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Clients' perceptions of health visiting in the context of their
identified health needs: An examination of process.

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This study aimed to explore the process by which members of a client group identify and interpret their health needs, and develop perceptions of health visiting services.

The study was carried out in two Phases. The first Phase used semistructured interviews and diaries to explore 41 parents' perceptions at one point in time. In Phase Two a series of three semistructured interviews were completed over a ten month period with 19 primiparous parents, commencing antenatally, and with 10 of their health visitors. Analysis was by the grounded theory method.

Eight concept areas emerged from the interview data. These were:

> Health, health problems and other concerns
> The need for help – locating the problem
> Knowledge and experience
> Legitimation
> Advice, support and comparing notes
> Choosing a helper
> Relationship or problem centred
> Power and control

A substantive theory is put forward which suggests that the nature of previous knowledge and the types of problems encountered influence the choice of helper and the degree of parental control desired at each stage. At stage one health is predominantly defined as socio-emotional, in line with social norms. At stage two, practical difficulties, especially with feeding, become important. At stage three, as other aspects assume less importance, the social norm appears to reassert itself. At stage one, independence is valued, but at stage two, parents assume a more dependent role. At stage three, parents feel more confidence in themselves. 'Comparing notes' offers a reciprocal helping relationship. The value attributed to the health visitor's involvement at each stage appears to reflect how far her views diverge from those of the parent concerned.

The recommendations identify changes of practice which will firstly improve communication between health visitors and clients, and secondly focus on the development by health visitors of appropriate knowledge and skills to meet the demands made by clients.

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Chapter One

Introduction

This chapter attempts to set in context what follows. It begins with a statement of the aims of the study, and continues with a discussion of the background out of which it arose. Brief reference is made to some of the significant work in related areas, discussed more fully in Chapter Two. The structure of the research is then described, and an outline given of the content of the thesis.

*   *   *

Aims

The study's aims were as follows:

1   To explore the process by which members of a client group identify and interpret their health needs

2   To examine the process by which members of a client group develop perceptions of health visiting services

3   To compare clients' process of identification and interpretation of health needs and their perception of health visiting services with those of health visitors

4   To make a comparison between the perceptions of clients from Priority Areas and those from Non-Priority Areas.

The background to the research

Consumerism

Both the Griffiths Report (on Health Service Management) (1983) and the Cumberlege Report (on Community Nursing Services) (1986) discuss the importance of taking into account the views of consumers when planning and operating health services. Consumer based research is commonplace in the commercial field, but, possibly because of the profession-centred philosophy of health care, has been slow to develop in the health area. The traditional belief that 'doctor (or nurse) knows best' has died hard, and the undercurrent of consumerism represented commercially by such publications as "Which?" magazine is only now beginning to percolate substantially into health care. Consumer involvement has often also been seen as threatening by health professionals who face a potential reduction in their power, as clients demand more information, and greater choice (Renshaw, 1987). Finding out what consumers think about health services is a first step towards change.

Despite a slow start, there have been a number of distinguished consumer based studies in the area of health care. As far back as 1964, Cartwright looked at medical and nursing services from a consumer perspective, interviewing 739 patients who had recently been in hospital, and finding one fifth of them critical of the care given by nurses. In 1967, Winifred Raphael undertook a now

well known piece of consumer research for the Committee of four hospitals, which found a high level of satisfaction with the care given, but that patients would have liked a say on issues such as their time of getting up. Since then, an increasing number of studies have been carried out to look at consumer views of health services, and many others have included some investigation of this area.

Health visitors and clients' views

The present study arose out of the involvement of the researcher as a health visitor in a child health intervention project (see Pearson 1985). Part of her work in this involved her with informal groups of clients who frequently asked her questions or delivered opinions about health visitors and child health services, and made her aware that she actually knew very little about how clients saw them.

Health visitors are registered general nurses who have undertaken a further year's study in a higher education establishment, to expand their knowledge and extend their skills in relation to promoting health and preventing disease in the community. They are involved with a wide variety of groups and individuals, representing all facets of the community, but predominantly with families with children under five, and elderly people. Home visits to these groups represented 71% and 18% respectively of the total recorded in Clark's 1973 study. In addition, health visitors are involved in child health clinics - health authority

and general practice based - as well as many other specialist sessions and groups, for about 15% of their time (Clark, 1981) .

Over the past ten years, there have been around 35 studies in the U.K. of parents' attitudes to child health services, as well as a number of others - for example looking at maternity services - which have touched on this area. However, only two studies have looked specifically at clients' perceptions of health visiting. Both used a social policy perspective as a starting point. Jean Orr, (1980), made a study of the views of 68 mothers in Northern Ireland, using structured interviews. She investigated their views within a framework which suggested that fragmentation, inaccessibility, discontinuity and unaccountability might be responsible for many of the difficulties encountered by clients. The study demonstrated that clients looked at health visiting from two perspectives - relationship centred and problem centred. Jane Robinson, in a study of 13 mothers published in 1982, confirmed this finding, and indicated that health visitors held similar views. She suggested that clients saw 'good' health visiting in respect of themselves as relationship centred, but used a problem centred model in respect of other people. No study has looked in depth at the perceptions of any other client group of health visiting.

Why are clients' views of health visiting important? A social work journal recently published a cartoon, in which an elderly person was shown chatting to a friend and asking - "Health visitors - are they the ones who come round every week to explain

their role?". What health visitors actually do, and what they ought to do has been discussed by professionals in this and related fields for many years. Doctors, social workers and other professional groups have frequently and vociferously put forward their views (see Barber and Wallis 1976, Clarke 1980, Perkins and Spencer 1986,for examples). The cartoon highlights the fact that few generally agreed decisions have been reached, and that health visitors seem to spend a lot of time explaining what they do, to everyone with whom they work.

Clients have rarely been asked for their point of view on the debate, yet they too have ideas and opinions to share. If they do not contribute, the quality of service offered to them will be less than optimum. Services will be designed primarily to suit health professionals, potentially alienating those clients who find it more difficult to express dissatisfaction with the status quo. To some extent it seems that this is already the case. Some groups of clients use health services noticeably less than others. Wedge and Prosser (1973) indicated that one in three disadvantaged children in their cohort study never attended a child health clinic, compared with one in five other children. Robinson (1982) summarised the situation which led her to undertake her study with a quote from the 1978 Eleanor Rathbone Lecture:

> "The most important failing of our present child health services is that the children who need them most use them least" (Right Honourable David Ennals)

If health visitors are to 'stimulate awareness of health needs' and 'facilitate health enhancing activities' - to quote the Council for Education and Training of Health Visitors (1977) - amongst all their client groups they must develop a clearer insight into clients' perspectives. This will be essential to an understanding of how best to offer an effective health visiting service.

Client groups however are not homogenous. In examining their views this needs to be considered. Mayall and Grossmith (1985) indicated that use and perceptions of child health services vary significantly according to social class. Simms and Smith (1984) found that 90% of a sample of teenage mothers were satisfied with the child health services received - a rather higher proportion than found in studies spanning a wider age range. Other client groups may be expected to use different criteria to judge the service received. In looking at consumers' views of health visiting, and indeed of health need, it is important to take into consideration some of these variations. The present study attempts to look to a limited extent at the influences of socio-economic groupings on consumer perspectives.

Health visiting is also a process. By its nature, it takes place over, usually, a lengthy time period, involving a number of interactions. Some of the studies already mentioned indicate that its relevance is seen differently at different points along the continuum. It seems possible that perceived (and actual) need may

also vary over time. This study therefore examines not only clients' perceptions of health visiting in the context of their identified health needs, but also looks at the process whereby those perceptions arise and develop or remain static, using a series of three interviews over the first year of contact.

In considering clients' perceptions of health visiting, it is also important to make some comparison with health visitors' views in more or less the same general context. Robinson (1982) asked health visitors to assess parents' response to health visitor home visits and clinics, but did this in general terms and retrospectively. The context in which interactions take place may alter over time. Interactions in general may be viewed differently to specific cases. In this study health visitors perceptions of their interactions with clients are therefore explored, including their development or otherwise over time, in a parallel series of interviews. In this way, areas where mismatches occur can be identified, and possible reasons explored.

The structure of the research

As the study is quite complex, a plan of the structure of the research is given at this point (Figure One) in order to clarify it for future reference. The primary focus of this thesis is on material from Phase Two, although some comparisons will be drawn with Phase One data. Detailed discussion of the method and of problems encountered will take place in Chapters Four and Five.

The fieldwork for the first phase took place in the summer and autumn of 1984. That for the second phase commenced in spring 1986, and was completed in summer 1987.

