to the health concerns identified by the client. It is hoped that by exploring the process that leads to the choice of a health care service something may be learned about the qualities women desire in health care. The initial research question is "What is happening when women with dependent children make health care choices?", and "What kinds of knowledge do they bring to a health care consultation?".

Research Method

Hutchinson states:

Nursing, in its present state of development, has few middle-range substantive theories that explain the every day work of patients, families, nurses and health agencies (1986,p.29).

The goal of this study is to explore the elements involved when the participants make health care choices. From these data a theory will be generated about what is happening when women with dependent children make health care choices. Because an understanding from the participant's point of view is being sought, indepth interviews and strategies to discover grounded theory (Glaser and Strauss 1967, 1978, 1987) are congruent with the purpose of the study. Hutchinson states:

Grounded theory is guided by the assumption that people do in fact order and make sense of their environment although their world may appear nonsensical and disordered. (Hutchinson 1986,p.113).

Thesis Format

The thesis consists of three parts containing twelve chapters. Part I contains material about the background of the study, the research method and procedure. Chapter 1 is the introduction and discusses briefly the genesis of the research question and selection of the research design.

Chapter 2, Context of the Study, contains material that provides a background to the study. In Chapter 3 the planned research method which could, ideally, be expected to occur when using strategies of grounded theory is described. Chapter 4 contains a description of the analytic strategies and the procedure, or how the research was conducted, in reality.

Part II contains the analysis. The categories described in Chapter 5 deal with the women's attitudes to health, their health concerns, the evaluation of risk and levels of health care. Chapter 6 contains categories associated with the social, material and personal context within which health care choices are made. Chapter 7, Skills for Knowing, contains categories that show the ways the women come to know what is happening when a change occurs in their children or themselves. In Chapter 8, the process of Striving to Know What and Striving to Master are discussed. The women made health care choices based on what more they needed to know in order to know what was happening and how to manage a particular health concern. These processes are central to the theory of Bonded Caring. Chapter 9 contains categories that describe resources and health care consultants the women used to get information and support. Chapter 10 contains a description of Sharing Concern, the response the women expected when they contacted a health care consultant about a health concern. It is a response that supports Bonded Caring.

Part III contains a discussion of Bonded Caring and related literature in Chapter 11. Chapter 12 concludes the thesis. It contains a discussion of the study's strengths and weaknesses; implications for theory, research and practice and a summary of the thesis.

Chapter 2: Context of the Study

The previous chapter contained an explanation of the purpose and initial questions this study intends to explore. This chapter provides background information consisting of a more indepth treatment of certain themes touched upon in chapter one. Topics to be discussed are women and health care; an ideological shift in nursing; and research related to the study.

Women and Health Care

As suggested earlier, providing health care is a category of work that women do within a family (Graham 1984,p.1).

This perception has been voiced in New Zealand where women have been identified as "guardians of health" (Pybus and Chick 1985,p.12) and as major providers, both paid and unpaid, of health care" (The Royal Commission on Social Policy 1988,Vol.II,p.237).

Women as health care providers are concerned with their own health needs, the needs of their families, and of persons and groups within their communities. Typically, they work at a grass roots level by becoming aware of a need and then finding ways to take care of it. At the community level this may include forming an ongoing group. It is an interesting paradox that while women's health care work is acknowledged to be essential, much of it is invisible. In the document, **Primary Health Care Statistics** (Maxwell 1989,p.27) women's involvement with health is recognised,

and it states, "There is very little information on the work that is done (largely by women) in maintaining health in the community." Another sign of this invisibility is Pybus' (1987) statement that "developments in women's health have followed the common pattern that they have occurred on the initiative of women without, even in spite of, health professionals." It is the purpose of this thesis to make visible some of the elements that go into health care choices of women with dependent children.

Women's Health Concerns

Women's health concerns identified by the World Health Organisation (1985,p.5-9) include issues associated with pregnancy and child birth such as maternal mortality, appropriate care during pregnancy and child birth, abortion, unmet needs and desire to practice family planning, early age at child bearing, and female circumcision. Other issues are malnutrition including anaemia, hazards of diseases and infections, occupational health hazards, cancer of the cervix and cancer of the breast.

As a developed country, New Zealand women's health care issues (with the exception of female circumcision) are similar to those identified by the World Health Organisation. According to the Royal Commission on Social Policy (1988), women's health needs include all matters relating to reproduction, disability (particularly in older women) and mental health concerns such as depression, alcohol dependence and stressor adjustment reactions. Violence against women including physical and sexual abuse and the social abuse of women through "soft" pornography (Pybus and Chick 1985,p.12), which undermines the concept of woman, are health concerns. In addition, Maori women have the dubious distinction of having "the highest death rate of any population of the world for lung cancer, cancer of the lower intestine and heart disease" (The Royal

Commission on Social Policy 1988, Vol. II, p. 243). In 1988, the New Zealand Board of Health stated that:

A new approach to women's health must be developed, and will involve incorporating women's views into health decision making, developing a comprehensive women's health policy and setting up appropriate programmes and services in area health boards. [1988, p. 11]

The Board of Health suggested that recommendations in the Women's Health Committee Report 1985-1988 be implemented. These are based on the Report's model of issues influencing wellness in women (p. 32). Issues influencing wellness in women are women as health care consumers; women as the health workforce; social influences on health; needs of special groups such as rural and immigrant women; health education; needs of elderly women; the 'ill' woman; occupational health; mental health; and issues about reproduction. It is suggested that the well woman requires information to make choices and access to screening and preventive health care; good mental health practices; childbirth practices; and exercise and nutrition.

Health System

The health system in New Zealand is a combination of public and private services with the former predominating. Public services are subsidized either wholly or partially by the government. Services completely subsidized are maternity care, hospital services, many nursing services, and accidental injury. Since 1974 costs of hospital and medical expenses, loss of income and physical disability, if they arise from an accident, are covered by the Accident Compensation Corporation, a government agency (Raffel 1987, p. 133-137). Visits to general practitioners are partially subsidized by the government. Prescriptions are also partially subsidized. Services of specialists and private hospitals are paid for by the person using them. The use of private services, by those who can afford them or who have insurance which will pay for their use, allows

some people to avoid waiting lists for care (in particular surgery) in public institutions.

Services identified as primary health care services by the Primary Health Care Statistics Working Group (Maxwell 1989,p.36-58), and available in 1986 were 1,640 full-time equivalent (FTE) general practitioners and 1,055 FTE practice nurses who worked with them. There were also 3,403 FTE registered pharmacists and an undetermined number of complementary therapists.

There were 482.4 FTE public health nurses employed by the Department of Health or Area Health Board to provide "family centered nursing service in homes, schools, workplaces and communities" on a referral basis. In addition 877 FTE district health nurses employed by hospital/area health boards who, upon referral, provide comprehensive nursing care within the home. Nurse practitioners are registered nurses who are self-employed and provide a range of holistic nursing services. In 1986, there were 4 full time equivalents.

Fifty point six FTE registered nurses were employed by the Family Planning Association in 1986 to provide contraceptive care and pregnancy advice. In 1987, there were 37 domiciliary midwives. These registered nurses who are also registered midwives work on contract with the Department of Health to provide antenatal, delivery and post-natal care to women who choose to have home births. The number of self-employed midwives is not known.

Registered nurses, employed by the Royal New Zealand Plunket Society (Plunket nurses), provide well child health services to children aged 0-5 years. Two hundred and twenty-nine Plunket nurses supervise 88% of the newborn infants (Maxwell 1989,p.36-58).

The health system in New Zealand is in the process of change. Since 1983, a major revision of the health system

has occurred resulting in fourteen area health boards which are under the direction of the Minister of Health. Each is responsible for the health services within its jurisdiction. The objectives of the area health boards are listed in section 9 of the Area Health Boards Act 1983:

- a) To promote, protect and conserve the public health, and to provide health services:
- b) To provide for the effective co-ordination of the planning, provision, and evaluation of health services between the public, private and voluntary sectors:
- c) To establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services." (Statutes of New Zealand 1983,p.1150)

Early observations of how the area health boards will incorporate community identified health needs, including women's health needs, is mixed. Some nurses have seen positive changes with greater community involvement (Ewart 1989,p.16; Moore 1989,p.13-15; Smail 1987,p.13-14). Another view states the area health board legislation is sympathetic to consumer interests but provides "few mechanisms to ensure these aims are carried out" (The Area Health Board 1989,p.19). This observation is seconded by Rivers and Drage (1990) who suggest that concern with women's involvement in health care is "centrally driven" at the national level, but that this concern has not filtered down to the local level of the area health board. They state:

Area health boards have no obligation under the Act to provide services that meet the specific needs of women.

The provision in the Act to set up committees which will ensure an effective framework to plan for and to monitor women's health, such as standing committees (as outlined in Sections 28, 29 and 31 of the Act), is not mandatory. The Act recommends that a board set up service development groups to advise on specific health services, such as surgery, child health and primary health care. Women's health, however, is not mentioned. (1990,p.154).

Quinn (1989,p.17) is concerned that a move to community

health care with a lack of financial resources will result in "women who'll bear the brunt of moves toward community rather than hospital care and who will provide voluntary care and give up their work to look after relatives and friends." Again, Rivers and Drage (1990,p.158) support this worry, stating "... we argue that the 'community' is mainly women, and that instead of women increasing their political or policy-making influence at the community level, they are more likely to be expected to provide unpaid care." It can be seen that the hopes and worries about what affects the change to area health boards will have on community health in general and women's health in particular are many. It is likely the 'personality' of each area health board will decide the extent to which these hopes and worries are borne out and will affect the diversity and quality of the health care services available as a basis for health care choices of women with dependent children.

Nursing's Ideological Shift

Throughout the world nurses, providing and directing health care services, fulfill a vital function within health care systems. However, prior to the late nineteenth century, hospitals, doctors and lay nurses associated with them had a somewhat dubious image (Dolan, Fitzpatrick and Hermann 1983,p.135-137). Poor people went to hospitals for medical treatment and to die. Doctors diagnosed and prescribed within the limits of their knowledge, but effective, organised care based on knowledge of health was not commonly available. The education and training of nurses initiated a process that elevated the status of the hospital and supported the development of a more effective medical system. Through the use of nurse probationers as a work force (Maggs 1983,p.16), hospitals became centers of nursing care administered under the directives of the medical staff. The nurse, doctor and hospital became a health care triumvirate focused on the patient, who was

expected to be an obedient recipient of care (Hawker in Maggs 1987,p.143-152).

Times are changing. Within the nursing profession an ideological shift is occurring. Instances of the health care triumvirate are still widespread, particularly in areas where the client has little power such as homes for the aged and mental health institutions. However, there is evidence that nurses define their profession in terms of client determined need (Orlando 1961; NZNA 1985,p.7). An example of this is two health awareness days held in the town of Waitara in response to community requests. Women had an opportunity to have a PAP smear done by a woman doctor and to talk about their health concerns. The clinics, designed to suit the cultural needs of Maori women, were open to all women and held on a marae (a Maori meeting house). "On these days women talked about things they had only thought about before." The nurses have received requests to repeat the health awareness days in Waitara and in neighbouring districts (Moore and Tuuta-Wellington 1989,p.20-22).

Theoretically, the nurse-client relationship is described as one in which the client participates in health care choices (King 1981,p.2; Orem 1980,p.11; Parse 1981,p.32; Patterson and Zerad 1976,p.13). In the area of research, nurses are increasingly adopting a philosophy of science that embraces both quantitative and qualitative research methods (Tinkle and Beaton 1983; Silva and Rothbart 1984). Qualitative research methods are being developed and used to discover the meaning of what is happening in particular situations for clients and nurses. And in practice, instances of nurses acting as client advocates, supporting clients and designing interventions that fit the client's view of what is needed can be found (Livingston 1990).

The fact that the shift is in process and not yet accomplished is highlighted by Allen's (1987,p.39-48) reappraisal of the American Nurses' Association Social

Policy Statement. He points out that the policy presents two competing definitions of person and of society. The deterministic model presents person as a passive product of biological and environmental forces. This view is predominant historically and currently. It allows the client to be 'acted upon'. The opposing agency model sees person as active with the capacity and the right to initiate change. Each of these models derives from Western thought and is highly individualistic. The two models of society are the society as an organism and society as interactions between groups or a pluralistic model.

New Zealand

Based on the foregoing definitions, the New Zealand Nurses' Association (NZNA) Social Policy Statement (1985) contains similar signs of this ideological shift. The concepts presented in the policy are a mix of the models. An indepth analysis of the Social Policy is not the purpose of this thesis, however brief examples will be presented.

The NZNA's Social Policy (1985) shows a mix between agency and deterministic orientations in reference to person (nurses or clients). Deterministic descriptions are:

The individuals that comprise the nursing profession are the product of environments constantly undergoing change. (p.1)

Nursing "... exists in response to the health needs of society." (p.7)

The client is the central focus of nursing. (p.7)

Agency oriented descriptions of person (nurses or clients) are:

Nurses are responsible and accountable for nursing decisions ... (p.9)

Nurses determine the boundaries for the practice (p.11)

... nurses have always influenced patient care planning ...
(p.11)

Individuals and groups are becoming more innovative in the search for well-being (p.4)

Individuals and groups will use a multitude of ways to achieve an improved state of health ... (p.5)

... a concept of health that recognises a continuing interaction between people and their environment in which they participate as total beings. (p.6)

The organismic view of society is represented in the following statements:

- the society having granted the [nursing] profession authority, autonomy, responsibility and accountability for its practice. In return, society expects an effective nursing service. (p.3)

The nursing profession has explicitly, and for the first time, acknowledged the contract it has with New Zealand society. (p.27)

Society, pluralistic in nature, is represented in the following statements:

It [society] requires knowledge of processes whereby the nursing profession ensures nursing practice that will enhance the health potential of individuals and groups within New Zealand society. (p.2)

Our society is not homogeneous in its needs. (p.5)

Individuals and groups will use a multitude of ways to achieve an improved state of health ... (p.5)

Despite the fact that there is a mix of conceptual representation of person and society, the Social Policy is weighted towards supporting an agency view of person and a pluralistic view of society. This is evident in the definition of an ideal nurse-client relationship and the definition of nursing.

The standards reflect a therapeutic alliance between the nurse and the persons for whom he/she provides care, making use of the nursing process. (NZNA 1985,p.10)

Nursing is a specialised expression of caring concerned

primarily with enhancing the abilities of individuals and groups to achieve their health potential within the realities of their life situations. (NZNA 1985,p.6)

The terms 'therapeutic alliance' and 'enhancing the abilities' imply a relationship in which the nurse and the client each actively participate and in which the abilities of the client are recognised and supported. Research that highlights the clients' perspective can assist nurses as they strive to attain, in reality, these ideal goals of the nurse-client relationship.

Related Research

Literature review is one of several Processes occurring simultaneously in a study using grounded theory strategies. It serves multiple purposes (Strauss 1987,p.280-282). First familiarity with a broad range of literature that comprises a discipline's base of knowledge allows a researcher to ask questions that are relevant to her discipline, and gives the researcher an idea of the discipline's stance in relation to the question under study. Second, the researcher may read papers that deal directly with the research topic in search of excerpts of data that may be useful as a supplement to data collected in the researcher's study. Third, data from papers not related to the study question may be useful in stimulating ideas about the study question and provide different ways of viewing the data. Reading theories, views and analyses about the same or a related study question is not advised. This restriction is to prevent researchers, particularly inexperienced researchers, from adopting theories and concepts from sources other than the data. However, in order to establish the necessity for research in the area of health care choices of women with dependent children and to present a proposal judged as satisfactory by the Massey University Human Ethics Committee, a limited literature review was necessary (Chenitz and Swanson 1986,p.45). The attitude of the researcher conducting this type of

literature review is not the adoption of particular theories, but what has or has not been done in this area?.

Prior to commencing data collection, no studies were found that dealt directly with health care choices of women with dependent children. Related studies concerned care seeking behaviour connected with a specific health care service; cultural groups and their choice of health care service; and choices of specific types of treatment.

Characteristics of the Health Care Service

Care seeking behaviours of clients in a community setting was the topic of Field's study (1982). Constant comparative analysis of precollected interviews resulted in five propositions about client expectations in relationship to locus of control or satisfaction. A care seeking model was also generated. The propositions were:

1. Clients who perceived themselves as having inner control over their daily activities will expect guidance and support from the nurse in response to their initiation of an interaction.
2. Clients who lack inner control over their daily activities will expect the nurse to act as an authoritarian figure who exerts external control.
3. Clients who receive nursing care congruent with their expectations will feel satisfied with the nursing intervention, whether or not their problem has been solved.
4. Clients who receive nursing care that is perceived as divergent from their general expectations will be ambivalent or dissatisfied with their care even when progress toward their goal has been achieved.
5. Clients who cannot identify their problems or who have no definite expectations of the care they will receive from the nurse will be ambivalent or dissatisfied with the care given. (Field 1982,p.26)

During the 1960's, 1970's and to the present, the client's decision to seek medical care has been studied by medical doctors and sociologists using the concept of illness

behaviour. Illness behaviour is defined by Mechanic (1966 in Jaco 1973,p.119) as "any condition which causes, or might usefully cause, an individual to seek advice from a doctor." These studies are primarily from the perspective of the doctor.

"What leads up to consultation?" is a synthesis of experience, research and literature review (Morrell 1979). Anxiety and symptoms were identified as factors influencing women to consult a physician. A model of care seeking behaviour is provided. Morrell (1979,p.113) states: "But studies of doctors in relation to patient expectations are singularly lacking."

Zola's sociological study (1973 in Tuckett and Kaufort 1978,p.122-131) centers on the decision to see a doctor. Five nonphysical triggers that initiated a visit to a doctor were identified. They were: (1) an interpersonal crisis; (2) a condition's perceived interference with social or personal relations; (3) sanctioning which consists of an individual "taking primary responsibility for the decision to seek aid for someone else" (p.129); (4) a perceived interference with vocational or physical activity; and (5) the setting of an external time criteria such as setting a time after which treatment will be sought if the condition persists.

Cultural groups' health care choices

Several studies examined the choice of health care from the perspective of a particular cultural group. Strategies of grounded theory were used to explore care seeking behaviour of Mexican American migrants (O'Brien 1982). The reasons for using or not using a medical clinic were explored, as was to a lesser extent the use of traditional healers. The resulting substantive theory was Pragmatic Survivalism. It encompasses the idea that economic survival determines the use of health care facilities.

Strategies of grounded theory were used to explore (1) "the values and meanings of certain childbearing and childrearing beliefs for a selected number of Northern Louisiana black women; and (2) "How can nurses provide culturally sensitive care for clients who hold those beliefs (Scott and Stern 1986,p.45-60). Elements identified in the study were a respect-fear process that includes respect shown to a health care consultant as opposed to the women's fear of breaking traditional taboos; testing, which consists of trying out new health prescriptions; and cultural interaction, the amount and kind of interaction with a dominant culture. The theory, called Ethno-Market theory, states that a balancing of the elements listed above determines whether a woman relied mainly on the dominant health care system (Corporate Buyer), the traditional health care methods (Cultural Buyer), or a mix of the two (Careful Shopper).

A case study of Gypsies' use of health services (Anderson and Tighe, 1973) showed that health is a high priority for Gypsies. However, the Gypsies' trust of health care providers had to be earned and was fragile. Hearing about previous experiences of other Gypsies was a major influence in the choice of health care.

Choice of specific types of health care service

Women's choice between traditional midwives and qualified personnel in rural India showed a preference for traditional midwives (Gupta 1978). Of the women interviewed, 66.67% indicated that traditional midwives more closely matched their expectations of care. Of the women who preferred trained personnel, 95.24% mentioned skill as the reason (p.180). Structured interviews were used to obtain data.

Mwabu (1986) used a household survey to investigate health

care decisions in Kenya. The study showed that a client is likely to approach more than one health care consultant during an illness. Non-government clinics were a preferred source of treatment. Mwabu (p.315) indicated that the study was not designed to discover the elements involved in the choice of health care.

Choice of health care strategies

Two studies, using strategies of grounded theory, explored choices of specific types of health care strategies. Swanson's study (1988) of management of contraception by couples included exploration of the choice of a course of action for learning to use and manage contraception (p.493-494). The theory, Privatised Discovery, "proposes that people find contraceptive options in a highly private context over time." (p.501)

Luker (1975) explored women's choices to not use contraception and to use abortion. The theory, Risk Taking, "the decision to not use contraceptive skills that had been previously demonstrated as effective," was discovered. The weighing of costs and benefits is a subcategory.

The examples of literature concerning health care choices show that a number of elements, such as expectation, culture and cost, is involved and that choices occur in a number of areas such as health care strategy, health care service, and whether or not to seek health care.

Conclusion

This chapter discussed women and health and showed that women have a wide variety of health concerns, women's health care activities are central to health care, and that women do health care in the family and in the community.

Next an ideological shift that is occurring within the nursing profession whereby nurses are striving to work with and on behalf of clients rather than 'on' clients was discussed. This was followed by a limited literature review in which no studies that dealt directly with health care choices of women with dependent children were found prior to the study. Research included in the literature review showed that a number of elements influence health care choices. In addition, choices concerning health care are made at various stages of health care seeking. The next chapter will present the research method as originally envisioned and the procedure as it happened in reality.

Chapter 3: Research Method

As indicated earlier, the purpose of this study is to explore what is happening when women with dependent children make health care choices. The research method is the researcher's ideal conception of how the various strategies would be carried out in order to explore the research question. Strategies of grounded theory were selected to analyse the data because a main underlying assumption is that people have reasons for what they do, and the strategies are designed to generate theory based on the participants' point of view. This and other background material will be discussed in the first section of this chapter entitled Strategies of Grounded Theory. Other sections include sampling, data collection and ethical considerations.

Strategies of Grounded Theory

Historical Development

The early development of strategies of grounded theory as an approach to qualitative data analysis was influenced by two streams of thought within the University of Chicago (Strauss 1987,p.5). In one, under John Dewey's leadership (1894-1904), the philosophical school developed a pragmatic philosophy:

The central orienting idea of Chicago pragmatism was that of activity, which was seen as having biological, psychological, and ethical dimensions ... The activity was undertaken by a conscious agent who had feelings and

emotions. And the activity had a purpose or object toward which movement was directed. The three elements, moreover, were interconnected. Biological process was not merely mechanical, the agent was a human being, not just a bearer of ideas, and ends were provisional and subject to change in the light of circumstances. (Bulmer 1984,p.28-29)

Lazarsfeld (1972,p.22) further states that Dewey recognised a relationship between concepts and indicators. The relationship was not definite. It was only probable that a particular indicator meant the occurrence of a particular concept.

In the other, the world's first sociological department to be established at a university (Harvey 1984,p.14) Albion W. Small (1892-1925), head of the department of sociology and anthropology, encouraged empirical research based on direct observation (Harvey 1987,p.112):

The canons of science advocated by Small were value neutrality, objectivity, and theoretical analysis. Value neutrality meant non-partisanship, objectivity meant rooting assertions in empirical evidence rather than conjecture and he saw science as necessitating inductive theorising, not just the collection of 'raw facts.' (Small and Vincent 1894 in Harvey 1987,p.27)

The climate of the early years when each of the schools was forming encouraged the exchange of ideas and research between the disciplines (Bulmer 1984,p.40). Thus the influence of the philosophical school is blended with the aims and methods of the school of sociology. Strauss (who completed a Phd. thesis at Chicago University in 1944 [Harvey 1984,p.205]) states that the interweaving of thought from the two Chicago schools was influential in the development of strategies of grounded theory (Strauss 1987,p.6).

Concurrently, Paul Lazarsfeld, under whose direction Columbia University became a leading center for sociological research after World War II (Harvey 1984,p.204), was developing quantitative methodology and R. K. Merton was becoming known for "laying out the basis

of middle-range theorising" and attempting "to forge a clear link between empirical research and social theory" (Harvey 1984,p.151). Glaser, who earned his Phd. at Columbia University, brought to the development of the strategies of grounded theory "some of Lazarsfeld's emphasis in multivariate analysis" (Strauss 1987,p.6). Glaser indicates that his training in core variable theories at Columbia University was the basis for his conception of the "notion of the basic social process" (Glaser 1978,p.97).

The two men, B. Glaser and A. Strauss, came together "by an ironic conjunction of careers" (Glaser and Strauss 1967,p.vii) and, as sociologists on the faculty of the University of California School of Nursing, San Fransisco (Glaser and Strauss 1964,p.119), conducted a "field observational study of hospital staff's handling of dying patients" (Strauss 1987,p.6). Strauss says that it was during this study that strategies for generating grounded theory were developed (Strauss 1987,p.6). It is of interest that the third member of the research team conducting this study was a nurse, Miss Jeanne Quint (now Benoliel) (Glaser and Strauss 1965,p.x). The purpose of strategies of grounded theory is to link theory more closely to empirical research (Glaser and Strauss 1967,p.vii).

Nursing and Grounded Theory

Since the early 1960's Glaser and Strauss have written three books, together and separately, which outline the development of strategies of grounded theory. The first, Discoveries of Grounded Theory (Glaser and Strauss 1967), introduces the strategies of grounded theory and outlines the method and its uses. If the theory accurately reflects the situation from which it was generated, it will be readily understood by the persons interacting in that situation. As a result it provides insights as to what is

happening and a basis from which to exercise control by making choices about the processes that are occurring (Glaser and Strauss 1967,p.239-249).

The American Journal of Nursing published one of the first articles resulting from research conducted using strategies of grounded theory, "The Social Loss of Dying Patients" (Glaser and Strauss 1964,p.119-121). This was followed in 1966 and 1967 with articles in Nursing Research outlining the process of generating grounded theory (Glaser and Strauss 1966,p.56-61; Quint 1967b,p.108-129).

Looking back, Munhall (1989,p.20) suggests that within nursing research the possibility of an "interpretive turn" appeared in 1966. Wright (1966,p.244-245) questioned the suitability of research methods of measurement and evaluation for the study of "behavioural manifestations of man". Nurses began to investigate and incorporate qualitative research methods into their studies. Quint's study, The Nurse and the Dying Patient (1967a), was the first piece of nursing research conducted using strategies of grounded theory. In Canada, Dr Moyra Allen and Dr Helen Glass "pioneered the application of grounded theory to the investigation of nursing phenomena, starting in the late 60's" (Stinson 1986,p.238).

Theoretical Sensitivity (Glaser 1978) provides detailed information about the process of theory generation. It provides 'how to' information and describes the personal experiences that a researcher conducting a study using strategies of grounded theory might expect to occur. It is noted that the uses of strategies of grounded theory have successfully overflowed into many disciplines (Glaser 1978,p.164). The number of nurses using strategies of grounded theory increased gradually in the 1970's. As a comparatively new research strategy, centers for training were limited and therefore the numbers of nurses using strategies of grounded theory as a research method were unavoidably few. Some nurses publishing research results

in the 1970's were Fagerhaugh (1973, 1977) on emphysema and pain management; Stern (1978) on Stepfather Families; and Wilson (1977) on processes used in an alternative mental health community.

Strauss' contribution, Qualitative Analysis for Social Scientists (1987), extends and deepens the 'how to' information contained in the previous books. It includes sections on integrative diagrams, writing up a generated theory and teaching strategies of grounded theory.

The numbers of nurse researchers generating grounded theory has increased steadily since the mid-1970's. More recently (1980's) articles, chapters and books written by nurses describing the background, method and uses of grounded theory have become available (Chenitz and Swanson 1986; Hutchinson in Munhall and Oiler 1986b, p.111-144; Stern 1980; Wilson 1985, p.415-423). Fifty-five studies resulting in grounded theory, listed in a computerised literature search (DIALOG), were published between 1983 and May 1990 inclusive. Some topics studied were mental health issues (Crockett 1988, Farran, Carr and Maxson, 1988; Limandari 1989; Malone 1989; Wilson 1982, 1983), parenting issues (Jordan 1990; Krone and Harriss 1988; Morse and Bottorff 1988, 1989; Stern 1978), fertility issues (Olshansky 1987; Sandelowski, Harris and Holditch-Davis 1989; Swanson 1988), pain (Fagerhaugh and Strauss 1977; Mills 1989), chronic illness (Thorne and Robinson, 1989; Wilson 1989), care of the aging (Boyle and Counts, 1989; Bowers 1987; Chenitz 1983; Miller 1989; Rempushki and Phillips 1985, 1988; Weiner and Kayser-Jones, 1989), intensive care (Coulter 1989; Hutchinson 1984; Podurgiel 1990; Frenn, Borgeson, Lee and Simandl 1989; Sutherland 1988; Turnock 1989; Weims and Patterson 1989), and addiction (Hutchinson 1986a; Chenitz 1989). In some areas, such as hope, care of the aging, and fertility issues, two or three initial studies conducted by the same researcher were followed by studies conducted by other nurse researchers. This kind of development extends the original theories and provides a basis for formal

theory. The question is, are these theories affecting nursing practice?

Within this same time period (1980's) nurses studying at Massey University, New Zealand, under the guidance and encouragement of Dr Norma Chick began to generate theory using strategies of grounded theory. Concerning this, Dr N. Chick stated (personal communication, 28 September 1990) that grounded theory (inductive theorizing) has been a component of 68.305, Knowledge in Nursing, since the course's inception in 1980. Increasingly grounded theory studies have appeared in the nursing literature and these have influenced graduate students' research approaches. Irena Madjar's thesis, *A Cross-Cultural Study of the Experience of Pain in Surgical Patients* (1981), appears to be the first study using strategies of grounded theory and was influenced by Fagerhaugh's work on pain (Dr N. Chick, 28 September 1990). Others followed in the later 1980's (Christensen 1988; Page 1987; Walton 1989). Recently, Christensen (1990) published her theory, Nursing Partnership, the result of Phd. level research.

Sampling

The purpose of this study, to explore what is happening when women with dependent children make health care choices, indicates that nonprobability sampling is appropriate. Non-probability sampling allows the selection of participants who are most likely to provide information and insight about the research topic. Morse (in Chinn 1986,p.184) states, "The purpose of selecting nonprobability samples is to facilitate understanding, for description, and to elicit meaning." Bearing this in mind, the primary techniques used to guide sampling were selective sampling and theoretical sampling.

Selective Sampling

The term selective sampling is attributed to Leonard Schatzman:

Selective sampling refers to the calculated decision to sample a specific locale or type of interviewee according to a preconceived but reasonable set of dimensions (such as time, space, identity) which are worked out in advance for a study. (Schatzman and Strauss 1973,p.38-39)

Two criteria guided selective sampling and were constant throughout the study. The first defines the substantive area of the study: participants were restricted to women with at least one child no older than 18. Secondly participants had to be English speaking, that being the only language in which the researcher is fluent.

Theoretical Sampling

Morse also commented that an essential characteristic of theoretical sampling is the selection of participants, or other sources of data, based on their knowledge about the research topic. Theoretical sampling is guided by the data analysis. As data collection and constant comparative analysis proceed, categories are identified by the pieces of data that 'indicate' or describe them (Wilson 1985,p.418). Initially, the descriptions of the categories may not be logically complete or may appear to conflict, and relationships between the categories may be unclear. These gaps in knowledge are a guide as to what kinds of data are needed to provide a thorough understanding of the characteristics of the categories and their fit within the theory (Glaser and Strauss 1967,p.47). Based on what more needs to be known, theoretical sampling occurs, and "Data is collected to advance the theory." (Stern 1980,p.22).

The guiding principle of theoretical sampling for the first sample of the study is that it must consist of persons having the most potential to answer the research question

(Glaser 1978,p.45). Since the concept of choice is central to the study question, an ideal situation for the initial theoretical sampling would be one in which it was clear that a choice relating to health had been made. The researcher, through personal observation, was aware that an interest in and use of complementary therapies occurs in New Zealand. Some complementary therapies available are chiropracty, homeopathy, naturopathy and osteopathy. These are not a formal part of the dominant medically oriented health care services. Since the decision to use complementary therapies in addition to, or in place of, the medical health care service is a conscious choice, it seemed likely that women who made this choice would have given the matter some thought and therefore would know the reasons underlying their decision. Following this line of reasoning, the initial sampling consisted of women who had chosen to use naturopathy as a resource for health care, within the last year.

In order to find women who would meet this criteria, a naturopath was approached and asked if an advertisement for participants could be placed in his clinic. Theoretical sampling, guided by analysis, determined sources of further participants. It was anticipated that additional participants could be found through a playcentre, a kindergarten, and personal contacts. A snowball effect, whereby participants might introduce friends who would be willing to be interviewed, was also expected.

If the analysis is to be a true representation of the participant's experience, it must be based on accurate data (Mishler 1986,p.138). To this end, face-to-face interviews were tape recorded. It was also planned to use telephone interviews, if necessary, to follow up brief questions concerning categories arising from analysis. The following system was used for the telephone and hand written records: Quotation marks to indicate an exact quotation, and no marks to indicate paraphrasing.

Data Collection

Interview

When the goal of research is to generate a theory based on the participants' point of view, obtaining data by using interactional techniques, such as participant observation and interviewing is most suitable (Bower 1988,p.55). For the purposes of this study, it was decided interviewing would be an efficient way to gather data.

Indepth interviewing was chosen because standardised questioning tends to contain the answer within the question (Palmer 1969,p.233 in Watson-Franke and Watson 1975,p.251) and tends to suppress the participant's ability to give a complete answer. As a result the context of the answer is lost (Mishler 1986,p.29). In contrast, the specialised conversation of an indepth, unstructured interview is guided by the researcher, while at the same time, allowing the participant the greatest freedom to contribute to the content of the conversation from his own experience and understanding. The interviewer "probes for detail, clarity and explanation" while avoiding "contrived formality" (Schatzman and Strauss 1973,p.72). Mishler describes the interview as discourse:

... interviewers and respondents through repeated formulations of questions and responses, strive to arrive together at meaning that both can understand. The relevance and appropriateness of questions and responses emerges through and is realised in the discourse itself. (Mishler 1986,p.65)

Circumstances in which the use of indepth, unstructured interviews is appropriate are when dealing with participants who have special knowledge of the research subject; when pursuing a subject in depth; when the researcher's intent is discovery rather than verification; when the purpose is to uncover some motivation, intent or explanation as held by the participants; and when the

research is trying to ascribe meaning to some event, situation or circumstance (Guba and Lincoln 1981,p.166).

Based on these guidelines, the initial interviews were unstructured and indepth in order to encourage participants to tell their story about the choice of health care. As analysis proceeded, and categories and their relationships were recognised, subsequent interviews were semi-structured using open-ended questions to verify data analysis and obtain information to fill empty spaces in the data.

Researcher as the data collection instrument

As the primary data collection instrument (Bowers 1988,p.54), elements that influence a researcher's success in data gathering are technical interviewing skills; the ability to understand what is happening from the participants' point of view; and the gender of the researcher and participants.

Phrasing questions clearly and in a manner that encouraged the participant to tell her story is a technical skill which was based on a style discovered while listening to oral history tapes. Questions, introduced with a phrase such as "Could you talk about a time when ...?", or "Would you mind talking about that in detail?", were used to encourage participants to describe their actions and experiences. The researcher discovered that the participant's definition of key words could be obtained by asking. For example, one participant indicated she was feeling stronger as a result of her health care strategies. When asked to talk about what stronger means, she described physical and nonphysical dimensions of feeling stronger.

The extent to which a researcher is able to "maintain one foot in the world of the subjects and one foot outside that world, viewing actions from the perspective of the subjects while standing back and asking questions about what

subjects take for granted," (Bowers 1988,p.43) determines how closely the generated theory reflects the participants' motivations and viewpoints. Bowers calls this research stance "marginality", a term borrowed from Park, a sociologist. Park (1950,p.354) uses the term to designate a person who stands between two antagonistic worlds and belongs to neither. From the point of view of nursing research the term may be misleading. Certainly the nurse-researcher belongs to the world of nursing. And, in this study, the researcher also belongs to the world of women with dependent children. An empathetic stance might be closer to what is happening. The term empathy, often used in nursing, closely resembles Bowers' definition of marginality. It is defined as lifting "oneself over the barriers of self in order to 'experience' the situation of another" while at the same time "a measure of the [nurse's] intellect remains objective in order to consider the problem." (Baumgartner in Carlson 1970,p.33-34).

As a woman with dependent children and a nurse, the researcher possessed a potential ability to stand with one foot in the world of the participant and one foot in the world of the health care consultant. Early in the study, the researcher discovered that an empathetic stance is a conscious process. One must choose to view data from the participant's point of view. For example, as a woman with dependent children, the researcher has had negative and positive experiences with health care consultants. During analysis, it was necessary to question "Is this concept from my experience or from the participants' experiences?" This questioning assisted the researcher to avoid making the data fit her own experiences. In addition, in order to keep the data balanced, the women were encouraged to describe positive as well as negative experiences. In many instances the participants provided this balance spontaneously by matching a negative experience story with a positive experience story.

When the researcher is a woman interviewing women it is a

"special situation." (Finch 1984,p.75). She elaborates on this point by stating that a rapid development of trust and openness by women participants during an unstructured, indepth interview conducted by a woman is based on three conditions. First, women are accustomed to accepting intrusions into their private lives through questioning. It is a situation they encounter with health care consultants, insurance agents, social workers, etc. Secondly, when the interview takes place in the woman's home, the interviewer acts as a friendly guest. And third, the comparatively isolated circumstances of women in the home makes it likely they will talk readily to a sympathetic listener.

The researcher was treated as a friendly guest, in several instances a cup of tea was offered during the interview. In turn, the researcher offered a cup of tea or coffee to the participant when the interviews took place in her home. Participants talked about their health concerns and actions with little prompting, often volunteering more information than a question required. Whether or not social isolation figured in the women's responses is undetermined. However, the researcher sensed that the topic was important to the participants, and feels the participants considered telling their stories as a way of influencing the way health care services are provided. This perception was not checked by the researcher.

Ethical Considerations

Standards of conduct are as essential to research as they are to nursing practice. Their purpose is protection of participants' and researcher's rights (Fowler 1988,p.111). In the interview situation, areas in which ethical conduct should be considered are consent and confidentiality.

Consent

Participation in the study was dependent upon the consent of the participants, and of persons who permitted the researcher to advertise for volunteers in their facilities. In each case, the participant or owner of the facility needed to know the identity of the researcher, the purpose of the study, what the researcher expected from them in terms of time, and some explanation of their rights in the interview situation. To provide this information, a consent form was prepared. It was anticipated that a clinic would be used one time for a period of two weeks, and only one consent would be necessary (Appendix 1). However, it was planned that some participants might be re-interviewed, and in order to allow participants the option to withdraw from the study the original consent form was reviewed and initialled at each interview (Appendix 2). When the interviewing was completed and the participants had an opportunity to review the analysis, a formal consent for permission to use the data for professional purposes was requested (Appendix 3).

Confidentiality

Arrangements were made for the protection of participants' privacy (confidentiality). This required that descriptive phrases and direct identification be avoided. To this end initials, changed from the actual initials, were used in the excerpts from the interviews. Health care givers were identified by their job title, ie: doctor, naturopath, nurse, etc. In addition, each consent form explained actions that would be taken to protect privacy.

Storage of data in a manner that promoted confidentiality was necessary. An organisational file was kept for names, addresses and phone numbers of the participants. When it was no longer necessary to contact participants, this file was destroyed. Until then, it was stored in a locked file

cabinet when not in use. The cassette tapes of the original interviews were stored in a sealed bank envelope after they had been transcribed. Prior to this they were stored in a locked file cabinet.

The possibility of encountering illegal activities during this study was small. However, the possibility did exist. As an example, as a choice of health care, a participant may have used a substance such as marijuana as a form of self treatment. Had such a circumstance occurred, I would have informed the participant that confidentiality is a right and a courtesy, but legally I would be obligated to provide information requested by a court of law (Cowles 1988,p.172). Fortunately, this did not occur. However, two participants asked for further explanation of the statement on the consent form which referred to this limit on confidentiality. The researcher explained its meaning as stated above and they seemed satisfied with the explanation.

Conclusion

Background material about the development of strategies of grounded theory as a research method and its use in nursing research was provided in this chapter. This was followed by a discussion of the non-probability sampling procedures, selective and theoretical sampling, that were used in this study. Data collection strategies to be used in this study, interviewing and the researcher as a data collection instrument, and the ethical considerations of consent and confidentiality were discussed. Chapter 4 contains analytic strategies and the decision trail.

Chapter 4: Analytic Strategies and Procedure

Chapter 3 contained background material about strategies of grounded theory, and discussed sampling, data collection and ethical considerations. A description of the analytic strategies, constant comparative analysis and integrative diagramming, are included in this chapter. There is also a description of the procedure, or how the researcher carried out the strategies of grounded theory. It is the decision trail (Guba and Lincoln 1981,p.122). Its purpose is to show how the researcher's activities and decisions during theoretical sampling and analysis are related to the theory that emerges. Due to the nature of its content, the chapter is not subdivided, and except where noted, the material is presented in chronological order.