Fig 1

STRUCTURE OF THE RESEARCH
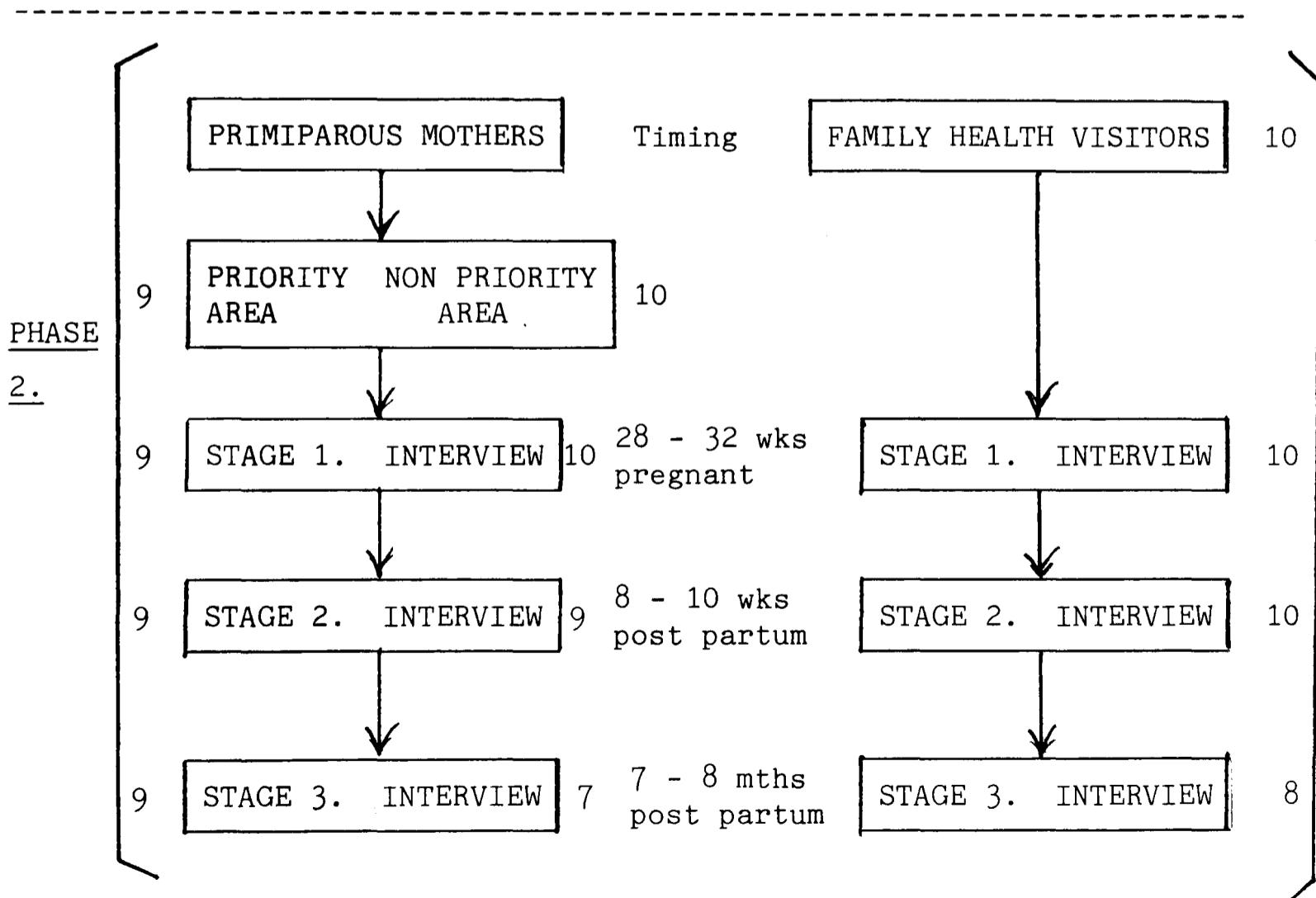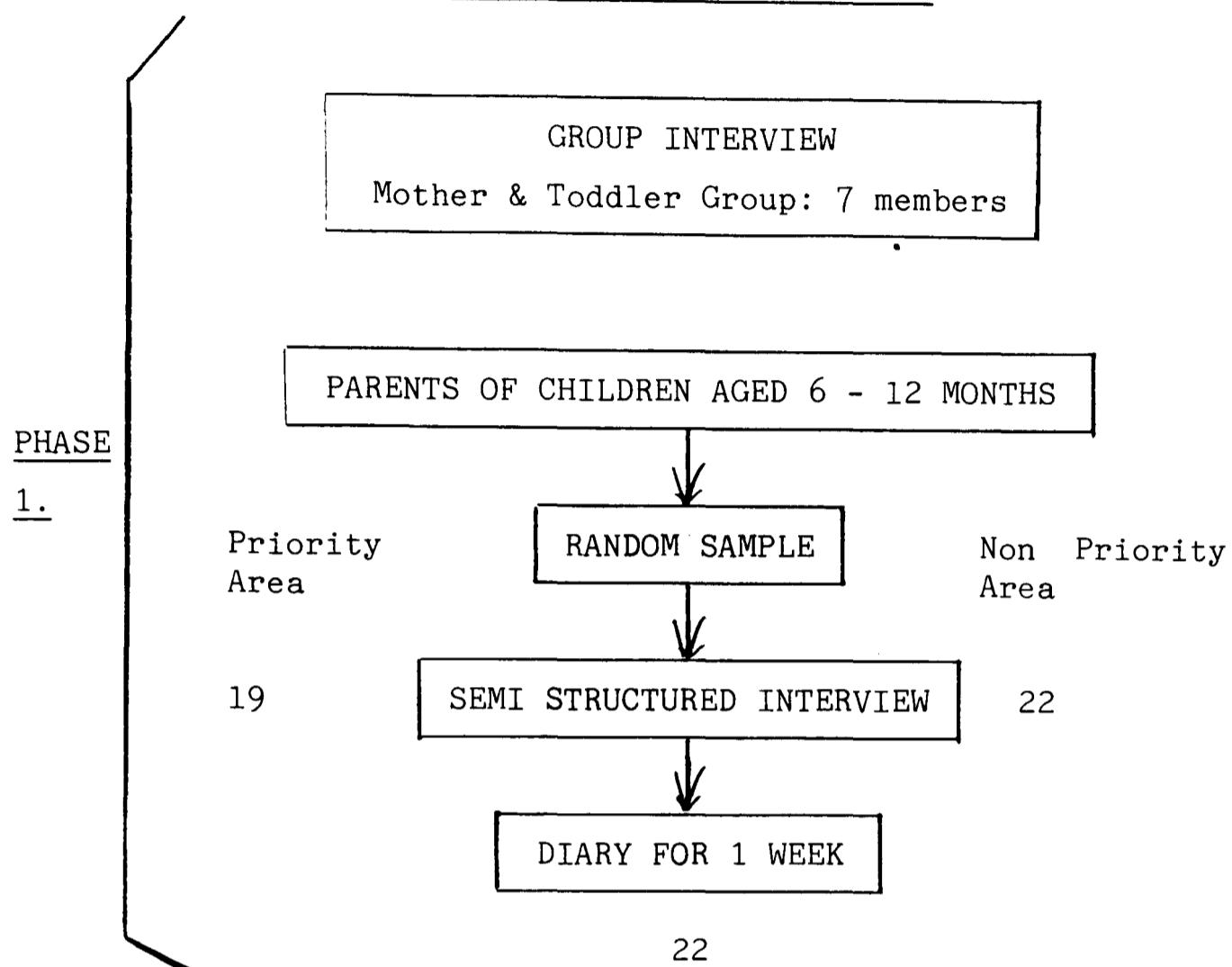
The Content of the Thesis

This section outlines the main features of the thesis which follows, and briefly summarises the main conclusions.

Literature Review: Chapter Two

In Chapter Two, literature relevant to the study area is discussed. Material on health, health needs and health knowledge is outlined. Studies examining child health services in general terms, and parents' attitudes to these, are described. Research about health visiting is considered. Whilst most studies of health visiting take a professional viewpoint, consumers' views have been the subject of some research, which is reviewed in more detail. Studies looking at clients' perspectives of nursing and of social work are also described for comparison purposes.

Theoretical Perspectives: Chapter Three

This study was undertaken from a symbolic interactionist perspective, focussing on the meaning attached to health and to health visiting by clients. Chapter Three outlines the main features of the interactionist approach, and describes the five main methodological options to which this approach gives rise.

Description of Methods Used: Chapter Four

The methods chosen to undertake the study are described in

Chapter Four. How samples were obtained, the design and use of research tools (interviews and diaries), and the process of analysis are considered. The use of tape-recording and transcription are also expanded upon. The development of grounded theory is described. The use of a case study approach to the examination of process in phase two is discussed.

Methodology - a Discussion: Chapter Five

Chapter Five discusses issues arising from the methods used. Issues relating to the categorisation of respondents by occupation or class, and social stratification, are considered in some detail. Difficulties arising in interviewing, particularly those relating to gender and class, and problems arising from repeated interviewing are described. Problems relating to the context of the research, and possible affective biases are discussed.

Results - The Context: Chapter Six

In Chapters Six to Ten, the results of the study are described. Chapter Six starts with an outline of the way in which the results are set out. It continues with the presentation of some simple quantitative data about the samples used - for example the age, employment status and social class of respondents, which is intended to place the interview material, discussed subsequently, in context.

Results - Parents-to-be: Chapter Seven

The next four chapters (Seven to Ten) describe how the themes and categories which were drawn out in the analysis of the data developed through the stages of the study, and examine comparisons between them. In Chapter Seven the main concept areas arising in parent interviews at Stage One of the study are discussed, with an outline of the main themes and comparisons. Mothers-to-be were around 28 - 32 weeks pregnant at this stage. Comparison is also made between responses from Priority Area and Non-Priority Area parents.

Results - Life with the new baby: Chapter Eight

Chapter Eight describes the themes and categories encountered in parent interviews at Stage Two of the study, when the baby was around eight weeks old. Changes and developments since Stage One are discussed. Priority Area / Non-Priority Area comparisons are again made, though few differences are found.

Results - Gaining confidence?: Chapter Nine

In Chapter Nine the content of the Stage Three interviews with parents is discussed. These were undertaken when the study babies were approximately seven months old. Themes and categories arising here are discussed, and compared and contrasted with those from earlier stages. Priority Area and Non-Priority Area data are looked at once again. Material from Phase One interviews

is also considered, where this appears to be illuminating. Phase One interviews involved parents of children aged between six and twelve months.

Results - The health visitors' view: Chapter Ten

The health visitors of half of the children involved in Phase Two were interviewed on three occasions, each about two weeks after the parent interview. In Chapter Ten, the health visitor sample is described. The themes arising from the health visitor interviews are outlined, and compared and contrasted with parent views. Themes found in each category are discussed stage by stage, sequentially, in the relevant section. Patterns emerging can thus be readily followed, and contrasted with those arising in parent interviews.