Constant Comparative Analysis

Qualitative analysis of data is a focused way of thinking about data that is systematic and purposeful. It involves a sustained interactive process between the researcher and the data (Schatzman and Strauss 1973,p.109). During constant comparative analysis, the researcher develops possible codes and categories based on pieces of data which suggest or indicate them. These tentative codes and categories are then checked by comparing them with incidents described by the data. Moving from data to analysis, and checking the analysis against previously gathered and incoming data enables the researcher to discover whether or not the codes and categories continue to be found in the data. The characteristics of each code

and category are also identified. This allows the researcher to generate a "theory that is integrated, consistent, plausible, close to the data" (Glaser and Strauss 1967,p.103).

It is necessary during constant comparative analysis for theoretical sampling, data gathering and analysis to occur jointly (Glaser and Strauss 1967,p.102). Sources of data are determined by theoretical sampling which is guided by constant comparative analysis. In turn, constant comparative analysis requires incoming data in order to check characteristics of, and connections between, codes and categories. This is a closely integrated, cyclical process. Strategies used in analysis of the data include a coding paradigm, open coding, axial coding and memoing, as described below.

Coding Paradigm

The coding paradigm is an analytic guide. Its use is central to coding procedures (Strauss 1987,p.27-28). The coding paradigm is used to discover the boundaries, properties and connections of the categories and processes identified in the data. Each is examined for the conditions required for it to occur, and consequences when it does occur; strategies, or long term plans with a specific goal; tactics, or planned activities with an immediate goal; and interactions among the persons taking part in the actions being analysed. Asking questions of the data helps to clarify what is happening. It also allows detection of gaps in the data which can be filled through theoretical sampling.

Open Coding

Open coding, an initial procedure, is unrestricted coding of the data (Strauss 1987,p.28-29). It is used on new, unfamiliar data. That is, it is the first coding procedure used in a study, and it is used on new data gathered as a

result of theoretical sampling. At these times, a detailed analysis of the data is done on a line-by-line basis (Strauss 1987,p.28). The data are separated into elemental components called concept indicators (Strauss 1987,p.25), and are named, or coded, with in vivo codes. An in vivo code is a name that derives from the words used by the participants in the study (see Table 1).

Concept-indicators are compared one to another. Those which seem to refer to the same phenomenon are placed together as a category. The category is coded using an in vivo or constructed name. A constructed name is one that is given to a category by the researcher. It involves a certain amount of concept analysis as the name must accurately reflect the characteristics of the category. If it does not, a slight movement away from the data may occur and the theory will be less well grounded.

Axial Coding

An essential part of open coding is axial coding (Strauss 1987,p.32). As categories are identified, each is analysed in detail using the coding paradigm. This involves (1) "laying out the properties of the category" by examining the concept indicators that make up the category; (2) hypothesizing, using the coding paradigm, "the varieties of conditions and consequences, interactions, strategies and consequences associated with the category; and (3) recognising connections with other categories" (Strauss 1987,p.64).

The result is that a great deal is known about the category, and that knowledge is grounded in the data; it is conceptually dense. In addition, recognising connections between categories assists in the discovery of the core category. The category which is central because it is connected to a majority of the identified categories and it explains their purpose.

Table 1: Example of Analysis

<u>INDICATORS *</u>	<u>IN VIVO CODES</u>	<u>CATEGORIES</u> (CONSTRUCTED CODES)	<u>COLLAPSED CATEGORY</u>
THERE WAS A CARD UP THERE _____	ADVERTISEMENT _____	MEDIA	** INFORMATION SOURCES (CONSTRUCTED CODE) OR HOW DO I FIND OUT ? (IN VIVO CODE)
SAW AN AD IN THE NEWSPAPER _____	NEWSPAPER _____		
THERE WAS AN ARTICLE IN THE NEWSPAPER _____	MAGAZINE _____		
I READ [MAGAZINE] A LOT _____	BOOKS _____	FORMAL GROUPS	
SHE GAVE ME BOOKS ON FEMINISM AND HOUSEWORK _____	RADIO _____		
ON THE RADIO THERE WAS A TALK _____	CLASSES _____		
I WENT TO ALL THE CLASSES AT THE HOSPITAL FOR PEOPLE HAVING BABIES _____	MEETING _____		
I WENT TO THIS MEETING _____	LE LECHE LEAGUE _____	PERSONAL CONNECTIONS	
I LUCKILY BELONGED TO LE LECHE _____	PARENTS' CENTRE _____		
I'D ALSO ATTENDED A PARENTS' CENTRE CONFERENCE _____	PLUNKET _____		
BUT THE PLUNKET COMMITTEE THERE IS REALLY GOOD _____	MOTHER-IN-LAW _____	FORMAL CONNECTIONS	
MY MOTHER-IN-LAW POINTED OUT _____	MOTHER _____		
MUM WAS THERE, SO I HAD A TALK WITH HER _____	OLDER MOTHER TYPE _____		
THAT OLDER MOTHER FRAMEWORK YOU CAN TAP INTO _____	BOSS _____	EXPERIENCE	
I CONFIDED TO MY BOSS [WOMAN] _____	SISTER _____		
MY SISTER WAS WORRIED _____	FRIEND _____		
I WAS TALKING TO A FRIEND WHO WAS A VEGETARIAN _____	HUSBAND _____	- TRY AND SEE	
I WENT HOME AND TALKED TO MY HUSBAND _____	DOCTOR _____		
I WENT TO THE DOCTOR _____	KARITANE NURSES _____		
SO THEY [KARITANE NURSES] SAID _____	HOMEOPATH _____	- I'VE HAD IT	
I RANG MY HOMEOPATH _____	- TRY AND SEE		
I THOUGHT 'TRY IT AND SEE WHAT HAPPENS' _____	- I'VE HAD IT		
I DID WHAT THE BOOK SAID _____	- SHOWED ME	NOTE: * ONLY ONE OR TWO EXAMPLES ARE GIVEN FOR EACH CODE ** THIS IS PART OF A PROCESS CALLED <u>FINDING OUT</u>	
I THOUGHT 'I'M WILLING TO TRY ANYTHING' _____			
I HAD THIS FLU AND I'D HAD AN EARACHE, I THOUGHT 'MAYBE THAT'S ALL SHE'S GOT' _____			
I FELT IT ON MYSELF, I'D HAD THE FLU WITH MY GLANDS UP, I COULD REALLY FEEL A BIG LUMP ON HIS NECK _____			
MY FRIEND SHOWED ME HOW TO FOLD NAPPIES _____			
SHE [NURSE] GOT ME A PUMP AND SHOWED ME HOW TO EMPTY SOME OUT _____			

The following example of axial coding (which also demonstrates use of the coding paradigm) is taken from the second participant's interview. She stated concerning her initial contact with a naturopath: "It must have been in the back of my mind, and on hearing about it [naturopathy], I thought, 'Oh well, try it and see what happens sort of thing'." The concept indicator of interest in this example is Try and See. Scanning the interview revealed the following antecedent conditions.

- Health concern* - *Child's asthma*
- Previous knowledge* - *I must have read about it [Naturopathy] a year before I took C.*
- Low risk* - *I've got nothing to lose.*
- Looking for another way* - *I thought there had to be another way, apart from the medication.*
- Convenient access* - *Because I think had he [Naturopath] not been coming to my City, he has his clinic in another City, I don't think I would have bothered straight away. All that travelling just to see him.*
- Trigger - Heard about it now* - *The woman in the shop was telling another customer about it. I listened in and thought 'That sounds like a good idea.'*

At this point, the woman decided to Try and See. She made an appointment and consulted the naturopath in order to Find Out about his methods. The following are consequences of the decision to Try and See.

- Finds out what* - *The naturopath was "telling me how some food, people are allergic to different types of food and things ..."*

Mastering:

- Becomes aware of need to know how* - *I really needed the guidance of someone to suss out what they need and what might not be suiting them.*
- Finds Out How (Guidelines)* - *"Just sort of knowing where to start. That was the biggest help we got."*

- Finds Out What to expect* - "and knowing the possible side effects"
- Follow guidelines closely* - "... the first six months because I kept it [diet] strictly."
- Make sure I'm doing it right* - "I occasionally go back for reassurance, make sure I'm doing the right things."
- Get child to follow guidelines* - It was hard starting off, on this very strict diet which was virtually vegetables, which he doesn't like very much anyway and cutting off all his favourite foods.
- Hard to change* - It was hard the first 6 months.

Evaluation:

- Makes a difference* - "We don't have occasion to see him [doctor] too frequently since we've been on the diets."
 "... asthma under control through diet and the thrush under control through diet as well."
 "The whole family is eating better quality food."

The persons taking part in the action are the woman, who is concerned about her child's health and the amounts of medication needed to deal with the asthma. She consults the naturopath and follows the guidelines he suggests. The child is the recipient of the health care strategy and reacts by not eating foods he doesn't like, so his mother must work to find foods he will eat that are within the guidelines. The dietary changes affect the whole family. The woman sees that the diet has made a difference and stated, "We persevere along."

In reality, axial coding requires taking each instance that occurs in the data and checking for concept indicators and how they relate to the category. For example, in another instance of Try and See, the participant tried waiting to see if the health concern was a childhood virus or if the attention of a doctor was needed. This involved supportive

health care and keeping watch to see if the signs of illness would change towards normal or continue and possibly get worse. As a result, keeping watch was added to the categories related to Try and See.

Selective Coding

When it is recognised that the connections between categories frequently lead to a central or core category, selective coding begins. At this point:

all other subordinate categories and subcategories become systematically linked with the core. In other words some of these links had already been established, now the search for them, and their coding, are done concertedly. (Strauss 1987,p.69).

Some properties of a core category are that it occurs frequently in the data, that is "the indicators pointing to the phenomena represented by the core category must occur frequently" (Strauss, 1987,p.36); it takes a longer time to saturate; it is easily related to other categories; it is a dimension of the problem for the participants in the study, and it has "clear and grabbing implications for formal theory" (Glaser 1978,p.95-96). The core category is central to the grounded theory.

Discovery of a core category for this study came later in the analysis rather than earlier. The researcher tried out various possibilities and was tempted towards premature closure. Some categories which might have become the core category were Finding Out, Observing Signs and Mastering. However, these categories did not answer the question 'Why do the participants do these things, ie: Find Out, Observe Signs, and Master?'. Each of these categories, upon analysis, is a process. They each consist of stages and they are inter-related. Observing Signs is essential to Finding Out and Finding Out is the initial stage of Mastering. They are all part of a basic social process whose core category, the motivating force from which these

contributing processes emanate, the researcher had yet to discover. Finally, the researcher looked at what was happening with the woman that was different from what was happening for the health care consultant. From this it became apparent that the constancy of the relationship between the woman and her children and the even more constant awareness of herself, of her concern, and of a supportive/protective stance was the motivating force. The researcher gave the basic social process the constructed name of Bonded Caring, and began selective coding.

According to Glaser and Strauss, when no new information concerning a category is found, it is theoretically saturated and data collection for that category ends. Hutchinson (1986,p.124) states that a code is saturated "when a researcher can answer, via the data, questions regarding the cause, context, consequences and so on of the particular code." The consequence of theoretical saturation is that "relations among categories and their properties become apparent and conceptually dense." (Strauss 1987,p.35).

Analytic Pitfalls

The process of constant comparative analysis requires the researcher to take the participants' stories and break them into pieces, concept indicators. It is then necessary to tease out the meanings behind the participants' thoughts and actions and re-fit the pieces of data together in a way that conveys these meanings. The conveyance of the meanings is the theory.

During this process, the researcher used the data, an element of intuition and questioning to discover the connections between categories and the core category. The researcher discovered that unless she moved constantly back to the data to verify hunches, it was easy to move away from the data and end up with portions of the analysis based solely on intuition or logical thinking. As an

example, the researcher discovered in the data the category, looking back. She decided that, logically speaking, women would also look ahead. Until further data collection and analysis occurred, this hunch was not grounded in the data. Data were gathered and the researcher discovered that women did look ahead and think about the consequences of the present health concern. However, it was discovered that women also looked ahead to the immediate future in order to determine what had to be done to coordinate the family's needs so she could be free to cope with the current health concern. Had the researcher relied exclusively on logical thinking the aspect of coordination would have been missed.

A second problem occurred when the researcher found pieces of data that might fit a favoured theory. This involved interpreting the data more broadly than it warranted so that the interpretation was not grounded in the context of the data. Avoiding and correcting this situation required a perceptive thesis supervisor, a willingness to let go of a favoured theory and to be open to the possibility that the data might have other meanings. Again, the constant checking of hunches, using the data as the standard of proof, helped circumvent the problem of fitting the data to a preconceived theory.

Theoretical Memos

Writing theoretical memos assists the researcher to keep track of ideas about codes, categories, processes and their connections (Strauss 1987,p.18). Memos are written under two circumstances. The first, a memo is written at any time an idea about the data occurs. It is written down immediately so that the idea is not lost. Second, a memo session may be initiated by looking at coded data and asking questions of the data.

Memoing begins when data collection begins and ends when the report is written. Flexibility is a key characteristic

of memos. They are written when ideas occur and it is not necessary to follow formal rules for writing (Glaser 1978,p.85). The memos should be written in conceptual language about categories rather than about people. This helps to keep the embryonic theory on a conceptual level (Strauss 1987,p.128).

Memos are kept separate from the data. Each is headed with the code or category to which it refers. Periodically, the memos are sorted into the categories they represent, analysed and integrated into the emerging theory. Thus sorted, they represent a major portion of the theoretical write up. Examples from the data may be included to illustrate points (Glaser 1978,p.86).

Strauss suggests that memos serve various purposes (1987,p.128-129). For this study, three types of memo were used. The theoretical memo contained ideas that are "sparked" by the data (Strauss p.128-129). Code memos referring to the coding paradigm in reference to particular categories and processes, and to connections between them were used. Method memos contained notes concerning data needed (theoretical sampling), what to do next, how interviews were proceeding, etc. (Table 2,p.49).

Integrative Diagramming

A second analytic technique to assist integration of the theory is integrative diagramming. It is a visual representation of the coded data. Once connections among the coded data are discovered, the connections can be diagrammed. The functions of a diagram are to pull together what you know about the data; to clarify what you do not know and thus assist theoretical sampling; to stimulate questions about relationships among data; and to assist with integration of new analytic discoveries about the data (Strauss 1987,p.171).

Table 2: Examples of Memos**■ Code Memos:**

Aware - Awareness is based on knowledge of principles. Knowledge comes from experience (try and see) and is acquired through books, health care consultants, friends, family, etc.

Consciousness - This appears to do with specific awareness, ie: conscious of what they eat, how much they sleep, basics like nutrition and hygiene.

I realised / looking back - Realising is one consequence of looking back. One can look back from different vantage points and come to new realisations. The ability to look back from more than one vantage point produces a greater possibility for change.

■ Theoretical Memos:

Home Care - In the final analysis the vast majority of health care occurs in the home and is initiated, maintained and coordinated by the mother.

Sharing concern - It appears that at its best, this is a reflection or mirror of processes the woman uses as a result of Bonded Caring. Similar processes, but with a different intensity because the constancy and intimacy of the relationship is different.

Approaches - Women develop their own approach to health care based on what they have learned and what works.

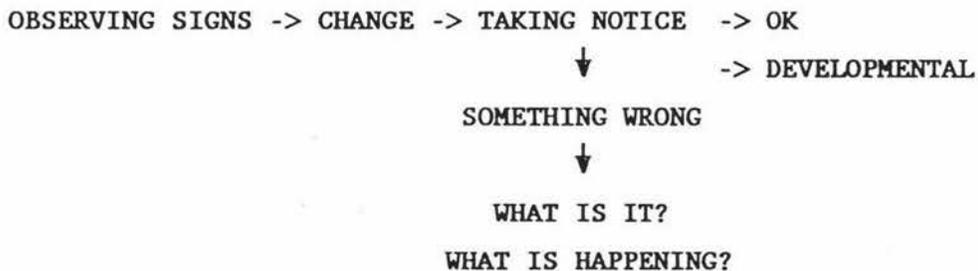
■ Method Memos:

Purpose is important. What is the reason for putting time, energy and effort into health care at home. How much time does a mother actually spend caring for and thinking about her children's health. I think it is a major activity in the home. How about her own health and her partner's health needs. Need to get some data about this.

I have found several levels of experience for the women based on situation. I need to sort through them and find out what characteristics belong to each level. I also have three major types of experience with health professionals: bad, okay, and wonderful. So putting these two together may show what makes a bad, okay or wonderful experience at each level of expertise and show whether or not there are differences.

Diagrams are done periodically throughout the data analysis. Each diagram is built upon the previous one (Strauss 1987,p.163). As analysis proceeds and density of the theory increases, the diagrams will show increasing integration. The last diagram of the series is a visual representation of the grounded theory (Strauss p.183).

Early attempts to diagram relationships between concepts were abandoned as the diagramming seemed premature. A concrete picture of possible relationships seemed to impede the researcher's conceptual thinking about these relationships. Later, the researcher began to diagram possible relationships for each category as part of the code memo. For example, a code memo about Something Wrong and Taking Notice included the following diagram:



These partial diagrams led to a more complete diagram of the process of Striving to Know What and Striving to Master (see p.107 and 135). However, the researcher did not complete a diagram of the process of Bonded Caring. This did not happen because the researcher felt overwhelmed by the inter-relatedness of the concepts and could not imagine how to illustrate a three dimensional process on a two dimensional page.

Decision Trail

In order to find participants who could, initially, best answer the research question (theoretical sampling), a naturopath was approached, the study explained and a

request for permission to advertise for volunteers in his clinic was made. A consent was signed which stated the purpose of the study and gave permission to advertise on the premises (Appendix 1). The naturopath also provided a list of names of persons who might be interested in the study. Two participants were found from the list. Another two volunteered for the study through the notice (Appendix 3) placed on a bulletin board in the naturopath's office.

When the study ended, eleven women had contributed fourteen interviews. The participants included in the sample varied in terms of age, ages of children, culture and income. The women's ages varied from 21 to over 50. One woman was 21 and one was over 50, the rest ranged between 30 and 40 years of age. The ages of the children in each household were one prenatal; four with preschool children only; two with pre-school and pre-teen children; one with pre-school, pre-teen and a teenager; one with a pre-teen child and two adult (out of the house) children; and two with teenage children. As to income, exact figures were not ascertained. Of the three single parents, two had fixed incomes and were selective about the health care services they used. The third had a teenage child and she was able to work part-time to supplement her income, however her own illness influenced the amount of work she was able to do. Seven of the participants seemed to have a moderate income. They spoke of being careful with the money spent on health care services but they did not have to choose between eating and health care, as the women on fixed income did. One participant seemed to have money for extra expenses. Cultures represented were Chinese, Maori and European. A weakness in the area of sampling is that five acquaintances were interviewed for opportunistic reasons. Four were well known and one had been met sometime previous to the study. It is possible that this contributed to the apparent uniformity of middle class values, i.e. striving for a better life for themselves and their children, held by the women. All participants except one were well educated, and all were articulate. This is perhaps an example of 'elite

bias' as defined by Sandelowski as occurring when the participants are "the most articulate, accessible or high-status members of their groups" (Sandelowski 1986,p.32).

Throughout the study, each interview began with an explanation of the study and the signing of a consent to take part in the study (Appendix 2). The main question asked of the first four participants was: "Could you talk about, in detail, what brought you to the decision to see a naturopath". Other information requested included a description of what information they received from the naturopath and what they did with it; under what circumstances they consult a doctor, and under what circumstances they consult a naturopath; and their personal definition of health.

As expected, open coding, the initial analysis generated a great number of codes. The codes were examined and similar codes were placed in categories. Some of the main concepts discovered in the first four interviews were: approach, way, must be another way, control, mastering, labelling, risk, medication, diet, homecare, health concerns, reassurance, knowing, try and see, and evaluation phrases such as 'these aren't working', 'something is better', 'come right', 'time will tell', 'I think there is a connection', 'I don't know whether it helped or not'. Contents of early theoretical memos centered upon the idea that women contact health care consultants for advice, remedies, to find out what the problem is if they don't know, and reassurance. However, health care is managed by the women in the home.

An attempt was made to diagram the connections between the categories. This resulted in a diagram that plotted the women's movement from identification of a problem through the decision to see a naturopath and the following of the naturopath's suggestions. The diagram was very similar to ones that demonstrate care-seeking behaviour (see Fielding 1982,p.19; Morrell 1979,p.115). The researcher realised

that while this might be part of the answer to the research question, it was not the full answer. There was something happening that underlies the care-seeking diagram. Further coding, analysis and data gathering was needed.

At this point a young Maori woman with whom the researcher was acquainted dropped by to share the news that she was pregnant. As she talked about her experiences with doctors two things became apparent. First, she had made a decision to change doctors. Second, she lacked basic knowledge about pregnancy and health care associated with it. The researcher asked if she would be willing to be interviewed. This is an example of opportunistic sampling combined with theoretical sampling. The participant suited the needs of the study and, in a serendipitous fashion, was available.

Codes from this interview included not knowing; family support; asking questions; poor experience with a health care consultant; emotionally upset identified with phrases such as 'sad', 'I felt horrible', 'I didn't feel like a human', and 'scared'; never trusted; good experience with a health care consultant; explained so I could understand; listened; referral; baby book; tests okay; nothing wrong; talk about anything; confidence; interested in something else; didn't work; and first time. Theoretical memos concerned how a woman's level of experience (i.e. first experience or more experienced) affects her and what she needs from a health care consultant; and the content and results of interactions with health care consultants that resulted in loss of confidence or increased confidence.

Of the first five women interviewed, one was pregnant with her first child, three had teenage or school age children, and one had school age and preschool children. It was decided that data from women with young children might be helpful. A playcentre committee was approached with a request for permission to advertise for volunteers on playcentre premises. This was not necessary, as three members of the playcentre committee volunteered to

participate. This is a combination of theoretical and volunteer sampling. Theoretical because it provided three participants with young children. And volunteer because they answered the request for volunteers and it was not presented to the playcentre mothers in general. The researcher wondered if the inter-relationships of these three participants influenced their health care choices to an extent that they would be a homogenous group. Would they pattern their health care choices after each other? This did not show up in the data. Three further participants were acquaintances of the researcher. One was a Maori woman with two young children whom the researcher asked to participate in order to add racial diversity to the sampling to see if it came through in the analysis. The second was a neighbour with young children who had expressed interest in being interviewed. The third was also a neighbour with one pre-school child. These three participants had not used complementary therapies. (See Table 3 for summary of participant characteristics.)

The first five interviews provided data about the choice of health care consultant. To approach saturation, data was needed about other types of health care choices. This included the choice to consult mainly a doctor; circumstances under which other health care consultants, including nurses, were visited; how it was decided that it was time to see a health care consultant; and what kinds of health concerns are handled at home. Therefore theoretical sampling directed the questions that were asked.

Examples of interview questions are: "Could you talk about the different types of health care people you have used?", "You have mentioned a doctor, a midwife, and a Plunket nurse, could you talk in detail about the last time you went to the doctor and what happened?"; "Moving on to the Plunket nurse, could you tell me how you became involved and your expectations?"; or "Can you talk about one of the last times you've been to the Plunket nurse and talk about what made you decide to go to see her, specifics?".

Table 3: Characteristics of the Sample

1.	CITY	HEALTH CARE	AGES OF CHILDREN	MARITAL STATUS	RACE
1.	A	COMPLEMENTARY	16	SINGLE PARENT	EUROPEAN
2.	A	COMPLEMENTARY	15, 17	MARRIED	EUROPEAN
3.	A	COMPLEMENTARY/MEDICAL	7	MARRIED	EUROPEAN
4.	B	MEDICAL	1, 3	MARRIED	EUROPEAN
5.	B	MEDICAL	PRENATAL	MARRIED	MAORI
6.*	C	MEDICAL/COMPLEMENTARY	4, 6	SINGLE PARENT	EUROPEAN
7.	C	MEDICAL	4, 10 mo	MARRIED	EUROPEAN
8.*	C	MEDICAL	1,3,5,11,13	MARRIED	EUROPEAN
9.*	D	COMPLEMENTARY/MEDICAL	4, 6, 6 mo	MARRIED	CHINESE
10.	E	MEDICAL	2, 4	SINGLE PARENT	MAORI
11.	B	MEDICAL	2	MARRIED	EUROPEAN
* INTERVIEWED A SECOND TIME.					
** PARTICIPANTS CAME FROM FIVE CITIES WITHIN THE BOUNDARY OF ONE AREA HEALTH BOARD.					
*** A MIX OF PURPOSIVE AND OPPORTUNISTIC SAMPLING, ELEVEN PARTICIPANTS PROVIDED 14 INTERVIEWS OF APPROXIMATELY 90 MINUTES DURATION EACH. THIS YIELDED APPROXIMATELY 200 TYPED (1½ SPACED) PAGES OF DATA.					

Information about what was happening when a woman chose to care for a health concern without contacting a health care consultant was obtained by asking a question similar to the following one. "I - Can you talk about a time a child was ill, how you noticed and what you did in detail at home. P - What would happen at home without involving a doctor? I - Yes."

As data gathering and open coding were ongoing, the stacks of paper rose higher. Each sheet contained one indicator. Indicators of each category were held together by paper clips. Connections between categories were tentative, and the researcher was feeling overwhelmed. Making sense of it all seemed impossible. At this point, the researcher began

reading to assist theoretical sensitivity which Strauss defines (1987,p.21) as being able to think about data in theoretical terms.

Having identified that levels of experience seemed to affect the women's decisions, the researcher reviewed Novice to Expert (Benner, 1984). This provided the idea that experience is situational (Benner p.178; Dreyfus and Dreyfus 1986,p.16-36). A person may be experienced in one area and inexperienced in another. This explained the situation where a woman might be inexperienced about a health concern, but could determine early in an interaction with a health care consultant what kind of relationship was occurring. At this point axial coding about levels of experience and what was happening in the interaction between the woman and the health care consultant began.

The women interviewed had vivid memories of certain interactions with health care consultants, and this seemed to affect health care decisions. Having stumbled upon the theory of neuro-linguistics, the researcher wondered if this would assist in understanding what was happening within the interactions for the participants. After reading Princes Into Frogs (Bandler and Grinder 1979), it became evident that the data had not been gathered to answer this question. The neurolinguistic theory suggests that every person has a dominant mode of interaction with the world. The major modes are visual, auditory, and feeling (kinesthetic). The words people use in their language reflects their main way of interaction with the world. According to the theory, people who talk in the same mode will understand each other more easily, while people who talk to each other in different modes are at risk of "talking past each other" (a term coined by Metge and Kinloch 1978) - that is, they will have difficulty understanding one another. Since it was not the research question, this line of thought was abandoned. However, the authors did distinguish between knowing what and knowing how. Bandler and Grinder (p.9-10) suggest that while they

don't "know what" a specific therapist does to achieve results, they could say "how" it is done. Similarly, Dreyfus and Dreyfus (1986,p.16-17) differentiate between "knowing how", which is the result of practice and experience (and which is what a specific therapist does), and "knowing that", which is the awareness of rules or sequences of operations (which is "how" it is done). As the researcher had a sizeable stack of indicators in the category of knowing, they were examined to see if there were sub-categories. The sub-categories of Knowing What and Knowing How were discovered.

Analysis of examples of health problems that women took care of at home and health care problems that they took to a health care consultant showed that women made detailed observations of their children and of themselves. There was a fairly constant, generalised awareness of what was happening while life proceeded in a normal or usual way. When a woman realised a change had occurred, she focused her attention on the change to find out more about it. This led to axillary coding of the categories of observing signs and interpreting signs. These categories are connected to levels of experience. Later in the analysis, the researcher realised that women observed and interpreted signs about what was happening in interactions with health care consultants as well.

Another group of categories that was extended concerned the women's valuing of the health care consultants based on the interactions they had. Experiences with health care consultants could be categorised as undermining, tolerable, efficient, and affirming from the women's viewpoint. A woman's knowledge, confidence and experience were elements that affected the woman's response to each interaction with a health care consultant.

Two more participants were asked to participate as the researcher was trying to confirm and saturate categories already determined. This was opportunistic sampling. In

addition, three of the women were re-interviewed to confirm and extend categories. One was interviewed when the researcher had considered that observing and interpreting signs might be a core category. However, it was later decided that this was premature closure as the question of why women do these things was still unanswered. In fact, many categories and several processes had been identified, each interesting and interconnected. They showed what these women were doing but none answered the question why do women do these things.

The researcher went back to the data and re-read the interviews. As a result, it was suspected that the mother-child relationship had something to do with why the women's health care activities were centered on observing and interpreting signs, striving to know what and striving to master. Two categories emerged, Bonded Caring and Getting On With Life. Bonded Caring became the core category and selective coding began. One result of selective coding was the discovery of a category, Sharing Concern, which explains how the participants hope others, including health care consultants, will respond to their Bonded Caring activities. As the analysis was written, edited and re-written further theoretical notes and coding revealed that two categories, social interconnectedness and caring and their relationship, were essential to Bonded Caring.

Once the core category was identified and most of the analysis written, the grounded theory was presented to a group of staff and graduate students (about 10 persons) at the Department of Nursing Studies, Massey University. In addition, each of the participants was sent a copy of the rough draft of the analysis with a covering letter (Appendix 4). They were asked to comment upon two sections of the analysis, stating whether or not each fitted their own experience. They were also asked to sign a consent form (Appendix 5) which allows the researcher to use excerpts from the interviews for professional purposes such as presentation of the grounded theory in journal articles

or professional meetings. Eight replies concerning the analysis and ten consent forms were returned. The participants' replies and some comments from staff and graduate students will be integrated into the discussion of the analysis.

Three participants asked if they would receive a summary of the completed research. This was provided for each participant. A summary was also sent to the naturopath who allowed the researcher to use his clinic as a source of volunteers (Appendix 6).

Conclusion

Constant comparative analysis and integrative diagramming, the analytic strategies, and the decision trail which underlies the analysis were presented in this chapter. This concludes the background material of the thesis. Part II consists of six chapters that contain the analysis. The categories and processes that contribute to the grounded theory, Bonded Caring, are presented. Also included are the fit from the participants' point of view and some integration with existing literature.

PART II: ANALYSIS AND THEORY FIT

Chapter 5: Health and Illness Categories

In Part I, the background of the study, the strategies and procedure used to generate this grounded theory were discussed. In Part II, chapters five through ten contain the analysis of the categories and processes associated with Bonded Caring and how they relate to the literature. This chapter begins with information about the organisation of the analysis. The categories of Health and Illness, Health Concerns, Evaluating Risk and Levels of Health Care are then discussed.

Organisation of the Analysis

Organisation of Chapters. Each chapter consists of several sections, each describing a category and its concept indicators. Integrated within the description of the category are the comments made by the participants in response to the rough draft of the analysis and the fit with literature.

Organisation of Categories. Each category described arises from indicators found within the data. Quotes (indicators) from the participants' interviews are used to support each category. These are indented and italicized. Each is followed by the pseudonym, in brackets, representing the participant whose interview is quoted. Within the quotes clarifying remarks added by the researcher are enclosed in brackets.

The units of comparison are each incident, phrase or word

within an interview. As a result, two situations arise. One, occasionally more than one example (indicator) is taken from a single interview for a single category. And two, at times a quote appears more than once in the analysis because one phrase is an indicator of one category, while another phrase is an indicator of a second category.

In reference to gender specific language. The use of gender specific language within a research paper requires diplomacy. It is necessary to be clear without reinforcing social bias towards women or men. Initially, the researcher approached this issue by using masculine pronouns in a generic sense. However, after reading the rough draft of the analysis, two participants indicated they were "grated" by this usage.

It's just a minor technical hitch really, but I feel 'he/she' would be better than making the gender of the health consultant male only. I'm usually not a stickler for such observances - feeling even reluctant to call myself a feminist. This page [referring to health care consultants] really grated, however. I feel as women we must encourage our daughters to look beyond expected limits. Consultants can be and are female as well. [Valerie]

■ ■
Just one little niggle - some references to health consultants as "he" only. [Lauren]

Therefore the researcher decided that since the participants are women, most nurses, many complementary therapists, and an increasing number of doctors are women, where use of a gender specific pronoun is unavoidable, the feminine pronoun will be used. However, gender references within quotes from participants' interviews will be unchanged.

Health and Illness

The women in this study suggest that health may be experienced physically, mentally, emotionally, spiritually and socially, and that these are interconnected. Health

feels good, supports proper functioning, and is associated with a sense of inner strength and peace of mind. Ill health or disease is viewed as an obstacle that can interfere with development in all areas. It is associated with increased stress on the individual and family.

Health is your body working properly and feeling good about yourself. [Debbie]

I really believe that health is a total philosophy about one's being. [Sarah]

Being healthy ... it's a state of mind and a state of body. If I had gone through just concentrating on my body, wholly, I don't think I would have achieved what I've got now without also bringing in spiritual health and mental health. [Kelly]

I know if you feel healthy, you feel good. It's not just a physical thing. You also feel good about yourself, good in your mind. [Christine]

I think health is being able to function at your best level and if there are any barriers that stop that, physical, emotional, mental, spiritual barriers, then those barriers have to be dealt with. [Valerie]

It's [health] really important, probably gives me peace of mind ...

If any others had been really bad asthmatics, I don't know how I would have felt about going on having any children because - lots of pressure on the whole family especially if there was one in and out of hospital, or the time pressure apart from the emotional pressure would be really great. [Ione]

And then increasingly the allergies were interfering with what I saw as my lifestyle to the point where I was finding it difficult just to go to work. [Alice]

A lifelong process, health changes from one level to another over time. If the change is considered destructive, efforts are made to halt the destruction and/or to support or promote changes towards regaining a previous or higher level of function. Support or non-support of developmental changes also influences health.

The stress levels sent me down the tubes again ... I got pretty sick again ... My health is pretty patchy, but I felt I'd climbed up a level or two from where I had been. [Alice]

■ ■
The change was sudden from quite fevery and listless, not wanting to do anything really except sleep. And then when she woke up the next time, she woke up bright as a button ... just back to her good old normal self. [Ione]

■ ■
I am very hesitant to use drugs and my children, until they became responsible for their own health care, which I feel they must be now at ages 15 and 17, the ages about - my daughter had her first aspirin and she took of her own choice which was 16. That's fine by me and once again looking back on my parents' example, I'm not going to make a hassle of it. It distressed me a bit, but and I think for the odd headache, now she will do so. [Sarah]

Concerning health and illness, participants confirmed and extended the analysis. The initial analysis shows that the women felt good health gave rise to a good feeling in the mind. In these examples, the women suggest that their state of mind could affect their physical health.

Agree with ideas on health. [Lauren]

I agree with what you wrote in this section. I skim read it initially and as I was writing my comments I began to think about "totality of health". I'd just decided it included a certain strength of mind, but not the stroppy assertive sort, when I saw you had the "mots justes" - inner strength and peace of mind. [Christine]

■ ■
We do need to look at health as a totality. I used to suffer with tension headaches. The first time I went to the Doctor's, she gave me Paracetamol and advised me to relax. The second visit she did give me Paracetamol, but she also told me I had to find what was causing the tension and remove it from my life. [Rachel]

■ ■
I agree health is experienced physically, mentally, emotionally, spiritually and socially and that these may be connected. Stress, certainly, from my experience extenuates one towards a general feeling of not feeling well. Therefore, the state of one's mind has a definite bearing on one's physical well-being. [Becky]

Being Healthy: Women's Images (Woods, et al. 1988, p.36-46) is a study in which content analysis was used to analyse 528 women's responses to the question "What does being healthy mean to you?" Results showed an emphasis on eudaemonistic images, the idea that health is exuberant well-being. These include actualising self; practising healthy life ways or taking action to promote health or

prevent disease; self concept or feeling good about oneself; social involvement; fitness or feeling stamina, strength and energy; cognitive function or thinking rationally and creatively; positive mood and harmony or feeling spiritually whole, centered, in balance and content. The study did not mention whether the women felt these images were interconnected.

Blaxter and Paterson (1982,p.27) state that participants in their study defined health functionally, "where to be healthy is to be able to carry out one's normal roles". In addition they state, "Health, to these women, was either the absence of symptoms of illness, or the refusal to admit their existence, the ability to define illnesses as normal or the determination to 'carry on' despite illness" (p.30). An important point, made by Robinson, is that signs of illness that interfere with one person's responsibilities and lifestyle may not be viewed as interfering by another person. "It is not inconceivable that a persistent sore throat may be more tolerated by the vast majority of Luton car workers than by school teachers for whom it would be an important impediment to the performance of one of their major social roles." (1971,p.117).

Health Concerns

The participants' health concerns fell into two broad categories, developmental health concerns and health problems, within the areas of physical, mental, emotional and spiritual health. A **developmental health concern** is one that arises as a result of normal growth and development. It is not an illness, but does require attention and care focused on ensuring circumstances that support optimum development. A **health problem** is one that arises from circumstances other than normal growth and development. Attention and care are focused on the return to a normal state or one that approaches normality. As stated previously, the participants did not view these as

distinct categories, but as inter-related. So, a sign of change could arise in one area, but the antecedent conditions may originate in other areas. For example, a woman may experience fatigue, but antecedent conditions could be a virus, being up and down at night with a baby, or depression because her marriage is breaking up.

A listing of some health concerns identified by the participants will follow. This area of the study is not saturated and this is only an indicator of the types of health concerns the participants had. The concerns the women had for themselves will be followed by the concerns they had for their children.

Participants' Own Health Concerns

Socio-physical health concerns. Because women conceive, give birth to and raise children, one area of health concerns has a social and physical origin. Some developmental concerns in this area were contraception, pregnancy, childbirth, breastfeeding and menopause. Some health problems the women discussed were lumps in the breast, cracked nipples, ectopic pregnancy, toxemia, caesarian, pre-menstrual tension and sexually transmitted disease.

Physical health concerns. Developmental concerns of a physical nature were diet, rest and activity. Health problems connected with diet were allergies, thrush, weight, digestive problems and eating too much or too little. Problems connected with rest and activity were insomnia and fatigue. Some participants stated their fatigue or insomnia was stress related and had a social origin. Other problems mentioned were accidents, sinus, carpal tunnel, headache and skin cancer.

Mental health concerns. In the area of mental and emotional health, developmental concerns mentioned were a

need for mental stimulation and an outlet for relief from the intense mother-baby relationship. One woman needed to learn to manage her extra-sensory abilities. Another was concentrating on changing her thought patterns as a means of enhancing her well being. Problems in this area were "baby blues", depression, confused thinking, and inability to remember. Stress was frequently mentioned.

Social health concerns. Developmental health concerns in the area of social health identified by the women were child training, family relationships and death in the family. Problems mentioned were past histories of abuse and rape, and marriage breakdown. While the women mentioned spirituality as a part of health it was not discussed in detail.

Health Concerns Associated with Children

Physical health concerns. Health concerns the women had for their children centered primarily in the physical and social areas. This does not mean that there were no other areas of concern, only that they did not arise in the interviews. Developmental physical concerns included how the child was affected during pregnancy, childbirth and breastfeeding. The child's weight and diet, hygiene, rest and activity and safety were also concerns. Physical health problems were accidents, allergies, ear infections, vision problems, eczema, thrush, digestive problems, and prolonged crying indicating a problem.

Mental health concerns. In the area of mental health one woman discussed providing her child with puzzles for mental stimulation, reflecting a developmental health concern. Another woman, whose marriage was breaking down, felt her child was having difficulty with the situation and sought counselling for the child. This is an example of a mental health problem.

Social health concerns. Developmental social concerns included child rearing, when to pick up a crying child, and toilet training. Health problems included concern about how various treatments for physical problems affect the child socially. For example, Ione was concerned about the affect wearing an eye patch to school would have on a child who would soon be entering school.

In a study carried out by Banks et. al. (1975), 198 women, aged 20 to 44 years, filled out a health diary for three to four weeks. The study showed that there were 37 symptom episodes cared for at home, to the one symptom episode that was presented to a doctor (p.118). In addition, a bar graph (p.119) showing symptoms perceived and cared for by the women and those presented to a doctor suggests that headache, changes in energy, backache, emotional and psychological problems, and colds are more likely to be managed at home.

Evaluating Risk

The motivating force that gives rise to health concerns is the preservation of life and preservation of the capability to function fully in its aspects; physical, social, mental, emotional and spiritual. The women in this study perceived the seriousness of a health concern in relation to the degree it interfered with life and developmental life activities. They were concerned not only with the immediate effects of acute health concerns but also with long term effects of chronic health concerns and of health interventions prescribed by health care consultants. In evaluating the risk associated with a health concern women might ask, "Do I know what this is?", "How serious is it?" and "Is there some way to manage it?". Based on the answers to these questions a degree of risk would be perceived and the participants' emotional response was based on this perception.

Low Risk Health Concerns

Low risk health concerns may be acute, such as minor accidents resulting in cuts and bruises, colds and childhood illnesses such as measles. Chronic health concerns that may be low risk are mild eczema or occasional tension headaches. Low risk health concerns are short-term, or easily managed, and interfere with developmental life activities only temporarily or not at all.

If it's just what I consider to be a childhood viral type thing where they are having fever one day, then I give them a spoonful or paracetamol and they're right the next day. [Ione]

■ ■
... various little niggly things like D. has got dermatitis on his ear. [Debbie]

■ ■
Oh, must have been the mumps epidemic we had over here and I knew that my child had mumps. [Valerie]

The participants' expressed concern about low risk health concerns conveyed a low level of anxiety coupled with a sense of responsibility to take care. Often the women knew what the concern was, knew how to care for it, and had some experience and confidence with managing it.

I think now that I realise if it's a cold or a virus, you can't do anything for it, I try even not to give them Panadol at home. [Debbie]

■ ■
It's getting bigger [skin cancer] but it doesn't bother me, because I know that when I get everything right, my own diet and my own mental health and so on it will just disappear. So it doesn't bother me. [Kelly]

Moderate Risk Health Concerns

Moderate risk health concerns interfere with developmental life activities in that they must be modified or stopped in response to the pain and discomfort or disablement of the health concern. There may be a prolonged but temporary loss of function. Acute problems such as ear infections, tonsillitis, deep cuts, broken bones or cracked nipples are

moderate risk health concerns. Allergies, sinus problems, and premenstrual tension are examples of moderate risk chronic conditions. The participants sought advice from health care consultants for moderate risk health concerns.

N. [baby] had chomped through my nipple and I had a cracked nipple and it was pretty uncomfortable, and I said to the Plunket nurse, 'I've got a cracked nipple, is there anything I can do for it?' [Christine]

Then I'd say it was actually a massive kick from a horse that picked me up and slammed me into something behind me. I thought I'd broken about three ribs. As it turned out I hadn't actually broken them, I'd dislocated them. [Had physiotherapy] [Kelly]

It just wouldn't shift [sinus problem]. Inside my head gets all blocked up and all my glands. Then you're going for weeks without being able to breathe properly and I think when I go then [to doctor] is when I end up feeling sick with it. [Ione]

Statements typical of the participants' response to moderate health risk concerns were: "It worried me" [Rachel], or "Another problem that was causing me concern ..." [Lauren]. Concern "implies an anxious sense of interest or responsibility for something." (Random House Dictionary 1978, p.278).

Other health concerns that initiate a degree of concern or worry are those identified from family history, past experience or anticipation of future developmental processes. In addition the women were concerned about their mothering abilities if they were first time mothers or were mothering under what they considered special circumstances.

There is a history of allergy or asthma in the family because his mother actually died of an asthma attack. [Lauren]

I think I have a high cancer awareness. Of my immediate family, I have two living brothers. My mother died of cancer, my father died of heart and cancer complications [sic] and my grandmother died of cancer. [Valerie]

I'm interested in mental health issues because of my past background. [Valerie]

■ ■
It is an extra sensitivity, I've never called it psychic but it is an extra sensitivity and now I realise that as a child I was shut down because I could tell what people were thinking. [Kelly]

■ ■
I've been to one or two seminars on menopause but I think I might be a bit early to be concerned about it ... I've actually been having an amazing amount of hot flushes. And I wanted to check out just how early one could start menopause. [Valerie]

■ ■
And I initially thought that my Plunket nurse would tell me anything I needed to know about feeding a child and anything of those other little care things that I wanted to know about and maybe even some medical things, whether to get worried about coughs and sneezes and snuffles... [Christine]

■ ■
She was a mother sort (Plunket nurse) and she treated me the way I needed to be treated, and that was that I was totally ignorant. [Ione]

■ ■
I used to have a bottle of milk every day. I thought because I'm that much older I better make sure I'm feeding him [baby] right, and I better make sure I'm eating right and this sort of thing. [Kelly]

■ ■
I was a new mother in a new suburb, suburb that was new to me; not knowing very many people; not having a resource to tap into as to how I was doing with a new baby. And also having the psychiatric field hover around me while I had this baby, waiting for a great blitz of post-natal depression as had happened with my first baby sixteen years ago. I was on pretty shaky grounds as a mother. [Valerie]

The women handled these concerns by gathering information from a variety of sources (see Using Resources, p.146-159) and in some cases by monitoring themselves by checking at intervals (see Checking, p.82 and 118) or seeking reassurance from a friend, relative, or a health care consultant (see Sharing Concern, p.178-197).

High Risk Health Concerns

High risk health concerns involve potential loss of life, function of a body part, or extensive interference with developmental life activities. Acute health concerns considered high risk might be signs of cancer, such as a lump in the breast, serious accidents or miscarriage.

Chronic conditions considered high risk are asthma, recurrent ear infections with resulting hearing loss, and severe allergies.

... and lo, I found one [breast lump] myself. I mean these are the sort of times I go to the doctor, I find a lump somewhere. [Christine]

Then she [doctor] turned around and said to me, 'Well you may have had a miscarriage, we don't know, we will have to wait eight weeks to tell.' Now that left me feeling lost. I didn't know what to do. [Ruth]

... but in my mind to have a baby who was asthmatic that would be quite scary because they wouldn't be able to tell you when they didn't have control. [Ione]

The women's reactions to what they perceived to be a high risk situation were described as: "I was frightened" [Kelly], "I was terrified" [Debbie], "I was really concerned" [Christine], "I was really, really worried" [Rachel], and "It was quite scary" [Valerie]. The health concern might be acute or sudden, such as the unforeseen need for a caesarian section or a wheezing child. Or, the health concern might have been continuing over a period of time with no sign of change for the better. Examples of this are a fretful child not gaining weight and one participant's continuing memory loss. As stated above, the women could foresee a possible permanent loss of function, of self concept or loss of life. The perceived seriousness of a situation increased if a woman didn't know what the problem could be, or if she was receiving no help and she didn't know how to manage it, which meant that the serious health concern would continue. In all instances the women sought help from a health care consultant. The choice of health care consultant will be discussed under Sharing Concern.

Participants evaluated the degree of risk connected with each phase of the evaluation and treatment process. The degree of risk connected with a method of treatment is weighted relative to the risk associated with the health concern. The greater the risk of the health concern the

less concern will be shown toward other considerations such as cost, inconvenience, or whether or not she will be considered "panicky" and treatment will be sought. A less harmful health concern will be managed with attention to other considerations. The evaluation of risk was made by the participants dependent upon their perception of the situation and previous experience and suggested their concern was weighted toward protecting their child or their self. As stated previously, risk was considered greater if a woman recognised that something was wrong, but did not know what.

And when we were coming home, she was wheezing and I was getting really, really worried. It was a Friday. And we got home about 2 or 3 in the afternoon. I got more and more worried and I thought 'Blow it, I'm going to take her down there. I'd rather go down today than to spend a weekend getting really worried and her getting crook.' So I rang up, and asked for a doctor's appointment. Because it was 4:30 on a Friday afternoon, of course, they wanted to go home. And I said that I was worried about her and they said, 'Well there's no doctor's appointments.' I said, 'Well, can I at least see the nurse.' They said, 'Okay then, bring her down.' It was more of a 'Come down so you'll shut up' type of thing. That was how I felt. Anyway, I took her down and went in. And we were sitting in the office and the nurse comes in and says 'Oh, are you the woman with the baby that is wheezing?' as if, you know, 'How dare you interrupt me' type of thing. She looked and listened to E. breathing and walked straight back out again. Came back in about a minute later with the doctor. And he prescribed her some ventolin to help her wheeze. [Rachel stated she felt she had been labelled a panicky mum in this situation.]

■ ■

When he was about five weeks old, I started feeding him in the evening and he was screaming with pain. Absolutely screaming with pain. And I sort of, I said to my husband, 'There's something very wrong here.' And anyway, I went to the doctor and he said, 'He's just got a bug. Stop feeding him for twenty four hours, and I'll give him some antibiotics.' I was 'anti' that anyway. But I thought, well, I had a problem. I couldn't put his life at risk and I didn't have any other options at that stage, not real options. I didn't know anybody in the alternative medicine field. And so I thought, 'Well, what do I do here?' So I thought 'Okay'. So I went off [breast feeding]. [Kelly]

Another participant describes the risk to the social development of her child.

And we chose to go privately because in my mind I was going to have everything right by the time she started school. I didn't want the same thing happening as what had happened [to another child]. [I - It would have affected her start ...] Well, I saw what it was with this other wee one. Because other children ridiculed her because she had to wear a patch and it makes her stand out as different. I think it's hard enough when they start without having that to cope with. [Ione]

Some participants considered the effects of frequent or regular use of medication to deal with a health concern to be almost equal to the danger of the health concern.

I got to the point where I was needing to take medication in order to just keep functioning. I wasn't prepared to continue that way. [Alice]

■ ■
Apparently these long term ones [asthma medication] are supposed to be quite safe, but in my mind I sort of think there have been so many drugs that have been brought in in the last 30 years, that nobody really is too sure about the long term effects on anyone because they haven't been going for long enough. [Lauren]

Another risk involves the right to have some responsibility for what happens to one's self during treatment. One participant discussed the risk connected with signing a consent form.

You have to sign your life away when you go to hospital, but I refused to sign mine away just this once ... The registrar gave me this piece of paper to sign and I said, 'Ah no, no.' It was about the time as somebody else had the wrong bit chopped off. [This incident had been reported in the newspapers.] So I said, 'Oh no, I'm a bit nervous about this anyway [removal of lump from breast] and really he's [specialist] been dealing with me, couldn't he possibly do it?'. And he [registrar] sort of crossed it out, or I did. [Christine]

Methods used to diagnose problems may also have a degree of risk. One participant chose not to continue injection tests for allergy because of the effects she experienced.

I went to a Doctor who has quite an interest in allergies and candida. He uses injection tests ... He tested me for candida and virtually wiped me out for quite some time. I really went into shock I think. For about a week I mostly just lay on the floor and cried intermittently. A weak,

weepy syndrome is part of the candida allergy ... I decided that I couldn't afford to continue testing for allergies, because that really messed me up for quite a long time, and it was quite scary. I just thought I couldn't afford to drop back, to let that happen again. [Alice]

Once conventional treatment methods have been tried and found to make some difference or to make no difference, and have been judged to entail a higher degree of risk, some participants tried complementary therapy because it was considered to be safer and there was 'nothing to lose'.

But I would also feel some beneficial effect from what he [Naturopath] did physically. I decided well, I didn't have anything to lose. I'll just follow it up for a while and see what happens. [Alice]

Well, I'll take C. to see him [Naturopath]. I've got nothing to lose, because I knew he [child] was taking so much medication anyway. [Lauren]

In Ditto, Jemmott III and Darley's study (1988,p.185), **Appraising the Threat of Illness: A Mental Representational Approach**, a model of illness threat appraisal is proposed.

... the individual confronted with an illness sign faces the possibility, but not the certainty, the illness will have specific consequences. To evaluate the threat the sign represents, the individual must estimate these probabilities and evaluate the seriousness of the indicated disorder's consequences. To the extent that the probabilities are estimated to be high and the consequences are viewed as serious, the illness sign should be perceived as threatening. (1988,p.185)

The above model suggests elements to an evaluation of risk which appear congruent with the participants' evaluations, but which indicate a need for further study in this area. In this study sampling for and coding of initial and later risk evaluation of a health concern was not carried out.

In a study of **Mothers' Rules for Problem Solving** (Pridham 1989), the women were presented two unnamed infant care problems related to infant feeding and crying twice during the first three months of their infant's life. The study

showed that the women's Commitments, or what was important to them concerning the situations, were first "the infant's condition or needs" and second, "the perceived seriousness of the situation" (p.65-66).

Evaluation of risk by mothers in their study is explained by Blaxter and Paterson (1982). "Dangerous symptoms", similar to high risk health concerns, were those "which were universally feared and known to be dangerous, for which emergency action - the calling of an ambulance, the summoning of a G.P. or an immediate visit to him - was likely to be taken". Low risk health concerns were, "At the other extreme, certain complaints and symptoms were seen as trivial, common and self-limiting that they were not believed to necessitate undue concern, or the problem was defined as not really illness" (p.53-54). They also suggest that perceived risk decreases as the mothers' experience with managing the health concern increases. "However, other chronic or frequent conditions could be treated lightly because they were normal for that child, the mothers were used to that problem and the diagnosis was known" (p.58).

Levels of Health Care

Women carry out, initiate or participate in health care practices on several levels, often managing health within a family on more than one level at the same time. A woman may also manage her own health on more than one level at the same time (Note Kelly's examples under the different levels of health care, p.79 and 80). Elements of protection and promotion are present within each level to varying degrees. A woman chooses the level of health care practice that is needed based on her perception of what is happening and what is needed and her perception of the degree of risk associated with the health concern.

An excerpt from Browner's (1989) article, **Women, Household**

and Health in Latin America, also shows that in a developing country, Columbia, women manage health on various levels.

There is, however, growing recognition of the fact that most women possess significant specialised knowledge concerning health care. This includes more than simply knowing how to provide their families with adequate food, fuel and water and how to dispose of household waste, although such tasks are ordinarily quite complex [basic health practices]. Women are also expected to meet the special needs of chronically ill, elderly or disabled household members for diet, exercise and rest [supportive health care]. They also manage acute illness episodes by determining when family members are ill and deciding what kind of care they will receive. It is usually women who prescribe remedies, decide at what point in an illness to seek outside attention and what type of practitioner to consult [curative health practices and evaluating risk]. (1989,p.465). [Bracketed comments are added.]

Raikes (1989) indicates that similar health care activities are carried out by East African women.

While the provision of food is a woman's primary responsibility for ensuring the survival of her children [basic health practices], linked closely to this is her responsibility for supplying the health supporting elements for the household, as well as being the initiator of health actions in an illness episode [curative health practices]. (1989,p.454). [Bracketed comments are added.]

Raikes also states that East African women recognise and identify illness and make choices as to what type of healer to consult.

Keeping Healthy

Keeping healthy, which might be equated with health maintenance, takes two forms. They are basic health practices and disease prevention. Basic health practices are designed to support developmental life activities. These include a conscious awareness of diet, dress, hygiene, rest and activity patterns and growth and development in social, mental, emotional, physical and spiritual areas. Health concerns arise in this level when

health practices stray from a standard that the woman uses to evaluate the adequacy of her efforts. The standard is based on the woman's personal beliefs and the principles and guidelines which flow from them, personal experience and acquired knowledge.

And one of the main reasons [for going to Parents' centre] was to meet people because you had coffee always afterwards with your group. I've only just pulled out of a group, and he's four. So we've been meeting a long time. Also by the time D. was coming up to six months, I needed an outlet, something to do. [Debbie]

In fact for F. I bathed her once a week because it was the middle of winter and I was in a cold house. With Q. he got bathed about every second day, sometimes every third day. When they are that young they don't get dirty anyway unless they are sick or they fill their trousers. [Rachel]

Well, I make sure they eat a balanced diet even when it's junk food it's balanced. [Rachel]

With their diet, I suppose that's one of the main things to a mum, thinks that's one of the main things helping their children remain healthy. [Ione]

But it was all so unpleasant in there [hospital] and so difficult to sleep, I decided I'd be better off at home. [Christine]

The second form of keeping healthy, disease or illness prevention, involves the known, and usually experienced, presence of a disease or health problem. Certain antecedents may be connected with its appearance, and its consequences are unpleasant. These health concerns are often chronic or recurrent such as asthma, eczema and premenstrual syndrome. Strategies, often aimed at preventing or altering antecedent conditions, are followed. Immunisations fall into this category.

So, if he goes to a birthday party, I say 'you can have a bit of this and that, but not too many lollies', but invariably 2 or 3 days later he'll come up coughing and he's really showing some sort of reaction to it. But then he'll go back to a more stricter diet and usually for a birthday party, I give him asthma medication beforehand too. So I'm trying to work it both ways. Because I've got all the medication here I'd rather do that than end up with a full blown asthma attack. [Lauren]

I have actually found that while breast feeding, I have cut out dairy products and eggs. In fact if I eat egg, like a whole hard boiled egg, next day he's as spotty as anything. So I think there is some connection. [Lauren]

■ ■
I'm also aware even in my management of the premenstrual tension I get, which of course affects my relationship with the children, I do things like I have a higher protein level of food before I menstruate. In consultation with a doctor, it's one of the few things that can help ease a bit of the tension. I also take Vitamin B supplements at that time. So it's just general sort of maintenance stuff that I do to stop allowing myself to get these things. [Valerie]

■ ■
And that was what was making my hair fall out. Because the girls were about eight, I was teaching them to swim in the ... pool. And the extra water supply, I can't tolerate the extra chemicals. So my hair was falling out. It was like I was being poisoned. And of course, you gaily sort of say you're allergic to water. You cannot eat any processed food whatsoever, if you are allergic to the water supply because everything is washed in water. Every single item of food has either got water in it or washed with water. All frozen foods, all tinned foods, all dried food, everything. It's all contaminated, as far as I'm concerned. [Kelly]

Efficacy of self-care measure for premenstrual syndrome (PMS) is an example of research that seeks to validate the usefulness of information on how to lessen the effects of PMS (Kirkpatrick, Brewer and Stocks 1990,p.281-285). This study provides valuable information in the area of illness **prevention** which women can use at home. Studies to discover and validate the usefulness of information circulating through a community can be valuable to women as they provide care in the home.

Enhancing Wellness

Enhancing wellness involves the management of basic health practices in specialised ways with the goal of not only keeping healthy, but of promoting development and functioning at one's optimum level. Vitamins, exercise, diet, and changes in self concept are often managed with this goal in mind.

I'm actually learning to seek to have my needs met in other ways. In ways which are positive and life enhancing. And

that's a big change. To actually see myself as a person with the capability and potential to do whatever I want to do. And the more positive I become, the stronger I get. [Alice]

And that has opened up a world of things, because I now realise I'm very sensitive and very psychic. And it's teaching me - the whole weekend was to teach you to cope with other people. Which of course I absolutely needed because I was psychic and I would have problems coping with what was coming at me, and that [the weekend workshop] taught me to cope with that [being psychic]. [Kelly]

Curative and Supportive Health Practices

When disease or accident occurs curative health practices and supportive health practices, or a combination of each are used. Curative health practices are aimed at eliminating disease and imply that once the cure is effected, the disease will not recur. Antibiotics and surgery are curative health practices.

Like I had a bad breast infection about three weeks ago. So I started taking lots of Vitamin C and everything, but ended up getting hot and cold and thought I must go to the doctor because otherwise I will be in a lot of trouble. So I went and got my antibiotics and I started coming right within two or three tablets. [Lauren]

And the nurse there at the doctor's surgery gave me a tube of antibiotic cream. And I put that on his leg and he was as good as gold. In a couple of days it [infected burn] started to clear up. [Rachel].

But, for instance, I've got skin cancer, I do not go to the doctor for that, because I know that if I get everything else right, it will go anyway. And people say, "You've got to go to the doctor." And I say, "No, they've had a go. And they haven't cured it, So, all right, my turn." (I - So you have given them a chance to look at that.) Oh yeah, yes, I have and its getting bigger but it doesn't bother me. Because I know that when I get everything right, my own diet and my own mental health and so on then it will just disappear. So, it doesn't bother me. [Kelly].

Supportive health practices do not cure the disease or heal the results of an accident. These practices support the child's or woman's health while the disease runs its course or healing takes place.

Oh I got the flu again, and it just wasn't on, I couldn't cope. And I came home and I, it was winter at that stage, I wrapped myself up in a sleeping bag, and I just stayed out on the deck everyday. For about a week I just lay out there. In the cold air and sunshine, I was quite lucky that it was sunny, let it have its effect on me and started going for walks. I was still married at that stage. But I managed to find things that I could do that made me feel better and I started to get strong. And continued to take vitamins and minerals, cell salts that were recommended to me by the naturopath. Had some massage from him, and osteopathy. And it seemed that at last I'd found something that really could help. [Alice]

So that's when I said, 'Well, I'll fill up the hotty and you go to bed for a while', and she agreed. Which is really unusual. She doesn't usually like to go to bed in the daytime. And within seconds, she was asleep. And when I went back to check on her she was really burning up. So I just let her sleep for a while, just let her sleep until she woke and then she really had quite a fever, so I gave her a teaspoon of Panadol mixture that was in the cupboard and she stayed like that for 24 hours really. She didn't want to eat, so I just kept giving her drinks and didn't encourage it. [Ione]

So appropriately I'm giving her more, getting her to bed earlier, giving her quieter times when she gets home from school, trying to ensure sort of up-moving the Vitamin C intake, intake with her food. [Valerie]

One major supportive health care practice which occurs at all levels of health care involves the presence of the mother when the child is ill. This presence is an aspect of bonded caring and fulfills a need of the mother and the child.

The familiar mother-child presence is really important for her not to be fazed within the hospital situation. But I - for me, I also had a need to be there, because I needed to know what was going on and the only way to know that information was to be there and keep asking. But my actual relationship with her - I mean I sang a lot to her while she was unconscious and talked to her and so there was definitely that sort of connection going on there but it wasn't a sense of control, it was just maintaining the connection. [Valerie]

She kept trying to take him away from me at night. Even when I said I wanted him. And I don't think the night nurse ... she should not do that. A mother needs her baby, however tired she is she needs her baby. [Debbie]

In regard to supportive health care and the effect of the presence of a mother during a child's illness, a recent study by Broome and Endsley (1989) investigated the effect of a mother's presence when her child was interviewed and later when the child received an immunization. They found "Mothers' presence had no significant effect on the children's behaviour during immunization, but contrary to prediction, was related to greater distress during the interview situation." In each circumstance, the interview and the immunization, when the mother was present she was asked to stand three feet away from the child, and during the interview was asked "not to prompt the child or answer any questions." The study does not state whether eye contact was allowed. Physical, verbal and eye contact are important means of communication. It is possible that under these circumstances the mother was present, but was not allowed to be supportive (or non-supportive). Therefore this study cannot be interpreted to show whether or not the mother's presence is supportive.

Checking and Keeping Watch

Checking for health is the act of observing and evaluating what is happening in reference to a specific health concern. It can involve specialised tests designed for early detection of health problems for which a visit to a health care consultant is often required. These tests included cervical smears, breast exams (which can be done at home), dental check-ups, etc. In some instances, checking was done on a regular basis as prescribed by a health care consultant. However, checking could also be sporadic.

The things I would do regularly would be, I have a regular smear test and a breast examination once a year and those things I remember to do consciously. [Valerie]

■ ■
When I remember I check my breasts, though they haven't been done for a while because I'm still sort of feeding and if I notice any lumps or anything I give it a couple of days, if

it doesn't go away then I'll talk to someone about it.
[Rachel]

■ ■
When I was pregnant with F. I had one [cervical smear] and they told me to have one every two years. [Rachel]

■ ■
I go and have all the regular checks, smears and all that. That's no big deal. (I - Is there a reason that you do that?) Oh, I just think it's sensible. If medicine has been able to find out and is able to help these things if we catch it early. It's common sense that we should use it.
[Ione].

Within the home, participants primarily used observation, and occasionally a thermometer, to check on themselves and their children. When there is a health concern, a woman might check at intervals to see what's happening, and thus keep watch over the situation. **Keeping Watch**, similar to monitoring, involves the comparison of information gathered over time through a series of checking episodes.

And when I went back to check on her, she was really burning up. [Ione]

■ ■
... she had a temperature. She's at an age now where she absolutely adores having her temperature taken. [Rachel]

■ ■
Or if there are a few things coming up where he will be eating a lot more sweet type things then we sort of cut back prior and after for a while, keep watch for little signs of eczema. [Lauren]

■ ■
I'd introduce one food and monitor how she reacted to it.
[Christine]

One participant commented on this section about levels of health care. She stated, "You have it in a nutshell!"
[Christine]

Page's (1987) substantive grounded theory, Vigilance-Harmonizing, emerged from a study of women's health practices in New Zealand surrounding breast self-examination and cervical smear screening. A sub-category, health orientation, consists of four dimensions: health-promotive, health-maintenance, health-protective, and health-depletive. Page (p.54) described the health orientation as not static but having a shifting capacity as

different dimensions were evident in different situations (ie: breast self examination and cervical screening).

A comparison of the four dimensions of health orientation and the levels of health care practised by participants in this study, suggests a relationship exists. Health-maintenance ("Look after your teeth and you won't have any fillings.") is similar to basic health practices. Health-depletive ("Well, I had an experience with that sort of thing ... I had a lump ...") is congruent with disease prevention. Health-protective ("Yes, I keep a fairly careful check ... because of cancer I make sure that ... ") appears equivalent to checking for health. And a Health-promotive orientation ("... it's just a better feeling. I think in yourself that you are doing something in the right direction.") is similar to enhancing health.

An exploratory study of 85 adults' (68 women and 17 men) patterns of health behaviour was conducted by Laffery (1990). The three primary reasons for health behaviours identified are similar to the three modes of Keeping Healthy (basic health practices, illness or disease prevention, and enhancing health) identified in this study. Health maintenance which is aimed at maintaining current health ("I try to eat right to sustain good health") is similar to basic health practices. Laffery's category illness prevention is very similar to the category with the same name that emerged in this study. Illness prevention activities are "primarily to prevent illness or disease, or if the condition was already present, to prevent it from getting worse" ("I get enough exercise, I keep moving so I don't become too incapacitated"). Health promotion has the purpose of achieving a greater level of health and well-being ("I exercise because it makes me feel great"). It supports the category Enhancing Health found in this study.

Conclusion

This chapter included some aspects of health that the women considered when making health care choices. Health had social, mental, spiritual, emotional and physical aspects that were inter-related. Optimum functioning at each level signified health. Interference with function was associated with illness. The women had a wide variety of health concerns for their children and themselves. The concerns encompassed support of normal growth and development and health problems. For each concern the women evaluated the risk involved and the level of health care needed. Health care was managed on several levels. At any one time, the women could be carrying out health care practices on one or more of the levels of each member of the family. The next chapter contains categories that show some more aspects of the context within which the women made health care choices.

Chapter 6: Context of Choice

Chapter five showed some aspects of health which the women considered when making health care choices. This chapter contains a discussion of some categories included in the matrix or life context within which the women made health care choices. It includes Ways, Approaches and Lifestyle; Structural Influences; and Personal Resources.

Ways, Approaches and Lifestyles

Ways

A way (tactic or strategy) is a system of practical activities, based on guidelines and principles, that a woman undertakes to manage a health concern. When a woman is learning how to manage a health concern she is learning a particular way. There may be more than one way to manage a health concern. Some ways are learned while growing up, others are acquired through experience.

There must be another way. [Lauren]

■
Okay. There is another way. [Kelly]

■
She got me a [breast] pump and she showed me how to empty some [breast milk] out to get the hardness away so that the baby could get on. [Ione]

Cultural Ways. The ways a woman chooses to manage health care are learned. The ways which are heard, observed and practised while growing up, are part of the woman's culture.

If we cut ourselves with cutty grass, find wool and wrap wool around it. Don't ask me why wool works but it does. It's just things that we did, you didn't even think about it. [Rachel]

Because you have different racial [cultural] remedies, and something that I might do instinctively because that's what I've been taught, someone else wouldn't think of doing or they would have an equivalent, like as a Maori, for a poultice we use a lily leaf, and I've heard that a lot of Pakeha people would use a bread poultice. [Rachel]

However, some knowledge which might be learned while growing up is either lost, because it was not passed on or the opportunity is not present within the family circumstances.

Like she [grandmother] used to make a steam out of these leaves, no I don't even know what the name of the tree is or anything, but I can remember her doing it and that was for a certain reason. I don't even know why and she used to make all these different drinks for various reasons and that knowledge is rapidly being lost. [Rachel]

It [lack of knowledge about baby care] really was because our family was three years apart with each child and so I didn't grow up with any little children around me in my memory. Like when I was older there was never any babies around and I was the first one to have a baby in my group of friends. [Ione]

The women were interested in ways of managing health care that are passed along within the family. In response to the rough draft, comments and examples were provided.

We use a Chinese herbal tea (adults only in our family) which is very good for colds, flu, sore achey joints. [Lauren]

"Alternative" medicine [referring to cultural remedies] can also save - in some cases - surgery being done. When Q. had his hernia diagnosed at 2½ months, my aunt growled at me for not massaging him thereby healing the hernia. My response was I didn't know how and being in the city no-one had taught me. Same with cutting the children's gums when teething. I know about it but not how to or when to. Unfortunately I couldn't find anyone in my circle of friends to help with that and doctors seem to think you're an idiot to even try it. A no-no in fact. [Rachel]

Something which my parents gave me frequently, also another

Chinese remedy which was effective for reducing a high temperature was to rub a very hot hard boiled egg (white only), cut in half with a silver coin in the middle wrapped in a hanky - rubbed over [the] forehead, [or] chest. My mother used to do this to us and it really worked. If the coin turned out red, this meant you had the 'fire' - a lot of heat inside you, or if it was blue it meant you had a lot of wind. I've tried it on myself a few times since leaving home (not the same as mum did it). Tried it once on C., but he has an egg white allergy and his skin started going all red and streaky, so have never done it again on him.
[Lauren]

■ ■
I too can relate to old "true and tried" remedies which my grandmother/grandfather used and passed onto my mother,
eg: a hot toddy before bed if you feel the flu coming on,
eg: eating raw onions to keep colds away.
[Becky]

In regard to cultural remedies, Browner (1989,p.466) states that the advent of modern medicine is connected with a decline in the knowledge and use of traditional ways of healing. However, Browne has discovered "that traditional health care practices persist when they meet specific needs." This comment is based on the discovery that in a Columbian town "younger women were as likely as older women to know about and use" ... "herbal emmenogues (menstrual inducing agents)". These herbal remedies are used as a form of post-conception birth control. "Younger women learn to use these remedies soon after menarche, primarily from older women in their households."

Women in Western cultures have also lost some knowledge about managing health. During a recent visit to New Zealand, Rima Apple (6 July 1990) presented a talk, Motherhood and Myths, to the Women's Studies Department at Massey University. She used advertisements from the late nineteenth century to the present to demonstrate how women have been encouraged to increasingly rely on the medical profession as the authority concerning correct ways to nurture and raise children, and to rely less on their own experience and knowledge. Janice Priest, at the International Women's Health Conference (15 November 1990, Massey University), stated that it is only within the last three generations, that women have lost the ability to

promote healing through self knowledge of herbs and home remedies. She suggests that this change has resulted in a generalised loss of self-esteem among women, because women continue to sense and know when something is wrong, but don't know what to do about it.

Approach

One way a woman learns ways to manage health concerns is by being taught by a health care consultant. The ways which are taught, are a reflection of the philosophy which guides the health care consultant's approach. **Approach** is a system of ways, the practical manifestation of the principles and guidelines that reflect a particular paradigm. A brief analysis of the ways, or health care tactics and strategies used by doctors, complementary therapists and nurses follows. This will be considered in more detail in Chapter nine.

Medical Ways. The ways or health care strategies associated with medicine were drugs and surgery.

... drugs and ... surgery. [Alice]

... in medical practice is that if it doesn't work you have to operate on it and if there is something the matter with a child they just give him an antibiotic. [Valerie]

... you always come away with antibiotics. [Debbie]

I was prescribed a medicine by a doctor ... [Ruth]

He [doctor] said he thought it was benign [lump in breast] but he'd chop it out. [Christine]

Complementary Therapy Ways. Complementary therapies encompass a wide range of health care strategies. Those mentioned most often by the participants were diet and massage.

My naturopath does an amazing back manipulation ... I use a few basic homeopathics ... I know several people who have had it [carpal tunnel] cured by acupuncture. [Valerie]

... massage, shiat-su ... put my back in shape ... vitamins, minerals, cell salts ... [Alice]

He put me on a cleansing diet ... [Sarah]

Cutting out these foods ... good advice about vitamins, supplements and things like that. ... under control through diet. ... herbal supplements ... acupuncture. [Lauren]

Nursing Ways. Nursing health care tactics and strategies included checking, such as weighing a baby; diet advice; community building; physical care; showing and telling how; coming to the home; information about ailments cared for at home and some tests.

I take my kids to Plunket to get weighed ... the morning nurses had to work on your body. [Debbie]

That good one, she was actually able to give some direction [about what to feed a child] and some medical things ... whether to get worried about coughs, sneezes and snuffles ... get children weighed and measured ... we did what they called a test weight [to check if the baby gains weight after being fed] ... good at breast feeding and telling you things about that ... The nurses were very stubborn about making sure that I could breast feed. [Christine]

I take him to the doctor's nurse and have her check [ears] ... [Lauren]

She told me when to introduce foods [baby] ... came back for a week or more, each day, to see me and support me ... got me to read Womanly Art of Breast Feeding ... A. wasn't walking or pulling herself to her feet at one year, the Plunket nurse wanted to send her on for a check ... heel prick ... weigh the baby, check your tummy and stitches ... she showed me how ... [Ione]

She weighed N. ... having her come to the home was important to me ... she would encourage certain practices ... [About] areas of childhood ailments, she would pass on that information ... set up a new mother support group ... trying to set up a Polynesian pre-school group ... building links between different groups. [Valerie]

The participants recognised a health care consultant's approach by the way a consultation was carried out and the methods of treatment prescribed. Only those participants who had experienced more than one approach recognised that there could be differences in the way a health care consultant practised. Women who regularly used a

complementary therapy identified it with a holistic approach and identified medical care with a body parts approach. Women who regularly used only the medical system did not discuss it as an approach.

When I first consulted a naturopath, that was a totally new and different approach to me and it was almost a little startling to be treated as a whole person. It was a little while before I really felt comfortable with that approach. I was used to being dealt with by bodily parts, although that's a little harsh, I mean there are plenty of doctors who look at one as holistically as time allows them, they are generally under quite a lot of time pressure. [Alice]

The doctor will look at, say, just one cause for a particular problem. Whereas I feel the naturopath looks at the body as a totality and so that while he may be treating one thing, you are improving the whole system as well. Like in B's case, I think through the diet and various other things, has been building up his immune system. Which I feel that with just the other medication, that's just been working on the lungs. It hasn't really built him up, the whole body. [Lauren]

When a woman visits a health care consultant she learns the interpretation of signs, what is considered dangerous or risky, and the various ways available to manage the health concern based on the approach, the guidelines and philosophy, of the health care consultant's practice. When the participant's health concerns, based on her own observations and interpretations, were not adequately addressed she investigated other ways of managing the health concern ('there must be another way!'). This involved learning something about the philosophy, approach, guidelines, interpretation of signs and what is considered a risk based on the new way of managing the health concern. Only if the way, the health care strategy, makes a difference does the philosophy earn its way into the woman's approach to health care. As a result, participants were able to use health care strategies, principles and guidelines from a variety of philosophies, as long as they made a difference.

I wouldn't reject orthodox medicine, orthodox health care because I feel it has its place. Like the naturopath doesn't like antibiotics, full stop. But there have been

occasions when I've really felt I've needed them, like I had a bad breast infection three weeks ago ... so I went and got my antibiotics and I started coming right within two or three tablets. But then I knew that when you take antibiotics, you start upsetting this and that, so when I take antibiotics I took acidopholous because it increases (...) so if I didn't have that knowledge beforehand through going to see the naturopath I would have taken the antibiotics quite happily and thrown a lot of things out of balance. [Lauren]

In reference to approaches, Baumann, Cameron, Zimmerman and Levanthal (1989,p.467) suggest that people develop their own approaches to illness. "Throughout a lifetime, people have extensive experience with illness and develop personal illness theories that place great weight on the concrete evidence generated by symptoms." Scott and Stern (1982,p.58) state their grounded theory "shows how lay consumers (in this case Northern Louisiana black women) approach and then select their own belief system from the bicultural influences of folk health beliefs and dominant culture 'scientific' beliefs." They (p.58) discovered three ways in which the women selected their health beliefs: the corporate buyer who "buys the dominant culture beliefs"; the careful shopper who uses a part of each system; and the cultural buyer who uses only folk beliefs. These studies suggest that while women are influenced by the dominant health system, those who have access to other approaches (through culture or learning) are selective concerning the health care strategies (ways) they use.

Responses to this section were varied. Two participants confirmed the analysis. Others made comments which led the researcher to feel that the women may have felt complementary therapy was being presented as the favoured health care option.

What you've written applies to me. [Christine]

No other comments on this section, tends to tie in with my experience. [Lauren]

My family's health is managed by our General Practitioner.

I do believe that naturopaths and certain other alternative consultants provide genuine health care. As our doctor, has thus far, provided us with excellent health care, I have no reason to seek other alternative medicine, other than specialists the doctor has sent us to. [Becky]

I must say I believe that the "traditional" medical consultants should be able to deal with the problems I have, especially since they receive Government subsidies. So I intend to battle right through the system with P.'s problems before I admit defeat and try a naturopath. NOT because I don't believe in naturopathy but because I think Doctors should also be able to accept some of the ideas of naturopathy - ie: food intolerance and allergies - and then to deal with them. (My own doctor does believe in herbal medicines ... his treatments are medical though not always medicinal.) [Christine]

I perceive the naturopath as being a "racial" remedy [cultural remedy]. In that they have a culture that healing has been based on. [Rachel]

Lifestyle

Each health care strategy must be adapted to the woman's lifestyle. She determines whether it will be used and how it will be used by evaluating the difference that it makes, the circumstances under which it is effective, the amount of risk that is involved and the lifestyle changes it initiates. If it can be used in ways that enhance or complement a chosen lifestyle, health care strategies will be used to do that.

Like, on the rare occasion we might go out to a restaurant or something like that or to a house where I know people smoke, usually he has a puff on his bronchodilator before we go, just in case. [Lauren]

We have our own sheep, not that that is intentionally done so that we would have unadulterated meat, but because we are on a property of four acres so we can have our hens, free range hens. Now that's an important part of our lifestyle. But we didn't go out to select that kind of living because we felt very strongly about food [this family's diet is based on naturopathic principles]. We bought that property because when we as a young couple intending to have a family, it was a lifestyle that appealed and it has given us the opportunity ... to pander more to our feelings about food. It has given us the opportunity. My husband has sheep and bee hives. We love it. I can recommend it to anybody. [Sarah]

If a health care strategy is necessary because of a present risk, such as an asthma attack, but it is perceived as being a risk to a future lifestyle, its use will be minimised.

Yes, I needed ventolin and teldane, but it is against my philosophy to have to keep taking medication in order to keep doing what I was doing. I decided I preferred to change what I was doing, to find another approach. [Alice]

■ ■
The other aspect I'm worried about [a reason she uses diet to help control asthma], the two older ones have been on various asthma medications and things - with the preventative on a daily basis, I sort of worry about the attitude to drugs. There's quite a lot of drugs that people take for abuse purposes. Since they've been taking medication since they were young, I really feel I've got to make them aware of the difference between taking something because you need it, because you are ill or something like preventing asthma - and the other drugs people take because it makes them feel good - so that is a worry in my mind. [Lauren]

If a health care strategy makes a difference, but the activities required to carry it out are perceived as interfering with a chosen lifestyle, it will be modified to obtain the greatest benefit with the least interference.

For a while we were completely off processed food and goods like that - but now we sort of, we have a bit of everything. Which he [naturopath] probably wouldn't approve of, but it suits our lifestyle better. But if they start getting little bits of eczema and that, I sort of know - well we've cut back on wheat or whatever, but we are still more or less basically dairy free. [Lauren]

Structural Influences

While making choices about how to manage a health concern, the participants balanced influences which are external to the health concern, but which are the structural forces within which they must carry out health management. Structural forces identified or implied by the women in this study were cost of health care, proximity of the health care consultant, time, presence of children and

changes in the dominant health care system (these will be discussed under Cost and Proximity). Transportation was not mentioned as a problem (this will come out in the literature).

Cost

Women who mentioned cost felt that medical health care was expensive, even if they were insured, and complementary therapies were considered most expensive.

I've got Southern Cross so that the actual cost of it really isn't a worry - we spent a bomb on it this year. [Debbie]

■ ■
My economic situation doesn't allow me to go for things like heavy colds or flus or tonsillitis. [Valerie]

■ ■
Occasionally, if I have the luxury, I would use a naturopath ... My naturopath has moved up the coast, and it would take petrol money to get there, let alone to pay him. [Valerie]

■ ■
It [naturopath] cost a lot of money. My husband, even occasionally now, he goes on about how much it costs. [Debbie - she visited a naturopath one time.]

Several women stated they would use complementary therapies more often if the cost was lower. However, the cost was apparently justified for initial visits because the women felt there was no other avenue for obtaining the information and guidance they desired. The women also indicated that as they learned to manage their health concerns through diet, that their visits to the complementary health care consultant and to the medical health consultants are decreased.

I've been going to a naturopath since my children were pre-schoolers. So probably my youngest was about three... I've not been to a registered G.P. since then... I think over the past few years really, I've gone to him [Naturopath] once or twice a year. [Sarah]

■ ■
But we don't have the occasion to see him [doctor] too frequently, since we've been on the diets, so something must be getting better ... Having been to the naturopath over the past three years, dietary wise, I know more or less what to cut out and so I occasionally go back for reassurance...

I would go more often if it didn't cost so much. [Lauren]

The participants who commented on this section provided further comments.

Health care is expensive. Health Center charges an admin. (sic) fee if you do not pay straight out and you are sent your bill by mail - extra \$4.00 for each month.