From Themes to Theory: Chapter Eleven

Chapter Eleven builds on the preceding results to develop a substantive grounded theory. The eight main concept areas which emerged from the interview data are outlined:

> Health, health problems and other concerns
>
> The need for help - locating the problem
>
> Knowledge and experience
>
> Legitimation
>
> Advice, support and comparing notes
>
> Choosing a helper

Relationship or problem centred?

Power and control

Each is explored in turn, considering the themes from which it is developed, and changes over the stages of the research. Links are made for each concept with the wider literature. Finally, a substantive theory is put forward, linking the concept areas.

Where should we go from here?: Chapter Twelve

In this chapter, the implications of this study for health visiting practice, management, education and research are described, together with the recommendations which arise from them. Some recommendations relate to more than one area. Twelve recommendations are listed.

Conclusions: Chapter Thirteen

Finally, in Chapter Thirteen, the overall study is reviewed. The original aims are considered, and related to the study findings. The recommendations are placed in the wider context of health care policy.

References and Appendices

The main body of the thesis is followed by two appendices (see below). A list of figures and tables, and an alphabetical list of references cited in the text are attached.

Appendix One: Case studies

Case studies are used to explore some of the main concepts which have emerged in the data as a whole in more depth. Six case studies are considered - three of Priority Area parents and three of Non-Priority Area parents. They offer illustrations of the way in which particular parents and professionals developed themes, and the contexts in which they did so.

Appendix Two: Research Instruments

Interview schedules for phases one and two are appended, together with a phase one diary form. Letters requesting appointments and re-appointments for interview are also included.

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<u>Summary</u>

This chapter has attempted to set in context the remainder of the thesis. After a statement of the aims of the study, it continued with a discussion of the background out of which the study arose. Reference was made to some of the important work in related areas. The structure of the research was described, and an outline was given of the content of the remainder of the thesis, chapter by chapter.

Chapter Two

Literature Review

In this chapter literature relevant to the study area is
discussed. Material on health, health needs and health knowledge
is outlined. Studies examining child health services in general
terms, and parents' attitudes to these, are described. Research
about health visiting is considered. Whilst most studies of
health visiting take a professional viewpoint, consumers' views
have been the subject of some research, which is reviewed in more
detail. Studies looking at clients' perspectives of nursing and
of social work are also described for comparison purposes.

*   *   *

Health

Health is a difficult concept to define. The Little Oxford
Dictionary describes it as 'soundness of body, mind etc.' The
W.H.O. (1948) defined health as "a state of complete physical,
mental and social well being" - rather than solely the absence of
disease. This brings in an extra component, 'social well being',
which considerably extends the range of the concept 'health' from
that of the dictionary. The central theme of this definition,
however, is 'well being'. Dubos (1960) suggests that "health is
not a state of being, it is a process of adaptation to the

changing demands of living and the changing meanings we give to life." On this model, health for a child might be very different from health for a normal adult or for an elderly disabled person. Schulman and Smith (1963) found that for Spanish speaking villagers in the American South West, 'health is a background feature of daily living and of a person's display of his essential normality.' For them, health is a background - by its nature ongoing though it may alter in shape. Goffman (1968) indicates that people who are 'disabled' will utilise various strategies to avoid appearing 'abnormal'. Many of these strategies depend upon others assumptions of normality - of health for example.

Defined on a medical model, health is rather the absence of disease. Barenthin (1975) evaluated the level of dental health in a community by looking at the absence of disease. He also cross checked with clients as to their satisfaction with their own dental health, and found dental status defined as 'unacceptable' in quite a large proportion of individuals who were satisfied with their own dental health. This indicated a difference in definition of health between client and professional, but did not indicate whether the clients were defining health in terms of well being, or of process, or both.

Herzlich (1973) carried out unstructured interviews with 80 middle class lay people (in France) about health, and illness. She found that the factors which were most frequently mentioned in association with health were rhythm of life, fresh air, food

and sleep. This fits in with the pattern of factors thought to affect a child's health by parents in the researcher's preliminary pilot work. Mayall (1986) found that virtually all the 135 mothers in her study of how women care for their children's health 'had high standards of good health for their children'. Health was described in terms of interest, liveliness, continuing development, and good appetite and sleep pattern. Mayall contrasts this with the more limited definition found by Blaxter and Paterson (1982) for working class mothers in Aberdeen describing good health for themselves - the ability to get through the day's tasks and duties. She suggests that there are standards for children's health and development, both formal, professional ones and informal ones developed among mothers, which enable a clearer definition of good health for children than that for adults, where such standards do not exist. Informal standards may also vary according to culture. Women with different lifestyles and resources may have different standards.

Cornwell (1984) made a study of twenty four people's common sense ideas about health, illness and health services. She used extensive taped interviews, and describes two types of account as emerging from the material - the 'public' account and the 'private' account. Public accounts are those which are felt by the informant to be likely to be widely - 'publicly' - acceptable. They

> 'reproduce and legitimate the assumptions which people take for granted about the nature of social reality'.

People can produce such public accounts on most topics which occur in everyday conversation. In producing such accounts for the interviewer, people are not necessarily attempting to mislead her, but "reproducing the culturally normative pattern" (Laslett and Rapoport, 1975). Private accounts on the other hand arise directly out of personal experience and the thoughts and feelings which this engenders. They represent the accounts given to the informants close friends and family. Cornwell notes that the majority of this type of account were given in her later interviews, when she had established more of a relationship. However, the type of account given also varied depending whether the informant was asked a direct question (usually producing a public account) or asked to tell a story (usually resulting in a private account).

She found that the public accounts of their health were put over in common sense terms, from which it was, she felt, obvious that health and illness were "considered morally problematic conditions." People negotiated the meanings of 'health' and 'illness' in their accounts in a way which put them in a morally 'right' position. They would normally attempt to take the 'healthy' position, but if describing illness would ensure that this was seen as legitimate. Three categories of health problem were described : i) Normal illness - for example the infectious diseases which children are 'expected' to catch, ii) Real illness - for instance the 'major and modern disabling and life-threatening diseases': cancer, cardiovascular disease etc.,

and iii) 'Health problems which are not illness' - problems associated with natural processes, or originating from someone's personality, and not amenable to medical treatment.

Cornwell describes the difficulty she experienced in getting people to join the study - they assumed that a 'health study' was in reality an 'illness study', and since their health was 'good' felt that she would do better to go to someone else, perhaps an old person. After these initial disclaimers, many went on to describe episodes of acute or even chronic ill health. She obtained no private accounts of health, because people did not spend time recalling episodes in their lives when they felt healthy - rather they discussed their experience of illness in relation to their employment position, their position in the sexual division of labour, and their past experience of health and welfare services.

Health needs and health knowledge

As perceptions of health itself differ, so clients' perceived health needs can be expected to differ from professionals' perceptions, which may in turn differ from each other. This is an important consideration in respect of the use of health services, and in compliance with health teaching. Becker (1974) put forward the health belief model which suggests that the likelihood of an individual undertaking a given health behaviour is a function of the degree to which he believes in the treatment or behavioural act, the perceived severity of the condition, the individual's

sense of susceptibility to the condition, the perceived benefits of engaging in the given action, the perceived barriers to such action and the cues to action. This suggests that only if a health need is perceived can the individual undertake appropriate behaviour to deal with it, whether prevention or cure is required. However, what the individual perceives as appropriate behaviour may not be the same as the professional's perception - for example, one might wrap an ill child up to keep it warm, the other might want to ensure that a normal temperature was maintained by giving paracetamol syrup and taking clothes off the child. It is also possible that the individual might serendipitously undertake some appropriate behaviour, totally unrelated to whether he or she perceives the health need.

Most often however it seems that parents do perceive health needs in children, even though they cannot specifically identify or diagnose them. Perception of health needs is closely linked to health knowledge. Spencer (1979) describes a study in which parents were shown pictures of children, or presented with descriptions of symptoms, and asked to say whether the children were well or not, and, if not, what might be wrong. Parents were found to be competent in distinguishing severe problems from normal situations, though not in giving accurate diagnoses. In other words, health needs seemed to be perceived without health knowledge. However, extracts from Spencer's interviews show that parents rely on knowledge from their own past experience of illness or health. Wilson et al (1984) indicated that parents' perceptions of which symptoms were of importance were at variance

with general practitioners' classification of major and minor symptoms. It may be that in Spencer's study parents were responding to cues other than the fairly limited range of symptoms of specific types of illness which Wilson et al were using.

Health knowledge for the lay person appears to relate directly to experience. Their perceived health needs may also then be expected to be practical in origin. Work by Mechanic (1968), and Cartwright (1967) suggests that people's perceptions of ill health, or conversely of health, are likely to be affected by their experience of what professionals have responded to in the past, the visibility of symptoms and their available information, knowledge and cultural assumptions. In the context of the present study, part of which was to explore alterations over time in parents' perceptions of health, the types of experience which could be drawn upon at different stages of pregnancy and postnatally will differ. For example, in pregnancy it might be postulated that the mother would draw her concepts of health and illness from her own experience (as child and as adult) of both, and her ideas about service responses from her own contacts. Ong (1983) suggests that other people in the community - the mother's own family, friends and others, as well as professionals influence her concepts of pregnancy and motherhood. Each of these are in turn mediated by their contextual setting. The mother's ideas about her baby's health would be closely linked to her ideas about her pregnancy and health/illness behaviour. Graham (1977) demonstrates through an analysis of antenatal literature,

how images of pregnancy as 'health v. sickness' have developed,
through the use of photographs and drawings in particular:

> 'Health...appears <in drawings> not as something
> automatically ascribed to pregnancy (as in the
> photographs) but rather something individually achieved
> through diligence and obedience.'