Seeing the naturopath especially in the early visits where there was a lot of follow-up, it was expensive. But I feel for the advice and support you got plus long term benefits - it certainly was worthwhile. He [naturopath] was really good though, that after a while, when virtually the whole family was under his guidance, we were charged just the one fee for one person per visit. [Lauren]

The medical profession is too expensive and in some cases far too slow. [Rachel]

Economic Health Strategy. In order to cope with expense, many women had a strategy for finding out what is happening and how to manage it. At home, a woman will wait and see what happens. If there is not a change towards normal, she will seek free advice. Free advice can be obtained from friends and family, a chemist, a Plunket nurse or a Karitane nurse.¹ Who she consults depends on her interpretation of the nature of the problem, and who she feels is best qualified to answer her questions about it. Thus, if she determines that the health concern will require medicine, she will consult a chemist. If she feels it may require other medical management, but is uncertain, she may consult a Plunket or Karitane nurse. In each case, she will ask if there is a way to manage this at home or should she consult a doctor. If she can manage the problem at home, she avoids a trip to the doctor which is costly in terms of money and time. She will also avoid being labelled a panicky mother.

1. A Karitane nurse has one year of training in infant and child care and works for the Royal New Zealand Plunket Society. Karitane nurses are based at a Family Centre and are available to assist women with infant care concerns (Burgess 1984, p.53).

However, if the chemist or nurse can tell her if the problem requires medical care, she avoids taking an unnecessary risk of prolonging discomfort or developmental problems for her child or herself. If a problem is acute a woman will go to the health care consultant with the expertise to manage it. In this study a medical doctor or his practice nurse was most likely to be contacted about an acute problem.

I deal a lot through the chemist, because we've got a very good chemist down next to my doctor. So I go to him for advice and he's also a homeopath. He stocks the homeopathic medicines, but I really haven't bought any, but he will tell me exactly what to do, so he's free advice. [Debbie]

■ ■
And we were at the Plunket with F. and so I mentioned it to the Plunket nurse... I said to her how I'd been noting that she [another child] shut this one eye whenever she looked into the distance, could she just check it out or should I just go to the doctor? [Ione]

■ ■
It [a burn] was starting to heal and it went really funny, so I went down to the chemist and found out whether I could just get a remedy from there or whether I really needed to go to the doctor. [Rachel]

A low income and lack of health insurance means that a woman will manage a health concern at home for a longer period before contacting a health care consultant. This raises the question of what sources of supportive care information are available to women providing supportive care for their children or themselves in the period between keeping healthy and being ill enough to visit a doctor regardless of the cost.

We are used to so many different varieties of those sorts of ailments around, that unless its glaringly obvious that its something that I need to take them to the doctor, I try not to. Economy is one of the very basic reasons I just can't afford to take my kids to the doctor every time - they have to be pretty crook for me to get them there. [Valerie]

Another, but less effective way of dealing with health care costs is described in an article, written by Legat (1990), about the effect of poverty on health care in Auckland.

Local people, says Griffith [a Plunket nurse], generally don't take their children to the doctor because they can't afford it; they may owe the doctor money for a previous visit and be too embarrassed to face the nurse behind the desk. So they do the rounds of G.P.s in the immediate neighbourhood and beyond, never establishing the sort of contact that would see more attention being paid to their family health needs. There are, however, two local doctors who never press for money and often don't charge. (Legat 1990, p.42)

Saving Up. Another tactic some participants use is to save up their health concerns and present them at a single visit to the health care consultant. Some health care consultants will charge a reduced fee for attending to more than one health concern during a consultation. When this happens, it appears that there is a relationship of some standing between the client and the health care consultant. It also appears to happen on the judgement of the health care consultant; the client has no part in this decision.

I went in and saved it all up because D. had conjunctivitis, S. had like a slight hernia, but he had a bit of dermatitis on his tummy button and something else, I can't remember, asthma I suppose, my medication. And so I saved it all up and took us all in together, but it still cost me the same bloody amount. It was horrendous. Thirty six dollars or something. [Debbie]

Also because I know that he's [doctor] quite fair with us when it comes to charging. Because we've been for so long to the same doctor and built up what I feel is a really good relationship, he doesn't charge us the second time. And so that encourages me to keep going ... We are there quite regularly for him [child with asthma], so quite often if I'm worried about something with them [other children], I'll ask when I'm there for Q. and he's [doctor] actually really good with that. [Ione]

If I do have to go for one of those things [cervical smear and breast exam], as I pay my fees I also make sure I have my list of any other ailments, that have been slightly tediously worrying me for some time and present them to the doctor because for the cost of one consultation, I want to get my money's worth. [Valerie]

Getting Insurance. Changes in the health care system also affect the cost of health care. In a system with waiting lists for specialist care, women who can or must afford it, are not willing to take risks involved in waiting for care

that can be readily obtained through private medical care. One participant has two children with eyesight problems and needed a tubal ligation for herself over the past year. In each instance she was told by her doctor that it would take months to get an appointment in the public health system. She made the following statement.

I suppose the one [health issue] that I could get up in arms about is that it looks like everyone is going to have to have medical insurance to be able to get any major health care. It's quite sad that we are losing the way it was. That's quite relevant to me, at the moment we are at the stage at starting to look at having insurance, but I sort of say that the more people that have insurance the sooner the public system ceases to exist. [Ione]

One participant made further comments about health insurance in response to the rough draft of the analysis.

Finally took out health insurance late last year - a special deal through Southern Cross which was made available through the Pharmaceutical Society. It took into account pre-existing conditions. C. was due to have an op. (sic) to correct undescended testicles early 1990, so we really took the insurance so he could have it done privately (we were told that there would be about 8 months wait at a public hospital). The fee for the insurance was high but at least this year it's paid for itself - also had some dental bills. Unfortunately it does not cover some alternative health consultants, eg naturopath. We could claim back on the homeopathic doctor's fees (as he is also a conventional G.P.) but not on the homeopathic medicines. The health insurance has been handy to have, but then who wants to be sick so that you can claim on it. I don't know how long we will keep on having it - it is expensive. [Lauren]

Proximity

The proximity or location of a health care consultant relative to the woman's home has some effect on the woman's health care decision. A health care consultant is too far away when the time required for travel and the cost of travel is more than the woman can afford.

The cost of travel time increases with distance. It also increases with the presence of one or more children who

have developmental life needs that must be attended to during the trip and subsequent consultation. If the financial cost or the cost in energy required to cope with children is too high, the woman may decide not to make an appointment, or she may take steps to modify difficulties.

Because I think had he [Naturopath] not been coming to this City, he has his clinic in another city, I don't think I would have bothered straight away. All that travelling just to see him. [This woman would be taking three children with her.] [Lauren]

■ ■
But the worst part of going to the doctor is not so much the cost of it, which, okay the prescriptions as well, and the waiting for the doctor is a real pain in the butt because he's usually got [fuzzy recording] about an hour. But I just ring out and say 'Let me know when he can' ... because it's down the other end of the valley, it's a ten minute drive. [Debbie]

Another example of the effect of travel, time and energy required to cope with young children is provided by Legat in her article, Children of the Poor: the poverty/health equation.

She [Plunket nurse] recalls a pregnant women who already had three preschool children. None had been immunised; all had tooth decay; one was pale with anaemia. The woman had no car and no support networks to help organise a lift to the Plunket clinic and doctor's surgery, which were at the top of a very long hill. As it was, she had to walk all the children a mile or so to the bus stop on Western Springs Road, then to catch a bus to St. Helen's hospital for her antenatal appointments. (1990,p.42).

Graham (1984,p.144-145) states that "the role of transport in shaping family health has not been systematically explored." Graham (p.145) goes on to define local facilities as "those within walking distance with children under three." She also suggests (p.145) that when transportation is limited "... a rational decision may be one which rejects professional care. The mother may choose instead to invest her limited reserves of time, money and energy in other areas of family health; in protecting the family diet, for example, or in keeping her children warm."

Personal Resources

One personal resource the women considered when making health care choices was their own health. They considered the effect of their health on their families, and several women mentioned the effect of the cost of their own health care upon family resources. As was shown under Health Concerns, the women were aware of their health concerns. This is a contradiction to Graham's suggestion that, "Her role in caring for others appears to blunt her sensitivity to her own needs" (1984,p.159). It appears the women are aware of their health concerns but under certain circumstances choose not to contact a health care consultant.

Getting On With Life

The women used the same processes found in Awareness, Observing, Interpreting and Integrating Signs, Striving to Know What, Mastering and Sharing Concern to care for their own health concerns (see Chapters 5 through 11). **Getting On With Life** occurred when a woman chose to ignore her own health concerns or care for them primarily with home care treatments. This was done in order to 'get on with' her responsibilities. A woman sought help for her own health concerns when she felt they were interfering with her responsibilities or life style. Sometimes, this meant that the woman had reached the limits of her physical capacity. Signs of high risk or death, such as a lump in the breast, meant a trip to the doctor. Health concerns of a lesser risk were tolerated or managed at home until they began to interfere with life.

And then increasingly, the allergies were interfering with what I saw as my lifestyle, to the point where I was finding it difficult just to go to work. [Alice]

■ ■
So for me to look for a doctor it would have to be something that is causing me to be dysfunctional within my family to a degree that unless I saw it seen to, I just couldn't

continue to be the one parent I am ...

I am also aware even in my management of the premenstrual tension I get which of course affects my relationship with the children, I do things like I have a higher level of protein food before I menstruate. [Valerie]

And if I go, I just go to make sure I'm not going to drop dead early ... I mean these are the sorts of times I go to the doctor, I find a lump somewhere [breast]. [Christine]

[I go to a doctor] When I'm desperate, probably once my tolerance is really down, then I go for me. [Ione]

Getting On With Life does not encompass all the reasons the women sought health care for themselves. It seemed to apply mainly for the women with small children. In addition, although many of the participants sought assistance when they felt they were reaching their limits, prior to this they did provide for their own health care at home.

If I do get flu's and if I do start to feel really stressed and feel a cold coming on, I would much prefer to spend six dollars on really high doses of Vitamin C and B and start taking that. [Valerie]

I knew what was happening in my life that was making it so difficult for me to sleep. And had tried the walk - quick, brisk walk around the block before bed, and the hot milk, lying in the bath and trying to blob out in front of the television and all those things and it just compounded. [Valerie]

It [cracked nipples] was so uncomfortable that I thought, "Well, if I stop letting her drink from me and just express the milk, perhaps that would help. [Christine - she later asked the Plunket Nurse for help with this.]

I notice, I take B vitamins, if my skin is not healing quickly I take B vitamins and it heals better. [Debbie]

This category was described to a neighbour and she stated, "Yes, that's the way it is. Last week my husband and children were down with flu, but I had to carry on." Graham (1984, p.159) states:

Being ill makes it difficult for individuals to maintain their normal roles and responsibilities: since the mother's role and responsibilities are particularly indispensable, mothers are reluctant to be ill.

Other Influences

Some elements that influence a woman's decision to consult for herself are cost, other people's perceptions of her health, her own inner sense of health and whether or not she feels anything can be done to manage her health concern.

Cost. The women considered the effect of the cost of their own health care on the family resources. If a woman felt the family finances were limited, she would not incur the cost of a visit to a health care consultant if she knew her health problem was self-limited. (See also Cost, under Structural Influences.)

So I've had all the amalgam taken out of my teeth. And surprisingly my husband agreed. I didn't think he would ever agree. Because it was two thousand dollars worth. And I said, "It's making me ill." And so he said, "Well, what's money." [Kelly]

I've got to admit, money comes into it. If it's a thing I know is going to come right and it's just a little cold or flu, I know that's going to pass and I don't really need help, I can carry on. [Ione]

My economic situation doesn't allow me to go for things like heavy colds or flu's or tonsillitis or any of those things that I know what it is and I know it has a natural course of running before it changes. Then I don't go to a doctor. [Valerie]

Others' perceptions. In this situation, the woman depends to a degree on other people's interpretation to help her decide if she is sick enough to require assistance.

My husband would say 'For goodness' sake, go to the doctor' ... I had a cold and so, even though I had been at the doctor [for children] I hadn't mentioned to him me, because I suppose I felt if it was that bad, he would hear and see it anyway and would say, 'OK, what's happening with you?' [Ione]

Own sense of health. The women had a sense of their own body and what it felt like to be getting better or worse. This is also discussed under Feeling Sensations (Chapter 7).

I've become extremely sensitive to what is going on in my body ... so I knew when I started to get better. [Kelly]

■ ■
It just wouldn't shift [sinus] ... and I think when I go [to doctor] is when I end up feeling sick with it - feels like it's going through my body and that's just the way I can describe it. And when it gets to that stage, I know I've got to go. [Ione]

What can be done. The women had ideas about the capabilities of each health care consultant to whom they had access. If they identified the health concern as one that a health care consultant could not effectively address, they did not seek help or they chose a different avenue of care.

I suddenly realised I was getting confused. And I'd pick up the phone, and I would try to dial a number, and I couldn't remember more than one number at a time and that frightened me. I thought, 'What the hell is happening here?'. And I thought, 'Well, I can't go to the doctor. What can I go to the doctor about? ... What do I tell him, I'm confused?' [Kelly]

■ ■
So if I had specific symptoms, I definitely would go to a doctor, but if it was generally a very, very lousy something I couldn't really explain to a G.P., pinpoint, this is my problem ... I'd probably use a naturopath. [Lauren]

■ ■
I feel run down a lot and I know a few women who go to the doctor under such circumstances, but I think it's my life stress and my life as a solo parent. [Valerie]

Conclusion

This chapter contained some categories that form the context within which the participants made health care choices. The basis of the women's knowledge is learned while growing up and has a cultural basis. The tactics and strategies the women used are the practical manifestation of the philosophy from which they originated [Approach].

In this study women used culturally based, medically based and complementary therapies based tactics and strategies of health care. When choosing a health care measure the women considered their current lifestyle, and finite material and personal resources which had to be juggled and stretched to cover the needs of each person in the family. In order to do this several participants chose to ignore or care for their own needs at home in order to 'get on with' their responsibilities. Chapter seven contains analysis that shows what the women do in order to recognise that a change has occurred and to discover what it means.

Chapter 7: Skills for Knowing

Chapters Five and Six focused on some elements of the context within which the participants made health care choices. This included their views of health and illness, the kinds of health care they do, evaluating health risk, ways, approaches and lifestyles, structural influences and personal resources. The next two chapters will present an analysis of Knowing. Knowing, an essential characteristic of Bonded Caring, is a process that underlies much of the women's health care activities. The participants felt they knew their children's and their own unique characteristics, and recognised when a change signalled further development or a problem. When a change occurred the women wanted to know what it meant and how to manage it. This chapter will show some skills the women used to determine that a change had occurred and what it meant.

Being Aware

Being aware consists of two categories; Generalised Awareness and Unaware. Each refers to a stage of knowing. Generalised Awareness is a result of knowing and experience, while Unaware results from a total lack of knowledge and experience. These two exist side by side, as a woman can have expert knowledge in one area and be totally ignorant in another.

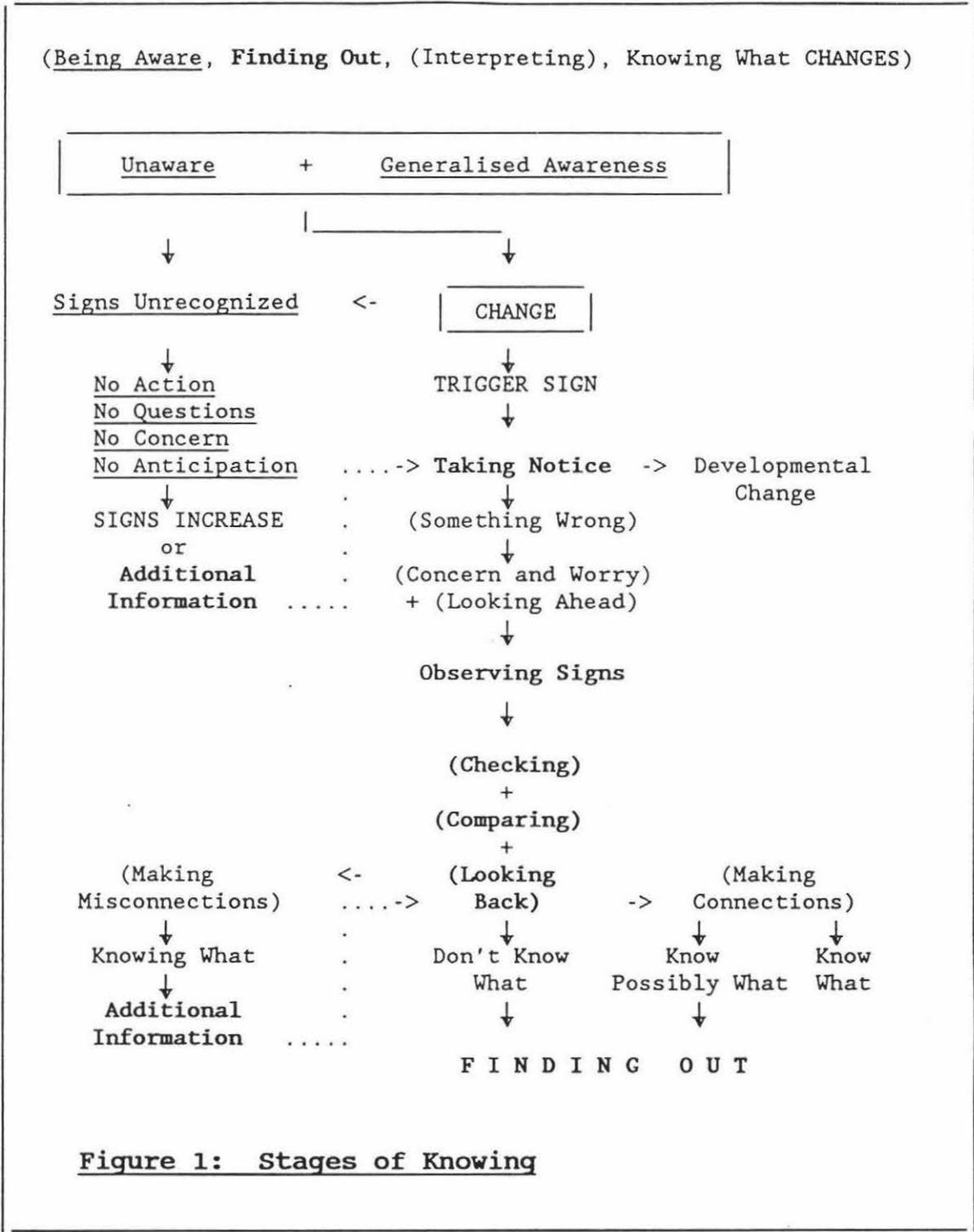


Figure 1: Stages of Knowing

Dreyfus and Dreyfus have studied the skill acquisition process and state that an "unstructured" area of decision making contains "a potentially unlimited number of possibly relevant facts and features, and the ways those elements inter-relate and determine other events is unclear." (1986,p.20). They go on to suggest nursing is such an

area. Women carrying out health care in a family are also working in an "unstructured" area. They also state:

A high level of skill in any unstructured problem area seems to require considerable concrete experience with real situations, and any individual will have had more experience with some types of situations than with others. Consequently, an individual will be at the same time expert with respect to certain types of problems in his area of skill, but less skilled with respect to others. (Dreyfus and Dreyfus, 1986, p.20)

Generalised Awareness

When life is proceeding as usual a woman has a generalised awareness of this. Her attention is focused on the developmental activities of life. Generalised awareness results from a woman's knowing what signs are usual. This knowing derives from her continual, moment by moment, experience with her family and her environment. Thus what appears as an ordinary set of activities is in fact a reflection of a woman's expert knowledge of herself and her family based on her interpretation of what is happening.

I knew my own baby's level of activity and his physical energy and I mean I knew he was wetting nappies and he was okay in terms of what went in and what came out and what he did with it once it was in there I didn't know. [Valerie]

■ ■
But I sort of look on the doctor as 'you take my word for it when I say something is wrong. Don't you tell me there isn't ... So you listen to me. You don't know my child, you don't spend time with her'. [Rachel]

Unaware

When a change occurs, there is a lapse of time between the beginning of the change and the realisation that a change has or is occurring (taking notice). Experience and acquired knowledge affect the length of time lapse. When a woman has no previous experience and no acquired knowledge about a health concern, she may see signs of what is happening, but may not attach any meaning to them. As a result, she is unaware, she does not take notice, and will not anticipate that any action is necessary, will not feel

concern and will seek no further information about the signs. They are considered part of the usual or normal state. Decisions are made using information she has, but this does not take into account the unrecognised but ongoing process. It is discovered when someone points it out or when some consequence of the change causes the woman to focus her attention on it and take notice. Often, the realisation is sudden and accompanied by surprise and shock.

One nurse asked me if I felt the contraction and I was on the monitor and I said to her, 'What contraction?'. And she said 'That one that you just had'. I said, 'Oh, was that a contraction? I've had those for three days.' [Rachel]

■ ■
... and she was on the breast and she just chomped on it for a couple of hours and I got cracked nipples. And it was after I had spoken to a Plunket nurse ages later, I realised that she should have been on only for a little while ... but I didn't have that sort of information, never had heard about it. It's not something you anticipate. [Christine]

■ ■
It was a preschool visit because I was there so he was probably four and she growled at me because of the state of his teeth, and she accused me of feeding him cordial and lollies and (...) because he had a couple of teeth that had abscessed and there was actually nothing left and she had to remove a couple and I left the dental clinic in tears. And so I went home really disillusioned because she was accusing me of things I hadn't done and I couldn't understand why his teeth would be like that. [Ione]

Finding Out

The process, **Finding Out**, is essential to knowing and mediates the woman's movement from Unaware to Knowing What and Knowing How. The activities related to Finding Out occur in the home, within the woman's social sphere, and in her contact with health care consultants. The work of Finding Out is a manifestation of the "concern, worry and serious attention to the needs of the persons involved" in a Bonded Caring process. In this chapter categories associated with Finding Out are Taking Notice, Observing Signs, and Interpreting.

Taking Notice

Taking Notice occurred when participants, prompted by a Trigger Sign, realised that there had been a change. An expected event did not occur (i.e. a cold did not get better), there was a change from the usual, or someone noticed a problem and pointed it out. Taking Notice involves focused awareness and the question "What is happening here?" It is the initial stage of Finding Out. If Taking Notice does not occur, Finding Out does not begin and the woman remains Unaware. To find out what was happening, the women looked for additional signs and began to identify a set or cluster of signs. This helped them to define what was happening and give it a label; decide how serious the health concern was, and what needed to be done to take care of it. It also helped the women to determine whether or not they had the knowledge they needed to manage the health concern.

My hair started falling out, handfuls, you know. I thought, "For goodness' sake! What's going on here?" [Kelly]

Taking Notice is described by Blaxter and Paterson (1982,p.51): "Having realised that something was afoot, the child's bodily, mental or emotional state had changed, the mothers had to determine the significance of what was occurring." In addition, the mothers in that study described signs that they observed in a diary. "These were the 'triggers' which initiated feelings that something was not quite as it should be ..." (p.51).

Similarly, Robinson (1971,p.25-26) notes that once a sign was first noticed, it was "impossible" for the participant in his study to ignore it; she had "become sensitive to the slightest change in usual behaviour ... she had to be continually seeking for evidence and 'making decisions'." Participants in Locker's study (1981,p.54) recognised signs that a change had occurred. "Faced with one type of cue an actor may wait for further cues to confirm the initial

suspicion that something is wrong. These subsequent cues not only confirm that suspicion, they may point to a diagnostic label or enable a choice between alternative labels to be made."

Observing Signs

The awareness that life is proceeding as usual, or that there has been a change, is based on the observation of signs. A sign is a marker or indicator of what is happening. Women in the study used the words 'signs' and 'symptoms', however signs seemed to have a broader application.

P - He [husband] showed me the signs [pregnancy]

I - What kinds of signs did you ...?

P - My eating habits changed. So much - all sorts of things happened. [Ruth]

I breastfed B. for a year, and I think I should have picked up the signs [milk allergy] then, because when we gave him cow's milk ... [Lauren]

Symptoms developed gradually over a number of years. [Alice]

It's like I no longer want to deal with symptoms. [Alice]

Because women are with themselves and their children over a long period of time and in a variety of situations, the signs women observe in themselves and their children are holistic to a degree unattainable by a health care consultant. As several women said, "I know my child".

The signs mentioned by women in this study were physical, mental, emotional and social in nature. The women observed signs through the senses and interpreted them, or developed an understanding of the meaning of the signs in the mind. This interplay between mind and senses comprises the woman's powers of perception. The exercise of her perceptive skills combined with a variety of processes (see looking back, comparing, looking ahead, and making

connections) to be discussed later in this chapter is one source of information which a woman uses to make health care choices.

Hearing. Auditory signs provide information to a woman about what is happening. What she heard was often the first indicator to a participant about how her children were faring. In addition to what a child said, the women listened to the volume, tone and pitch of the child's voice and from this inferred what the child was experiencing. Similarly, the woman heard what a health care consultant said within the framework of how it was said, that is the volume, tone and pitch of voice.

Her throat, she sounds like a cabaret singer. [Valerie]

He stopped crying and was laughing at the nurses. [Debbie]

She kept complaining that she was sore. [Rachel]

She just cried and screamed. [Ione]

And every time I go in he's [doctor] always got a really good tone to his voice. [Ruth]

And he [dentist] said 'Oh yeah!' [sarcasm] and he said 'Give me the symptoms'. [Kelly]

Looking. Looking at what was happening provided further information. Behaviour, colour, shape, location and extent of a health concern were among the visual signs the women noted.

She was always drawing her knees up to her stomach. [Christine]

I could see it [Thrush] on his mouth and tongue. [Ione]

It [burn] was a sort of whitey colour. [Rachel]

I'm receding [hair] up to here. [Kelly]

She had incredibly runny motions and they were green. [Christine]

Touching. The women used touch to examine a physical change in their children or themselves.

I could really feel a big lump on his neck. [Debbie]

She was really burning up. [Ione]

Feeling Sensations. Closely related to touching, are the bodily sensations. About these a woman may note location, intensity, duration and frequency. A woman does not have direct knowledge of what sensations her child is experiencing, she must infer this from the signs she picks up through observation, hearing, touching, etc.

And I mean she radiates at night, you can feel it when you walk into the bedroom at night. [Valerie]

... and he was screaming with pain. [Kelly]

Sometimes she says she has a headache in her tummy [Lois, her four year old's description]

The sensations a woman feels within her own body may be the first indication she has about the state of her own health. Some, such as pain, are localised.

Suddenly I had these terrible, hard, painful, rocklike boobs. [Ione]

I would get headaches, my stomach would be upset and things were uncomfortable inside ... Because I had abdominal pains ... My stomach was feeling good. [Kelly]

Global Feeling of Well-being. In addition to specific sensations, there is a more global feeling of well-being which is a non-specific but important indicator of the woman's state.

So why do I feel fantastic on these days and grotty on these days. [Kelly]

It is a feeling of inner strength, at peace with myself. [Alice]

One aspect of the global feeling of a woman's feeling of well-being is her level of energy. Again, for a child, this must be inferred through observing behaviour.

It was almost impossible for me to find energy to speak.
[Alice]

■ ■
*I do know I have a lot more energy after he's [naturopath]
done my back. [Valerie]*

■ ■
Within seconds she was asleep. [Ione]

■ ■
... or if he was lethargic or listless. [Debbie]

Participants in Zola's (1973,p.126-127) research had two ways of talking about "one's bodily complaints". "One type reflected a rather specific organic dysfunctioning while the second type represented a more global malfunctioning." An excerpt from *A Misplaced Pregnancy* (Loates 1990,p.71) describes one woman's experience prior to the discovery of an ectopic pregnancy. It is an example of the more global way of observing signs.

'Of course people thought I was paranoid and neurotic,' remembers Raewyn. 'I began to think that myself, eventually - but deep down, I just knew there was something wrong. A woman really does know these things.

Being Touched. The way a woman is touched during a visit to a health care consultant may indicate to her the nature of the interaction and the competence of the health care consultant.

My naturopath is amazing, an amazing back manipulator. I feel he is really competent. I mean he has certain healing in his hands. [Valerie]

■ ■
You know, just doing his job, straightforward. [About doctors and touch.] [Ruth]

■ ■
He [doctor] only touched me with his hands, but he touched me right down here [pubic area] and I didn't feel he should have. [Ruth]

Feeling (Emotion). What a woman feels emotionally is a response to a situation.

Because I had the blues and went crazy on the third to fifth day, really, really upset. [Debbie - post-natal.]

■ ■
I had good feelings when I found out I was pregnant. [Ruth]
■ ■

I felt I didn't care about myself because I thought I could have lost this baby and I went to a real emotional and tearful state. [Ruth]

■ ■
So then I started to cry because I was really concerned. [Christine]

Social Interconnectedness. The lives of a woman and her child are so closely interconnected that what affects one can extend to have an effect on the other. Thus the degree to which the mother is affected, or the child is or could be affected, is a sign of the extent of the problem. In general, ill health in the children meant hard work, and in the mother it meant worry about who would 'take care' while she was ill. Social Interconnectedness and its essential connection to Bonded Caring will be discussed in Chapter 12.

I couldn't stop her crying but I could sort of pacify her by picking her up, it was very wearisome. [Christine]

■ ■
Because for me, long periods of insomnia, and I mean getting to days where there is no sleep whatsoever is a very dangerous situation for me to be in. And with responsibility for the children, I knew I had to do something about it. [Valerie]

■ ■
I guess, as a mother, if health is not there, children particularly physical health, you set yourself up for a lot of hard nights. [Valerie]

■ ■
Before my daughter was born, I'm a smoker and I smoked in the house. When she was born I banned smoking from the bedrooms. And just recently, about three weeks ago, I banned smoking totally in the house because I felt, I didn't see why the kids should have to put up with it. [Rachel]

■ ■
... but as soon as he starts waking me up in the night, I suspect an ear infection. [Debbie]

Timing. Timing is an important context which women consider when observing signs, both chronological time in seconds, minutes, hours, days, months and years, and process time in terms of sequences of events are used to mark the place and course of a change. Women note when a change began and how long it continued. If a change is intermittent, the frequency with which it recurred, and the time of day might be noted. The context of time allows

women to discover patterns of occurrence among signs, processes.

When

When she was only three months old, she came out in a terrible rash. [Christine]

They [headaches] began early in my married life. [Sarah]

Frequency

But I had a period of which it [insomnia] was really rampant. [Valerie]

It seemed to be sort of three to four hours. [Ione]

I think I've probably had them [sinuses] blocked off and on for years. [Lauren]

How Long

And they [headaches] continued.

I couldn't breathe for days. [Kelly]

It [yoghurt] stripped through her in a matter of ten minutes. [Christine]

Time of Day

It's a particular time, it's in the evening. Never during the daytime. It's always in the evening. [Kelly]

By eleven o'clock in the morning my stomach was in turmoil. [Kelly]

As soon as he starts waking me up too much at night, I suspect he has an ear infection. [Debbie]

Signs were categorised as "heard", "felt", "smelt", "seen" and "behaviour" by Blaxter and Patterson (1981,p.51-52). Locker (1981,p.50) calls them "symptomological, behavioural and communicative".

Symptomological cues involve changes in physical or psychological states that are experienced by the individual concerned or observed in another. Typically they involve

some change in the way one feels or some change in external appearance. Behavioural cues refer to observed changes in behaviour or conduct on the part of another, and communicative cues consist of claims made by an individual to others or others to an individual that all is not as it should be. (Locker 1981,p.50)

The women in Robinson's (1971) study, *The Process of Becoming Ill*, filled out health diaries for four weeks. Robinson states that behaviours were most frequently recognised as indications that family members were becoming ill. Behaviours most frequently mentioned were "more irritable than usual; more tired than usual; more quiet than usual; and eating less than usual." Excerpts from the health diaries in Robinson's study show that the women recognised other signs of health problems.

J. must have had abcess in ear [location], found dry crustiness [looking] in her hair and over face [location]. Knew she was cross [behaviour] for some reason [making connection]. A. has started passing watery liquid [looking] from the bowels again [frequency]. Cried over 2 hours [heard] (p.29). I had very bad back and stomach [location] pains [sensation] before the laxatives worked [making connection] (p.32). [Comments in brackets are added.]

Bunting (1989) has synthesised a definition of perception from a historically based concept analysis. She (p.170) suggests "perception is the process of neurologically sensing and selecting stimuli from all those available, interpreting the selected stimuli in light of past experiences and assimilating new experience into the repertoire of the perceiver." This definition fits the observation of signs and the skills used to interpret them as used by the participants in this and other studies, as shown above. However, as Bunting (p.170) points out, the definition "assumes a world view which includes linear time and causality." It does not include an intuitive awareness which is part of the dictionary definition of perception (Random House 1971,p.985), "immediate intuitive recognition, as of moral or aesthetic qualities." However the overall global feeling of 'something is wrong' based on 'I know my child' or 'I know myself' might reflect this intuitive aspect of perception, and is perhaps a reflection

of the woman's expert knowing as it is demonstrated in Generalised Awareness.

Interpreting and Integrating

Even as the women take notice and observe signs, they begin to look for the meaning of what is happening, this is Interpreting. They also try to understand how what is happening fits with current and past situations and how it will fit into their future; this is Integrating. Some skills used to do this are checking, comparing, looking back, making connections, recognising misconnections, and looking ahead.

A report of three experiments to determine the relationship between blood pressure, stress and the search for symptoms (Baumann, Cameron, Zimmerman, and Levanthal 1989, p.449-469) provides some support for Interpreting. The authors state, "In answering the question of how the match between labels and symptoms comes about - through automatic suggestion or through a systematic search process - our data suggest the latter." This would indicate the existence of skills with which a systematic search process could be carried out.

Checking. Checking, a form of Taking Notice, is purposeful observation and interpretation of signs in a specific situation. Because the woman is concerned about the situation, she uses checking to answer the questions 'What is happening?' and 'Is everything all right?'. Checking may be periodic if the situation is ongoing and there is a possibility of change (keeping watch), or it may be once only if the situation is short lived (see Checking, p.82).

And when I went back to check on her, she was really burning up. [Ione]

■ ■
But I also was a bit careful about what I fed her and I did what the book said and I'd introduce one food and monitor how she reacted to it. And I was monitoring all these things and nothing seemed to affect her until I started feeding her cows' milk. [Christine]
■ ■

One of the teachers at School where I taught had just had one, I'd come back from holiday and she'd just been a little bit concerned about a lump on her breast. When I came back, I was fencing overseas, so when I came back, there she was minus one breast, so soon. And then shortly afterwards the other one. So everyone was busy checking themselves all the way around and lo and behold I found one myself. I mean these are the sorts of times I go to the doctor, I find a lump somewhere. [Christine]

If a woman cannot answer the question 'What is it?' or it appears that there is something wrong that is beyond her skill, she may go to a health care consultant to check it out. The health care consultant may carry out tests that require the use of machines, instruments or techniques and specialised knowledge to interpret the test results.

I take my children to Plunket to get weighed. [Debbie, Christine]

■ ■
Yes, I mean I did, I had blood tests, and I had barium enemas and x-rays. [Kelly]

■ ■
Actually what you do, is you do a special thing called a muscle test [a test for allergies] which is beginning to be used by a lot of people. It's actually being used by my dentist now. [Kelly]

Women also check on themselves. This is an aspect of Bonded Caring manifested by the need to protect their children or themselves and to provide effective care. Women may ask health care consultants to confirm that they are using correct or appropriate health care strategies at home ('Am I doing the right thing?'). And they may use results of certain tests to evaluate how well they are doing ('Am I doing all right?').

[I go back to the naturopath] to make sure I am doing the right things. [Lauren]

■ ■
I had this creeping doubt of my nurturing physically and my milk and these things and I thought 'Well, I'll just get it [baby's weight] checked next time I go for a scheduled Plunket visit'. [Valerie]

■ ■
[I] told him [doctor] what I did about it, which was more or less nothing, drink water or something until the pain went. I can sit back and explain how I did it, why I did it; did I do the right thing? He'll say yea or nay. [Ruth]

Comparing. Comparing involves taking the present situation and comparing it with information about similar situations to determine fit (integrating). If there is enough similarity, the woman can use the information to determine what is happening, what to expect and how to manage it. If the information does not fit, the woman knows it does not apply to her situation.

First hand information comes from the woman's own experiences and from experiences of her children. A woman will look back to determine if she has had a similar experience or has acquired knowledge about the situation. Personal experience is valuable because she has access to 'how it felt' as well as what is happening, what to expect and how to manage it. If the situation is similar to one experienced by another child, the woman will have first hand experience in managing it, and information about how the child reacted. Lacking experience, acquired information may provide enough guidance to allow her to manage the situation or to know that she needs help.

*Sometimes I give C. a vitamin supplement because I notice, I take E vitamins and if my skin's not healing quickly, I take the B vitamins and it heals better. And C. had a couple of things that weren't healing so I went to the chemist and got some vitamins, Brand name, for him. I'm not really a great believer in vitamins. I think, I know they work for me so hopefully they work for him. And his skin did clear.
[Debbie]*

■ ■
And I thought she might have had an ear infection because she was really troubled and playing with her ears but then again because I'd had this flu I'd had earache, I thought maybe that's all she's got, but because we were going away, I really wanted to have it checked straight away. [Ione]

■ ■
He picked up, had something very similar to the first child and the doctor prescribed antibiotics for him, so I gave the ones he had left over. But I mean not very thoroughly anyway, he only got the end of them. He's fine now, his nose is just about clear. [Debbie]

■ ■
Yes, according to the naturopath, H.'s constitution is more like C.'s. A. is fairly sturdy. This little one [H.], he sort of has allergic tendency [like C.]. [Lauren]

Debbie, in response to the rough draft of the analysis, provided this example of yet another comparison. In this case, she did not know what the child's problem was until she experienced it herself. By looking back she was able to name the child's problem, "tummy bug".

Once S. didn't have one [she took S. to the doctor thinking he had an ear infection], but I realised a few days later that he had a tummy bug ... The only way I knew [what it was] was that I got it from him. [Debbie]

An example of comparing is provided by Blaxter and Paterson (1982,p.59), "Certain problems might be interpreted in a serious manner if the mother had knowledge of the serious consequences of the symptoms, not because of the child's history, but from experience with another member of the family or even herself."

Women also make comparisons between current situations and information from family, friends and media. **What's** going around was a useful type of information that allowed some participants to recognise and anticipate the possibility of illness.

My mother and my husband spoke out. They were worried about my abdominal pains and explained how my sister had had her baby stuck in the tube and they were worried it was the same way because apparently my troubles and pains were the same as my sister's. And my sister was worried, she said, 'If somebody had told me to go and check up, my baby could have been saved, or the situation wouldn't have been as bad as it was'. So we did. [Ruth]

■ ■
My dentist, there is a series of things, like on the radio there was a talk about children being confused after they've been to the dental clinic and had a filling. And then there was A., I went to a homeopathic course and they were describing a certain series of symptoms [...] whole year course, and I thought that sounds remarkably familiar [to what she was experiencing]. [Kelly]

■ ■
Often you can guess as to what sickness you have mainly because that is what is going around the playcentre/school at the time. In some cases you have been waiting for it. [Debbie - response to rough draft of the analysis.]

Locker (1981,p.61) states that 'so many things going

around' provided a time-place context from which participants in his study could watch for cues of a possible health problem and interpret what is happening should the cues appear.

Another comparison a woman makes is her own experience or observations compared to what a health care consultant states is happening.

These three have been really little so they've been way down below the graph, and what they - and what the nurse started to do a wee bit of a panic and then she realised that it was okay. That everything was all right. And when it came to E. it was a different nurse and she started to panic with her about how she wasn't growing quickly enough. So I went after to the next visit with their books and showed her it was completely okay. [Ione]

I was sort of aware that my health was not good, at some stage. And I thought, 'Well, there has to be', when I went to my doctor about it, it was a little bit of this and a little bit of that and so on. And my doctor said 'Oh, you're just getting old. You do a lot of work and you're going to university and you're studying' and all this sort of thing, and I sort of walked down the surgery and I thought 'Bugger this, I'll not accept, I won't accept that I'm getting old. That's not, that's not the issue at all. I don't feel well'. [Kelly]

And this is quite funny even though it was frustrating. I said to the doctor, 'I've got tonsillitis. I need penicillin.' She checked me out, she goes: 'You've got tonsillitis, you need penicillin'. [Rachel]

Participants also compared information they received from the various health care consultants and from other sources, checking to see if the information was up to date and consistent.

O. had quite serious nappy rash at one stage and she [Plunket nurse] told me something to do and it was quite the opposite from, well she had said to put on vaseline and I'd been told, I'd been to Karitane, and they had told me not to, this is, I had been there with M. So she had told me to use vaseline and the Karitane unit had told me that it's best not to use vaseline if they got nappy rash because it seals the moisture under and stops the air getting in to dry it out. And she seemed to not know the names of current nappy rash products, she never heard of Hewlett's which in M's time I think Hewletts was the thing because they reckoned - but she said use Ungvita - and the chemist had

said to me Ungvita is not the best thing to use because it seems to feed the nappy rash ... And she hadn't heard of things like Canisten and which is a bacterial ... a prescription one. [Christine]

So I don't really think a lot of Plunket because they haven't got this La Leche experience and also the nurses in the hospital haven't got the experience of really breast feeding so they can't offer any advice, if they haven't read Maureen Mention, Breastfeeding Matters, she's Australian and she's done a lot of breast feeding work and said that breast feeding is easy, it's often the positioning that does it. [Debbie]

I explained exactly what happened with Dr Z. And he [Dr E.] explained the same things [about miscarriage] that this other doctor [Dr B.] said and a little extra. [Ruth]

Looking Back. Once a woman has observed signs and has an interpretation of what the signs mean, integrating to make sense of what is happening is the next step. The woman checks to find out if the interpretation fits with her personal experience. **Looking back**, is a way of comparing the past with the present in order to make sense.

Family history, a major source of information for a woman about herself and her children, provides information about growth and development patterns and diseases which can be used to anticipate what is normal and what diseases might occur. The anticipation and acceptance of a disease occurs more readily if a woman is aware of its presence in her family history. In addition, she is more likely to gather information and take appropriate steps to avoid the development of the disease.

Also B. [husband] is asthmatic, well he got that asthma when he was a child, it's an occasional wheeze now. But I thought there is this history of allergy or asthma in the family because his mother actually died of an asthma attack. I thought it [naturopathy] might seem the right course to take. [Lauren]

I think I have a high cancer awareness. Of my immediate family, I have two living brothers. My mother died of cancer, my father died of heart and cancer complications, and my grandmother died of cancer. I know that statistics are one in three and I don't think I'm overly anxious about having cancer, so I just see it [smear/breast exam] as a matter of procedure and common sense. I have smear tests

and breast examinations. And it gives me some sense of 'Well, I've done my bit, I'm clear' - it's not that I'm clear for another year and I've got another year to live, in this time and age we live in I think it's important to have those things done, checked out. [Valerie]

She was gaining how she was supposed to be. In fact she was a normal baby even if she was in there following the bottom of the line. The bottom 3 percentile or whatever it is. And then to come home and have the Plunket Nurse at home tell me that she's got a high instep and I'd say to her, 'Like her mother'. E., from what I could gather from my family, followed me in development. I told the Plunket Nurse this three times, she still didn't hear me. In the end I turned around, I said to the Plunket Nurse, 'She's just like me and I turned out all right'. So she stopped making these sort of comments after that. [Rachel]

Looking back with new information can make sense of a past situation or can enable a woman to see how the information affects her choices. Making sense of the past can be done purposefully. In this case an interpretation is compared with past experience to see if it fits. Or, the woman, as a result of new information, may suddenly realise that there is a connection with a past situation.

I breast fed the first two but only for a little while because I had problems with ulcers, breast ulcers, and I now know I could have fed through but of course in those days there just wasn't information. And so they said 'Off you come, you are poisoning your baby' sort of thing. But when he was born I thought 'Well, I'm going to feed him anyway'. [Kelly]

Of course when I was teaching my girls to swim, I was in the pool everyday for weeks. And that was why my hair was falling out. My body said 'I can't tolerate this'. It took me, it was a huge difference, it was like ten years. Looking back one day, I suddenly twigged what had gone wrong. [Kelly]

Here I was, busy giving him all these lovely dairy products and he was getting asthma more and more frequently. I think, in retrospect, that may have been some warning signals that his body wasn't tolerating milk, and he was getting eczema as well. [Lauren]

Biographical information was used by participants in Locker's study (1981,p.69) to construct explanations of health concerns. This consists of personal and family health histories, life situations, life events or life

stages (developmental). In another study, *The Health of Regionville*, a participant used looking back to interpret the need to visit a health care consultant.

I'd look silly, wouldn't I, going to see a doctor about a backache. My mother always had a backache, as long as I can remember, and didn't do anything about it. [Koos 1954,p.36]

Making Connections. Making connections, used to interpret and to integrate, is a combination of the observation of signs and looking back. In this way signs can be connected with an antecedent activity or event. At the time a sign was recognised, participants could often name events and situations which preceded the sign and their connection to the sign. If no connection was recognised, the participant might say, 'I couldn't find a cause.' If information is lacking, a connection will not be made until the missing information is supplied. Alternatively, the connection may be observed, but its meaning may not be known until further information is acquired at a later time.

Because when we gave him cow's milk, he didn't really like it, sometimes he actually brought it up. At that stage I hadn't cottoned on to it [milk allergy]. [Lauren]

■ ■
And so really, I didn't see her [nurse] again after I had O., and she was on the breast and she just chomped on it for a couple of hours, and I got cracked nipples. And it was after I'd spoken to a Plunket Nurse ages later that I realised she should have been on for a little while ... [Christine]

■ ■
And it was summer, a really hot day and she just didn't want a bottle ... Day two went by, and by mid-afternoon I was getting pretty worried, because she wouldn't take milk, but she seemed happy as Larry, just her normal old happy self. I went across the road and saw old Granny K., the granny of the neighbourhood. And she said, 'For goodness' sake, girl! It's 28°C. Do you want to drink milk today?' And she said, 'Don't worry about it'. [Becky]

As stated above, looking back and tracing events and activities that occurred prior to the appearance of the signs is one way of making connections. Signs of an acute situation could often be traced directly to a preceding event, for example, "I cut myself", or "A horse kicked me"

[Kelly]. Observing the results of actions is another way. A third way, if signs are recurrent, is looking back and noting the frequency with which an antecedent event occurs prior to the signs. Some participants could name a set of circumstances, a trigger, which appeared to initiate the signs which caused concern. For example, milk products were connected with a runny stool [Christine] and the smell of tobacco was associated with nausea [Alice]. Making a connection means that the interpretation of the signs must include it. It also allows the possibility of some control over what is happening. If the antecedent event or activity can be changed, a recurrence of the signs might be prevented.

In fact, if I eat an egg, like a whole hard boiled egg, next day he's as spotty as anything, so I think there is some connection. [Lauren]

■ ■
I've actually started him on a bottle because it's really hurting to feed him and that's how I knew I was pregnant, because of the hurting. [Debbie]

■ ■
I gave her yoghurt and it really stripped right through her, in a matter of ten minutes. And you'd end up with a puddle on the floor, green puddle on the floor, and that was every time. I mean that coincides with every time you gave her yoghurt. [Christine]

Recognising Misconnections. Some participants made a misconnection and thus misinterpreted what was happening because they lacked essential information. As a result health care was based on what the woman thought was happening. At some point more information gathered either through personal observation or from outside sources would act as a trigger to correct the misconnection. The woman could look back on the process of the health concern and make sense of past observations in light of the new information.

[See Debbie's account of the 'Tummy Bug' under comparing, p.121.]

■ ■
My second daughter failed the eye test at school and she'd been saying to me for months that she'd been having lots of headaches. It was where I actually slipped up, because she

gets sinus like I do and I'd put all those headaches to sinus and it was probably more like eyestrain because it turns out she needs glasses. [Ione]

[Ruth was told she might have miscarried, but she didn't know what a miscarriage was.] I just felt if I had lost the baby and I didn't know about it, then I must be really stupid, I felt horrible, I didn't feel human. I felt very irresponsible ... I felt every time you are pregnant, you can have a miscarriage and you don't know; or a woman could have had five or six miscarriages in her life without knowing it. That's what I was starting to believe. [Several days later she spoke to another doctor who explained miscarriage to her.] He even made me understand to the point that even if I was having a miscarriage there's nothing they could do ... There's no way you won't know if you've had one ... I was really rapt! [Ruth]

Looking Ahead. When there is a health concern, a woman will look ahead at the near future so she can make plans that allow her to manage the health concern. This includes coordinating what happens to other family members while she is occupied with the health concern. One woman discusses this using the example of her daughter's admission to the hospital with a head injury.

K. [friend] came over here [my home] because they [hospital staff] said they'd have to admit her [my daughter]. She'd come over here to get some clothes for me and some things for H. and it was all these kinds of dynamics pulling me, and I wondered if O. would be alright, if he had to stay there [friend's home] for the night. ... I think I went into operational stress mode and just coped with this and that and getting to the hospital and getting these things organised. [Valerie]

Participants also looked ahead at the possible future in an attempt to come to terms with it and cope with it (integrating). They might ask "Is this really going to happen?", or if they are sure it will happen, as in a developmental stage, they might ask "How can I prepare for it?".

It wasn't until that point where I was standing alone outside of the x-ray office, that I really started to think what will this [unconscious child] mean now. I mean what does this mean for H. Surely this little girl is gonna not just lie like this all the time. [Valerie]

Q. was in hospital in January because he'd hurt his kidney,

and we definitely wanted to know what was happening long term with that ... we wanted to know the long term because kidneys being so precious. [Ione]

Based on their interpretation, participants might decide that they don't know what; possibly know what; or know what was happening. This will be discussed in Chapter 8.

In their grounded theory, **Mazing: Infertile Couples and the Quest for a Child**, Sandelowski, Harris and Holditch-Davis (1989) describe how their participants responded with regret to looking back and looked ahead anticipating regret in reference to fertility choices.

Already regretting or, at the very least, reviewing fertility choices made in the past (e.g. delaying child bearing, elective pregnancy terminations, elective sterilizations), fertile couples anticipated regret in their cost accounting of the benefits and liabilities of pursuing any one path to parenthood. [p.223] [Underlining has been added for emphasis.]

Conclusion

The participants were experts in their own homes, having a generalised awareness of what was normal for each member of the family and when activities were proceeding as usual. Their experience was acquired through ongoing observation, interpretation and integration of signs of what was happening. Depending on their experience, a change in the signs would cause them to Take Notice. Using Observation, and Interpreting and Integrating Skills (Taking Notice, Checking, Comparing, Looking Back, Making Connections, Recognising Misconnections and Looking Ahead) the participants interpreted and integrated their observations with past experience and acquired knowledge in order to understand what was happening and to look ahead at implications for the future. The next chapter contains a description of the processes Striving to Know What and Striving to Master. The participants engaged in these processes when the sign of change was beyond their knowledge or they didn't know how to manage the situation.

Chapter 8: Striving to Know What and Striving to Master

The previous chapter contained categories associated with Skills for Knowing. These are some skills the participants used to determine what was happening when a change occurred. This chapter contains the processes, Striving to Know What and Mastering (Striving to Know How). These processes occupy a pivotal position within the theory of Bonded Caring. When a change occurred, the women's first response was to use Skills of Knowing as they began Striving to Know What and to Know How. If the health concern was beyond their knowledge they began to use Information Resources including health care consultants whom they hoped would Share their Concern (see Chapters Nine and Ten).

The women's efforts in Striving to Know What and Mastering support the aspects of "serious attention to needs" and "protection of capabilities" of Bonded Caring. Categories connected with Striving to Know What are Naming, Doesn't Know What, Knows Possibly What and Knowing the Process. The categories Try and See, Doesn't Know How, Possibly Knows How and Conscious Awareness are associated with Striving to Master (see Figure 3).

Striving to Know What

Naming

Once a cluster of signs had been identified, participants compared their observations with previous experience

(Looking Back) and acquired knowledge in an attempt to find a name for what was happening. Having a name for the cluster of signs meant that it was a real health concern that would be recognised by others. The participants could find out more about the health concern by talking to others including health care consultants and by other means of information gathering (see Chapter 9). A name also means that there is information available about how to manage the health concern.

And I know that in each label there is not a finality of actual - whether it is Alzheimers or whatever it is. I know it is something to begin to get familiar with rather than an absolute diagnosis. I find that information is - I want that information. For my own peace of mind. [Valerie]

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Nothing had changed except they'd given it a name. They had diagnosed, so its not so much having the name, it's knowing that they know what's wrong. [Ione - her son had internal bleeding after an accident and it was two or three days before the source of the bleeding was located.]

As these excerpts infer, having a name provides a certain 'peace of mind' that is not present when a woman Doesn't Know What.

Pridham (1989) shows that interpretation and observation are connected with naming a health concern. Two situations were presented to the mothers in her study. One concerned an infant who had been successfully fed an hour earlier and was now crying. The second concerned an infant who took about half of a usual feeding and was now disinterested. The two decision rules most commonly used when naming the situation were "Refer to a generalisation about this type of situation (e.g. "A baby is not always hungry")," and "Note how the infant is behaving/what the infant is like" (p.69). The first is an Interpretation and the second is Observing Signs. The fact that the interpretation was mentioned most frequently may be a result of having a situation described rather than being in the situation.

Doesn't Know What

In this study, a participant Doesn't Know What when she has taken notice and realised that something is happening but due to a lack of knowledge and experience she is unable to name the change. After noticing the change she becomes very alert to detail and might state 'What's happening here?', or 'Something is wrong.' If time passes and she is still unable to name the health concern and find a way to manage it, she imagines what it might be. Because she hasn't found a name within her own knowledge, she might imagine a high risk scenario and her concern and worry increases. With a sense of urgency to know what is happening she begins to tap into her information resources in an attempt to find a name for what is happening and a way to manage it.

When he was about five weeks old, I started feeding him in the evening and he was screaming with pain. I said to my husband, 'There's something very wrong here'. And anyway I went to the doctor and he said, 'He's just got a bug'. [After trying the doctor's directions with no change, Kelly went to a La Leche leader.] Luckily I belonged to La Leche, so I went around to her place in despair one night and said 'What's going on?' ... We talked about half an hour, and she said 'It's something you are eating.' [Kelly]

■ ■
He must have been about 4 months and it was the middle of the night and I was worried sick. I just didn't know what was wrong with him. He was just crying and crying and I couldn't settle him. And so, I went to A & E. It was about 4 o'clock, 5 o'clock in the morning. And he stopped crying and was laughing at the nurses. But a young guy looked at him. A very young trainee doctor looked at him and said he thought he might have an ear infection and gave me antibiotics which it turned out from my G.P. that that is what it was. [Debbie]

Knowing Possibly What

Based on observed signs, previous experience, and acquired knowledge, a woman may be able to identify one or several possible names for what is happening, but may be uncertain if her interpretation is correct. She knows possibly what is happening. She may (or may not) know how to manage each

possibility, but is unable to determine which care strategy to use because she is uncertain which name applies to the situation. At this point, she uses her information resources to confirm an accurate name for what is happening. If she is unable to confirm a definite name for the observed signs, a woman may find that management of the problem is difficult and must be determined on a try and see basis.

I was sick, I had abdominal pains down here [lower abdomen]. And I just thought it was something serious. He [husband] thought I was pregnant. So I went to the doctor and I made a pregnant test first, and if it came out negative then I would know to go forward with it. [Ruth]

She [baby] cried a lot and I wondered whether what I was eating seemed to affect her ... But I also was a bit careful about what I fed her and I did what the book said. And I'd introduce one food and monitor how she'd react to it ... And nothing seemed to affect her until I started feeding her cow's milk. [Christine]

Knowing the Process

Applying a name is the beginning of Knowing What. As stated previously, having a name enables the woman to find out about the health concern. Even as the participants were observing signs of a health concern they were not working with it as a fixed state. Looking Ahead (see p.127) to determine how a health concern may affect the near or far future, and Keeping Watch (see p.82) to monitor what is happening are indicators that the participants work with health concerns as processes. Participants wanted to know how a health concern came to be, what would happen as it progressed, how long it would continue and how it would affect future development. If a participant perceived the risk as high, or the health concern was long term, her need to know the process was greater.

Participants achieved a level of knowing when they knew the process and the points at which they could make a difference using remedies or health care strategies. If

the process has been learned through a combination of experience and acquired knowledge, the woman's concern and worry decreases and she has a higher level of confidence. However, if the woman's knowledge was mainly acquired, she may recognise what is happening but may lack confidence and need confirmation that she has correctly recognised what is happening and reassurance as she manages the health concern.

Oh, must have been the mumps epidemic we had over here and I knew that my child had mumps. There were lots of obvious things about having mumps. But it was like her recovery was very, very slow and, not having dealt with mumps before, I didn't know how long the process was. [Valerie]

[See also Debbie's description of how she recognises ear infections, p.121.]

Luckily I had had two friends that had caesarians, and I also attended a Parents' Centre Conference and attended a workshop on caesarians. In actual fact I know quite a bit about caesarians; a lot more than the lay person would know. In that respect I knew it was a possibility. I didn't know it was definite, but I knew it was a possibility. But when he [doctor] said it, it was also very, very scary because you think of people that die under anaesthesia. [Debbie - when she had a caesarian.]

A longitudinal study by Lau, Bernard and Hartman (1989, p.195-219), suggests that Naming and Knowing the Process are connected with the way people think about illness. At the time they enrolled at university, 532 students were asked to describe their last cold. Two years later, they were asked to describe their last sickness. Their answers were coded in predetermined categories. Identity (Naming) included "a label for the disease and knowledge of the symptoms associated with it". Overall, 95.5% of the responses listed an identity. A timeline, "beliefs about the cause of the illness, how long it will last, and whether it is acute or chronic", was mentioned by 72.1%. Consequences, mentioned by 45.8%, included "the short term and long term effects of the disease." Fifty-one point eight percent mentioned cause or "what factor or factors led to disease onset." In addition, 53.1% mentioned cure, "what the person did to recover from or get

over the illness." The categories were adopted from a study of commonsense illness representations by Leventhal, Meyer and Nerenz (1980). Three of the categories, timeline, consequences and causes, are part of Knowing the Process. Cure is related to Knowing How (see p.140). The authors state:

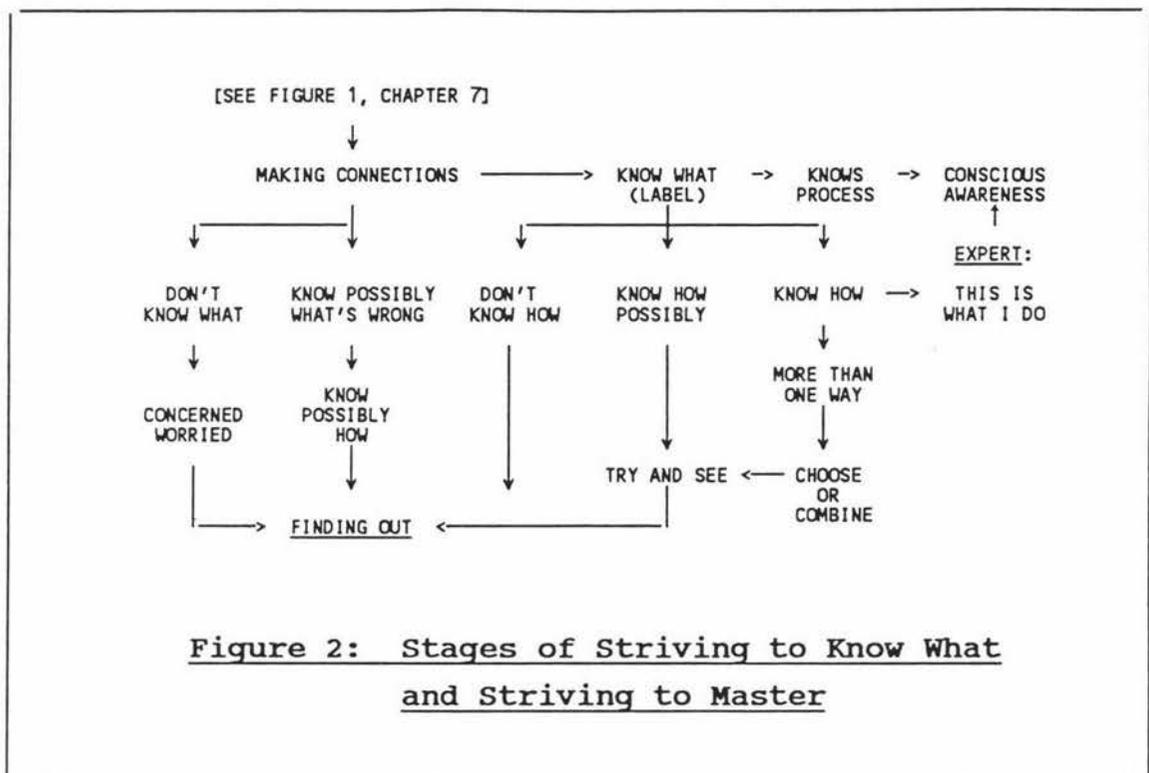
There is strong evidence for the generality of these five components in people's commonsense representations of their common illnesses. Most people do not use all five components in describing any one illness, at least not with the length of the descriptions typically reported here. But most people do have these components generally available to them and do use them in describing some illnesses. [Lau, Bernard and Hartman 1989, p.207.]

Striving to Master

While the participants were trying to discover what was happening, they were also trying to find ways to manage the health concern. This happens because the health concerns were ongoing and the women needed to learn how to manage them as they were occurring. The stages of Striving to Master that were identified are Doesn't Know How, Possibly Knows How, Knows How, and Conscious Awareness. In order to Know How, the participants would Try a way of managing a health concern and See how it worked.

Try and See

Women find out about the effectiveness of a way of handling a health concern, and gain experience in how to handle the problem through a process called Try and See. Ideas for ways to handle health concerns come from a variety of sources. A woman may read about it, hear about it, be shown how, or ask someone more experienced (older woman or health care consultant). Or it may be something she has tried on herself or another member of the family.



Women try various ways of managing health concerns because they might make a difference. They might cause a change of signs toward a more normal or usual state.

I thought, 'One child seems to be allergic'. I thought if I did the right things, ate the right things through pregnancy, it might make a difference. [Lauren]

When a woman tries a health intervention, she waits to see what happens. The time of waiting may be a few moments or several weeks. During this time, she watches for signs of a change, and interprets the effectiveness of what was tried. Alternatively, if using supportive health care, the woman may try responding to the needs of the child (or herself) by providing extra rest, a different diet, and temperature control through bathing and medication. Again she will wait to see signs of a change.

As she monitors (keeping watch) what is happening a woman will interpret the effectiveness of what she is doing. She may decide it made a difference; it made a difference but something more is needed; there has been a change, but she

can't tell if what she did made the difference; or there is no difference.

Makes a Difference. When the health intervention the woman has tried makes a difference, the woman makes a connection between the intervention and a change in the signs. This results in a sense of relief, and the next time the signs occur, the same intervention will be tried again.

He's had the odd cold and things and what used to happen was he was really bad, the cold got automatically, the first sniffle, I thought 'Uh oh, he's going to have an attack'. And sure enough after two or three days his chest would get wheezy. But now he seems to be coping a lot better. When he has a cold it's a cold. [Lauren]

■ ■

And so I ran through all the symptoms I was having and he said 'I think you might be allergic to amalgam', and he took it out. But that didn't cure the problem because of course, I was having fillings done every six months, and of course it was building up and building up over a number of years, over four or five years as I was gradually replacing a lot of the old ones. And I thought, 'Well, it's still not right'. And that was frightening me. I thought I couldn't think straight, I couldn't even do a crossword puzzle. And I went to my dentist [a second dentist]. She tested me and she said, 'You are definitely allergic to mercury and amalgam'. And so, as I said, she did the muscle test. Then she tested me for the things that she was going to put in my mouth as a replacement. She found that I could tolerate two of the six possibles. I would tolerate two, so she used those. So, I've had all the amalgam taken out of my teeth, every single bit of it. And in fact it was only about three or four weeks ago, I was saying to my osteopath, 'I'm enjoying doing crossword puzzles'. I do them all the time now because it is such a joy to actually do a crossword puzzle. [Kelly]

Something More is Needed. A health intervention may make a difference, but it may be decided that something more is needed or another way is needed. Something more is needed if the health concern is beyond the woman's skills or knowledge. Another way may be sought if the health intervention is judged to be risky.

Like, one day I burned my arm. So I immediately ran cold water on it, and this sounds stupid, but the water was so cold, I couldn't put my arm underneath it. So what I did then, was, I wrapped ice in a cloth and put that on my arm and it still wasn't right. So I knew I needed something on

it, but what I needed, I didn't know. So I went to the chemist. [Rachel]

■ ■
B. started asthma when he was about one and between the ages of one and three he was going in and out of hospital, on a lot of medication. My husband's a pharmacist, he knows what is going in him. I thought there's got to be a better way because just the thought of filling him up on all these antibiotics, bronchodilators and everything, there must be some other way. [Lauren]

Doesn't Know if it Made a Difference. When a woman has tried a health intervention but is uncertain whether it is connected with a change in the signs, she will say she doesn't know if it made a difference.

... and drink raspberry leaf tea. I actually had a very easy labour with him [third baby]. So I don't know whether that helped. [Lauren]

One woman decided not to try a way of managing her health concern because it did not fit her philosophy. Looking back she might say, "I don't know if it would have made a difference."

I had a lot of problems because I was not a La Leche person, and I was not a Leslie person. I was right in the middle and I was torn between them all the time. I didn't know how to deal with it. I don't think kids should be left to scream for a long time at all. Although, maybe it does work, I don't know. In the end I did the toddler taming where you pick them up every five minutes. [Debbie]

Made No Difference. If there is no change in the signs or there is a change that is worse, the woman will interpret the effectiveness of her intervention as having made no difference. This results in disappointment, frustration and a decision to stop the treatment, and possibly to stop seeing the health care consultant who recommended the treatment. In addition the woman may decide to find another way of handling the health concern.

When we were in City, that week because I'd had the 'flu before, I actually ended up with terrible sinus. And if I'd been at home I would have gone to the doctor. I just went and bought some of those (...) and supposedly treated

myself, but it didn't get better. I was quite disappointed.
[Ione]

So I went a whole fortnight, every single day. And it was being paid for by the government, and I walked out of there [physiotherapy] exactly the way I walked in; still feeling that there is something wrong. So I then went to my osteopath. [Kelly]

For instance, cough medicine, I was prescribed a medicine by a doctor and it actually made me worse. It made me cough more, made my flu come up worse ... It wasn't just noticed by me but was also noticed by my husband and so I stopped. We actually threw that away. [Ruth]

My sinuses started to get really bad, this was when I was breast-feeding B., and I was taking all these decongestants and nasal sprays which I hate. I thought 'These aren't working. I'll try something else.' [Lauren]

Trying Another Way. When women in this study tried a different way of managing a health concern they often felt that it was a forced choice. They had tried what they knew with little or not enough effect, and the risks or discomfort they associated with the health concern or its treatment were such that another way was sought.

So in every instance I was forced into alternative medicine. It was not something I chose readily, although I'd been interested in herbal medicine all my life. It was something that I was actually forced into because I was getting nowhere with my own doctors. And I thought, well there had to be some other way. It was funny series of quite dramatic happenings. [Kelly]

P- I had developed a multiple allergy syndrome which I think we can conveniently label M.E. or chronic fatigue syndrome. And I found that standard medical approach really didn't seem to have answers to let me deal with that, though there are a few medical practitioners who are looking at it and have things to offer. It just didn't seem that I was getting anywhere with that approach. I was also married to a doctor at that stage. So it was against a bit of bias, built in bias that I decided to try a naturopath.

I- How did you come to select the approach you are doing now?

P- I had had a motorbike accident and I was having treatment from a physiotherapist who recommended a naturopath, and it was some time, I think a few months before I actually followed up on that. I heard his name mentioned by someone else and decided to check that out, by which time I had actually become quite ill. [Alice]

Initially, a new way was approached with uncertainty, a

degree of hope and willingness to try and see what happened. This new way had to prove itself by making a difference so the women were alert to notice its effects.

I thought, 'Okay, I'll give it a go'. Its pretty strange and outlandish, but I'll try it and see. ... It was so totally foreign to anything I'd experienced before. He gave me some massage and put my back in shape, and I found that all quite scary. But I could also feel some beneficial effect from what he did physically. I decided, well I didn't have anything to lose. I'll just follow it up and see what happens. [Alice]

■ ■
I think the first time [in hospital], it was quite distressing, because not knowing what to expect, what was going to happen to him [baby with asthma]. But then the second time it happened, I was a bit more familiar with the hospital procedure. I was still upset that he had bad asthma, but I had come to terms that perhaps that was the best place for him and it wasn't as frightening as the first time was. [Lauren]

If the health care strategy made a difference, it was validated and the women continued to use it and incorporated its guidelines, principles and philosophy into their repertoire of health care strategies.

When I had my own children, I thought, "Well, all right, I want these babies to be healthy. How can I best give them protection?" ... Right, think, "What is the best diet for these kids?" And with that, I went to a naturopath here in Wellington. [Sarah]

■ ■
My children haven't had anything resembling an asthma attack or wheeze since I've been more aware of dressing them properly. [Rachel]

■ ■
I didn't manage to breastfeed T... But I was determined that I had missed out on something, and that I was going to make it with the next one. So I was honest with this Plunket nurse that came with S, and I told her how I felt and she was really supportive. ... And I managed to feed the rest of the girls right up to the present day. [Ione]

A special case of Try and See is provided by Sandelowski, Harris and Holditch-Davis (1989) who generated a grounded theory called, **Mazing: Infertile Couples and the Quest for a Child**. They state that couples move from trying to have a child (Try) to either conceiving or continuing to "Try" (and See). Within a year or less couples who tried to

conceive but did not (didn't make a difference) sought medical assistance. **Made a difference** occurred when a couple became pregnant or were put on an agency's adoption list. The study implies that there are patterns to Try and See called Entitled Patterns of Pursuit. They are sequential tracking, or one thing at a time; back tracking, or restarting a regimen that had been tried previously but it hadn't made a difference; getting stuck, or continuing to try a regimen that doesn't make a difference; paralleling, or trying more than one regimen at the same time in hopes that one will make a difference; and drawing the line which means deciding at some point to stop a treatment regimen that doesn't make a difference. This study, therefore, extends the concept Try and See and suggests further study is needed.

Knowing How

Once a participant recognised the existence of a health concern, she might not know, immediately, what it was. However, she still needed to manage the health concern. This could mean waiting to see what would happen and supportive health care or a visit to a health care consultant. Once a participant knew what was happening, she might or might not know how to manage the health concern. However, her efforts to find out how could now be focused on a known process.

Doesn't Know How. If a woman doesn't know what to do she will seek that knowledge. However, if she is inexperienced and has no acquired knowledge, she may not know enough to know what questions to ask in order to get the information she needs.

But sometimes you go to the doctor and you don't quite know what questions to ask and because you don't know you can't follow it up. [Christine]

At this point she needs specific guidelines about what to

do and what to expect. She will feel a need to check to see if she is doing things the right way. As she is learning how to manage the health concern, she may experience this as a difficult task and lack confidence. So she will seek reassurance.

Because I think that first dietary, you know, cutting out things. I think going to a naturopath has been very supportive. I don't think I could have mastered it by myself. And it was just sort of knowing where to start.
[Lauren]

■ ■
But initially, everything had to have some sort of answer and everything had to be something or other that was in a book. It was pretty intense to begin. [Valerie]

■ ■
She [Plunket nurse] was a mother sort, and she treated me the way I needed to be treated. And that was that I was totally ignorant. And she wrote everything in the book. And I referred to that book with all the girls. And I've loaned it to other people, because its there. Like she told me when to introduce foods. In great detail she wrote it.
[Lauren]

Initially, in order to learn how to manage the health concern and to produce the desired effect, the guidelines will be followed closely. During this time the woman gains expertise and experiences the effects of the guidelines on her and her family's lifestyle; their limitations as well as their benefits. She will relax her adherence to the guidelines and adapt them to produce the greatest benefit with the least interference with other aspects of life. If there is more than one way to manage a health concern, she may use a combination of the methods to achieve the desired effect, to support the greatest degree of normal function possible.

My kids, my son likes white rolls. For years I didn't give him white rolls, but now I do. That way I've compromised, and of course, more of this is being introduced because of the teenagers' attitude to food. [Sarah]

■ ■
So if he goes to a birthday party, I say 'You can have a bit of this and that but not too many lollies', but invariably two or three days later he'll come up coughing and he's really showing some reaction to it. But then he'll go back to a stricter diet. And usually for a birthday party, I give him asthma medication beforehand too. So I'm trying to

work it both ways. [Lauren]

■ ■
I started taking lots of Vitamin C and garlic and acidopholous because he was on the antibiotics and I was doing my bit to try to keep his system clean. In the end he had to have minor surgery to have it drained. So, as I say, using both things, care as it were, to create a balance. [Lauren]

Possibly Knows How. Participants know possibly how to manage a health concern when they have acquired knowledge about what to do, but have not yet tried it. This means that there is a lack of experiential knowledge about how well the idea works, what difference it makes. The women either tried the idea to see how it worked, or sought confirmation of the idea as a possible way to manage the health concern and then tried it.

[Christine tried a way of managing her cracked nipples.]
Yes, at that stage it was so uncomfortable that I thought well, if I stop letting her drink from me and just express the milk, perhaps that would help. And so, I was expressing these strawberry [blood tinged] milkshakes. [Christine]

■ ■
... But when we started to see the naturopath and he started telling me how some food, people are allergic to different types of food and things, I thought, well, I really need the guidance of someone to suss out what they need and what might not be suiting them. [Lauren]

■ ■
And the doctor at that stage said, 'You're well on your way to a stomach ulcer'. I thought, 'There must be some other way'. And that's when I really started concentrating on my herbs. [Kelly]

Knows How. When a health concern occurs frequently within a family or is a chronic condition of one member, a woman will gain experience using the care strategy she has selected and will gain expert ability. Her knowledge of the health concern, its antecedents, how it manifests, consequences, and care strategies may also be indepth as she collects information about it. In many instances her knowledge can be greater than that of many health care consultants.

I'm actually doing a series of things. I still see the homeopath, I do a lot on my own, because he's told me what I can do. I now go to a naturopath and an osteopath and I use

both of those. [Kelly]

■ ■
Say they get sick. If it's just what I would consider to be a childhood viral type thing where they are having fever one day, then I give them a spoonful of paracetamol and they are right the next day. [Ione]

■ ■
You have to go [doctor] for like conjunctivitis ... I think now that I realise if it's a cold or virus you can't do anything for it and I try even not to give them Panadol at home. [Debbie]

■ ■
I'm pretty familiar with psychiatric medicine. I had a whole decade of psychiatric medicine and am also therefore pretty wary of it as well. So I had an idea in my head of what I would need as a short interim measure to break my cycle [of insomnia]. [Valerie]

Conscious Awareness. Conscious Awareness means that a woman purposefully chooses to act in ways that will approximate her chosen guidelines and principles concerning basic health practices and supportive health practices that are ongoing because the health concern is ongoing. She will also keep watch to determine if she is doing so. When a woman becomes experienced with how to manage a health concern, particularly an ongoing health concern, it becomes part of her conscious awareness. The principles and guidelines are learned through experience and acquired knowledge and are adapted to the family's culture and lifestyle.

A woman may be conscious of what is eaten or how much rest is attained, and what levels of exercise or mental stimulation are happening for her child or herself. A result of conscious awareness is that the woman adjusts her or her child's lifestyle to approximate the guidelines she is using.

I always go on the principle of dressing them with the same amount of clothes that I am wearing plus one layer. I know that some people think that's excessive, but my daughter hasn't had an asthma attack since she was eighteen months. [Rachel]

■ ■
Sometimes if there's just enough left in the bowl, I'd make sure they got it before us because I have this thing in my mind that says if the children are having plenty of fruit and vegies, they'll stay healthy. [Ione]

■ ■
But basically I was saying, my own diet I try very much to stick to mostly raw foods. I eat very little meat and [I eat] vegetables, rice, polished rice, the brown rice, because I feel that basically I'm trying to eat as natural a diet as possible. [Sarah]

■ ■
Basics. Like basics in terms of nutrition I would attempt, I am very conscious of what my children eat. That does not mean I monitor fanatically what they eat but I am conscious of what they eat and how much they're eating and how much they sleep and very basic things like that I am very aware of. [Valerie]

Blaxter and Paterson's study touches upon Striving to Know What and Striving to Master. They state:

Factors which seemed most favourable [for managing chronic conditions] included: the feeling of the mother that she understood the condition and its cause; her belief that something was being done; having been given, by people she trusted, some grounds for hope; and the mother's confidence that she knew what to do in emergencies and how the condition could best be handled. [Blaxter and Paterson 1982, p.85]

The connection between confidence and Striving to Master is further explored in two studies by Froman and Owen (1989, 1990). The studies were conducted to evaluate and refine an Infant Care Self-Efficacy Scale. They state (1990, p.247), "Knowing how to perform a task is insufficient preparation for successful performance. One also needs confidence in the ability to succeed at the task." This sense of capability is named self-efficacy by Bandura (1977, p.193).

Both studies showed that women with more than one child and thus more experience had greater self-efficacy. Based on the 1989 study, they state that showing a first time mother a new skill might be insufficient. The addition of verbal persuasion that she will do a good job and "ensuring success by careful arrangement of environmental stimuli" are needed. They further suggest that nurses should base their decisions about teaching on a combination of their observation of the mother's skill and on how confident she feels.

An unanticipated outcome of the second study (1990) was that frequently "new mothers, when asked before leaving hospital if they need information about child care, often deny concerns". However as the mothers completed the detailed questions of the Infant Care Self-Efficacy scale they began to "ask questions and request information". The authors feel the questionnaire informed the women about common concerns faced by new mothers. "It gave them a place to start asking questions - something the nurses hypothesize may have been missing previously." This demonstrates an instance of Doesn't Know How, where a woman may not know enough to know what questions to ask. According to Fromen and Owen's research, an open-ended question such as 'Do you need any information' may not be helpful in this situation, but a more detailed approach may be helpful.

Conclusion

The processes Striving to Know What and Striving to Master were presented in this chapter. These processes are central to Bonded Caring because the women needed to know what was happening and how to manage it in order to provide the care necessary to protect and support growth and development.

The women used their observations, previous experience and acquired knowledge to decide if they knew the name and process of what was happening and how to manage it. They would try a way of managing the health concern to see if it made a difference. It at any point the women decided they did not know enough about the health concern or how to manage it, they would begin to check their information resources. Information resources will be discussed in the next chapter.

Chapter 9: Using Resources

When the participants decided that a health concern and/or how to manage it was beyond their knowledge, they sought information from other sources. Less personal sources of information such as the media or meetings were used mainly to gather information. When sources of information involved personal contact such as friends, family or health care consultants, participants hoped the person would share their concern. Sharing Concern is a response to and support of the activities of Bonded Caring, and will be discussed in Chapter Eleven.

Information Gathering

In order to know what and to know how, women use a variety of resources and gather information casually, serendipitously, and purposefully. Casual information gathering occurs when a woman picks up information for her own interest. She does not have an immediate use for the information, but because of past experience or curiosity she acquires it.

Before that I was always interested in herbs, medicinal herbs, which is something I've sort of been interested in right through my life, since I was quite small. But, I had never used it, I just collected information, I just happen to enjoy doing that. [Kelly]

■ ■
I read the LISTENER and the WOMEN'S WEEKLY and they've been going on a lot about Age of Aquarius or the New Old Concepts of Energy, Chakaras and things like that. All these things I'm not really into, but all those sort of things. So they are health issues, but not really for me, I suppose, I mean in ten years time. I could have said that I'd never go to a

homeopath, but I did. [Debbie]

Serendipitous information gathering occurs when a woman has a specific health concern. Because she is alert about this health concern she may stumble on information concerning it, she may overhear something in a nearby conversation, or happen serendipitously upon a book when she is looking for something else, or may find it in the media.

I was just browsing around the shop and the woman who owned the shop was telling another customer what the naturopath did. I listened in and I thought 'Oh, that sounds like a good idea'. [Lauren]

■ ■
So, it was a whole series of circumstances ... like on the radio there was a talk about children being confused after they've been to the dental clinic and had a filling ... [Kelly]

Purposeful information gathering, in contrast, occurs when the woman has a health concern and she actively seeks information. She might contact a health care consultant, pick up a book, tune into a radio or television program because its topic is related to the health concern, go to a meeting or join a self-help group.

Impersonal Information Resources

When a participant reached any stage of Striving to Know What or to Master and realised that what was happening was outside her skills and knowledge, she continued the process of Finding Out by exploring various avenues of information. Impersonal information resources mentioned in this study were media, books and meetings. These required little or no interaction with another person.

Media

Radio, television and newspapers are sources of general information for knowing what. They are also sources of

information about new avenues or ways of caring for health concerns. Advertisements provide information about when and where to contact certain health care consultants. With this information, a woman can decide, based upon her own structural influences, whether or not she can contact the health care consultant or if it will be too hard. Advertisements also provide information about where to get more information at a meeting. Advertisements may be found in newspapers or on bulletin boards. A woman may note them casually, but will be alert to them when her need and circumstances make her ready to pursue the avenue being advertised.

There is a series of things, like on the radio there was a talk about children being confused after they've been to the dental clinic and had a filling. [Kelly]

■ ■
There was an article in the Evening Post. I must have read it in a year actually before I took C. to see the naturopath. It was an article about the naturopath, his theory and all that. [Lauren]

■ ■
There's a shop up here which sells health foods and supplements and things like that and I went in to get something and there was a little card up there saying the naturopath calls in [City] every second Wednesday of the month or something, second and fourth Wed. of the month. I think had he not been coming to [City], he has his clinic in another city, I don't think I would have bothered straight away, you know. All that travelling about just to see him. [Lauren]

Books

Participants used books as an information resource and as an authority for guidance while managing a specific health concern. The participants used books most at times when they were inexperienced and learning to manage a health concern.