A particular type of response to professionals is being built up,
it is suggested. MacIntyre (1976) discusses how the attitudes and
theories held by professionals affect their response to the
client during pregnancy. In the early days of the child's
independent life, the mother might base her ideas on all of these
plus her experience around the time of the birth of
professionals' responses to her and the baby. Later on, she might
be expected to have had further experience of health and illness
with the child, and further contacts with health professionals,
from which to judge, and might therefore, having greater
experience, feel more confident in making judgements about health
and illness.

Experience of itself is not however the only contributing factor
in decisions about health and health care. Cornwell (1984)
suggests that images of doctors and of medical practice 'dominate
the ideological framework within which people make sense of their
experience' to the extent that where image and experience don't
match up, the experience rather than the image is over-written.
For some reason, community maternal and child health services did

not appear to follow this rule. Cornwell states that one bad experience may be cited as an example of poor services generally. She suggests that the women's perception of maternal and child health as being amenable to common sense and interpreted experience, offers an explanation. They may see health professionals dealing in these areas as functioning at a more ordinary level, and therefore more open to criticism than those working in more technical (and more mysterious) areas.

Decisions about health need may also be mediated by factors such as culture. Zola (1973) describes the variation occurring between patients in decisions to seek medical help, dependent upon cultural responses to similar symptoms. He compares Americans of Italian, Irish and Anglo-Saxon descent, who had been referred to E.N.T., medical or eye clinics, in their response to symptoms. The Italians were influenced by the presence of an interpersonal crisis, or perceived interference with social or personal relations. The Anglo-Saxons were triggered to seek help by perceived interference with vocational or physical activity and hence often delayed seeking help until a later stage. Culture is of course only one of a number of factors which might be thought to influence perceptions of health or illness. Others might include age, (see for example Denehy (1987) - a study of children's perceptions of their bodies), socioeconomic group, and education or training.

The literature suggests that parents can perceive health needs in children, but do so without health knowledge. Health knowledge

relates directly to experience. Whilst other factors may influence perceptions of health or illness, the present researcher's exploratory study (Pearson, 1984) suggested that parents decide that they require help when their child's symptoms are outside their experience. Anxiety is caused by such symptoms, which is allayed when they are enabled to comprehend the situation which exists within their own frame of reference. The level of perceived health (or illness) need, and associated anxiety, emerged as an area which was linked to perceptions of 'appropriate' child health services.

Child health services

Over the past ten years or so, many studies of child health services have been made. Roche and Stacey (1984, 1986) in their overview of research on the provision and utilisation of child health services review 542 articles and research projects. Among these they list 35 articles which discuss parents' attitudes to child health services. Of these the greatest proportion are concerned with attitudes towards immunisation (9 articles). However, among the remainder several describe difficulties with the available provision. Oakley (1981a) describes how the new parent, travelling in 'a foreign country' finds that 'communication of these experiences is hindered by the gap between mother and expert'(p.308). She suggests that experts too rarely see experience as any sort of qualification, despite its important role in empirical testing of theory.

Mayall (1986) in a report of a longitudinal study carried out at the Thomas Coram Institute describes a low take up of preventive services in all classes: 58% of eligible children had completed all their developmental checks at the time of the study. 51% had had all the immunisations on offer. Mayall suggests that 'low education' may account for the lack of congruence between professional and lay beliefs about prevention. (Her education measure amalgamated academic qualifications and training, since neither alone would account for the variety of educational experience of many women. She used four groupings.)

In a further report of the same study (Mayall and Grossmith, 1985,) mothers' satisfaction with their health visitor is found to be high, but biased in terms of the middle class mothers, who were more likely to be satisfied. Mayall (1986) indicates that this probably 'derives from mothers' different circumstances and different experiences of health visitors'(p.165). She felt that mothers in Social Classes IV and V in her study were 'more vulnerable to the inspecting side of the health visitor'. Griffiths (1981) looking at parents perceptions of child health services in Central Birmingham concentrated more upon use, and found that late attendance at antenatal clinic was a good predictor of long waits in child health clinics and low immunisation rates. Since other studies have linked late attendance at antenatal clinic with various indicators of deprivation or lower social class, (Cartwright 1970, Brotherston 1976), it may be that this group both meet with poorer services - for example long queues - and tend to use them less - attaining

low immunisation rates for instance. It is not however clear from Griffiths' study how far the parents' perception of the service influenced their use of it, nor how far that perception was influenced by their ongoing experiences, nor yet what other contributory factors might exist.

Graham (1979), Buswell (1980), and Field et al (1982) all describe a degree of parental dissatisfaction with child health service provision. Graham (1979) reports on a major study of pregnancy, childbirth and the first months of motherhood. As part of this, mothers were asked to give their opinions on the child health services they received. By four weeks, 68% of mothers had attended the child health clinic and 98% had been visited by the health visitor. By five months, 78% of mothers were attending the clinic on a routine basis, and all had been visited by a health visitor. However, the general level of satisfaction with these services declined over the first five months, and, as in Mayall's study, showed a class related skew. The working class mothers' initially favourable reaction became unfavourable by five months, and the middle class mothers' reaction improved over the same period. Since perceptions of health and health need may be influenced by culture or class, it is possible that the class difference found by Graham is influenced by differences in the perceived health need of the two groups.

Buswell (1980) describes a qualitative study undertaken with 34 mothers, each interviewed four times in the baby's first year of life. Her aim was:

' to establish parental views, for example, concerning what my respondents thought, or perceived, of the categories of staff involved in the encouragement of normal growth and development, i.e. health visitors, general practitioners and clinical medical officers. '

She found a drop in clinic attendance occurred at round about six months. Mothers cited the conflicting advice they received as a reason for this; Buswell notes that mothers also turned more to their lay referral networks for advice (i.e. grandmothers, aunties, friends). She does not discuss whether the mothers found these a more satisfactory source, and if so, why. Many mothers in the present study felt that their own mothers could offer support but were more doubtful about advice because of generational differences in child rearing patterns.

Field et al (1982) interviewed 78 first time mothers as part of the Cambridge University Early Parenthood Project. In this paper they presented their analysis of the mothers' responses about their health visitors. 60% of the mothers were classified as having positive feelings towards their health visitor, 20% as indifferent, and 20% as definitely hostile. Many of the mothers expressed criticisms of the child health clinics, feeling that the staff were too busy, there was too much queuing, and a lack of privacy. In a subsequent paper (Field et al 1984) they describe the health visitors' views about these criticisms, which in general support the need to make changes in the clinics, and

are divided on other aspects, such as their role in the antenatal period, or extending the hours during which the health visiting service is provided.

Whilst this suggests that health professionals may be aware of the need for change, as described earlier, professional and client perspectives may not always, or even often, match as to the most appropriate action to take. Orr (1980), in her study of health visiting, suggests four principal causes for problems of service delivery: fragmentation, inaccessibility, discontinuity and unaccountability. Fragmentation of the service between for example child health clinics and general practice may lead to problems such as conflicting advice. Inaccessibility may be geographical - how far away the clinic is, whether it is across a major road etc., or cultural - a different type of client, or professionals who can't communicate effectively. Discontinuity may occur in the nature of the health visiting service, in which quite often, when a family is progressing normally, routine visits are only paid at intervals. Unnaccountability reflects the unaccountability of the child health services to the clients whose service, as tax payers and citizens, they are: rarely are clients involved in any form of decision making about services, and even when they are it is usually through the medium of an agency such as a community health council.

Roche (1980) discusses professionals' power to define, without apparent reference to client views, what should constitute the major tasks in the practice of child health care. Here the

clients' perspectives are not even taken into account. Perhaps they are assumed to mirror professionals' perspectives. However, there is considerable evidence from many fields that this is not the case. A study by Milio (1975) looking at maternity patients suggested that middle class mothers adhered most closely to the professionals' "ideal" prenatal regime, but that lower class mothers had relatively uneventful pregnancies and healthy babies. It may be asked whether in fact the 'ideal' prenatal regime had any effect or value. Since Milio advocates the adoption of a "relevant" programme of prenatal care based on lower class values (though these are not defined) it might be assumed otherwise. Wilson et al (1984) in a study of infants presenting to general practice in a 16 week period, found that parents' perception of which symptoms were important was at variance with a medical classification of major and minor symptoms. (See also however Spencer (1979) quoted above). Friedson (1961) discusses the clash between lay and medical perspectives in referral patterns.

Knowledge is the key to many things, but not least to health care and the understanding and use of health services. Knowledge must be communicated. In a later book Friedson (1970) suggests that communication between doctor and patient is hindered by the doctor's attempts to maintain dominance by the control of information. Byrne and Long (1976) describe how doctors wrest the initiative from the client, and dictate both the direction and the duration of the interview. West (1976) suggests that when parents increase in experience and understanding, in this case of their child's epilepsy, they are able to challenge this control,

and force the doctor to 'open up the agenda'. Warner (1984) describes how health visitors negotiate control of interactions with clients in the clinic situation, by the use of humour. She tape recorded 15 clinic sessions and analysed the interaction which took place. She concluded that by using humour, health visitors were permitting clients to decide the course of conversation by allowing them space to steer away from difficult topics.

Studies of child health services indicate that parents feel some dissatisfaction with provision. Levels of satisfaction decline in the child's early months, and appear to show a class related skew. There is some evidence that parents turn more to lay referral networks in the later months. Parents' perspectives on services are often assumed to mirror those of professionals, but studies suggest that this is not the case. Control in interactions may rest with the parent or the professional.