And this book told you about signs of pregnancy and you are table to tick, there's about ten of them. Ten different ways of checking out if you are pregnant. I ticked them all. And then it told you the in's and out's of pregnancy. It explained all about breast feeding which is the best. It didn't say not to breast feed and it didn't say to breast

feed. It left it your choice. It told you all about ceasarians, forceps, it told you everything. [Ruth]

■ ■
But initially, everything had to have some sort of answer and everything had to be something or other that was in a book. [Valerie]

■ ■
She'd give me books, books about housework and quite a few feminist books as well. [Valerie]

■ ■
I just started reading about it [complementary therapies]. [Lauren]

■ ■
Because I've done a lot of reading lately, there's a book called DIETER'S DILEMMA. [Debbie]

■ ■
I did what the book said ... [Christine]

■ ■
And she got me to read the WOMANLY ART OF BREASTFEEDING and that set me on my way. [Ione]

Meetings

Meetings and classes are attended to find out about a new approach, about a health concern or how to manage an anticipated or current situation (i.e. prenatal classes, asthma society, naturopathy etc). The women go to meetings to hear about the health concern, and to ask questions of an authoritative resource person.

First of all, I went to a series of evening lectures that he [Naturopath] gave and then became a patient of his. [Sarah]

■ ■
I went to all the classes at the hospital for preparing people for babies. [Ione]

■ ■
[If the baby has been diagnosed as asthmatic] I probably would have gone and joined the Asthma Society because she was so little ... But in my mind to have a baby who was asthmatic, that would be quite scary because they wouldn't be able to tell you when they didn't have control. [Ione]

Concerning sources of information, Scott and Stern (1986,p.57) in their grounded Ethno-Market theory, found that black women from southern United States used television and talked to neighbours. In addition, contact at schools, churches, jobs and civic activities provided opportunity to exchange ideas and beliefs. Fromen and Owen

(1990,p.252) suggest:

... proliferation of disposable diapers and successful models (in print media or TV) using various brands may boost mothers' confidence levels beyond their actual confidence ... Feeding skills, on the other hand, are not so widely demonstrated in popular media. If a primiparous [first-time] mother decides to breastfeed, she may have few models available for successful task performance.

In New Zealand, an example of modelling in the media is the New Zealand Child Health Research Foundation's current television spot in which a woman demonstrates how to resuscitate a baby that has stopped breathing.

Personal Information Resources

Personal information resources include support groups, friends and family. They involve a degree of relationship with another person or group of persons, and thus they are another example of **Social Interconnectedness**. Within the relationship participants hoped information would be provided in a way that indicated the person shared their concern. Sharing Concern occurs within a relationship and is the expectation of the woman involved in a Bonded Caring relationship that the person she has chosen to contact will provide assistance and information with a degree of goodwill, concern and serious attention to her concerns. She also expects that the person will share her goal to protect and support the development of the child or herself.

Support Groups

Support groups were an important source of information for some participants. This section has been added because one participant noted its absence in the rough draft of the analysis and suggested it be added. Because they are organised around a specific need, support groups could be placed between impersonal and personal information sources.

However, participants joined support groups with the expectation that the group members would understand, share and assist with their concerns. Therefore, support groups are placed under personal information resources. The participants who mentioned support groups connected their association with a group with a change in their lives or the desire to change.

I guess this consciousness about dying and the mode we choose to die is something that I've been made aware of when my brother died and then I did a six week intensive death and dying course. [Valerie]

[I was pregnant] my sister-in-law, the La Leche supervisor ... she said, 'You've got to do the Parent Centre antenatal classes'. [Debbie]

I went away to this weekend with a mental attitude, 'No matter what happens I am going to change'. [Kelly]

Some of the women joined a group because they were asked or advised to join.

[See Debbie, above]

But as a Plunket Nurse, she set up in this area a new mother support group and knew that I knew very few people and sort of said, 'Would you like to join one?' [Valerie]

It was actually the osteopath that sent me. [Kelly]

Because I was on the playgroup, one of the women on the playgroup thought, 'Oh, here's a good organiser' and asked me if I'd like to join. [Christine]

Some stated reasons for joining a long term support group were to meet people, from a sense of duty, and as an outlet for their talents.

Originally, I said no. Then I thought well perhaps it would be a good way to meet other people and perhaps I should do something seeing I've got something out of Plunket, at last [the self-help health care course]. [Christine]

And one of the main reasons was to meet people because you had coffee afterwards with your group ... Also by the time D. was coming up to six months, I needed an outlet, something to do ... And so I went to the annual general meeting at Parents' Centre and took on the job of president, straight away. [Debbie]

Most participants did not say they went to a support group for information and support concerning the change they were experiencing. However, they did receive these as a consequence of joining. One participant said she was going to set up a group for over-eaters in order to get support for her own efforts to modify eating habits.

I was very interested in trying to get a group to help support myself not to eat too much ... and I've got about eight people to start our own group up. [Debbie]

■ ■
... also I'd attended a Parents' Centre conference and attended a workshop on caesarian. In actual fact I know quite a bit about caesarians, a lot more than the lay person would know. [Debbie]

■ ■
The whole weekend was to teach you to cope with other people. Which of course I absolutely needed because I was psychic and I would have problems coping with what was coming at me and that taught me to cope with that. [Kelly]

As in the choice of persons they discuss health problems with, the participants were selective about the groups they joined. If a group did not match a woman's needs or current ways of managing, she would decline to join the group.

I joined one [new mothers support group] and then as my evaluation of it, I said that really it didn't do a lot for me. Basically being older and generally having had a different education, I just didn't find a lot that really I could relate to via that group. [Valerie]

■ ■
I did ring them [La Leche] at one stage with my second one, but I didn't go to any of the meetings or anything, because they told me things that I wasn't happy with then, which I could cope with now, like telling me to go to bed and lay down and feed my baby in bed every two hours. Well I just couldn't cope with that where I was at then. [Ione]

Norton (1990) identifies support groups as a health resource for participants in her study of women who use or do not use Plunket nursing services. She states:

While these networks are essentially informal, they are the most important health resource on a day to day basis for the women as they provide health care for their babies. The

women consult each other about a wide variety of health issues including health promotion and prevention and treatment of illness. (p.156)

In her paper on Women's Health, Pybus (1987) states that "developments in women's health have followed the common pattern that they have occurred on the initiative of women without, even in spite of, health professionals." She also outlines steps of planned social change and provides examples of how women in New Zealand are active in changing health care services, starting with the personal situation and moving into the wider community. In the first step the awareness of suffering develops along with the realization that this is a situation shared by others. The realization of a common concern is dependent upon the sharing of concerns. The second step requires the acknowledgement that the suffering can and should be alleviated. From this there may evolve the third step, "the development of groups of people to work to bring change." When concern about the issue becomes widespread, the fourth step has been reached. At this point the concern moves from word of mouth to mass media. Finally the last step involves changes in "social organisations through which we arrange our lives." Thus in the final step social organisation must be fluid and responsive to needs for change identified at a personal level.

The first two steps described by Pybus are confirmed by Norton (1990,p.156), who noted that "It is significant that the women often established their support network after having experienced a time of isolation and struggle after the birth of their first baby."

Although this study did not explore support groups indepth, there are indications that the women who joined or initiated support groups were involved in changes in their lives and had experiences similar to those described above by Norton (1990) and by Pybus (1985) in the first three steps of social change.

Family and Friends

Family and friends are a source of information and support. Often they have previous personal knowledge about the woman and her family which serves as a basis for sharing concern.

Women are selective about the health concerns they discuss with which friends. It appears the topics are tailored to the friend's interests or, possibly, their ability to manage the health concern both practically and emotionally. What is discussed also reflects the woman's own need. Health concerns that are currently problematic are most likely to be introduced in conversation. This area of the study is not saturated and could be a topic of further research.

And I've got a couple of close friends that I could talk to about my worries. I've been having [concerns] about my Mum over the past few years. I can talk about that with friends. So that helps share the load. And quite often they can help with suggestions about helping her without having to go and talk with a doctor because a lot of it is sort of emotional sickness rather than physical. But I don't actually share with my neighbours. Probably because I haven't been really close to my neighbours and I would only share those sort of things with very close people. I wouldn't spill that out at Playcentre. [Ione]

It's interesting that as a mother I don't find a lot of other mothers talking about children's health. But then, I've got healthy children and so do most of my friends. [Valerie]

And I'm interested in mental health issues, probably because of my background, but once again because that's past background, I don't actually talk about that much with other people. [Valerie]

Other women's issues would relate to contraception. And of my own choice I've gone to forums on women's health issues related to sexually transmitted diseases and the female areas of the body in relationship to cancer and other things like that. But I don't actually get a chance to talk about it much. I move amongst too stable a population to talk about these. [Valerie]

Friends as a source of information, may provide new ideas about how to approach a health concern. A different way of

managing a health concern was most likely to be tried if a woman heard about it from a person who had tried it and reported that it made a difference. Although it was not explored in this study, it is a hunch that friends and family provide a certain amount of peer pressure, supported by a woman's desire to do what is best, to encourage her to carry out basic caring practices in certain ways.

With the iridologist, the workmate went on and on about it. That got me quite interested. I said 'Oh well, that's good, let's see what this is all about'. [Lauren]

■ ■
For me personally, it [how I came to use naturopathy] goes back many years. I suppose to a family who were friends with my parents who did have an alternative lifestyle. You know back then it was quite unusual and I guess for a teenager that was an added attraction. Soon after that I met with a woman who was a vegetarian and those two were my first contact with people who had alternative styles of eating as well as lifestyle, from what I had in my family home. It caused no problem within my own family and these people became friends of my parents too. [Sarah]

■ ■
So, one friend was quite extreme in her philosophy and even in those years was into meditation - but I had not enjoyed eating meat as a young person and these friends of mum and dad's had said, 'Well, look she doesn't like eating meat. Why make her?'. However, I ate meat really quite happily through the teenage years and my early years of marriage. I can see looking back, there was always a trend not to eat meat. [Sarah]

Expert Mothers

One frequently mentioned source of support and reassurance is the **Expert Mother**. She is an experienced mother relative to a less experienced mother. She is easily accessible, often living near by in the same neighbourhood, or accessibility may be through family relationship. She may be called upon about minor but puzzling questions, for reassurance and confirmation in decision making, and emergency situations. Both parties acknowledge the mentor aspect of the relationship. Expert mothers in this study were close neighbours, a grandmotherly neighbour and one woman was an Expert Mother herself.

We have one family friend, at the moment, who has only just had her first child and she rings me because of having the other children. Yes she will quite often ring me and ask should I take her to the doctor or what should I do. And even sometimes my sister-in-law, who has four children of her own, but they are all very young, sometimes she'll ring and talk out 'What should I do?' And so really she's just looking for reassurance that she should or 'Yes it's okay'. [Ione]

■ ■
I haven't got any of that older mother framework that you can tap into when your need for some sort of validation for what you are doing is quite a real one. [Valerie]

■ ■
And Granny K. [a neighbour] across the road, she heard the noise [baby crying in pain] and she came over. And she was really worried and I said 'Oh help'. And actually she was just coming out the door I think when I wrapped D. in a towel and went over. I was going over to see what she [Granny K.] thought. [Becky]

Mothers

This section was added in response to questions posed at the presentation of the rough draft to lecturers and students in the Nursing Department at Massey University. Four participants mentioned their mothers in connection with health concerns. Two contacted their mothers for information, but indicated time, or a difference in their approaches, had made the information less useful. Each, however, considered her mother's support, or absence of support, as important.

She [Mum] was handy, so I had a bit of a talk to her if I needed, but things had changed so much from when she brought us up to us bringing up these kids. [Ione]

■ ■
Because I guess mothering in small children is such an uncertain area, when you don't have your mum to ring up and say, 'Hey, I think my kid's got such-and-such, what do you reckon?' [Valerie - her mother died when she was a teenager.]

■ ■
But the thing is, I rang my mother and I told her what the Plunket Nurse had said [if the breast-fed baby didn't gain weight she might have to "comp" or give the baby bottle fed supplements]. And to my mother, Plunket Nurse is gospel. I actually went to mum's and she'd written all these things down about how selfish I'd been wanting to feed [breast feed] when it wasn't good for him, and I mean he was a

perfectly happy, healthy baby. She just doesn't understand about bottles, really, my mother. [Debbie]

[Ruth's doctor didn't explain miscarriages and she became upset that she might have had one.] Mom turned around and told me to go to her doctor. Mom highly recommended him. [And at the next doctors visit] My mother and my husband spoke out. They were worried about my abdominal pains ... [Ruth]

Husbands

Husbands' involvement in health care and the nature of their involvement might be a topic for further research. Husbands in this study pointed out health concerns, were involved in problem solving, visited health care consultants with, or on behalf of, the women, and confirmed the woman's perceptions that something was wrong.

Yes we have, we've been very lucky to be able to do that and that is where I think a husband and wife who have a similar philosophy [Naturopathy, whole person philosophy], because had L. gone off one way and had really wished to retain a refined type of diet apart from ... [Sarah]

At any rate he [son] ended up with this really bad attack [asthma] and we took him off to the doctor. And so between B. [husband who is a pharmacist] and our G.P., they sort of put him on everything going [medications]. [Lauren]

And even my husband noticed. He said 'The doctor's talking through his hat when he said there's nothing wrong with your hair. I can see it'. [Kelly]

I mean my husband very much wants me to lose [weight], but it's not really what I want. [Debbie]

[I - So it is usual that you talk about health decisions with your husband?]. Yeah, it is actually. Because sometimes he would go [to the doctor] more readily than I would, and so that's quite often we do talk about it. [Ione]

And because he's home at the moment, that's why he took her [daughter], because he doesn't usually have the opportunity to take the children to the doctor, it's usually always me. [Ione]

When Q. was in the hospital, he [husband] would go and ask the doctors for information, where I would wait until they told me. [Ione]

The effects of friends and family, or the social network, on a person with a health concern, are dual in nature. There can be positive and negative effects. Koos (1954,p.36) suggests that family and friends can define what symptoms are to be considered an illness. "If group patterns dictated that one 'did something about' a symptom, there was a good chance that the symptom would be treated. However, if group patterns dictated that a symptom was unimportant, nothing was done." Tilden and Galyen (1987) studied the cost and conflict of social support. Twenty-nine participants each designated five important support persons. In descending order of mention they were spouse or partner, relative and friend. Regarding this, they state (p.15), "A point of interest is the absence of health professionals within the inner network even among seriously ill persons."

Mishel and Braden (1987) conducted research to explore the connection between social support and uncertainty. They identify (p.48) affect, affirmation and aid as functional properties of social support. They define uncertainty "as the cognitive state of the person when an event cannot be adequately structured or categorised because sufficient cues are lacking." This is similar to any point when a woman decides she doesn't know and needs further information. The connection between social support and uncertainty was studied with 35 women diagnosed as having a gynaecological cancer. The longitudinal study focused on the stages of diagnosis, treatment and stabilisation after treatment. The findings showed for diagnosis:

During diagnosis women who report more emotional expression in their relationships [affect] and who have significant others who respect their ideas and opinions [affirmation] have less ambiguity [uncertainty] about the state of their illness and have a greater fund of information. [p.49]
[Comments in brackets have been added.]

The research suggests that in the treatment phase:

Women who receive more feedback and sharing of ideas

perceive their treatment as less complex. This clearer view of treatment results in more positive attitudes toward the caregivers and the system of care. [p.54]

During stabilisation, the post-treatment phase, they state:

The social support function of aid has an indirect impact upon psychosocial adjustment eight months after treatment by modifying the degree of unpredictability about the future. Receiving material or symbolic assistance functions to decrease the sense of unpredictability in gynaecological cancer, thus influencing overall adjustment. (p.54)

These conclusions suggest the importance of expressing affect, respect of ideas and opinions, and tangible aid in decreasing uncertainty. They also suggest further research could be conducted to delineate categories connected with Sharing Concern.

Conclusion

The women acquired knowledge about health concerns based on their interest and needs. Information gathering occurred casually, serendipitously and purposefully. A variety of information resources were used as the women strove to know what a health concern was and how to manage it.

Impersonal resources were the media, books and meetings. Personal information resources could provide support and information. The women joined or initiated support groups as a result of a change in their lives or a change they wanted to make. The women turned to their families, especially their husbands and mothers, and their friends for support and information. An Expert Mother was often a friend or neighbour who was experienced with child care and who would answer questions and give advice. Another source of information and support, health care consultants, will be discussed in the next chapter.

Chapter 10: Consulting for Health Care

Information resources were discussed in Chapter Nine. Another source of information which the women used was health care consultants, people expected to have specialised skills for diagnosing (Knowing What) and managing health concerns. Within their homes the women carried out health care for themselves and their children. In general, they contact health care consultants to supplement and extend their own health care activities. Health care consultants used by the women in the study included chemists, Plunket nurses, Karitane nurses, practice nurses, homeopaths, naturopaths, osteopaths, physiotherapists, doctors, specialists, psychologists and nurse midwives. Institutions used were Accident and Emergency, Hospital, Labour and Delivery Unit, Maternity Wards and Psychiatric Hospitals.

The women went to health care consultants for a variety of reasons or health concerns (refer p.65). As shown in Chapters Seven and Eight, when participants were inexperienced with a health concern, they wanted to know what it was, both the name and the process; and they wanted to know how to manage it in a way that made a difference. They also needed reassurance that they were doing all right as they learned how. Women more experienced with a health concern needed to have current abilities recognised, perceptions confirmed and their choice of management acknowledged and supported. Based on their expectations and experience of the kinds of assistance they could get from each health care consultant the participants were selective in their use of health care consultants. The

ways in which the participants used chemists, doctors, complementary therapists, and nurses will be discussed next. The approaches the women identified with the doctor, naturopath and nurse were discussed previously in Chapter 6.

Chemists

Participants consulted a chemist to fill prescriptions obtained from a doctor, and for advice about low risk health concerns. They also spoke to a chemist to help define whether or not a health concern required a doctor's attention. They might also go to a chemist's shop for a remedy selected on the basis of their own experience and acquired knowledge.

He's [son with asthma] on preventative and Ventolin. [Ione]

So I knew I needed something on it [burn] but what I needed I didn't know, so I went to the chemist. [Rachel]

And the chemist said to me Ungvita is not the best thing. [Christine]

I deal a lot through the chemist, because we've got a very good chemist. So I go to him for advice. He will tell me exactly what to do, so he's free advice. There was something D. had and he said Cortisone. I had some at home so I didn't have to buy it. If I don't know what to do, I just ring him and he tells me and I know to go to the doctor or whatever. [Debbie]

[What makes you go to the chemist?] Well if the children aren't well in any way, I just go down and ask him ... My son's burn was starting to heal and it went funny, so I went down to the chemist and found out whether I could just get a remedy or whether I really needed to go to the doctor. [Rachel]

So I went to the chemist and got some vitamins. [Debbie]

I just went and bought some of those [something for sinus] and supposedly treated myself, but it didn't get better. [Ione]

If I do start to feel really stressed or a cold coming on I would much prefer to spend six dollars on really high doses of Vitamin C and B and start taking that. [Valerie]

Complementary Therapists

Participants using complementary therapies identify a holistic philosophy with the health care they receive. They expect complementary therapists to consider the interplay of their physical, mental, social and spiritual state when diagnosing and treating their health concerns. The methods used to treat health concerns are considered safe and non-invasive.

Whereas I feel the naturopath looks at the body as a totality. And so while he may be treating one thing, you are improving the whole system as well. Like in C.'s case, I think the diet and various other things have been building up his immune system ... Which is why I think we should take a holistic approach to health. [Lauren]

But I really believe that the health is a total philosophy about one's being. It's not just a physical thing. It's very much bound up with the whole being. I think that the strongest thing I have to say about health is that I believe it is a total overall awareness of one's body's completeness. [Sarah]

And I have I think now embraced the philosophy that it is actually natural and more normal to be healthy and to be well, and that the body has its own ways of achieving this, and the less we invade those ways the better chance the body has of dealing with things. There are gentle methods and safe methods that can trigger those ways without the side effects that can commonly be experienced with the hefty treatments of drugs and invasive surgery. [Alice]

... but there's something about being able to talk about things that happen in your life relative to physical pain that he's able to sort of tie up. [Valerie]

Diagnostic practices and treatments. Because complementary therapists use diagnostic practices and treatments that are different from those used by the medical profession, some participants had questions about the validity of what was being done. So that the complementary therapies were accepted on a Try and See basis because they made a difference.

Then he [homeopath] did the arm bending on me for D. and then for myself. And I asked him to take his finger off the label so I could see what that was. (I - How did you feel about that test?) Oh, sort of a bit skeptical, but I mean,

he didn't come up with any wierd things. So I actually felt relieved, because I really did believe it. [Debbie]

And I got there and he [naturopath] pulls out his pendulum and starts using it, and I thought, "My God, what's going on here?" Because I'd never seen that done before. It was just so totally foreign to anything I'd experienced before. He gave me some massage and put my back in shape. And I found all that actually quite scary. But I could feel some beneficial effect from what he did physically. I decided, well I didn't have anything to lose. I'll just follow it up for a while and see what happens. [Alice]

There are people that are healers within our community that also are not necessarily medically trained. But there somehow has to be, how does one know that they are bona fide? Some sort of standard [is needed] really, because there are lots of alternative ways ... new age kind of avenues of healing but for me they have to have some sort of scientific plausibility ... I actually think that his [her naturopath's] sort of potions and pills for whatever need your system is having, is somehow placebos ... I like the holistic method of what he's looking at I guess. As I say, whether it's scientifically plausible or not, I don't know. I do know I have a lot more energy after he's done my back. [Valerie]

Reasons for using Complementary Therapies. Participants approached complementary therapists with a variety of health concerns. In many instances, they were looking for another way to provide supportive health care. They had consulted doctors about health concerns such as asthma, allergies and headaches, and had decided the long term use of medications was a problem.

I began to get asthma ... I got to the point where I was needing to take medication in order to just keep functioning. I wasn't prepared to continue that way ... I decided that I preferred to change what I was doing, and find another approach. [Alice]

C. started asthma when he was about one ... he was going in and out of hospital, on a lot of medication. I thought there's got to be a better way because just the thought of filling him up on all these antibiotics, bronchodilators and everything, there must be some other way ... We started to see the naturopath. [Lauren]

I did have a health problem myself, in having bad headaches. And had been to a doctor and he had suggested a course of drugs which I didn't want to take. So of course, that was another step towards the naturopath. [Sarah]

The women also took problems that were less well defined to the complementary therapist. These were often presented as fatigue or stress.

He's always done very well, alleviated tension via slight back manipulation, neck manipulation ... I do know I have a lot more energy after he's done my back. [Valerie]

■ ■
For a naturopath, I would probably go to see a naturopath if I'm feeling tired and run down. [Lauren]

Injuries were also taken to complementary therapists.

With my son, he went more regularly about a year ago because he had a back injury from rugby and my naturopath helped him a lot with that. [Sarah]

■ ■
I'd been kicked by a horse, and badly kicked on one side ... So I then went to my osteopath. [Kelly]

Another reason participants consulted complementary therapists was to learn ways to provide illness and disease prevention for their families.

I thought, "I want these babies to be healthy. How can I best give them protection? ... What is the best diet for these kids?", and with that I went to a naturopath. [Sarah]

■ ■
When I was pregnant with H. I got advice from the naturopath. I thought, "One child seems to be allergic." I thought if I did the right things, ate the right things through pregnancy. It might make a difference. [Lauren]

Participants' Expectations of Complementary Therapists. Complementary therapists use a wide range of methods to assist with health concerns. Some mentioned by the women in this study were massage, homeopathics, shiat-su, accupuncture, and diet. Changes in diet were used to treat food intolerances and allergies. The women expected complementary therapists to determine which foods were a problem and to provide information about effects of the diet changes.

D. was a very hard baby to handle. I didn't know what to do with him. I'd read a lot of things about milk being an

allergen so I went to him [naturopath] ... He said that D. and I were both allergic to milk and chocolate. [Debbie]

I was having headaches. They really knocked me out for two or three days. And when I first went to the naturopath, he put me on a cleansing diet and advised me not to eat anything which contained wheat and to be careful with dairy products and really to concentrate mainly on raw fruit and vegetables. [Sarah]

And then he tested me for food allergies and he said definitely dairy products ... He gave me a whole range of things I could and couldn't eat. [Kelly]

So the first visit after we went to see the naturopath, he was cut right off everything he liked, yoghurt and butter, and things that contributed to mucous formation. [Lauren]

In addition to information about food intolerances and allergies, complementary therapists guided and supported changes in some participants' personal philosophy and contributed to their spiritual/mental growth and development.

For me, I don't think I could have ... if I had gone through just concentrating on my body wholly, I don't think I could have achieved what I've got now without also bringing in spiritual health, and mental health ... And by going to this particular weekend [psycho-synthesis, suggested by her osteopath], which is a very spiritual thing, I opened a door, because now I realise I'm very sensitive and very psychic. [Kelly]

The naturopath helped him [son] a lot with that [back injury]. Not only helping the actual injury, but giving very good sensible guidelines about himself as a person. [Sarah]

And so the philosophy of naturopathy is really to have each person learn to take responsibility for their own life. And to support each person in that ... I've had a real drive and determination to change myself into a person who is positive and to actually choose to be well. Because I believe that is a choice we make on some level. [Alice]

As the women made changes in their diets or themselves, they found it was not easy. **Slipping Back**, which is the return to previous habits, often occurred.

I don't always find it easy. It's not. In my own eating habits, you know, I really do go on binges. Things like coffee which I love. I've never been able to give up coffee completely. So it's not clear cut and dried for me at all.

Early on in this I really went on great guilt trips but I don't anymore. I've sort of accepted myself for what I am.
[Sarah]

■ ■
And I'm actually learning to seek to have my needs met in other ways. In ways which are positive and life enhancing. And, that's a big change. It can be quite scary to make such a fundamental change. And from time to time, I catch myself out, slipping back into the old ways and that has to be okay too. Just to accept that whatever I do, I am learning from it.

■ ■
And it was hard the first six months because I kept it [diet changes] really strictly ... But now, I think we must have gone back a bit the other way in that we are eating - for a while we were completely off processed foods and goods like that - but now we sort of, we have a bit of everything.
[Lauren]

As the women worked to make changes, they went back to the complementary therapist for support and guidance.

I was having trouble coping with it [being psychic] the next day and I got home and cried a lot ... So I tore in and said, "Is the naturopath in?" He was busy, but he came out and said, "Come on in. I've got five minutes for you." "Oh, [Name], I'm frightened!" So he sort of let me cry and he mopped me all up and he said, "So what's new?" It was exactly what I needed, and it just brought me right down to earth. And then he said, "Right, okay. You've got that door in front of you, you are right at the door, you can either close the door and go back to the way you were or you can open the door and take what comes." And he said, "You are going to be in for some huge surprises if you keep open that door." And I had already had a glimpse of it. There was no way I was going to go back. [Kelly]

■ ■
I do feel that it's very important that the person you are confiding in is somehow a - not just there to be analytical, but also to be a partner almost in what you are going through. To be able to share what else is you as a person as well. [Sarah]

■ ■
I think if I hadn't gone to a naturopath, or paid somebody, who said, "Try cutting out these foods and see what sort of result you get" I think I would have given up because it was very hard starting off on this very strict diet. I think going to a naturopath has been very supportive. I don't think I could have mastered it by myself. And it was just sort of knowing where to start. I think that was the biggest help that we got. And the sort of possible side effects. [Lauren]

The women stated that eventually they reached a point where they knew how to manage their diet or their life changes

with less support from the complementary therapist.

I like to think that I have responsibility for my own health and I like to think that there is someone there who can reinforce, who can guide. I think over the past few years really, I've gone to him once or twice a year. [Sarah]

Having been to the naturopath over the past three years, dietary wise, I know more or less what to cut out. I occasionally go back for reassurance. [Lauren]

I still see the naturopath. I do a lot on my own, because he's told me what I can do. [Kelly]

In fact, I very much look after myself. [Alice]

Doctors

Participants initiated doctors' consultations for a variety of reasons and expectations. One underlying expectation is that doctors have attained a standard of education and are knowledgeable about the medical and technological means to investigate and care for physical health concerns.

I'd probably go to see the doctor first, because the doctor has probably got the training and doing all the general checks and things which they do. [Lauren]

I really do have tremendous admiration for the medical profession with its technology it has today to help people. And I must admit had it not been for the technology I probably would have died with my first pregnancy that was ectopic. So I don't underestimate the role that they play in modern society. [Sarah]

With myself and my children's physical needs I would use the G.P. [Valerie]

So I suppose I go to the doctor for really physical things. It's always been something physical ... With the children, I go because they've got something specific that can be cured with a bit of medicine. [Christine]

So if I had very specific symptoms I definitely would go to a doctor. [Lauren]

Reasons for Visiting a Doctor. Some circumstances leading to a visit to a doctor include infection, accidents, a sense that something is wrong, physical dysfunction and life threatening situations.

... If they [children] come down with a really bad infection, chest infection, that is when I would take them to see a doctor ... So it's really for emergency type things I go to the doctor. [Lauren]

I'm allergic to metal. My ears were sore and I had scabs on my arms and fingers. I thought, I finally want to clean up my ears. I'll stop wearing this horrible false metal. So I went to a doctor. [And in another instance] And there was one time I went to a doctor because I was sick and spewing up bile. [Ruth]

About the only time now that I go to the doctor is if I've got something like an injury, like I cut myself and it needs to be stitched. [Kelly]

[Foster daughter fell off the bars at school] But it didn't seem to get better, and still seemed sore, so I took her to the G.P. [Christine]

Q. was in the hospital in January because he'd hurt his kidney. [Ione]

She kept sort of going in and out, phasing in and out of consciousness in my arms and vomiting a lot and then I took her to Doctor W. [Valerie - her daughter had fallen at a swimming pool.]

I was sort of aware that my health was not good and I went to my doctor. [Kelly]

My first pregnancy that was ectopic. [Sarah]

I was using a doctor in [City] and attending the fertility clinic. [Christine]

I mean these are the sorts of times I go to the doctor. I find a lump somewhere. [Christine]

I was struggling for breath. My temperature was sky-high. I called the doctor. [Kelly]

When she woke up on Sunday, she was wheezing. I took her to the doctor. [Rachel]

In addition the women visited doctors because it was through the doctor that they could gain access to certain treatments and services such as prescription medication, blood tests and x-rays, referrals to specialists and eligibility for subsidies.

Conjunctivitis, I know that that goes to the doctor, and thrush. Just automatically you go to the doctor [to get a

prescription]. [Debbie]

[I don't go to the doctor] unless I know that the children might need antibiotics. [Rachel]

I went to my own G.P. and I said, "Look things are not right, I suspect that I might have Candida." I said, "Can you do a test for it?" [Kelly]

I took S. because his glands were up and he [doctor] sent a blood test. [Debbie]

And he [doctor] said he thought it [lump] was benign and he gave me a biopsy. [Christine]

I got this letter to refer to the specialist. [Kelly]

I heard that if you had a child that was intolerant of milk you could get a subsidy from the hospital ... And he [doctor] said that we'd have to be referred to the hospital. [Christine]

Expectations when visiting a Doctor. What the women expected from the doctor was related to their acquired knowledge and experience with a health concern. Participants who were experienced with a health concern, because it was chronic or occurred frequently within the family, knew what the problem was and how to treat it. They expected the doctor to confirm their evaluation and prescribe the expected treatment.

I suffered a lot from tonsillitis when I was young. I knew what I needed and I told her [doctor] what was wrong. All she had to say was, "Yes, you are right. Here's your prescription. [Rachel]

We go regularly [to doctor] for Q. because he only gets a couple of months medication at a time for his asthma. He's on a preventative and Ventolin. [Ione]

I had a bad breast infection about three weeks ago ... and I thought I must go to the doctor - so I went and got my antibiotics. [Lauren]

Women who knew possibly what a health concern might be also tended to know possibly how the problem might be treated. They hoped a doctor would confirm or disconfirm their suspicions. Based on their observations of the health concern it was determined that two participants required a referral.

So I went to the doctor and made the pregnancy test ... And that's what they came up with. You are positively pregnant.
[Ruth]

First of all I went in because I was having regular contractions, but they didn't seem very strong ... Luckily the doctor was there and he said, "You can stay in." And I said, "But I can go home." He said, "Yes, you can if you want." [Christine]

[Ione had been observing her daughter for vision problems for some time and went to her doctor.] He [doctor] could see it straight away and said it was quite definite and so we got a letter for the specialist. [Ione]

See also Christine's comments concerning her child's milk intolerance which she detected by observing the child's reactions to food. She required a referral to a pediatrician. [p.126]

When participants knew something was wrong, but didn't know what, they consulted a doctor to find out. They wanted to know what was happening and how to care for it. This has been described previously under Doesn't Know What (Chapter 8).

It was important to the women that a doctor identify and know something about their health concern. An unidentified health problem could not be treated.

It's when they don't know, when the health officials don't know and they are still wondering, that's when I worry.
[Ione]

In addition, an unrecognised health problem is also untreated. So, some participants took steps to prove the existence of their health concern.

So we went to the pediatrician and just to make the point, I had given her some milk just before we went in, about ten minutes before we went and, I thought, "Well this is great, we'll be able to prove it." [Christine]

Because her breathing was so horrible right from the beginning [from birth] I did sort of pressure him to check her breathing often. I suppose I was thinking ahead that perhaps she was going to be asthmatic and I wanted it to be found out before she had an attack ... Anyway, last week she got a cold like the rest of us but her breathing sounded

yucky. So we took her and he [doctor] put her on the nebulizer for ten minutes ... and he thought she was a wee bit asthmatic. [Ione]

In addition to finding out what is wrong and how to treat it, participants felt it was important to know when everything is okay.

I used to go in [to doctor] every week and weigh him [baby]. And sure he was relatively a very slow weight gainer but he was a weight gainer. There really was no problem. [Valerie]

When I do take them to the doctor, it is a symptom of something and I would like some sort of explanation even though he might say, "Oh, there's nothing wrong there." ... Sometimes you take them along and he says they are fine, and they are. [Lauren]

He [doctor] said that because I came out all okay, all my tests were fine, there's nothing to worry about. So when I got off the phone, I felt fine. [Ruth]

He [doctor] confirmed that it was the flu that was out there and there was no infection in her ears or chest. [Ione]

Nurses

The categories of nurse with which the women had most contact were maternity nurses and midwives, practice nurses and Plunket nurses. Except for some practice nurses, the services of the nurses were free. Nurses were the only health care consultants that came to the women in their homes. In institutions, nurses were recognised as individuals working together to care for a client(s). One participant described a nurse as a community builder. These three characteristics of the work of nurses were described only in reference to nurses.

And the midwife had been two visits [to her home] before I had her [baby] ... She came [to her home] up to my sixth day [post partum]. [Ione]

I was still having home visits ... [Christine]

If she [Plunket nurse] called in the morning [for a home visit]. [Valerie]

Because P. was born about two o'clock and the new nurse came on at three. [Christine]

She'd [night nurse] written notes to the people in the morning to let them know what had gone on in the night. [Ione]

One time D. [child] came in and he pushed the buzzer. You know how you push it three times [for emergency], and boy, they [nurses] came in quick. Two of them just came running. [Debbie]

She [Plunket nurse] was sort of responsible for trying to set up a Polynesian pre-school group here. And where she saw a need, if she didn't do it, then she'd put energy into stimulating someone else to do it; to help women in the home. [Valerie]

Approach. The women talked about nurses who were very helpful and nurses who weren't. In either case, the women did not identify the nurses' services with a particular philosophy or approach. There is some indication that the women felt the nurse's care was influenced more by her life experiences than it was by a knowledge base.

Well, the first Plunket nurse was very pleasant, young and hadn't had children, so I found often that if I asked questions she wasn't able to answer it. [Christine]

She [maternity nurse] was a Dutch woman, and she was used to having a baby and leaving hospital straight away ... so she really pushed that. [Christine]

I was breast feeding and I mean he put on so much weight and his graph was going just beautifully, and this particular time it hadn't done that. And she was quite worried about it and she got all hyper. I know she's a real bottle person, which I'm not and I wasn't bothered. She was bothered. She said, "You might have to comp him" [supplemental bottle feedings]. I said, "No bloody way!" [Debbie]

One circumstance that supported the women's view that a nurse's service was influenced by her life experience was that each nurse had her own opinions and ways of managing health concerns. This caused the women some difficulty when they encountered several nurses in one setting (e.g. the maternity ward).

(I - You weren't finding the information you needed and some of it was against ...) Yeah, I mean everything was down to the individual nurse. Whatever, it's very hard as a

professional person to support somebody to do the opposite thing. If you've bottle fed your children and you think that they are healthy, it's going to be very difficult for you to say to people, 'Yeah, breast feeding is the best thing for your child' and actively encourage it. How can you do that when you've bottle fed your kids and you don't want to think your kids aren't healthy. Look, the nurses in the hospital, it's the same thing. How can they encourage breast feeding? And in City hospital, I don't know what it's like now, but they've been terrible about comping babies in the past. And they've also been terrible about (I - in that they did it?) Yes, and they say, 'A big baby needs it because he's big and a little baby needs extra', so you can't - I've always been very irate about the ... After D. I wasn't happy with the hospital with the maternity side of it because of every single nurse having a different thing to say. And they didn't really know the answers anyway. [Debbie]

■ ■
But the fact that was most upsetting to me at hospital was that because of the great change in staff, not one of them told you the same thing. They all had their own ways about feeding babies and you would come out confused. [Ione]

Although particular perspectives were not identified, there are some activities that the women in this study identified with nursing. These are monitoring, interpreting, advising, showing how to do home care, physical and comfort measures, emotional care, and some technical procedures.

Monitoring. This is similar to Keeping Watch as practiced by the women in their homes. It is the usually ongoing, purposeful observation of signs in a specific situation. In many instances, the women contacted a nurse in order to have expert help to keep watch. In this study, women did this to keep watch over a baby's physical growth or the woman's and baby's post-natal progress. Occasionally the nurse monitored situations covertly.

[Christine, who had four Plunket nurses in one year, made the following observation.] I know that they do the house over when they first come. They ask if they can wash their - the first time they come they ask if they can wash their hands, the Plunket nurses. And then they don't ever wash their hands after the first visit. They just [wash their hands in order to] check the house out and look for safety points. [Christine]

■ ■
[Ione opted to leave hospital early and be cared for by a midwife at home.] It's really wonderful, you have to be out

of hospital within 48 hours to have this planned early discharge and then you have midwife care for up to seven days. And they come each day and they weigh the baby and check it and they check your tummy and stitches if necessary. [Ione]

■ ■
I take my children to Plunket to get weighed ... [Debbie]

■ ■
... In that A. wasn't talking or pulling herself to her feet at her one year check so, she kind of failed. So the Plunket nurse wanted to send her on for a check. [Ione]

In her grounded theory, Nursing Partnership, Christensen (1990,p.198) states that monitoring is one method the nurse uses to "evaluate the status of the client and the situation". This suggests that it is a contributing category of Interpreting. Benner's study (Novice to Expert, 1984) based on nurses' descriptions of their work in a hospital setting, identifies three types of monitoring as within the domain of nursing. The Diagnostic and Patient-Monitoring Function involves observation and recognition of signs of change within a patient. It resembles Keeping Watch. Benner also suggests that "diagnostic and patient monitoring are central to the nurses' role." (p.96). Monitoring Therapeutic Interventions includes observation and adjustment of a therapeutic regimen for the benefit of the patient. Monitoring and Ensuring the Quality of Health Practices means spotting and preventing errors. It requires knowing the patient as a person and having a "keen sense of the patient's usual behaviour and appearance to detect subtle but significant changes." (p.137).

Interpreting. Nurses were often consulted to assist with the decision as to whether or not a health concern needed the attention of a doctor. The participants also contacted nurses to find out what was happening when a trigger sign(s) suggested something was wrong.

She [nurse] looked and listened to F. breathing, and walked straight back out again. She came in about a minute later with the doctor ... Usually, I only go to the doctor if the chemist or if the Plunket nurse says I should. [Rachel]

■ ■
I said to her [Plunket nurse] how I'd been noticing that she [daughter] shut this one eye whenever she looked into the

distance, could she just check it out or should I go to the doctor? ... So she checked it out and said she definitely had astigmatism and she wanted me to go to the doctor. [Ione]

■ ■
And we [Valerie and two neighbours] were all unsure as to what we should do with her [daughter who had fallen at a swimming pool and was semi-conscious]. And I said, "Well, I think I'll just ring the doctor's nurse and check out." So, that situation was full of uncertainties as to what I should do, and the doctor's nurse just said, "Bring her down immediately." [Valerie]

■ ■
I went down because the cold didn't seem to clear up and all the normal things. And she [practice nurse] said to me, "She's teething." [Rachel]

Christensen (1990,p.198) states that Interpreting is part of the nurse's work as she assists the client through "a passage which is characterised by the giving and receiving of nursing in order for the person, as patient, to make optimal progress through a health-related experience" (p.27). In this study the women confirmed or supplemented their own interpretive skills by asking nurses to confirm their interpretations when they knew possibly what was happening or to interpret what was happening when they didn't know.

Advising. Nurses gave advice and information to participants about ways to manage normal growth and development and common illnesses.

She was very good at breast feeding and telling you things about that. [Christine]

■ ■
Like she told me when to introduce different foods and all this. [Ione]

■ ■
I can remember ringing her [Plunket nurse] about measles or something and saying, "Exactly what does it look like?" And she would pass on that information. [Valerie]

Showing How. Showing How includes demonstrating what needs to be done and supporting the woman as she learns how to provide in the normal situation of wellness.

She was just wonderful. She came in with two tin foil plates and she got me flowing. She got me a pump and she showed me how to empty some out to get the hardness away so

that the baby could get on. And it was no sweat. She was just so helpful, and willing ... And she'd written notes to the people in the morning to know what had gone on in the night and to tell them where I was at. And they were really encouraging as well. And I left, not confident, but I left able to feed fer. [Ione]

Advising and Showing How are similar to Coaching, "the guiding, motivating and teaching work of the nurse" (Christensen 1990,p.198).

Physical Care and Comfort measures. This included self-care and activities that the women were unable to do themselves and usually occurred in a hospital.

The first two days were a bit of a haze [after a caesarian]. And when the night nurse said, "I'll take S." [baby], I was quite happy with that. [Debbie]

■ ■
And the first thing she [night nurse] said to me was, "We'll give you a bath, they never clean you up properly in theatre" [caesarian delivery]. So I felt really good. She gave me a bath and put deodorant on and all this sort of thing to make me feel a lot better. [Rachel]

Emotional care. Emotional care includes interactions with the purpose of supporting the woman or her child(ren).

She always addressed the child. I mean to us, to the mums, it is a person, it doesn't matter that it doesn't seem to respond. People only respond, anyway, to people that react to them so I liked the way that she always greeted N. as well as me. [Christine]

■ ■
They gave her a doctor set, the kindy teacher and the nurses were brilliant because they would stop, they would come in to take her temperature and all that and they'd let her do the same thing to them, even the doctors which I was most surprised at. But the nurses they were quite happy to sort of let her take their temperature and listen to the heart beat. They had the patience to, even though you knew they were busy. [Rachel]

■ ■
It's quite important if a nurse can sense that someone needs to talk. Like one of the night nurses came in and I was chatting to her and I said, "Well, it's nice to have somebody to talk to", and so she talked to me. [Debbie]

Emotional Care, a complicated concept, is only touched upon in this thesis. Christensen (1990,p.197) calls it

attending or "being there for the person", and lists Being Present, Ministering, Listening and Comforting as four subconcepts. She further states that Attending is the "first essential work of the nurse".

Technical Procedures. These are procedures nurses performed, often to gather specimens for lab tests. Some procedures could be interpreted for the participants.

If I need a cervical smear for instance I would go to, actually we've got a nurse who does it, I like that better and she's lovely and more time too. [Kelly]

■ ■
She [midwife] wanted to break my waters. [Debbie]

■ ■
So she [midwife] did the heel prick thing at home. [Ione]

■ ■
I look at Plunket as a place to get the children weighed and measured ...

We [Karitane nurses] did what they call a test weight. They weighed her, I fed [breast fed] her and they weighed her again. She put on next to no weight between - so they said, you could comp her if you like. [Christine]

Technical Procedures are nursing skills and are a part of Nursing Knowledge (Christensen 1990,p.204). Nursing knowledge is a Contextual Determinant which "exerts a specific influence on the shape of the Nursing Partnership" (Christensen 1990,p.201).

Conclusion

This chapter contained a discussion of some health care consultants whom the women contacted for information, assistance and support. The discussion attempted to show how the women selected each one for different purposes. The health care consultants discussed were the chemist, complementary therapist, doctor, and nurse. The next chapter contains the analysis of Sharing Concern, and its contributing categories. Sharing Concern describes how the women hoped a health care consultant would respond when they presented a health concern.

Chapter 11: Sharing Concern

Thus far, it has been shown that upon noticing a sign of change, the women tried to determine a name for, and information about, the process they were observing, and tried to support changes toward a more normal state. In the last chapter, some sources from which the women sought information were discussed. When participants went to family, friends or health care consultants, in addition to information, the women hoped the person they contacted would share their concern. In this chapter, Sharing Concern will be discussed as it occurred between the women and health care consultants.

Sharing Concern occurs within a relationship. It is a response to and support of the activities of Bonded Caring. As the women work to provide health care, they expect health care consultants to be supportive, to receive and provide information, to be technically competent and to provide, suggest and teach ways to manage health concerns. The manner in which information and assistance are provided is an indicator to the woman about the degree to which a health care consultant is Sharing Concern. Based on her perception of the extent to which Sharing Concern is occurring, the woman experiences the interaction with the health care consultant as affirming, efficient, tolerable or undermining.

Affirming

An affirming style of interaction is characterised by an easy flow of information and warm feelings. The woman

experiences being understood and confirmed. She feels the health care consultant knows her to a certain extent and accepts her. The result of an affirming interaction is that the woman feels more confident, capable and able to manage.

I guess what I saw her [Plunket nurse] doing, was recognising something within each individual that was of value and saying, "Hey, that's really great." [Valerie]

■ ■
She [Plunket nurse] was really supportive ... that set me on my way. And I didn't look back. And I managed to feed the rest of the girls right up to the present day. [Ione]

■ ■
He [doctor] just supported me, he gave me a lot of encouragement. He says you don't have to worry. This way I've gained confidence. [Ruth]

Talking

When a woman visits a health care consultant, she describes her health concern and the health care consultant finds out about it through questions and examination. A diagnosis is provided and ways to manage the concern are discussed. The ways in which the health care consultant and the woman talk to each other affects the relationship. Talking with a health care consultant can take several forms; business, chatting and talking about anything. In an affirming style of interaction the form(s) of talking used depends upon what is needed in each situation.

Business Talking. Each time a woman contacts a health care consultant, Business Talking occurs. The woman expects that the health care consultant will find out about her concerns by asking questions and by making an examination. In addition, information is provided about the purpose of the examination, and about the health concern and how to manage it. If the problem requires specialised treatment, a referral is made and the woman's movement through the health system is assisted when necessary information and guidance are matched to the woman's level of experience with the health concern.

The first question after the formality of "How is everybody?" - the rest of us - is, "What are we here for today?" And I've got to tell him straight away what I'm feeling is the problem with whichever child. [Ione]

I explained exactly what happened to me and he explained the same things that this other doctor [referring doctor] said and a little bit extra. [Ruth]

I only went to him [naturopath] once and that was about - D. and I both went about allergies. He did the arm bending thing; he did a big long survey on us and he had a lot of questions. [Debbie]

And the doctor asked her questions like, "What sort of ground did you fall on?" ... He explains everything because there is always a reason for everything he does. And he explains what the reason is and that teaches you too. [Christine]

Chatting. When the business talk is finished, some health care consultants take time to chat. Chatting is appreciated when it follows competent business talk. It raises the level of the relationship from talk focused on the health concern at hand to one where the health care consultant is willing to get to know the woman and to be known. Talk can remain at the chatting level or it can be a basis for discussion of personal problems. If the woman senses that it is all right, chatting can evolve into being able to talk about anything.

And she was very efficient with the things she did but somehow seemed to have a bit of time to chat with me. It wasn't just business. That's a confidence thing and of course I never know when I go to a doctor whether he'll, I should sit and chat with him if he wants to or whether I should get to the nitty gritty because there are hundreds of people in the waiting room, but she always seemed to have time to do that and didn't seem to run overtime. So I liked that. [Christine]

Talking About Anything. Being able to talk about anything occurs when a woman perceives a warmth and friendliness from a health care consultant, who is also experienced as being knowledgeable about a wide variety of concerns. The woman has a personal liking for the health care consultant who is viewed as having time and enjoying a chat. It is a

friendly and a working relationship as the health care consultant gives serious attention to the health concerns raised by the woman. In addition to tangible assistance, emotional and social support are given. Because the health care consultant shares her concern, the woman feels encouraged and supported and gains confidence.

And I've never, ever been able to feel so comfortable with a doctor. I can just sit down and go "Oh I had a bad day today" to my doctor, or "Gee I didn't feel this good on such and such a day." And told him what I did about it ... things like that. [Ruth]

If she [Plunket nurse] called in the morning and was going to weigh the baby, she would like a cup of tea and yarn with you. And these sorts of people in the early stages of mothering and isolation are really very precious. So it kind of evolved that we could talk about anything and everything. [Valerie]

And the midwife had been two visits before I had her and I felt it was a neat relationship. The first visit, sounds silly to build up a relationship in two visits, but she came the first day. We sat and had a cup of coffee and talked for an hour and a half just about ... She had questions to ask me about my health and having babies and what-have-you, to get my records right, but - we just sat and talked and I felt like I knew her. She was that sort of lady. [Ione]

A study designed to evaluate the effectiveness of three styles of nursing, the responsive nursing, replacement-of-the-physician nursing, and assistant-to-the-physician nursing was carried out by Allen, Frasure-Smith, and Gottlieb (1982). Part of its results showed some nursing behaviours related to "a positive impact in terms of helping clients deal with stressful events" (p.45). Briefly, the responsive nurse was available by telephone and during visits; spent time with the client that was focused on discussion and listening; was a supportive listener encouraging the client to speak and gathering information by listening rather than by direct interrogation; focused on coping, adapting or dealing with disease, illness and hospitalisation; and she had goals for the clients. This research suggests further areas that could be studied concerning the affirming style. Their findings show that being able to 'talk about anything' is a

therapeutic use of the nurse-client interaction.

Interested

A category related to Talking About Anything is being Interested.

She was really interested in the women. She was really interested in the situation in their homes and what kind of background they came from and therefore whether they had any problems being at home and isolation. She really was a woman's woman. And her special caring, special abilities was in the fact that she really cared about the mothers. And that was really why she was such a success. [Valerie]

Perceptive

In addition to the health concerns the woman brings, the health care consultant may recognise unspecified problems and offer assistance or support in these areas.

It was more, odd comments that I'd made and he [naturopath] picked up on that, which - and it grew quite naturally from that so we've been fortunate, we've had a really good relationship with him in that respect ... He tuned in on different things. Or he might say, "Oh, you look a bit tired today." At one stage I was lacking energy and pretty run down, I hadn't gone to see him about myself. It came about in the course of the consultation about the children changing diet, he said it might be good for me to go on a sugar free diet for a while. [Lauren]

She'd give me books, books about housework and quite a few feminist books at the same time. She knew I needed something to stimulate the grey matter. [Valerie]

I went to the doctor and told him I had something terrible wrong with me and burst into tears and cried and everything else, and after we sat and talked for a long time; he - it was that I was really scared of getting pregnant and knew that I didn't want to have any more children but wasn't going to do anything about it. [Ione - her doctor helped her to resolve this problem.]

Extra Support

When the woman has need of extra support, the health care

consultant checks to see how she is doing, provides encouragement and support when there is an ongoing problem or the woman is learning how to manage a health concern.

We went in and he [doctor] got me a scan the next day. Anyway, then he rang me up and explained to me what had happened. [Ruth]

■ ■
And she [Plunket nurse] came back, for a week or more, each day to see me and encouraged me. [Ione - learning to breast feed.]

Matching

Matching occurs when the health care consultant's services are tailored to match the woman's level of experience. It is an indication that the health care consultant knows the woman well enough to acknowledge her level of expertise. Information, guidance and support are provided in a way that the woman can understand and use in her efforts to manage her health concern.

I guess that's something else I like about my [children's] doctor, in that he kind of respects what I feel about certain things and certain medical practices and he leaves a certain element over to my discretion. [Valerie]

■ ■
But he also made sure that he explained what he was talking about, kept breaking it down all the time for me so that I'd know what he was saying. Rather than talk in doctor terms, he kept breaking it down until I understood everything. [Ruth - when concerned about a possible miscarriage.]

Confirming

The woman's observations and interpretations of a health concern are acknowledged. The health care consultant investigates and either confirms the woman's perception or defines what is happening.

I told her [a new Plunket nurse] right from the beginning that my babies didn't put on lots of weight ... She looked at the records and said, "You've had - this is your fifth baby and you know what you are talking about." She was

marvellous. She was just reassuring. [Ione]

I even told him [doctor] of my previous experience with Dr. Z. in town. And he turned around and said he had heard of her. That he thought she was good. But he did sympathise with me and did see what I was getting at. [Ruth]

Considerate

The health care consultant is experienced as courteous and considerate, placing the woman's needs in priority above guidelines.

And she [Plunket nurse] would not for one minute think of disturbing a baby that you had a fretful night with, who was now asleep. [Valerie]

And one day she [midwife] came and I'd just put F. down [to sleep] so we just sat and talked. And she checked me [stitches] and didn't even - she had a look at her, saw she was all right, didn't bother getting her up or anything. So it was all flexible and caring. [Ione - she had a midwife come to her home to provide postnatal care.]

Technically Competent

The health care consultant carried out procedures in a way that was efficient and sensitive to the needs of the person being "worked on".

... So she did the heel prick thing at home and did it with so much more sensitivity than it was done in the hospital where they wheel your baby down and bring it back screaming. Because I sat and fed her while she did the heel prick thing. And she didn't even cry. The others came back screaming. She was really wonderful. [Ione]

My husband did ask if he [doctor] could do another urine sample [pregnancy test]. The doctor even told us I could take the sample home. So I could put it in my baby book. [Ruth].

Opening Avenues

Opening avenues occurs when a health care consultant

arranges a situation or helps the woman to see a situation in a way that increases her choice about what is happening.

... but as a Plunket nurse she set up in this area a new mother support group and knew that I knew very few people and sort of said, "Would you like to join one?" and I joined one and then as my evaluation of it I said that really it didn't do a lot for me basically being older and generally having had a different level of education I just didn't find a lot that really I could relate to or even (...) via that group, that group in particular. I had the kind of relationship that I could say "Oh J. that was a bit of waste of time, but thanks for opening that avenue". [Valerie - this was a mismatch, but the attempt was appreciated.]

And so he [doctor] helped us what I consider to be tremendously. In that he wrote - first of all he phoned a specialist and talked to him about it [tubal ligation] and we went to see him in a matter of weeks. And I was in the public hospital and jumped the waiting list and was done within - was operated on within a month because he didn't think we should have to wait until we saved up the money to go private. And I'd have to call that excellent medical care. [Ione - mother of five children, with three aged 5 and under.]

I thought, "No, I'm not going to be reliant on drugs to control it [severe headaches]. There's got to be some other way." So that was - the naturopath offered me something very solid to grasp on to. He offered me a way of controlling it myself. [Sarah]

Information

This is possibly related to opening avenues, because the health care consultant encourages the woman to find information from a variety of sources. In some instances the sources were provided in the form of loaned books.

[See Valerie's comment under Perceptive.]

And he [doctor] gave me a book, a pregnancy book ... And he gave me this piece of paper to explain how it goes there. The routine at Medical Centre for pregnant mothers. [Ruth]

And she got me to read the *Womanly Art of Breastfeeding*. And that set me on my way. [Ione]

Advocacy

This constructed category encompasses the actions health care consultants took on behalf of their clients. The participants recognised the health care consultant's efforts to guarantee that their health concerns were understood and continued to receive attention, as necessary, from other health care consultants.

He [doctor] just had a quick look and said, "I'm ringing the hospital, take her over immediately." [Valerie]

■ ■
And she'd [maternity nurse] written notes to the people in the morning to know what had gone on in the night, and to tell them where I was at. And they were really encouraging as well. [Ione - learning to breast feed.]

■ ■
He [doctor] explained there is nothing to worry about, that he would put me on to an obstetrician at fourteen weeks, but he said, "Until then, everything is okay." He said if there are any problems before that time, he'd put me on to an obstetrician. [Ruth]

Scott and Stern (1982) suggest a category that might be an indicator of an affirming style; respect. They state:

The crux of this system (Ethno-Market system) seems to be the importance of nurses showing respect to their clients and the clients' values ... It seems important for nurses to show respect for older black women since it is the older woman who is responsible for health teaching ... This woman is unlikely to accept the nurse's ideas about health care, even on a testing basis, unless the nurse honors the older woman's beliefs. (p.59).

Efficient

When the women experienced an efficient style of interaction, they found the health care consultant to be technically competent, confirming, providing information, matching, considerate, willing to chat, and an advocate, but often limited in dealing with social and emotional concerns. The participants were selective. They learned what health concerns were outside the health consultant's interest or abilities and chose not to present these.

If you went in there [doctor] really distressed though I don't think he'd have much time for you. I've actually heard that from others, if you are really depressed he's not the one to see for that. He's been very good with things he hasn't been too sure of, he's been good at referring us on to a specialist for a second opinion. [Lauren]

But when I was talking on the emotional language of what was happening to me, he [doctor] was uncomfortable about his response. What does he do here. But he's okay. I don't go to him for my emotional responses. That's where I have to go to a counsellor. [Valerie]

So the dentist put a new one [filling] in. And that was the difference. And what was happening was, I suddenly realised I was getting confused. And I'd pick up the phone, and I would try to dial a number, and I couldn't remember more than one number at a time, and that frightened me. I thought, "What the hell is happening here?" And I thought, "Well, I can't go to the doctor, what can I go to the doctor about?" It was frightening me enough to make me consider going back to the doctor, but I thought, "What do I tell him? I'm confused?" So I went back to my dentist and I said to him I thought I was allergic to amalgam. And he said, "Oh yeah!" And he said, "Give me the symptoms." And so I ran through all the symptoms I was having and he said, "I think you might be allergic to amalgam." And he took it out. [Kelly]

The categories, Technically Competent, Matching, Confirming, Considerate and Advocate were described previously under Affirming. In accordance with the limited ability to deal with social and emotional concerns, Talking is focused on Business Talking and Chatting.

Whereas I feel with the G.P., that one specific problem that we've come to see him about and we get that out of the way and then we can small talk. He's quite interested in running. And I've done a bit of jogging off and on, and A. [husband] runs. We talk socially. [Lauren]

Also, while information was provided, there was no indication that a variety of means was used to do this in an efficient style of interaction.

Tolerable

A few technical skills which can provide desired information characterises the women's view of a tolerable health care consultant. While the health care consultant is skilled in techniques to produce the information, there is limited ability to interpret its meaning. Information that is provided may be dated. An experienced woman will recognise that the health care consultant's concern about health is connected with following certain guidelines. She may tolerate this and use the information she can get. She may listen politely to advice and then do whatever she thinks is best or she will seek information elsewhere. The health care consultant may be tolerated because she causes no harm. A health care consultant that is tolerated by an experienced woman may generate anger, frustration and loss of confidence in an inexperienced woman, thus becoming undermining.

In fact the Plunket nurse had only discovered he was born via some mistake of coming across some information via somebody else. Because she had charged me and said this is a home birth I never knew about. I felt like I'd had a baby in shame or something. But this same woman was... she's okay. She's just an older variety of the Plunket nurse with set ideas on a few things and would like to wake your baby to weigh him, and a few things like that which I was never too keen on. But nevertheless, I went to her ... [Valerie]

But if I suddenly got a pain somewhere I would think, 'Okay what's that?'. Or if I, now my eyes start weeping I'll go to him [doctor] and say, 'Look, what is it?' and he'll say, 'Oh well, it's just this'. I'll say 'Oh is that what it is, okay. Thanks very much.' Pay the money and go home and get in my herb garden or my homeopathic kit or whatever and do it that way. So I use them; strictly as a diagnostician, or as a cleaner upper of accidents. [Kelly]

And I had initially thought that my Plunket nurse would tell me anything I needed to know about feeding a child and any of those other little care things that I wanted to know about and maybe even some medical things, whether to get worried about coughs and sneezes and snuffles, little things and I found that you don't get those medical things from them. I was quite disappointed about that... And so now really I look at Plunket as a place to get the children weighed and measured; that's how I see the Plunket nurses. [Christine]

The middle lady [Plunket nurse] perhaps didn't [recognise her experience] and if I had been a first time mother, I would have been quite panicky that these babies didn't put on weight because she thought they should and she used to question me about having enough sleep and told me to take vitamin tablets, supplement my diet with [Brand name] and all sorts of "bugs". Which on the whole I did what I knew I wanted to do and what I felt was good and sort of ignored the list of what she said. I still was eating healthily and all those things so I knew I was doing the right thing. So I wasn't worrying. But if I'd been a first time mum and she was telling me to do all these things I would have felt a failure. [Ione]

Undermining

An Undermining experience with a health care consultant is more like a catastrophe than a consultation. When the woman presents her health concern, she may find that her concern is disregarded or minimised. She may be given little or no information. Or she may be given information she does not understand. Information that is given may be presented in tones of accusation or blaming and may be incorrect. The result of an Undermining experience is that the woman loses confidence, may be confused, is unable to manage the health concern and feels herself a failure.

Disregarding

The woman perceives that her health concern is not acknowledged, and that the health care consultant has concerns that may or may not be congruent with her own, but which are given priority. A dishonest approach may even be used to achieve the health care consultant's goals.

The form that I filled in said that I gave the right, said that if anything happened that the hospital could do whatever they wanted done by whoever was there at the time. It's sort of, it's fair enough in a way but it seems to sign away an awful lot of my rights. And like in an emergency you will, would like to be, have some sort of control over what they do but it didn't seem that you would have it. It's just the normal form but it alarmed me and I said no, well I didn't really want to fill it out, sign it and I

crossed this bit out and she said "Oh no, it doesn't matter because it's a formality. There's another form to fill in when you come in." And I signed it. I don't know why I signed it because I often stick to my guns but I thought "Oh well, if there's another form then we'll have a fight about the other form." So I signed it and there was no other form and so had signed away all my rights under false pretenses well because of a lie that the nurse had told me.
[Christine]

Well she [doctor] asked me when was the last time I'd been to a doctor. Well I'd had a swab [cervical smear] once before, but that was the year before I went to her. And she thought it was positive for me to have a swab with her now. (I - she thought it was time to have one.) But she didn't give me anything for my illness. (I - You came to her because of the illness.) Yeah, so I was feeling crook and really rotten but I didn't get anything for it. So I felt that was a wasted trip. I could have stayed laid up in bed.
[Ruth]

Nothing Wrong

When a participant has observed signs and is convinced that something is wrong, to be told there is "Nothing wrong" can be an undermining experience. When nothing is wrong, there is no possibility for help with the health concern, and the woman's perceptions are negated.

I went up to the Karitane unit and I don't quite know what they thought I was doing up there but they put N. down to bed and she slept and I just sat around and then I fed her again, but they didn't seem to cotton on to why I was up there. I said because I was having trouble with her to put on weight and that she cried a lot. And they said that - they said that there was nothing wrong with her, that there was nothing particular wrong, she was just a bit colicky and so I said, "Well do you know why it is she didn't put on weight", and they said, "Ah, it'll come right". So then I started to cry because I was really concerned. [Christine]

I would get headaches, my stomach would be upset, and things were sort of uncomfortable inside. And of course he [doctor] went through all the things in creation [tests]. He said, "There's nothing wrong with you. Absolutely nothing wrong with you." [Kelly]

Monitoring

The woman may feel that she is being monitored in a way

that conveys she is not to be trusted.

I mentioned that she and N. loved being in the bath together. She wrote something down. (I - What does that mean to you?) To me well, I always think it's a bit peculiar actually. I think it's very unsubtle. If they want to write something down about me they should do it while I'm not there. But I don't care what they are going to do, they can't use it against me really. Because I'm not likely to belt my kids up so they can write all these other things, test all these other things out, I wonder why they do it. I'm often interested to know what they have written down. But I wouldn't bother asking. [Christine]

And she [Plunket nurse] wrote in my book, "Mother says he seems to be accident prone." I thought, "You bitch. As if [the nurse meant] 'I say' [the mother says] and it might not necessarily be true." [Debbie]

Uninformative

Health care consultants may be experienced as reluctant to provide needed information, guidance or support.

I asked a lot of questions for her to answer for me, what I thought was a lot. Like "How do I know that I've lost the baby?". She says "Well, I don't know, we will have to wait". And I said, "What can I do about my abdominal pains?". "You'll have to wait". Now that left me feeling lost, I didn't know what to do. I thought, "Well if I've had a miscarriage, she hasn't explained to me what a miscarriage is, what does it look like, how does it feel, can you feel it? Can I see it, or does it just happen and I don't know about it?." [Ruth]

This was while N. was very young because I was still having home visits and N. had chomped through my nipple and I had a cracked nipple. And it was pretty uncomfortable and I said to the Plunket nurse, "I've got a cracked nipple, is there anything I can do for it?" "Oh, everybody gets cracked nipples", she said, "You just have to put up with it." And I said, "Well can I do anything?", and she was just incredibly unhelpful and uncaring and I was getting - I think I was, yes at that stage it was so uncomfortable that I thought well, if I stop letting her drink from me and just express the milk perhaps that would help. And so I was expressing these strawberry milkshakes, and - but she wouldn't suggest anything or didn't suggest anything. She just said I'd have to put up with it and that it would get better! I knew that. I assumed that. But I thought there might be something you could do now. [Christine]

Blaming

A health problem may be presented by the health care consultant in a way that leaves the woman feeling accused or blamed, and a failure.

It was a preschool visit [to the Dental nurse] because I was there so he was probably four and she growled at me because of the state of his teeth and she accused me of feeding him cordial and lollies and ... because he had a couple of teeth that had abcessed and there was actually nothing left and she had to remove a couple and I left the dental clinic in tears. [Ione]

■ ■

I knew N. was little and people used to say, "Oh he's little." I'd gone through the stress of my father's death after he was born and the fifteen months gap between the two of them, it was pretty hard work and I had this creeping doubt of my nurturing physically and my milk and these things and I thought well I'll just get it checked next time I go for a scheduled Plunket visit. I went to her and she weighed N. and looked at the last time she had seen him, some time before and got very alarmed at him being an underweight baby; it wasn't underweight, there was another word for it. I can't remember now I must have erased it from my memory because it had such horrible connotations. Not malnourished but a word that's very similar to it, non-thrive, a non-thrive baby. I had a non-thrive baby. And said that you should get this checked out by the G.P. and he would follow it through and presented to me as an ongoing problem that this poor infant was unable to cope with life. [Valerie]

Mismatching

Mismatching occurred when health care was provided in a way that was not suited to the participant's level of experience. The result was a possibility of confusion or the woman's management of the health concern was jeopardised because not enough or too much information was given. A woman whose expertise was not acknowledged could be inconvenienced. The health care consultant was viewed as undermining or tolerable.

And so when I had this baby and all of a sudden I had these terrible, painful, hard rocklike boobs. I wondered what on

earth had struck me. No one was there to explain or to help, and I couldn't get him [baby] on. And so I made this choice to put him on the bottle ... Yeah, no help to make the decision and I felt like I didn't get any help at all. [Ione - explains why she chose to bottle feed her first baby.]

And this is quite funny even though it is frustrating. I said to the doctor, "I've got tonsillitis, I need penicillin." She checked me out. She goes, "You've got tonsillitis, you need penicillin." And I just looked at her blankly. I suffered a lot from tonsillitis when I was young, so ... [I - You knew what it felt like.] Yeah, I mean I knew what I needed and I told her what was wrong. She didn't have to say ... to repeat it. All she had to say was, "Yes, you're right, here's your prescription." [Rachel]

I'd had two children, and I'd had a six year gap and then another one [baby]. And she [Plunket nurse] started treating me like a beginner ... She used to call me back for extra visits and I played her game a little bit. I went and kept her happy - but I never worried. [Ione]

Being Labelled

Being labelled means that the women became aware that they had been classified as a 'type' of patient and that the health care consultant interacted with them on the basis of this classification. The label possessed a negative connotation and allowed the health care consultant to disregard the women's health concerns to a degree. Labels mentioned by the participants were Panicky Mother, Hypochondriac, and Fussy Type (troublesome).

Well I probably did used to rush off to the doctor much quicker with him [first child]. I actually do remember once being told by the doctor that I didn't really need to be there. It wasn't actually my own doctor. But it was the weekend and we'd gone to the emergency doctor and he really made me feel like I was a panicky mother who shouldn't be wasting his time. I don't remember what was wrong with him, but I very much remember what this doctor said to me. [Well talk about that.] He actually said, he called him a pale face, my precious baby. And he said that he needed to be out in the sun a bit more and then I wouldn't be rushing down every time he coughed. But it turned out later that they diagnosed him as asthmatic. [Ione]

Because sometimes when you go to the doctor, I have the experience that the nurses down there think you are a panicking mum. [Rachel]

And so when she'd [nurse] come back I said, "I have just a few questions I want to ask you," and she said "No, I'm going to tell you some things. You listen to me", and she tore my character to pieces and sort of said I was the fussy type that liked to get everything right. Well, that may be true you know but it doesn't have to be a fault, does it. Well she really sort of tore me to shreds, I felt as if that had happened and she didn't answer any of my questions but just told me that was the matter with me. [Christine - while in maternity ward.]

He put me down as a hypochondriac. [Kelly]

One result of being labelled was that the women learned they had to be certain that their health concerns were legitimate and deserved attention. Consequently, the women developed various strategies to find out about or care for their health concerns. They checked with other people to confirm their perceptions prior to contacting the health care consultant by whom they were labelled; they looked for another way to find out about the health concern; they insisted that their health concern be given attention; or they left.

Usually I only go to the doctor if the chemist or if the Plunket nurse says I should. [Rachel]

That was I think when I really decided I wanted to leave. So I suppose that's one good reason for being unpleasant to everybody. It gets rid of them. [Christine - she left the maternity ward.]

I then, it wasn't until in actual fact, when I really started going to a homeopath that I then found out the reason why I lost my hair. I'll talk about that in a minute. And then, he [doctor] then sort of put me down as a hypochondriac, he sort of labelled me as a hypochondriac because I was feeling not well, but I couldn't pin it down to anything. [Kelly]

And I mean I get angry when they try to fob me off, but I think, "No, this is supposed to be a public health service and because it's daylight hours I can't take my child to the hospital, so I've got to come to you. So you listen to me. You don't know my child, you don't spent time with her." I'd rather be thought a panicking mother than not do that and have something really wrong happen or really bad because I didn't go, because I waited one day and ended up in hospital or something when it's worse. I sort of work on the assumption that prevention is better than the cure. [Rachel]

■ ■
When she was little, I did sort of pressure the doctor to check her breathing, often, because I wasn't happy with it. But he kept reassuring me that it was okay and I suppose I was thinking ahead that perhaps she was going to be asthmatic and I wanted it to be found out before she had an attack. [Ione - her daughter's breathing was 'terrible right from birth' and another child has asthma.]

Two statements about labelling are made by Blaxter and Paterson (1982).

... but the fears about a child's injury being misinterpreted which were generally expressed, even by the most careful and loving of mothers, were a sad commentary on the way which mothers in this social group thought they might be stigmatised. (p.97)

■ ■
The consequences over identification, and over the subsequent management of chronic conditions could be very unfortunate. If it seemed to the mothers that 'nothing is being done' this might well be transformed into 'no one will take this seriously'. The mother might feel that she was not being believed, that she was being labelled as a 'fusser' or that 'nobody cares'. The result might be anger, displayed in a desperate thrashing about for attention, or it might be apathy and the avoidance of contact with health services. (p.78)

Feeling Undermined

A woman who is inexperienced, and is caring for her child or a specific health concern for the first time is most likely to feel undermined as she has little knowledge with which to refute what is happening and to validate her own concerns. If the interaction leads the woman to feel she has failed in some way, her reaction may be highly emotional and negative.

So, here's me, I got really upset to a real emotional state. I just felt well if I'd lost the baby and I didn't know about it, then I must be really stupid, I felt horrible, I didn't feel like a human, I felt very irresponsible, (I - like how could you miscarry). Yeah, without knowing it, I also felt fragile, because I felt every time you are pregnant, you can have a miscarriage and you don't know; or a woman could have had five or six miscarriages in her life without knowing it. That's what I was starting to believe. All these things just came to me and it hit me mentally and

emotionally. [Ruth]

I was in a really vulnerable situation and I suddenly thought, well you know (... unless in ...) response to personal grief that I was going through maybe I had forgotten to feed him a few times and ended up convincing myself I was quite doolally over this. Did I have a relationship with my baby that did actually involve nurturing him enough physically. [Valerie - she was told her baby was non-thriving.]

In addition, when the participants were feeling undermined, they sought the advice of another health care consultant to get further information or to re-define the situation. Ruth went to another doctor, Valerie went to her own doctor.

I rushed back to the G.P. And there really was no problem. But there was a huge problem when it was presented to me by the Plunket nurse and really undermined my motherhood so I wiped her off my slate of people to see about children. [Valerie]

My husband realised how much of a bad state I was, and he stopped working that day. And we found a good doctor in Medical Centre. [Ruth]

In an editorial, Brink (1986) announced the results of a casual survey in which she asked recently hospitalised patients about their evaluation of their nursing care. They were mainly concerned about the interpersonal aspects of their care. Good care was described as "checking the patient frequently"; "being competent and efficient"; "giving explanations"; and "being friendly, kind, helpful, concerned and available". Poor care was described as "the nurses were not around"; "they had to be waited for"; "they were unconcerned"; "they gave me no explanations"; "they were bossy"; "they were rude"; and "they treated me like a child". These two descriptions are congruent with an affirming style and an undermining style.

Conclusion

This chapter showed the caring styles of the health care

consultants as they were perceived by the participants. The content of the interaction as it is perceived by the participant determines if it is affirming, efficient, tolerable or undermining. However, there is some indication that individual health care consultants are viewed as somewhat consistent in their caring style. Part III contains Bonded Caring and the conclusion of the thesis.

PART III: BONDED CARING AND CONCLUSION

Chapter 12: Bonded Caring

In Part I, the background of the study, and the strategies and procedure used to generate this grounded theory were discussed. In Part II, chapters five through eleven contained the analysis and discussion of the categories and processes that describe the activities of the women as they provided health care for their children and themselves.

Part III contains, in chapter twelve, a discussion of the grounded theory, Bonded Caring, and chapter thirteen contains a discussion of the strengths and limitations of the research, implications for research, theory and practice, and a concluding summary of the thesis. As stated above, in this chapter a discussion of the theory, Bonded Caring, will be presented.

Bonded Caring

Each of the categories and processes presented in the analysis, thus far, is related to the core category, Bonded Caring. In this chapter, Bonded Caring will be defined and the ways the other categories contribute to it will be discussed.

Bonded Caring defined. Bonded Caring requires an intimate and ongoing relationship in which there is the development of indepth knowledge of the unique characteristics of the person(s) involved. It is characterised by a strong and enduring affective quality, and by concern, worry and serious attention to the needs of the person(s) involved.

This concern necessitates gathering of information about the nature of the needs and making the best possible choices concerning their management. These choices are made within the context of the current situation which includes culture, past experience, lifestyle, structural influences and personal resources. Because it is organic in nature, the activities manifested by Bonded Caring are systematic and inter-related. They change over time as needs change while maintaining the goal of supporting and protecting development.

As the definition implies, certain characteristics (concepts) are essential. These are Social Interconnectedness and Caring. One quality of these categories is explained by a concept called self-similarity that states there is symmetry across scale; patterns are found within patterns (Gleick 1987,p.115-116). Symmetry is defined as "having structure that exhibits a regular repeated pattern of the component parts" (Random House Dictionary 1968,p.1331). This characteristic is illustrated by the Russian doll which when opened reveals another doll, and when that doll is opened there is another, and so on. They each have hair, eyes, nose, mouth and an apron. Yet each is different. The eyes and hair are a different colour; the mouth is a different shape; and there is a different design on the apron. Social Interconnectedness and Caring provide symmetry because they are a pattern that is repeatedly found in caring relationships. Within Bonded Caring, other processes that exhibit social interconnectedness and caring are Sharing Concern and Getting On With Life. Within the literature, another instance is Duffy's (1989,p.676-693) description of the relationship between a primary support person and a newly divorced woman. The difference (scale) between these processes is determined by the intensity of the relationship and the care required. It is the way and the degree to which social interconnectedness and caring are manifested that make them Bonded Caring.

Social Interconnectedness

The interconnection, or bond, in Bonded Caring is an intimate and ongoing relationship. The relationship is characterised by a strong and enduring affective quality.

And she was getting pretty upset because she didn't know where mama and dada were. [Becky]

■ ■
... my precious baby ... [Ione]

■ ■
But with H. that unspoken connection is always felt ... sounds all esoteric and wonderful, but we can fight like hell as well. [Valerie]

■ ■
I think probably because I love and care for my children ... [Ruth]

■ ■
I had good feelings when I found out I was pregnant. [Ruth]

A result of the ongoing nature of the relationship is the development of an indepth knowledge of the unique characteristics of the person(s) involved.

But K. who has just turned 12, she will hide it [if she's unwell] until it gets so bad. Whereas Q. will tell you straight away that he's not well. [Ione]

■ ■
It was dreadful that first month [starting diet advised by naturopath]. I said, "What can I feed him? What can I feed him?" Because he wouldn't eat this and he wouldn't eat that.

■ ■
... But he doesn't like pears. And other fruits like melon and pawpaw, which are safe fruits for eczema, he doesn't like the taste. [Lauren]

■ ■
H. woke up in the middle of the night and said she was growing. I said, "Oh, you're growing." And she said, "Yes, because I ate lettuce last night." Alice in Wonderland maybe. But I'm aware of those sorts of things. [Valerie]

The organic nature of Bonded Caring is an inherent characteristic of Social-Interconnectedness. It is manifested in three ways. One is that what happens to one member affects the other. Therefore if a change in a child is a developmental one, it delights the mother. However, if a change signals a health problem it causes worry,

concern, and physical repercussions such as fatigue as the mother attends to the problem. Similarly, the mother's state of health affects the care of the child. Examples of this are given in Evaluation of Risk (Chapter Four), Social Interconnectedness (Chapter Seven), and Getting on With Life (Chapter Six).

A second manifestation is the responsive nature of the relationship. The women observed signs of what was happening and responded in a patterned way (to be discussed under Caring). The women's activities were purposeful and suited to the situation and the characteristics of the child. This resulted in the third characteristic of the organic nature of Bonded Caring. The women changed their responses over time as the needs of the children and their own needs changed.

I let the older ones do it now [talk to the doctor]. They're old enough to express how they feel. [Ione]

■ ■
My children, until they became responsible for their own health care, which I feel they must be now at the ages of 15 and 17 ... [Sarah]

■ ■
... Once my family, my teenagers are through, I and my husband too, I'm sure will be much more selective of what [foods] we have in our home and quite happily so. [Sarah]

Caring

The need to care arises because the bond is an unequal one. The child is dependent on the mother. As a result, the relationship engenders a feeling of responsibility and purposeful activity to support growth and development.

Well for me, it's just been the natural course of things that I suddenly think, "Oh yes, it's a good idea, I'll do this with her now or that with her." [Becky - referring to developmental changes.]

■ ■
Because I'm that much older, I thought I better make sure I'm feeding [breast feeding] him right, and I better make sure I'm eating right and this sort of thing. [Kelly]

It's quite a lot of responsibility ... [Ione]

■ ■
And I know it's to do with mental health, but just try and do things as a family rather than push your kids away all the time. Have outings as a family and get out in the fresh air and explore different things. [Debbie]

It emerged that making the best possible choice meant that the women were selective about the health care they provided and the assistance they sought for a health concern. The women considered their own perception of the health concern; of the risk associated with it; of their knowledge and abilities; of the capabilities and cost of the health care consultants to whom they had access. These elements were considered within the context of women's culture, lifestyle and past experience. Using this information the women juggled and arranged their finite resources to make the choice that would protect and support growth and development in the best way possible.

The concept of Bonded Caring has been described in other research and literature. In her thesis, *Access to Health: Women's Experiences of Providing Health Care for their Babies*, Norton (1990, p.8) suggests that health care consultants and persons providing care in the home "have a different relationship with the person who receives their attention." Her description of this relationship as it occurs in the home matches very closely Bonded Caring as it is employed in this study.

Within the family where health care is provided the relationship is much more intense, creating strong feelings. These may include a range of seemingly conflicting emotions: love, anger, guilt.

... The integrity of the care rests within this family relationship and brings with it responsibility and obligation. The relationship between a mother and her baby is assumed, no matter what that relationship is nor how it is expressed.

Linked to this is the factor of time. ... health care is provided by family members for others in their household 24 hours a day, 7 days a week.' (p.8)

. A statement from Blaxter and Paterson's study, *Mothers and*

Daughters: A Three Generational Study of Health Attitudes and Behaviours, also fits the concept of Bonded Caring. It is about health care for children with chronic health problems or handicaps.

Where the child had handicaps or chronic conditions continuing for years, however, and given the number of professionals who might be involved, responsibility for making the best choices, ensuring that no avenue of help was overlooked, fighting for the child at every step, remained - the parents felt - with them. (Blaxter and Paterson 1982, p.86)

It is likely that this portrays an attitude most parents have concerning their children's health under special circumstances.