Health visiting -the professional viewpoint

Health visiting has been described from the professional's point of view in various studies over the past twenty-plus years - many of which are listed by Clark (1981) in her 'review of the research 1960-1980'. Clark's own study (1973) is perhaps the best known of these. 79 health visitors were interviewed by Clark, 78 completed an additional questionnaire, and 72 kept records of their home visits for her. She found that seventy-one percent of visits were to families with young children, and 18 percent to

the elderly (over sixty-five). The most common purpose in
visiting was a routine visit to a young child. However, Clark
found that

" the content of health visiting (was) much wider than that
described in the stereotype. Topics not specifically
concerned with young children were recorded in more than
80% of visits, and comprised more than half (57%) of all
topics recorded. "

A study by Marris (1971) also using diary sheets, for two weeks,
showed that the range of content of health visitors' work was
very wide. However, problems with his method of analysis make his
figures less useful than Clark's. (He presented his data as a
proportion of all topics recorded - the number of occurrences of
an individual topic divided by the total number of topics
recorded. Under- or over-recording of the total may distort the
result. In addition, he assumed that equal time was devoted to
each topic - an assumption for which there is no evidence.) Clark
herself (1981) suggests that Watson (1979) gives the most valid
and reliable data on subject matter discussed in home visits. He
states that topics in groups headed 'infancy' and 'child care'
"are the main topics of discussion in 43% of all visits and in
67% of visits to families with children under school age. "

Health visitors' priorities are oriented towards existing client
groups. Wiseman (1979) examined the perceptions of a group of
health visitors of priorities in clients' health needs. The

O.P.C.S. study of community nursing (1982) used similar methods to discover health visitors' priorities firstly in terms of need, and then in terms of interest. In both studies, preschool children and elderly people ranked high. Neither study looked at more specific needs perceived within each group.

Since the present study was commenced, Clark (1984) has completed a further study, in which she utilised tape recording as a means of obtaining 'specimens' of health visiting. She describes the use of this method to record health visitor - client interactions over the first year of life, and indicates how it can produce a much fuller picture of health visiting, as well as the basis for a theory of health visiting.

Health visiting, seen from the professional's point of view, has been shown to cover a wide range of work. However, home visits are predominantly made to families with children under five, with elderly people forming the second largest group of clients. These groups are also those where health visitors identify their main priorities for visiting. New techniques are making it possible to obtain a clearer picture of health visiting practice.

Health visiting - the consumer view

There are two key studies of health visiting from the clients' point of view, though many take a brief glance in passing. Jean Orr (1980), undertook a study in Northern Ireland, already quoted, of the views of 68 mothers from social class IV and V on

the health visiting service. She used a structured interview, which limited the depth to which she could probe, but looked at their knowledge of the health visitor's role, clients attitudes to home visiting, and the attributes of an "ideal" health visitor. In her conclusions she noted that mothers sought two components of consumer satisfaction:

1)Relationship centred - the consumer's sense of closeness to the counsellor, and

2)Problem centred - the counsellor's ability to demonstrate expertise which was relevant.

Her other findings included a description of those areas which mothers thought their health visitor might be able to offer help with, (children's health and development as well as social development) mothers' perceptions of appropriate courses of action by parents in various circumstances, and their desired patterns for home visits (36.8% would have liked more visits).

Jane Robinson (1981) carried out a feasibility study with 13 families, aiming to compare the perceptions of utilising families with non attending families. She used a fairly broad based semi structured interview. She suggested that there was a polarisation among health visitors between problem centred and relationship centred approaches, which was mirrored by client responses. The problem centred approach focussed almost exclusively on solving specific problems experienced by the family. The relationship

centred approach concentrated on building up a relationship with the family. In the former case relationships were seen as relatively unimportant, in the latter case, problems were often not effectively tackled. A 'good' health visitor - 'success' judged by the client - was dependent upon the establishment of a satisfactory relationship (cf. Sainsbury et al, 1982). Some clients with problems were not helped because their health visitor lacked the time or ability to probe beyond the superficial level.

As part of her larger longitudinal study of health visitors' work, Clark (1984) recently published some findings from two semi structured interviews (tape recorded) with 26 mothers. Included in the first interview were details of their perceptions of the health visitor's job, what they expected her to do in the coming year, and how they would describe their 'ideal' health visitor. In the second interview, clients were asked how this had worked out in practice. Three issues are raised by Clark in her discussion of the results. These are firstly, problems relating to child health clinics - for example the public nature of consultations, secondly the limitation of the health visiting service to weekdays between 9am and 5pm, and thirdly 'the lack of understanding among consumers about what the service is for and how it works' - for example, mothers had no idea what the health visitor was trying to achieve in her visits.

Simms and Smith (1984) describe another extensive study, of 533 teenage mothers in England and Wales, concerning their lives,

their babies and their partners. Although the intention here was not specifically to gather information on clients' perceptions of health visitors, some useful material was obtained. While 90% apparently said that they had found her helpful, 9% (45) did not find contact helpful. Various reasons for this were described: non-communication and 'interfering', as well as lack of time, or personality clashes.

Consumer based studies of health visiting indicate that the quality of relationships - levels of communication, closeness - and understanding and perceptions of role - for example as problem centred or 'interfering' - are important in the success or failure of the health visitor - client interaction.

Clients' perceptions of nursing

Studies of nursing have more often attempted to consider the patient's point of view than have those of health visiting. Cartwright (1964), interviewed 739 patients about a recent stay in hospital. One fifth of the patients were critical about the care given by nurses, although in some cases it was commented that the nursing staff were under strength. Fifty-three percent were enthusiastic about the nurses. These people tended to discuss the care received rather less. Raphael (1967) undertook a survey of the views of patients, staff and committee members, in four non teaching general hospitals, using unstructured interviews. She found a high level of satisfaction with the care given, but also noted that many staff did not know that patients would have liked a say (on issues such as their time of getting

up, and others). Raphael also contributed to the methodology of this type of study, since she found that the most effective question for getting patients to voice other than generalities : "they're very good" etc., was one which asked them what changes, if any, they would like to see in the service offered.

As well as examining patients' perceptions of nurses and nursing care as they are, some studies have looked at patients' ideas about "ideal" nurses, or possible changes of role. Robinson (1978), quoted by Swansburg (1981) used a market research approach to gather data from 300 health service consumers about nursing. A majority felt that nurses should confine themselves to traditional areas of service, though some felt a wider brief was possible.

Clients perceptions of social work

Social workers are often compared with health visitors, since they work in closely related fields of family care and support, though with a social rather than a health orientation. Studies in the social work field such as that by Mayer and Timms (1970) have looked extensively at clients' views of the relationship and of professionals. In 1970 there was little or no research which looked at social work from the clients' perspective. Mayer and Timms suggested that there were four reasons for this: first, general suspicion of clients' judgements; second the desire for professional status which might be threatened by allowing clients apparently to challenge competence; thirdly the isolation of

clients such that grievances were frequently privatised, and went unrecognised; fourthly, the low status of exploratory and qualitative studies. These are equally valid as explanations of the dearth of work on consumer viewpoints about health visiting.

Sixty one clients and nine social workers were interviewed. Clients were divided into those who appeared satisfied and those who did not. Mayer and Timms suggest that the significant difference may lie in social workers' approaches. Satisfied clients were generally offered more guidance and more enlightenment. They also received more relief through unburdening and more emotional support. This fitted with their expectations. Social workers who used insight oriented approaches were more common amongst dissatisfied clients, who did not expect to be asked to look at their own actions. Clients typically preferred social workers of the same age, marital status and sex as themselves - because, being similar, they would understand what they, the clients, had been through.

Lishman (1978) looked at 12 of her own families, and found that those of her clients who were dissatisfied with their relationship did not share her treatment perspective. Those who were satisfied did on the whole share her perspective. She found that this affected her own attitudes to them. Robinson (1982) has indicated that, similarly, clients and health visitors may see the health visitors' role differently. Understanding the differences could be important in providing an effective and responsive service.

Sainsbury et al (1982) in a study which compared the perceptions of clients and social workers in long term social work, found that social workers found more areas of need than clients. Clients rated "encouragement", and financial or material help as very important. Later on in the relationship, "friendship" increasingly outweighed the importance of material help. In health visiting, where the problem oriented/ relationship centred dichotomy has been identified by Orr (1980) and Robinson (1982), the present study indicates that the importance of the relationship also alters with time.

Corney (1981) interviewed clients in a scheme where social workers were attached to general practitioners. Though the clients found the attachment helpful there was considerable disagreement between the social worker's assessment and that made by the client, especially regarding the type and number of problems helped. Social workers tended to over estimate their helpfulness to the client. The present study suggests that health visitors' perceptions tend to diverge from those of the client in the long term, and that some health visitors overestimate their value to some clients.

Social work clients were more satisfied with their care if they shared a treatment perspective with their social worker. They generally received more guidance from the social worker. Clients valued relationships, and preferred social workers of similar age, sex and marital status to themselves, as they expected

greater empathy from them. Social workers tended to over estimate their helpfulness to the client.

These findings from social work link up with the findings of the author's own small exploratory study of child health services (1983). In relation to health and ill health, parents of 12-15 month old children would turn to advisers whom they regarded as having the requisite experience or expertise to cope. Being a parent was seen as one relevant qualification. Some parents wanted guidance and were dissatisfied or turned to other advisers when it was not forthcoming from their health visitor. Others valued a non-directive approach and used the health visitor's information as a support for their own decision. The present study sought to extend this work to examine clients perceptions f health visiting in more depth, and in the context of their identified health needs at particular times, and to examine, by means of a series of 'snapshots', the process by which these perceptions develop.

*   *   *

Summary

Health can be defined in a variety of ways - as a state of being, a process of adaptation, or as the absence of disease. It can be defined more clearly for children, where formal and informal standards exist, than for adults. Adults describe three categories of health problem - 'real', 'normal' and 'not

illness'. Parents can perceive health needs in children, but do so without health knowledge. Health knowledge relates directly to experience. Decisions about health and health care are also affected by factors such as culture and age, and perceptions of services.

Studies of child health services suggest that parents feel some dissatisfaction with provision. Levels of satisfaction decline in the early months. They appear to show a class related skew. Studies suggest that parents turn more to lay referral networks after the first few months. Parents' perspectives on services are often assumed to mirror those of professionals, but there is evidence that this is not the case.

Health visiting, seen from the professional's point of view, has been shown to cover a wide range of work. However, home visits are predominantly made to families with children under five, with elderly people forming the second largest group of clients. These groups are also those where health visitors identify their main priorities for visiting. The use of techniques such as tape-recording is making it possible to obtain a clearer in depth picture of health visiting practice.

Consumer based studies of health visiting suggest that the quality of relationships between health visitor and client – levels of communication, closeness – and consumers' understanding and perceptions of the health visitor's role – for example as problem centred or 'interfering' – are important in the success

or failure of the health visitor - client interaction.

Studies looking at clients' perspectives of nursing and of social work were also briefly considered. Social work clients generally received more guidance and were more satisfied with their care if they shared a treatment perspective with their social worker. Clients valued relationships, and preferred social workers of similar age, sex and marital status to themselves. They expected greater empathy from them. Social workers tended to over estimate their helpfulness to the client.

Chapter Three

Theoretical perspectives

This study was undertaken from a Symbolic Interactionist perspective, focussing on the meaning attached to health and to health visiting by clients. This chapter outlines the main features of the interactionist approach, and describes the five main methodological options to which this approach gives rise.

*   *   *

Symbolic Interactionism

The present study was undertaken from a Symbolic Interactionist perspective, focussing on the meaning attached to health and to health visiting by clients. G.H. Mead outlined the main ideas of this approach in a series of lectures given between 1894 and 1931. Blumer, one of Mead's students at Chicago University attempted to interpret Symbolic Interactionism to a wider audience. In a paper in 1969 Blumer described three basic assumptions of Symbolic Interactionism:

"1)   Human beings act toward things on the basis of the meanings that the things have for them.

2)   That the meaning of such things is derived from, or
        arises out of, the social interaction that one has with
        one's fellows

3)   These meanings are handled in, and modified through an
        interpretative process used by the person in dealing with
        the things he encounters.

In the context of the present study, these assumptions could be
translated as:

1)   Clients act towards health and health visitors on the
        basis of the meanings that they have for them.

2)   That the meaning of 'health' and 'health visitors' is
        derived from or arises out of the social interaction that
        clients have.

3)   These meanings are handled in, and modified through an
        interpretative process used by the client in dealing with
        the health and health visiting situations she encounters.

In traditional health care research, most studies have been based
on a quantitative approach, with an essentially positivist
theoretical stance. This has derived logically from the basis
which many of the health care professions, including nursing,
have in the natural sciences, particularly biology. Medical
trials of drugs and other treatments have been mimicked by
nursing trials of care plans and equipment. Surveys have been

carried out to determine attitudes and behaviour, and to discover why people act in particular ways. That is not to say that such studies are not of value. However, they form only part of the story, and in addition are designed as if the world which they study was a tidy laboratory experiment. It is not!

Symbolic Interactionism demands a qualitative approach because, in attempting to examine the actor's meanings, the researcher must obtain as rich and in depth a picture of the actor and his environment as possible, and must attempt to minimise his or her own influence. Pratt (1978) discusses objectivity and bias, and concludes that probably:

> ' despite the possibility of objective work, it will take an exceptionally strong mind to resist the power of the several biasing influences upon it' (p.107)

The problem of achieving 'tabula rasa' has sometimes been advanced by critics of symbolic interactionism as a reason why other approaches might be preferred (Williams, 1976). However, the researcher's influence on the content of research undertaken on a hypothetico-deductive approach is just as great, probably greater, and does not offer the depth of qualitative methods.

In nursing, as in other areas of health care, quantitative methods have also enjoyed considerable popularity because most of the problems researched have been, as Dingwall and McIntosh (1978) point out, for reasons of access, those defined by

administrators and managers. Melia (1982) suggests that many of these questions are asked in order to obtain material for policy making - and that in a profession relatively new to research, 'scientific' results, and results which are generalisable have been important. To this the present author would add the difficulties faced by any qualitative researcher in gaining credibility with those who formally control access. The District Ethical Committee in the Health Authority researched consists of 20 members, of whom only 5 are non medical, and designs its work around the clinical trials which were of course the original reason for its existence. One of its criteria for acceptability in a study is its 'scientific validity' - understanding of an inductive approach is limited, and failure to supply a list of statistical tests with which to harness the data obtained causes at the least puzzled frowns.

Selection of methods

Various methods are open to the Symbolic Interactionist in looking at the meanings which lie behind interactions. The most commonly used are five in number, three of which were used in the present study. Participant observation is perhaps the most frequently utilised method, followed by individual in depth or guided interview. Group interview is a further possibility, and projective techniques are another. Diaries and other documentary data, for example analysis of official records, may be used on their own or as back up to one or more other methods. Each of these methods will now be discussed, and the reasons for its use

or rejection as a technique explored.

Participant observation

Although this is the method most frequently used by those who take the Symbolic Interactionist approach, it has certain built in disadvantages for the present study. First of all, health visiting is essentially a 'private' job. Even more than in most situations, the presence of an observer, of any sort, seems liable to cause differences in the responses and behaviour of both clients and health visitors. Schwartz and Schwartz (1955) discuss the effect of introducing an observer into a small mental hospital ward, when they found that it took around six months for patients to accept the observer in the same way as staff. Altschul (1972) used participant observation, also in a psychiatric setting, and became accepted over a period of a few days. Simmel (1903), quoted by Gergen and Gergen (1981) describes how the introduction of a third person into a dyad changes the nature of that interaction.

Watson (1979) observed 21 health visitors, for four consecutive days each, on a total of 564 visits. However she was utilising a method in which a stop watch is used to determine the time at each change of activity. The time spent on each activity can then subsequently be calculated. She felt that her results "portray(ed) health visiting in Aberdeen much as it actually is". However, she did not obtain material which could be used to examine the meaning attaching to certain activities within the

interaction.

Clark, in her most recent study, (1984), attempted participant observation in the pilot stage. Empirical work for her study overlapped with that for the present study, but its methodology is illuminating in considering the difficulties of participant observation in health visiting, and how they can be overcome. Her first difficulty was in obtaining a sufficient number of colleagues willing to take her as an observer on visits to clients. There were also potential practical difficulties in arranging visits with a variety of health visitors to clients over a period of time, since almost inevitably, some would book visits at the same time on the same day. Clark also found that whatever instructions she gave to health visitors, they tended to involve her in discussion, and that a number identified alterations in their approach due to her presence. Morse and Field (1985) describe this as a common problem for nurse researchers undertaking participant observation in a setting in which they are known, and have a role. Colleagues in particular will

> 'have certain expectations of that nurse...she will be
> considered a "native" by those in the setting.'(p.77-78)

Clients too in some cases appeared to limit their contributions to discussion of certain areas because of Clark's presence. She subsequently developed tape recording as a more practicable means of observing health visitor client interaction.

Clark used small Sony taperecorders, worn on the body, with a tie-clip microphone for preference. Enquiries made of subjects (clients and health visitors) indicated that they felt that these had less effect on them than anticipated. However, a "conscious improvement in performance" was reported by both groups. Diers and Schmidt (1977) stress that the recorder should be hidden or inconspicuous to minimise distortion. The use of a hidden recorder without patients' consent was thought to be ethically unacceptable by Clark, and the recorders used were as small as she could obtain with a satisfactory length of recording tape.

In the present study, participant observation was discarded as an option mainly because of the length of time which would have been involved, probable difficulties in obtaining access, and problems of reactivity discussed in relation to Clarks experience. Observation would have been slightly easier in the clinic situation, as described by Warner (1984) but it was felt that the interaction in the home was more likely to be of significance. Tape recording was not considered to be a satisfactory alternative, for four reasons:

1)   Colleagues' perceived resistance to tape recording, though this had not been tested out other than in discussion.

2)   The level of involvement by colleagues was felt to be too high, and the back-up requirement too substantial to be contemplated in the researcher's work context. (It is notable here that Clark provided extensive instructions and back-up for health visitors in her study).

3)   Reactivity was still thought to be a substantial problem. Some effect was noted by Clark, and the present researcher did not have access to such unobtrusive equipment.

4)   A number of tape recorders would have been required, and the researcher had no extant budget for capital items, nor access to a sufficient number of small machines.

The most important reason for discarding participant observation as a means of data collection was that in examining the action of clients towards health visitors, the meaning which health visitors might have for them seems unlikely to be transparent. The same would apply to tape-recording or videoing. In depth interviews appear to offer a means of exploring with respondents the meanings they attach to health and to health visitors, in their terms.

Interviews

Benney and Hughes (1956) suggest that 'sociology has become the science of the interview', not only because the interview is perhaps the most favoured tool of many sociologists, in one of its many forms, but because it is in essence part of the subject

matter for study, since it is in form a conversation, but one

> 'designed to minimise the local, concrete, immediate
> circumstances of the particular encounter... and to
> emphasise only those aspects that can be kept general
> enough and demonstrable enough to be counted'. (Benney
> and Hughes, ibid).

Malinowski (1922) however, indicates that an alternative approach
can be taken by the anthropologist, or indeed by the
interactionist. Burgess (1982) quotes him as saying that it is
important for the anthropologist to talk to the natives, so that
ethnographic statements can be collected which would 'grasp the
native's point of view'. Rather than emphasising the unusual
nature of the interview encounter, and the need to minimise the
influence of immediate circumstances, Malinowski's stress is on
the content of the natives' statements - what is in their minds.
Dean et al (1967) suggest that:

> 'The researcher should be a thoughtful and analytic
> listener, or observer, who appraises the meaning of
> emerging data for his problem and uses the resulting
> insights to phrase questions that will further develop
> the implications of these data.'

Structured interviews appear inappropriate in this context. 'Unstructured' interviews were considered. 'Unstructured' interviews are also sometimes known as depth interviews.