Blaxter and Paterson (1982) used data quantification and an ethnographic approach to analyse data gathered from 58 families living in poor circumstances in a Scottish town. While the ethnographic approach does not result in the emergence of a core category, many of the study's categories are similar to those generated in this study. Similarly, Norton (1990) used quantitative and qualitative strategies to analyse data gathered from 29 women from a variety of social and economic backgrounds from one city area served by the Royal New Zealand Plunket Society. Again, some concepts discussed in her study are similar to those which emerged in this study. This is exciting for two reasons: 1) the studies provide data that may be used to supplement the data gathered in this study; and 2) the samples are from a different city and a different country and the participants are from a range of socio-economic groups in Norton's study and a poor socio-economic group in Blaxter and Paterson's study. Therefore the 'slices of data' and the concepts identified in these studies potentially broaden the scope of the categories that emerged in Bonded Caring. Wherever applicable, data and comments from these other studies have been integrated into the discussion of the analysis.

The concept of interconnection is part of caring according to Benner and Wrubel (1989,p.4). They state that the "enabling condition of connection and concern is another way in which caring is primary". Caring places people in the condition of connection and concern. "This is what enables people to discern problems, to recognise possible solutions and to implement those solutions." (Benner and Wrubel 1989,p.4).

Gaut (1981,p.27-44) used semantic analysis to examine caring as it is used in ordinary language; and explicative analysis to "refine the term and render it theoretically unambiguous and theoretically correct" (p.31). The resulting action description of caring included three logical conditions for caring.

Condition I: S must have knowledge about X to identify a need for care, and must know that certain things could be done to improve the situation.

Condition II: S must choose and implement an action based on that knowledge and intend the action to be a means for bringing about a positive change in X.

Condition III: The positive change must be judged solely on the basis of a "Welfare-of-X" criterion.

The categories of Awareness, Observing Signs, Interpreting and Integrating Signs, Striving to Know What, Striving to Master and Sharing Concern show how women carry out the first two conditions. The third condition was assumed and was not explored in this study. However, the category of Social-Interconnectedness would indicate that keeping healthy, supportive and curative health care is beneficial to the woman and the child(ren) involved in a Bonded Caring

situation, and that a health problem is a problem for both of them.

Basic Social Process

Every grounded theory has a core category (Glaser 1967,p.100). It is the motivating force, the golden thread that connects the contributing categories and explains their purpose. A core category can be a basic social process. It is identified as a process when it has at least two distinct stages. It is a basic social process and a core category when it is pervasive, fully variable and accounts for change over time (Glaser p.100-101).

The main stages of Bonded Caring are Observing Signs, Interpreting and Integrating Signs, Striving to Know What, Striving to Master and Sharing Concern. While these stages may occur in a loosely linear fashion, they are inter-related and may not necessarily occur in the order stated above.

Pervasive

According to Glaser (1978,p.100) basic social processes as core categories are "pervasive since they are fundamental patterned processes in the organisation of social behaviours which occur over time and go on irrespective of the conditional variation of place." The following excerpts demonstrate the occurrence of Bonded Caring in places other than the study setting.

The percentage of households in East Harlem headed by women - 48 percent - is among the highest in the US. While men play dominoes in the shade or drink from brown paper bags on the corner, women take care of the family. I saw them day after day, walking the kids to school in clean clothes they can be proud of, waiting for them in the afternoons, making sure they got past the [drug] dealers. Women often make the difference between a child who survives and one who dies early. (Van Dyk 1990,p.70)

■ ■

You know, women are very passionate, in fact they very often drive men crazy because they're so passionate and emotional ... Often, when I lay out the effects of nuclear war, the person interviewing me on television will say: 'Aren't you a bit emotional?' (But) it's appropriate to be passionate about our survival. When I had my first baby, I knew I'd die to save that life. Now I had never felt like that about any other human life before; it was a profound revelation for me. If we can mobilise that instinct women have to save their babies, across the world, we may survive. (Dr Helen Caldicott 1990,p.19)

Fully Variable

To be fully variable, a basic social process must occur in other very different circumstances (Glaser 1978,p.100-101). The following is an excerpt from Bower's study (1987,p.27) "Intergenerational Caregiving". It is an example of "providing care in a way that was not perceived by the parent as caregiving." It is also an example of Bonded Caring.

A 62-year-old daughter who was caring for her frail, 92-year-old mother discussed her mother's increasing forgetfulness and confusion. The daughter was concerned because her mother's weekly trip to the bank involved three bus transfers. The daughter was fearful that the older woman might become lost in the large inner city during one of her trips. The younger woman convinced the elderly mother that their bank was unsafe. It had been robbed recently. Both women changed all of their accounts to another bank, which, coincidentally was only a few blocks from their home. (Bowers 1987,p.27)

Another example can be found among identical twins. The following comments were included in an article about New Zealand's first adult twin convention held this year.

Most twins view their twin as a soul-mate, a friend who instinctively knows how they feel and think. "Whatever happens, you know you'll always be there for each other," Michael Smythe explains, "That bond gives you a fundamental sense of security and confidence." [Kedgley 1990,p.5]

The section on husbands in this thesis suggests that Bonded Caring occurs between husbands and wives and fathers and

children. Self-similarity, a concept similar to Full variability, was discussed earlier in this chapter.

Accounts for Change

Change over time must be accounted for by a basic social process (Glaser 1978,p.101). Bonded Caring suggests that the participants evolved, over time, from Not Knowing through Striving to Master in order to care' for themselves and their children. In addition, as the current health system changes, the participants' tactics will change as needed in order to maintain Bonded Caring.

For example, at the time of the early interviews, the Area Health Board considered and later did close a local Accident and Emergency service during night time hours. Prior to the closure it was used as one way to manage night-time health concerns.

But I mean if it was night time and I just didn't know what to do, I would take my child to A. & E. just so I was consciously doing something. [Debbie]

Considering the possibility of closure, Debbie's comments suggest she must change her health care strategy to adapt to a change in the health service. She must now examine other options and select the one(s) that will suit her needs.

If A. & E. closed? Well, if one of the children developed asthma [a possibility in her family] ... I suppose it's only half an hour more, quarter of an hour more to Another City, but then if it's an ambulance it doubles the time. I don't know. [Debbie]

The examples provided in this section demonstrate that Bonded Caring meets the requirements of a basic social process as a core category.

Conclusion

Bonded Caring as the core category of the analysis was discussed in this chapter. A definition was provided and the connection of the statements within the definition with the categories that emerged in the analysis was discussed. The qualification of Bonded Caring as a core category was demonstrated using the standards of being pervasive, fully variable and accountable for change as described by Glaser (1978,p.100-101). The next chapter concludes the thesis.

Chapter 13: Standards of Rigor, Implications and Conclusion

Strengths and Limitations

The purpose for meeting standards of rigor is to establish trust in the outcomes of research (Guba and Lincoln, 1981,p.103). Rigor is defined (Random House 1968,p.1137) as "scrupulous or inflexible accuracy or adherence". The definition implies that the outcome of a piece of research can be trusted to the extent that the conduct of the research approximates the standards of rigor. Sandelowski (1986) outlines four criteria of rigor for qualitative research that were developed by Guba and Lincoln (1981) and suggests strategies to achieve rigor based on these strategies. The four criteria are auditability, creditibility, fittingness and confirmability.

Auditability. Auditability relates to the consistency of a qualitative study. Guba and Lincoln (1981,p.122) suggest that in order to be auditable, accurate documentation of a decision trail must be maintained. Based on the decision trail a person or persons "external, independent and disinterested" in the research could examine the data and decide "Yes, given that perspective and those data, I would probably have reached the same conclusion". Concerning grounded theory, Glaser and Strauss (1967,p.5) state that "One canon for judging the usefulness of a theory is how it was generated ...". They also suggest that other criteria for assessing theory are dependent upon how the theory was generated. For this research, method notes were kept as a means of documenting the decision trail which is presented in Chapter Four under Procedure. An independent

examination of the decision trail and data was not organised.

Creditibility. Creditibility establishes the truth value of a study. Truth value means how closely the research reflects the phenomena under study. One way to establish creditibility is to ask the research participants if the study's results accurately reflect their experience (Guba and Lincoln 1981,p.105). Glaser and Strauss (1967,p.239) refer to this as "understanding". They state, "A grounded substantive theory that corresponds closely to the realities of an area will make sense and be understandable to the people working in the substantive area".

Reason and Rowan (1981,p.248) suggest that "One of the most characteristic things about good research at the non-alienating end of the spectrum is that it goes back to the subjects with the tentative results, and refines them in the light of the subjects' reactions". In this study, a rough draft of the analysis was sent to the participants and they were asked to comment on two parts of the analysis; Bonded Caring and one other part. The participants' responses (eight out of eleven responded) are recorded in the discussion of the analysis and, overall, were confirming. Some of their comments are: "Bonded Caring - I don't really understand this concept - I think probably because I love and care for my children and have not tried to analyse it. I think everyone loves and cares for their children without putting a name to it" [Debbie]; "I giggled in some places, giggled because it was a knowing that other people can react the same as me" [Rachel]; "I agree with the report, as much as I've had time to read" [Kelly]; "I didn't really have time to give your work a detailed examination, but the sections you highlighted (Bonded Caring, Sharing Concern and another section) fit largely with my experience" [Alice]; "Bonded Caring is, as you described it, for me. But I have to admit that outside demands on my time can influence the quality of my 'caring'" [Christine]. In addition, the rough draft was

presented to a group (approximately eight) of lecturers and students at Massey University's Department of Nursing Studies. Again, comments, overall, were confirming. One lecturer, also a mother, stated "This certainly reflects my experience!"

Fittingness. Fittingness, which has to do with the applicability of a study, is evaluated in terms of whether or not the working hypothesis of a study can "fit more or less well into a context other than the one in which they were derived" (Guba and Lincoln 1981,p.118). Guba and Lincoln go on to say that the applicability of a working hypothesis is assessed by the degree of fit between the context within which it was derived and the context within which it might be applied. Sandelowski (1986,p.32) states, "A study meets the criterion of fittingness when its findings can 'fit' into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences".

Glaser and Strauss discuss ideas similar to fittingness using the terms "control" (1967,p.245) and "full variability" (Glaser 1978,p.100-101). In reference to control, a grounded theory that "provides a sufficient number of general concepts and their plausible interactions" (or working hypotheses) provides the person using the theory with "understanding, with situational controls and access to the situation in order to exert control". As an example of this, one participant reported, after reading the rough draft of the analysis, that she had several times visited her doctor about her child's daily bouts of diarrhea. She had been seen by registrars who were working under her doctor's guidance. They either did not identify the health problem and told her "there is nothing" to worry about or had given her no information. She decided that she had had undermining experiences and made a request to see her doctor rather than the registrars. As a result the problem was identified and a

referral was made.

Full variability refers specifically to the core category as a basic social process and is discussed in Chapter Eleven as it applies to Bonded Caring. It means that the core category arises in situations where the context may be different, but the structure of the situation gives rise to the basic social process. Therefore, as demonstrated in Chapter Eleven, Bonded Caring may be found in the caretaking of elderly parents by adult children or in a twin relationship.

The applicability, or fittingness, of a grounded theory may also rest upon the degree of saturation of the theory. Saturation, according to Glaser and Strauss, is reached when the researcher finds no additional data with which to develop properties of a category. With reference to the category, the same properties are seen over and over again in the data. Saturation is further established if the researcher has used the widest possible variety of data sources in an attempt to "stretch diversity of the data". The theory of Bonded Caring is not saturated in any area and is mainly an indicator of what is happening when women with dependent children make health care choices.

Confirmability. Confirmability as a criterion for neutrality means that the researcher should "report his data in a way that it can be confirmed from other sources if necessary" (Guba and Lincoln 1981,p.126). This, according to Guba and Lincoln, "shifts the burden of proof from the investigator to the information itself". This is, perhaps, fulfilled by the discussion of the grounded theory's fit with literature. The fit with literature includes data from other studies which can be used to supplement the study's database, and the literature as it supports or has findings which are different from those of the study (Strauss 1987, p.281-282). In this study, the literature search connected with the various categories did not occur until after the basic social process was

identified and sampling had stopped due to time constraints. Literature which supports the grounded theory and suggests areas for further exploration in the various categories has been included in the discussion following the category. The literature search has not been exhaustive of all possibilities. In addition, accurate description of the study's sample would allow others to confirm the data by checking with persons whose characteristics are similar to those included in the sample. A description of the sample is included under Procedure in Chapter Four.

Implications for Theory, Research and Practice

A single nursing theory is incapable of encompassing, explaining and guiding all aspects of nursing practice (A. Meleis, November 20, 1990). Nursing, according to Meleis (1985,p.65) has moved in a convoluted fashion from a solely received view approach to theory and research towards a perceived view "that accepts values, subjectivity, intuition, history, tradition and multiple realities; a view that is more congruent with nursing and its commitment to human beings" (p.68). This view is mirrored by the activities of the women in this study who tried various ways of managing a health concern and when one made a difference, they incorporated it and its philosophy into their own approach. As a result, the health care tactics and strategy of more than one philosophy of health could be used.

Theory, research and practice are, ideally, interdependent. When a nurse begins practice, the pattern of her work reflects the philosophical underpinnings of the theory and research on which it is based. This base was acquired during nursing education. As time passes and the nurse becomes more proficient, she develops theories about what might work, tries them and incorporates the results into her knowledge base. Benner (1984,p.178) states,

"Experience refers to a very active process of refining and changing preconceived theories notions and ideas when confronted with actual situations." She further states (p.187), "The theoretician must always depend on the practitioner for clinical knowledge development and for finding puzzles and questions that current theorizing does not predict or cover."

Theory. In the home, the woman is the practitioner, and theories must include "puzzles and questions" that are a concern to her as she carries out health care for her family and herself. In the case of this grounded theory, the initial research question was, "What is happening when women with dependent children make health care choices?" The experts, women with dependent children, were interviewed. Some of their questions included: Taking into consideration the seriousness of the health concern and my structural and personal resources, when a health concern is outside of my knowledge, who is most suited to provide the knowledge and assistance I need to understand and manage the health concern in a way that is safe and that makes a difference?; Will this person recognise and respond to my concern?; Will this person provide knowledge and assistance in a way that acknowledges my level of experience? Exploring the kinds of questions a client has about health care assists the development of theories that make a difference for the nurse and the client.

For the women in this study, their experiences and reactions to nurses they consulted in a community situation were different from their experiences and reactions to nurses they encountered in an institutional setting. An obvious example is that nurses in the community may visit the woman at home while the woman goes to the nurses in an institutional setting. While many of the categories associated with Bonded Caring will be evident in each setting, there may be differences in the way they manifest. Therefore persons attempting to use this substantive theory must consider its origins.

Bonded Caring explains some of the work participants do on an ongoing basis. Their work is done at home before and after a health care consultant is contacted, and during the consultation. Sharing Concern explains how the women hoped health care consultants would respond to support their concern. It arose from the analysis of community based and institution based situations involving a variety of health care consultants. However, as an unsaturated grounded theory, it reflects more of the community focus.

Many of the categories that emerged in Bonded Caring are found in other research (Blaxter and Paterson 1982; Locker 1981; Norton 1990), describing women and health care of families and children. In addition, some categories are found in other grounded theories (Bowers 1987; Christensen 1990; Sandelowski, Harris, and Holditch-Davis 1989). This indicates there is potential for the development of formal theory.

Research. As stated earlier, Bonded Caring is an unsaturated grounded theory. The analysis shows that literature exists indicating that the contributing categories are not new to research. It also shows that certain categories, such as Try and See and Sharing Concern, are processes. Further exploration of each category and process would extend knowledge about their indicators, contributing categories and connections, thus providing further density to Bonded Caring.

Of the six levels of health care identified by the women in this study, curative health care and some supportive health care practices are associated with medical care. Research exploring the ways each of the other levels of health care are managed in the home could provide valuable knowledge with which nurses can encourage and support women as they learn to manage health on each level.

Many women are using health care tactics and strategies

(Ways) derived from a variety of sources such as culture, complementary therapies, personal experience, nursing and medical advice. Nurses could explore the philosophies that underly these sources and conduct research to discover how and under what circumstances the health care tactics and strategies that arise from them make a difference. One result would be that nurses could understand and use ways of managing health concerns that derive from a variety of philosophies in addition to those that arise from germ theory. Another result would be that women using non-medical means to manage health care would be able to discuss them and receive support.

Women caring for their children and themselves need information about developmental changes and changes that signal a health problem, about ways to manage them, support and affirmation. In order to provide this the orientation of nursing must shift (van Maanen 1990,p.914; Watson 1988,p.175) from supporting cure as a main focus to supporting care. Supporting cure need not be abandoned and should continue when a health concern requires curative health practices. However, in other circumstances, such as when the woman is the primary care provider, supporting care becomes necessary. Further research would possibly show that the two are not mutually exclusive, but can occur simultaneously. Research designed to investigate women as care providers and how nursing can support their activities would reflect this shift in orientation.

Research that explores how women support each other in providing health care both informally (Expert Mother) and formally (support and self-help groups) might provide nurses with ideas about how to cultivate and support these activities.

Practice. Practice that arises from this grounded theory will reflect the assumption that people are conscious agents with feelings and emotions, and that their activities are purposeful (Bulmer 1984,p.28-29). The

theory uncovers processes that show the conscious selectivity, balancing and juggling of resources to achieve health care that is part of motherhood. The women in this study carried out an active and ongoing effort as they monitored their own and their children's health concerns. The constancy and attentiveness of their efforts make them experts in knowing about their own and their children's health and wellness. Awareness of the necessity of the woman's development of expertise in these areas suggests that the nurse's role would be to work alongside the woman and to provide nursing care that matches and supports the woman's efforts. This is a step towards two aspects of the nurse's role in the community as recommended at the 75th session of the WHO executive board (1985 in van Maanen 1990,p.922). It was recommended that:

The role of nurses will change as more of them will move from the hospital to the everyday life in the community, where they are badly needed.

Nurses will become resources to people rather than resources to physicians, they will become more active in educating people on health matters.

Examples from some of the major contributing processes will follow.

Observing, Interpreting and Integrating Signs. A nurse can help a woman to further develop her skills by using the contributing categories of Observing Signs, Comparing, Looking Forward, Looking Back, Checking and Keeping Watch while talking with her. A nurse could Find Out by asking questions such as, "Does this occur in the family history?" or, in the case of a chronic health concern, "How does this episode compare with previous ones?" or, "How do you see this affecting her future?". Or, when a health concern is initially presented, in order to hear about the signs the woman has observed, a nurse could ask, "What brought this to your attention?" or, "Tell me what's happening". Questions like these will encourage the woman to talk about her own observations,

interpretations and concerns. They can also affirm her skills in these areas.

Striving to Know What and Striving to Master. In Striving to Know What and How (Mastering) a woman who is inexperienced with a health concern can be given detailed information about its process and management. Alternatively, a woman experienced with a health concern can be given the information she requests and might also be asked to share health care tactics she has used and found to make a difference.

The women approached health care consultants to find out what was happening and to learn ways to manage it. This suggests that methods that can be transferrable to a home situation are preferable. For example, if a woman is taught to express her engorged breasts by switching on a pump while in hospital, she will be unable to care for herself if her breasts become engorged at home. It may require more time to teach a woman to manually express her breasts, however it will provide more confident management of the problem when it arises at home.

Try and See. Through the process of Try and See, the women developed and discovered health care tactics that make a difference. Ways need to be developed to encourage women to share their successes with each other. Two possibilities are first, nurses could assist women to establish support and self-help groups to address particular health concerns. Secondly, health clinics could be designed to simulate interaction among the women who are attending. One possibility is that women could be given group appointments. The discussion of health concerns and sharing of information could be stimulated while the women take turns seeing the nurse.

The possible implications for practice given above are logical deductions based on the grounded theory of Bonded Caring and require validation through research at the

practice level. This section has covered implications of Bonded Caring for theory, research and practice. It is suggested that to support Bonded Caring nurses need to move towards an orientation of supporting care; to investigate a variety of theories of health care; and to act more as a catalyst and resource to stimulate, guide and provide information as needed to women as they provide health care. The next section will conclude the thesis.

Summary

It is the aim of this section to highlight the main themes of the foregoing research report. It reviews the research question, research method, sample, interviewing, the grounded theory, Bonded Caring, and some implications for research, theory and practice.

Research Question. As a nurse and a client I had experienced and observed health care services that resulted in frustration and additional problems for the client. I reached the conclusion that health care that did not match the client's self-identified needs and desires concerning health care often became wasted health care. The research question arising from these observations was, "What is happening when women with dependent children make health care choices?"

Research Method. Strategies of grounded theory was chosen as the research method. Its underlying pragmatic philosophy is that people are conscious agents with feelings and emotions and whose activities are purposeful (Bulmer 1984,p.28-29). This fits with the assumptions underlying the research question. The research method included carrying out in a cyclical fashion data gathering using in depth interviews; sampling; analysis that including coding, memoing and integrative diagramming; and literature review. The analysis uncovered the basic social process Bonded Caring as the core category and its

contributing categories.

Sample. The eleven participants came from five cities within the boundaries of one area health board. They ranged from 20 to over 50 years of age. Their children ranged from prenatal to 17 years of age. One participant had two grown children not living at home in addition to her seven year old. Three participants were single parents. Eight were European (caucasian), two were Maori and one was Chinese. Two used primarily complementary therapies; six used primarily medical care; and three used a mix of complementary and medical care. All participants valued doing the best they could for their children and themselves within the context of their situation. All were articulate.

Interviewing. The eleven participants contributed fourteen indepth interviews. The interviews lasted an average of 90 minutes and resulted in approximately 200 pages of typed, 1½ spaced, data. Early interviews were unstructured. Women using complementary therapies were asked to describe how they came to use complementary therapies. Later interviews were semi-structured to gather data about categories arising from the analysis.

In addition to the interviews, ten participants reviewed a rough draft of the analysis (one had moved away and could not be located). They provided written comments concerning the basic social process, Bonded Caring, and one other section of the analysis. Nine participants returned comments. One stated she had read the analysis but has not returned a written comment. Overall, participants agreed with the analysis and provided additional examples in some areas. Suggestions were also made concerning omissions in the analysis.

Grounded Theory. The basic social process, Bonded Caring, became the core category that emerged from the analysis. Bonded Caring requires an intimate and ongoing relationship

in which there is development of indepth knowledge of the unique characteristics of the person(s) involved [Skills of Knowing]. It is characterised by a strong and enduring affective quality, by concern, worry and serious attention to the needs of the person(s) involved [Evaluating Risk; Striving to Know What; Striving to Master]. This concern necessitates the gathering of information about the nature of needs, and making the best possible choice concerning their management [Finding Out; Information Resources; Sharing Concern].

Just as the researcher is a tool for analysis, the women use themselves, their own experience and acquired knowledge as their primary tool for the provision of health care. When they determined that the needs of the health concern were outside their own knowledge, they sought help from sources selected according to the urgency of the need; the woman's perception of the person's or health care consultant's ability to deal with the health concern; and contextual concerns such as cost and proximity, and personal resources.

When a woman seeks help she expects the health care consultant (or friend or family member) to share her concern. Sharing Concern is a response to and support of Bonded Caring. The resource person provides information and assistance with a degree of goodwill, concern and serious attention to the woman's concerns. Based on her perception of the interaction, a woman may decide her experience with a health care consultant has been affirming, efficient, tolerable, or undermining.

An affirming health care consultant provides emotional and social support to the woman as well as competent technical skill and needed information. This is matched to the woman's level of experience. The woman feels affirmed in her work and acquires needed information and skills which she can use at home to provide health care, thus Bonded Caring is supported.

During the search for knowledge and skills needed to carry out health care, the woman assesses her own knowledge and experience; the level(s) of health care needed by each individual; the availability, competence and expected response of the resource person or health care consultant; the perception of the risk associated with a health concern and the family's culture and lifestyle. The elements are considered within a framework of finite material and personal resources. The woman juggles the distribution of the resources in a way that allows her to select the avenues of health care that provide the best degree of safety and protection of development within the context of her circumstances.

Implications for Research. This grounded theory is not saturated and exploration of its processes and categories to further delineate their characteristics and connections is warranted. Research of an exploratory nature is needed to find out what is happening when the Bonded Caring process breaks down or appears absent within a family.

The participants would incorporate a way of dealing with a health concern into their knowledge when it made a difference. As a result they could be open to a variety of philosophies as long as the health care strategies made a difference. Therefore research to discover what successful health care strategies women use in the home to deal with specific health concerns might be carried out.

Theoretical Implications. The research that generated Bonded Caring suggests that women develop their own substantive theories of health care based on cultural and lifestyle considerations and the experience of trying to see what works. Because the women accept health care strategies based on what is effective, they are able to accept strategies from a variety of philosophical backgrounds. Nursing needs to support this by providing theories that support the use of effective health care

strategies from a variety of philosophical backgrounds, and accept that what works for a client and is safe is valid. Theories need to encourage nurses to find health care strategies that match clients' needs. This can only be done by understanding the client's health care desires and existing expertise. Nursing needs to support this by providing theories which support more than one approach, encourage finding ways that match the client's needs, and accepting what works for the client.

Bonded Caring provides a beginning understanding of the work and effort that supports the women's expertise in the health and wellness care of their families. It also contributes to the knowledge available about the client's work, particularly in the community setting, in the nursing partnership as described by Christensen (1990) in her grounded theory.

The processes uncovered in this research are similar to processes found in inter-generational caregiving. This provides a beginning foundation for a higher level of formal theory in the future.

Implications for Practice. Nurses working with clients will need to find ways to support the processes the client is using as she engages in Bonded Caring activities. Ways might be found to help women to help each other and to support and re-create the sharing and support of relationships that is essential to women's work. In addition, nurses must become familiar with lay literature and the variety of ways available to manage health concerns. Thus a community based nurse can become a resource person for women exploring avenues of health care.

Conclusion. In conclusion, Bonded Caring is a theory in process. It makes visible some processes that occurred when the participants made health care choices. As they engaged in the processes of Bonded Caring, the women repeatedly juggled and balanced a number of elements

(lifestyle, risk, timing, cost, health care consultant characteristics, needs of family members, etc) in order to make health care choices that protected and supported the development of their children and themselves. The women's constant effort and attention to the health and wellness of their children and themselves means they develop an expertise in this area that is often unrecognized. Recognition of women's development of expertise as they provide health care for their families means nurses working alongside women must focus their practice to support women as they develop this expertise. Nursing theory needs to include recognition of the woman's skills and expert knowledge in the area of family health care, and research needs to be carried out to determine practices that are affirmative and facilitative to women as they carry out health care for their families.

APPENDIX 1

CONSENT TO REQUEST VOLUNTEERS ON CLINIC/FACILITY PREMISES

I am willing to allow Beverly Ann Enslow, a student of Massey University's Nursing Studies Department in the Master Degree program, to request volunteers for her research in my clinic/facility.

The purpose of the research is to explore the elements involved in health care choices of women with dependent children. I understand that it is not the purpose of the study to evaluate my clinic/facility or my skills as a professional.

In order to protect my privacy, my name and the name of my clinic will not be identified in the interview transcripts or research reports.

The request for volunteers will consist of a form that briefly explains the purpose of the study and a sealed box to collect forms completed by volunteers. Beverly Enslow will check it daily or every second day at the least. It will be removed after two weeks or less.

I will be given a summary of the research findings when the report is completed (approx. 9 to 12 months). Other than this there are no tangible benefits for allowing the request to take place in my clinic/facility.

I may withdraw my consent at any time.

SIGNED

Clinic/Facility Manager

Beverly Ann Enslow
Student/Researcher

DATE

APPENDIX 2

CONSENT TO BE INTERVIEWED

I am willing to be interviewed by Beverly Ann Enslow, a student of Massey University's Nursing Studies Department in the Master Degree Program, and give consent for the interviews to be used as data in her research project.

The interviews are part of a study to explore what elements are involved in health care choices by women with dependent children. It is not the purpose of the study to evaluate the skill of my doctor, naturopath, or other health care provider. It is also not the purpose of the study to evaluate my own abilities or choices in health care.

Involvement in the study will consist of two or three face-to-face interviews and possibly some telephone interviews. A tape recorder will be used during the face-to-face interviews. However, I may ask that it not be used if I wish. Any questions concerning the research are welcome.

In order to maintain confidentiality, initials will be used in the interview transcripts rather than names. All forms of identification will be kept separate from the interviews. A supervisor may need to see the transcribed interviews, however she will not have access to names and addresses. Confidentiality does not apply to illegal activities.

I may withdraw from the study at any time. I may also withdraw my permission to use any completed interviews. In this case the transcribed interviews will be destroyed and the cassette recording will be erased. This consent will be reviewed at each interview.

I will receive a copy of the summary of the completed report.

SIGNED

2ND INT.

3RD INT.

Participant

Researcher

DATE: _____

APPENDIX 3

VOLUNTEERS NEEDED FOR RESEARCH STUDY

A study concerning health care choices of women with dependent children is being conducted by a student in the Masters Degree Program of the Nursing Studies Department at Massey University. Women with at least one child of 18 years of age or under are needed for interviews. The women or their child(ren) will need to have had a health problem within the last year. Participation in the study will involve two or three interviews of approximately 1 to 1½ hours length in time. There will also be one or two phone calls. If you are interested in being part of this study, please fill in the form below and put it in the box provided, or call me at 696-469.

NAME

ADDRESS

PHONE NUMBER

NUMBER AND AGES OF CHILDREN

What is the best time for me to call to arrange an appointment?

APPENDIX 4

LETTER SENT WITH ROUGH DRAFT OF THE ANALYSIS

14 Anderson Grove
Lower Hutt

9 August 1990

Dear

Greetings. It has been some time since you participated in an interview for my research 'Health Care Choices of Women with Dependent Children'. I am nearing completion with the analysis and am requesting your assistance once again. Enclosed you will find a rough draft of my analysis. I want to know if it does or does not fit with your experience. The analysis is fairly lengthy and I do not wish to impose upon your time. So, I am asking for your comments on two portions of the analysis. You will note that the outline (pages 1-3) has two sections circled in orange. If you could read and comment on these two sections and their subheadings in the small notebook which is provided, I would appreciate it. Please record whether or not these sections of the analysis are similar to your own experience. If your experience is different, please provide an example of how it is different. If you wish to comment on other sections, please do.

Enclosed, you will also find a consent form (another one!) which allows me to use your interview and comments for professional purposes. If this is agreeable, return the signed form and the notebook with your comments on the analysis in the self-addressed, stamped envelope. It would be most helpful if these could be returned by August 1990.

My Appreciation,

Beverly Enslow

Encl:

APPENDIX 5

CONSENT TO USE DATA PROFESSIONALLY

I, _____ give Beverly Ann Enslow, student of Massey University's Nursing Department in the Master Degree program, permission to use data obtained through interviews in which I participated. The data will be used to complete a Master's Degree thesis. It may also be used as part of a report for professional publication, or for presentation of the research findings at a professional meeting. In order to protect my privacy, my name will not be associated with the data.

SIGNED

Participant

Beverly Ann Enslow
Student/Researcher

APPENDIX 6

LETTER AND RESEARCH REPORT FOR PARTICIPANTS

14 Anderson Grove
Lower Hutt

26 January 1991

Dear

It has been some time since you consented to be interviewed for my research about Health Care Choices of Women with Dependent Children. I have completed my research and written the thesis (research report). I want to thank you for your time and interest. Your interview was a valuable source of information for this research and I appreciate your willingness to share yourself in this way.

As promised, I have enclosed a summary of the research. Although I have made some changes, the summary plus the rough draft of the analysis should provide a good idea of the results of the research.

Once again, thank you.

Beverly Ann Enslow

Encl:

.. Research Report

APPENDIX 6 (Continued)

Bonded Caring: Health Care Choices
of Women with Dependent Children

The question for this study came about because as a nurse and as a client, I saw and experienced the frustration and problems well-intentioned health care interventions can cause. After a series of experiences over the years, I decided that making health care assessments and selecting courses of action without knowledge of the client's desires, goals and previous experience with the health concern was a source of the client's frustrations and would cause the client additional problems. Health care that did not match the client's self-determined needs and desires concerning health care was wasted health care.

The purpose of the study was to explore what is happening when women with dependent children make health care decisions. The hope is that this information could be used to find ways to decrease the incidence of frustrating experiences for the client.

Eleven women were interviewed, and three were interviewed a second time. Some characteristics of the women interviewed are shown in Table 1. It is important to know that in spite of social and economic differences, the women expressed themselves easily and held middle class values of trying to do the best they could for themselves and their children. This means that the results of the study do not apply to everyone, and further research needs to be done.

The interviews were typed and analysed. Each sentence was divided into phrases and each phrase was given a name that described its main theme or meaning. The phrases were each taped on a piece of paper. This allowed me to group phrases with similar meanings together. Then the groups were studied to see if they were similar to other groups

and could be combined, and to see if there was an order in which they occurred. The rough draft of the analysis shows how the groupings were at that time.

Table 1: Characteristics of the Sample

1.	CITY	HEALTH CARE	AGES OF CHILDREN	MARITAL STATUS	RACE
1.	A	COMPLEMENTARY	16	SINGLE PARENT	EUROPEAN
2.	A	COMPLEMENTARY	15, 17	MARRIED	EUROPEAN
3.	A	COMPLEMENTARY/MEDICAL	7	MARRIED	EUROPEAN
4.	B	MEDICAL	1, 3	MARRIED	EUROPEAN
5.	B	MEDICAL	PRENATAL	MARRIED	MAORI
6.*	C	MEDICAL/COMPLEMENTARY	4, 6	SINGLE PARENT	EUROPEAN
7.	C	MEDICAL	4, 10 mo	MARRIED	EUROPEAN
8.*	C	MEDICAL	1,3,5,11,13	MARRIED	EUROPEAN
9.*	D	COMPLEMENTARY/MEDICAL	4, 6, 6 mo	MARRIED	CHINESE
10.	E	MEDICAL	2, 4	SINGLE PARENT	MAORI
11.	B	MEDICAL	2	MARRIED	EUROPEAN

* INTERVIEWED A SECOND TIME.

** PARTICIPANTS CAME FROM FIVE CITIES WITHIN THE BOUNDARY OF ONE AREA HEALTH BOARD.

*** A MIX OF PURPOSEIVE AND OPPORTUNISTIC SAMPLING, ELEVEN PARTICIPANTS PROVIDED 14 INTERVIEWS OF APPROXIMATELY 90 MINUTES DURATION EACH. THIS YIELDED APPROXIMATELY 200 TYPED (1½ SPACED) PAGES OF DATA.

The rough draft was sent to you to find out if what I was coming up with fit your own experience. In this type of research, it is important that the findings mirror as much as possible, the experiences of the persons participating in the research. Where it didn't, I needed to go back and look at the interviews and phrases again. Your comments on the rough draft were a great assistance in doing this. Changes were made based on the comments.

The purpose of this type of research is to discover in the data (your interview(s)) the motivating impulse, the reason, for the activities that are occurring. In this case I wanted to know something about what was happening as women carry out health care and why they do it.

Bonded Caring is the name that has been given to the motivating impulse for many of the choices and activities of the women taking part in the study. From Bonded Caring arises the willingness to choose to acquire the knowledge and skill needed to carry out health care on several levels for the benefit of the children and the women themselves. Bonded Caring has two main concepts, Social Interconnectedness and Caring. In the paragraphs that follow, I will define Bonded Caring, Social Interconnectedness and Caring. It is important to remember that the definitions arise from the interviews.

Bonded Caring. Bonded Caring requires an intimate and ongoing relationship in which there is the development of indepth knowledge of the unique characteristics of the person(s) involved (in this case the mother and the child). It is characterised by a strong and enduring affective quality, and by concern, worry and serious attention to the needs of the person(s) involved. This concern necessitates the gathering of information about the nature of the needs and making the best possible choices concerning their management (this means if your child has a problem you find out what it is and what to do about it). These choices are made within the context of the current situation (what the health concern is) and includes culture (what you've learned growing up), past experience, your lifestyle, cost, time, travel involved, and personal resources such as your own health and energy. Each of these things are considered when deciding what to do about a health concern. Bonded Caring changes and develops over time as the needs of the child and mother change. The goal of Bonded Caring is to support and protect development. The following quote is taken from a thesis by Valerie Norton (1990), **Women's**

Experiences of Providing Health Care for Their Babies. It is an example of Bonded Caring.

Within the family where health care is provided the relationship is much more intense, creating strong feelings. These may include a range of seemingly conflicting emotions: love, anger, guilt.

... The integrity of the care rests within this family relationship and brings with it responsibility and obligation. The relationship between a mother and her baby is assumed, no matter what that relationship is nor how it is expressed.

Linked to this is the factor of time. ... health care is provided by family members for others in their household 24 hours a day, 7 days a week.' (p.8)

Interconnectedness. The interconnection or bond in Bonded Caring is an intimate and ongoing relationship. The relationship is characterised by a strong and enduring affective (emotions or feelings) quality. This is shown in the following excerpts from the interviews.

And she was getting pretty upset because she didn't know where mama and dada were. [Becky]

■ ■
... my precious baby ... [Ione]

■ ■
But with H. that unspoken connection is always felt ... sounds all esoteric and wonderful, but we can fight like hell as well. [Valerie]

■ ■
I think probably because I love and care for my children ... [Debbie]

■ ■
I had good feelings when I found out I was pregnant. [Ruth]

One result of the ongoing nature of the relationship is the development of an indepth knowledge of the unique characteristics of the person(s) involved. Again, excerpts from the interviews demonstrate this.

But K. who has just turned 12, she will hide it [if she's unwell] until it gets so bad. Whereas Q. will tell you straight away that he's not well. [Ione]

■ ■
It was dreadful that first month [starting diet advised by naturopath]. I said, "What can I feed him? What can I feed

him?" Because he wouldn't eat this and he wouldn't eat that. ... But he doesn't like pears. And other fruits like melon and pawpaw, which are safe fruits for eczema, he doesn't like the taste. [Lauren]

H. woke up in the middle of the night and said she was growing. I said, "Oh, you're growing." And she said, "Yes, because I ate lettuce last night." Alice in Wonderland, maybe. But I'm aware of those sorts of things. [Valerie]

One characteristic of Social Interconnectedness is that what happens to one member affects the other. That is, what happens to the mother affects the child and vice versa. Therefore if a change in a child is developmental it delights the mother. However, if a change signals a health problem it causes worry, concern and sometimes, physical repercussions such as fatigue for the mother as she attends the problem. Similarly, the mother's state of health affects the child.

A second characteristic is the responsive nature of the relationship. In this study, the women observed signs of what was happening and responded by trying to find out what was happening and how to take care of it. The women's activities were purposeful and suited to the situation and characteristics of the child. This leads to the third characteristic of social interconnectedness, as mentioned earlier, the women changed their responses over time as their children's needs and their own needs changed. The following excerpts show something of this.

I let the older ones do it now [talk to the doctor]. They're old enough to express how they feel. [Ione]

My children, until they became responsible for their own health care, which I feel they must be now at the ages of 15 and 17 ... Once my family, my teenagers are through, I and my husband too, I'm sure will be much more selective of what [foods] we have in our home and quite happily so. [Sarah]

And I realised that some foods were affecting me, but in order to keep going to work, I actually didn't have the energy to change the way I was eating ... I got to the point where I was needing medication in order to just keep functioning. I wasn't prepared to continue that way. [Alice]

Caring. The need to provide care arises because the bond is unequal. The child is dependent on the mother. As a result, the relationship causes a feeling of responsibility and purposeful activity to support growth and development.

Well for me, it's just been the natural course of things that I suddenly think, "Oh yes, it's a good idea, I'll do this with her now or that with her." [Becky - referring to developmental changes.]

■ ■
Because I'm that much older, I thought I better make sure I'm feeding [breast feeding] him right, and I better make sure I'm eating right and this sort of thing. [Kelly]

■ ■
It's quite a lot of responsibility ... [Ione]

■ ■
And I know it's to do with mental health, but just try and do things as a family rather than push your kids away all the time. Have outings as a family and get out in the fresh air and explore different things. [Debbie]

■ ■
I started teaching her [jigsaw puzzles] when she was 18 months so that by two, she was able to do it herself. [Rachel]

When problems arose, the women purposefully observed what was happening, interpreted what it meant and integrated the observations and interpretation into their own knowledge, by looking back over past experience and comparing the current problem with past problems in order to put a name to what was happening. At the same time the women were evaluating the risk associated with the problem and deciding what level of health care was needed in order to take care of it. If more information or assistance was needed, the women contacted friends, family or health care consultants. When they did this they hoped the person they contacted would share their concern. Four styles, associated with whether or not concern was shared by a health care consultant, were identified: affirming, efficient (formerly competent), tolerable (formerly okay), and undermining. (Please note that underlined phrases correspond with sections of the rough draft.)

Making the best possible choice means the women were

selective about the health care they provided and the assistance they sought for a health concern. The women's perception of their own situation, knowledge and abilities, of the risk associated with the health concern, and of the capabilities of the health care consultants to whom they had access were all considered when selecting the avenue that would result in health care that makes a difference.

The research shows some of the work that you, as participants in the research, do as you manage the health and wellness of yourselves and your families. It is hoped that this will assist nurses to recognise women's expertise in this area and to support them as they provide health and wellness care for their families.

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