What is a depth interview? How structured should it be? Jones (1985) discusses this, and suggests that 'the crucial point is that there is no such thing as presuppositionless research.' In the process of interviewing, the interviewer is continually making choices as to when to start asking the next question, when to alter the direction of the interview, when to stop the subject rambling, and indeed which topics to cover. Whilst the structured interview is too rigid to allow respondents to say what is important for them, no interview is totally unstructured, or undirected. Jones (ibid) suggests that this may best be illustrated by responses to the 'non-directive' style of interviewing: what the respondent will say will depend very much upon what he or she perceives as the interviewer's motives - he may feel more constrained 'by the need to put energy into guessing what (the researchers intentions) are', than he would if he knew what the research topic was.

Whyte (1960) describes his attempts at non directive interviewing when examining human relations in restaurants:

> 'I began each interview simply by asking the informant to tell me whatever he cared to that was important to him about the job situation. The usual answer was : "What do you want to know?" Some informants were willing to respond to questions, but no-one poured out his feelings

in response to my general invitation. Rather, the approach tended to make the informants quite uneasy, and I quickly shifted to providing a good deal more structure in the interview.'

Melia (1982) describes a classical depth interview when she says that her opening remarks were 'the only part of the interview which (was) constant for the whole 40'.

Guided interviews offer a slightly more structured approach to the qualitative researcher. Morse and Field (1985) suggest that a guided interview would be appropriately used when information is required about a topic, and 'the structure of the topic is known but the answers cannot be anticipated'. The researcher uses an outline schedule, which ensures that questions on all major areas of interest are included, but at the same time allows the respondent 'freedom of responses and description to illustrate concepts' (Morse and Field, ibid).

In the present study, it was decided to use semi structured guided interviews, containing open ended questions as an overall guide, but allowing the researcher to incorporate questions arising either from the current interview, or from recently analysed earlier interviews. Thus although the interview schedule gave the general shape of the interview, the transcribed interviews incorporated changes and additions according to the needs of the situation. Below is an example of the interviewer's questions over three pages of transcript. It shows how the interview (in phase two) was based upon the schedule as given,

(underlined) but included expansions to build upon the answers given, and in particular to explore i) the contact with the clinic, ii) the content of help and advice from relatives, and decision making in relation to that advice, and iii) changes/ improvements which the respondent spontaneously mentions she would like to see.

P05/3   WOULD YOU SAY HE'S BEEN IN GOOD HEALTH SINCE I LAST SAW YOU?

HOW LONG WAS HE ILL?

AND YOU JUST WENT TO THE CLINIC?

SO WHAT DID THE EMERGENCY DOCTOR SAY?

SO WHEN HE WAS ILL, YOU MADE THE DECISION THAT HE WASN'T WELL. HOW DO YOU GENERALLY, WOULD YOU SAY, DECIDE WHETHER HE WAS WELL?

SO WHAT WOULD YOU SAY WERE THE IMPORTANT THINGS ABOUT GENERALLY KEEPING HIM HEALTHY?

DID HE MANAGE TO EAT THE SKIN AS WELL?

WHO HAVE YOU ASKED FOR HELP OR ADVICE ABOUT LOOKING AFTER HIM?

SO YOU'VE REALLY USED YOUR MUM. IS THAT IT?

THAT WOULD BE A CHANGE THAT YOU WOULD WANT TO SEE?

SO WHAT SORTS OF THINGS HAVE YOU TALKED TO YOUR MUM OR YOUR SISTER ABOUT, OR ANYBODY ELSE?

Interviews do have limitations as a method for examining people's perceptions. (Some of these are discussed in more detail in Chapter Five). The two most important problems are that it is difficult to evaluate a respondent's subjective report of his or her views - views may alter depending upon the time and the place when they are requested - and that distortion may occur in reporting. Dean and Whyte (1958) indicate that four types of factors are likely to influence a respondent in reporting her views. These are: ulterior motives which modify reporting, bars to spontaneity in reporting - trying to appear in a good light for example, the desire to please the interviewer, and idiosyncratic factors - for example mood, or question wording. Cornwell (1984) indicates that encouraging people to tell the stories of their experiences, and establishing relationships with them, reduce the tendency to give 'public' accounts.

Distortion in interview reporting occurs in four principal ways: firstly, when respondents cannot remember what happened in a situation, and report what they suppose happened. Secondly, the respondent subconsciously modifies the 'facts' to fit with his views, and avoid dissonance, or (thirdly) observes selectively because of his views. He may also (fourthly) consciously attempt to modify his report. Cross-checking accounts with other sources is normally used to reduce this. In the present study, health visitor views were compared with those of parents, and questions were asked about specific incidents. Parents' views were also compared with themselves over time.

Group interviews

Group interviews are another commonly used method for qualitative studies. They are best used to explore areas where the social context is important in the development of ideas. In terms of concepts such as health some studies (for example Mayall 1986) suggest that a mothers perceptions of health may be shaped by informally agreed standards held by her in common with other mothers, as well as by formal standards provided by books, magazines and professionals. It seems from the researcher's previous study that ideas received from relatives and friends may also be of significance in the initial development of ideas about health visitors. The major advantage of group interviews is that the social nature of the interview is stimulating. In listening to other people's ideas and thoughts, subjects are enabled to analyse their own views and to express their feelings and beliefs with more facility than is often the case in the individual interview. The researcher may gain increased insight into competing views, or how conflict or consensus occur.

Among the problems to be faced in using group interviews are:

1)   The greater reactive effects of increased insight (which can be an advantage in action research, but not in longitudinal studies)

2)   Decreased opportunity to explore each individuals point
      of view - typically one or two will be more dominant, and
      others will need encouragement to contribute to the
      discussion. In following up one person's point, others
      will tend to be neglected, particularly if they are not
      forcefully made.

3)   Social pressures will tend to function so that
      individuals not only do not disagree violently with other
      group members, but will attempt, consciously or often
      unconsciously, to 'deodorise' the picture they present to
      their peers. Whilst this effect occurs to some extent
      also with individual interviews, it is more marked in
      group interviews. This makes group interviews less
      satisfactory as a means of examining sensitive or
      'private' topics, though to some extent this is affected
      by the composition and relationships of the group itself.

4)   Group members are generally stronger than individuals in
      negotiating, for example, acceptable subject matter,
      timing, even venue. Since the researcher is an
      individual, it seems likely that, as is the case when a
      researcher interviews a member of an elite/ someone more
      senior in their own or a related field (see for example
      Scott (1984), or Benney and Hughes (1956)) a certain
      amount of manipulation of the researcher could occur in
      relation to these areas.

In the present study, a group interview was used at a relatively early stage. It was thought that it would assist in the secondary development of the interview schedules for individual parents, by generating a maximum range of ideas for inclusion, and perhaps indicating some of the more common experiences of and responses to health and health visitors. It was thought that the group setting, by supporting individuals, might enable expression of problem areas in relationships in a way which individual interviews would not.

Projective techniques

Projective techniques involve the presentation of stimuli designed so that their meaning or interpretation is determined by the respondent. Although these have been successfully used by qualitative researchers on a range of projects including an examination of the development of the SDP (Branthwaite and Lunn, 1985), and in various pieces of market research, they were not seriously considered in their traditional form for the present study since the difficulties of making valid interpretations appeared to be too great. Photographs were however used in the interviews in Phase One to attempt to generate a 'story' about a health visitor - client interaction. In practice this did not prove successful, possibly due to the quality of the picture used. (Further discussion of this can be found in Chapter Five).

Diaries and documentary sources

Diaries have been used by historical researchers among others to illuminate the motives and meanings attached to people's actions through their words recorded more or less contemporaneously. Latterly, diaries have become a popular means of data collection in medical and nursing research, particularly when the information otherwise available would only be through retrospective interviews. Pattison (1980) asked parents to complete a diary of their child's health over a month. She obtained a high response rate by collecting diaries weekly. Wilson et al (1984) also used diaries to look at parents ideas about the symptoms of their children, and precursors to seeking medical help. Moser and Kalton (1971) discuss the difficulties of obtaining a high response rate with diaries, and the need to follow up their issue with a specific collection date. In the present study, diaries were used in the first stage to examine people's actual experiences of health and health services in the week following interview.

* * *

Summary

This chapter has outlined the main features of the Symbolic Interactionist approach, and described the five main methodological options to which this gives rise. Semi-structured interviews, group interviews, participant observation, projective techniques and diaries have been discussed, and the reasons for using the methods chosen in the present study discussed.

Chapter Four

Description of Methods Used

This chapter describes the methods chosen to undertake the study.
How samples were obtained, the design and use of research tools
(interviews and diaries), and the process of analysis are
considered. The use of tape-recording and transcription are also
expanded upon. The development of grounded theory is described.
The use of a case study approach to the examination of process in
phase two is discussed.

*   *   *

Background

The theoretical universe for this study consisted of health
visitors and their clients in England and Wales. One client
group, parents of children under five, was taken for study as it
was believed to represent the major portion of most health
visitors' workloads. Clark (1973) indicated that 70.6% of client
contact was spent by health visitors with parents of children
under five compared to 18% with elderly people, and 11.4% with
other groups. The O.P.C.S. study of Community Nursing (1982)
indicated similar figures. These groups also represented clients
whom health visitors ranked as important in listing priority
groups for visiting (Wiseman, 1979).The inclusion of a further

sample, of elderly people, in Phase One of the study was originally considered, but not pursued due to limited resources and a change of policy by the Community Unit in relation to this group.

The sampling technique was different for each phase of the study. For the first (cross-sectional) phase of the study, a sample was taken of the relevant client group. For the longitudinal stage, samples were taken of prospective parents and their health visitors.

Sampling - Phase One

Parent and Toddler Group

A group interview was used to explore parents perceptions of health and health visitors in general terms, and to test out lines of questioning. It was originally intended to interview two groups, representing present and future client groups. The groups to be approached were an antenatal group, and a parent and toddler group. Parents attending a parent and toddler group in a middle class area not familiar to the researcher agreed to participate, though not to be tape recorded. An antenatal group was not included, due to time constraints and difficulty in obtaining access to a suitable group at the time. There were seven mothers and slightly more babies and toddlers at the parent and toddler group.

Parents of Children aged 6-12 months

Clients of health visitors in Newcastle Health Authority who were
parents of children aged six to twelve months, formed a working
universe, from which the sample was drawn. There are 71 health
visitors employed in Newcastle (66 full-time, 5 part-time).
Although accurate figures for their client population are not
available, the population of Newcastle aged 0-4 was 15,313 in
1981. This represented 5.6% of the total city population of
272,914 at that date (City of Newcastle 1983). Children aged six
to twelve months were chosen because resources for the study were
limited and this age group had been identified in studies by
Graham (1979) and Field et al (1982) as falling within the age
group 0-1 having greatest contact with health visitors, in the
home and in clinics, but also as having parents less satisfied
with the services offered than the 0-6 months age group. This
group appeared likely to possess and be able to articulate
opinions on health visiting, having experienced a number of
contacts with the service.

A listing was obtained from the Health Authority of all city
children born between 1.9.83 and 1.3.84 (to be aged between 6 and
12 months at the time of interview). 1636 children were listed as
falling within this age group. Each address was allocated, with
the help of postcodes linked to a city map, into Priority Areas
and Non Priority Areas. (Priority Area Teams were established in
1976 to channel extra city council funds, over and above basic

service budgets, to wards identified as particularly
disadvantaged). It was thought that stratification of the sample
by area in this way would allow some comparison to be made of
responses from people in different socio economic groups.

A sample of 80 children, 40 from each group, was selected at
random (using a random number table). The list was then
circulated to all health visitors in Newcastle. They were asked
to mark any child where they felt that a visit by the researcher
would be inappropriate. Seven were eliminated in this way.
Reasons cited by health visitors when questioned included
children on the Child Protection Register, families where there
was considerable involvement by other professionals, a child with
a severe disability and a family which had recently been
bereaved.

Letters with appointments for interview were then sent out,
starting at the top of the list and working down until a total of
44 interviews had been completed (24 in the non Priority areas
and 20 in the Priority areas). It had been intended to complete
20 in each, but more were completed due to delays in responding
by some parents. Of these interviews, 23 in the non Priority
areas and 18 in the Priority areas were fully usable. Problems
with recording were responsible for the losses at this stage. Up
to two follow up letters were sent to each individual before it
was assumed he or she was refusing.

A 72% overall response rate was achieved on this phase (44 out of 61 parents approached). Five parents had moved from the listed address and could not be traced: Four were from Priority Areas. Six parents from Non-Priority Areas and six from Priority Areas refused to take part. One parent had recently been bereaved. Another refused to participate in 'a student project'. One could not speak enough English to understand what the researcher wanted. The remainder were not in on three occasions for appointments requested, and did not communicate with the researcher.

Methods - Phase One

In Phase One, following the group interview, semi-structured interviews were undertaken with all sample parents. The interview schedule was developed from that used by the researcher in exploratory work (Pearson 1983,1984). A modified version was used for the group interview to explore broad responses. Interview schedules for individual parents were finalised based on this work, after discussion with colleagues (medical, community work and secretarial) and testing with three parents from a local mother and toddler group. After six study interviews had been completed, some additional prompts were added to examine topic areas which arose in more depth - in particular to examine health advice and advisers. Interviews normally lasted between 45 minutes and one hour, though some took as long as 90 minutes and others were completed in 30 minutes. At the conclusion of each

interview, parents were asked if they would be willing to complete a diary of their child's health and use of health services over the subsequent week. Half of these (22) were successfully completed and returned. (The Priority / Non-Priority Area breakdown is not known.)

Interviews

The Phase One interview schedule is attached in Appendix Two. A brief outline of the schedule's contents follows:

The first eleven questions were in each case simple open-ended questions.

Questions 1-4 were designed to examine their perceptions of the health of their own child, then their ideas about what constituted good health, and what factors influenced health.

Questions 5 and 6 asked parents to look at their most recent experiences of using child health services, in particular doctors (hospital and community) and child health clinics.

Question 7 asked parents to identify 'their' health visitor, if possible, and to describe their most recent contact or contacts (home and clinic based) with her. They were then asked how they felt about that contact. Finally they were probed to express their feelings about health visitors in general.

Question 8 explored how far parents felt that the health visitor fulfilled the role which they had expected.

Questions 9 and 10 asked respondents to identify any changes which they would like to see in health visitors' activities, Question 10 asking specifically about visiting patterns and contacts in settings other than the home.

Question 11 asked parents how far they thought that their health visitor could help with their child's health, and why, or why not.

Question 12 was an attempt to use a different stimulus, two photographs of health visitors with families, to encourage parents to discuss their perceptions of health visiting in general.

Question 13 used a list of topics based on Orr's 1980 study to check whether topics which had not been mentioned up to that point had ever been discussed with the health visitor, and whether she had been or might be helpful in relation to each.

Question 15 requested ages and occupations, or most recent occupations for each parent. A final section offered the respondent the opportunity to ask anything she (or he) wanted about the study.

Diaries

An example of the diary format used in Phase One is attached in Appendix Two. The diary consisted of three sides of A4 paper, on which parents were asked two questions. Question one asked 'how has the baby been this week?'. Question two asked them to complete one section for each time they were in contact with health services during the week. Each section asked them to identify the service, say why they were in contact, describe what happened, and how they felt about it.

The development of the study - An examination of process

Analysis of the Phase One interviews indicated that a number of factors might influence parents' perceptions of health and of health visitors. Amongst these were the baby, friends and relatives, other professionals and experience of the health visiting service. It was decided to develop the study to examine the process by which parents identify health needs and develop perceptions of health visiting.

Sampling - Phase Two

In order to develop the initial phase of the study to examine the process by which clients identify and interpret their health needs and perceive the health visitor, it was decided to follow a sample of parents longitudinally. For this phase of the study,

the working universe was health visitors in Newcastle and their primiparous antenatal clients (those expecting their first baby). Primiparous mothers were chosen because most of them would currently be encountering health visitors for the first time as adults, enabling a clearer picture of the process to be obtained. Their health visitors were also included in order to make some comparisons between client and health visitor perceptions over time.

Parents-to-be

Twenty mothers resident in Newcastle at the time of sampling were initially sampled. The sample was stratified to give 10 mothers in Priority areas and 10 in non Priority areas. On the advice of the Director of Midwifery, and after discussion with the Professor of Obstetrics, the sample was taken sequentially from the women attending one consultant's weekly clinic session. It was felt that there would be very considerable delays involved in negotiating access with more hospitals or more consultants. The sample used was therefore one of convenience. Two main problems exist with this. Consultants have differing referral patterns, and the two hospitals in Newcastle have differing geographical catchment areas. The consultant whose clinic was used tended to receive more referrals for obstetric problems than some of his colleagues (reported by antenatal clinic staff). This led to the exclusion of two women from the study (see below). The hospital used tended to receive more patients from Non-Priority Areas, although the rate of attainment of Priority Area clients was not

in practice any slower. Each primiparous woman attending for an appointment between 28 and 32 weeks' gestation and with suitable residence qualifications was identified. A request for inclusion was attached to the notes. Whichever doctor saw her would decide whether or not she should be included and the attending midwife would then send her through to see the researcher.

Two women were excluded by the doctors - both because of severe problems with the pregnancy. Of the women who were seen by the researcher, one refused to take part with no reason given. Two stated that they would be moving house during the currency of the study, one to Scandinavia and one to London. (The latter was subsequently seen in another setting about four months later, and said that her move had been put off but was now due any day). One other woman agreed to take part in the study and was included in the sample but failed to keep the appointment made, or two subsequent ones.

This left 19 mothers in the overall sample, ten from Non-Priority Areas and nine from Priority Areas. The overall response rate among women approached was thus 83%. This improvement on the Phase One rate may be attributable to the personal approach which was made to each mother, in the hospital setting - the former perhaps reassuring mothers that the researcher was relatively friendly, the latter possibly reinforcing the 'official' nature of the study. Sampling was completed over a period of four months, April - July 1986, taking approximately one month longer than initially anticipated from clinic attendances. No clear

reason for this was identified. The number of primiparae resident in Newcastle and at the required gestational age during April was lower than expected.

At subsequent stages, three women were lost, one at stage one and one at stage two - all from Non-Priority Areas. One moved away from the area, and though she said she would write, did not respond to a letter from the researcher. One (a single parent) moved from her parents home to her own flat, and thereafter failed to keep any appointments. The third returned to work, and despite the offer of alternative interview times (an evening interview was carried out with another mother) did not contact the researcher. It is possible that these mothers had found the study intrusive at earlier stages, or that it was relatively of low importance in the changes which occurred in their lives.

Health visitors

A sample from among the health visitors involved with the clients taking part in the study was also followed longitudinally, with the intention of examining health visitor/ client dyads in order to further illuminate the process by which clients identify and interpret their health needs and perceive the health visitor. Although it was originally intended to interview all health visitors involved with study families, in parallel with the parent interviews, in practice difficulties arose with sickness and vacancies which meant that only ten of the health visitors involved could be included within the study timescale. Of the ten

health visitors involved, five were visiting sample families in Non-Priority Areas and five visited families in Priority Areas. One health visitor was lost at stage two when 'her' family dropped out. Another was lost at stage three because of illness, leaving eight.

Methods - Phase Two

Case studies

In order to closely examine process it was intended to examine a series of case studies of the development of parents' perceptions of health visitors in the context of their perceived health needs. In practice this was to be done by consideration of the series of interviews, like a series of 'snapshots', with some attempts to reconstruct the time between. For some of these a parallel set of 'pictures' from the health visitor's perspective were obtained.

Glaser and Strauss (1977) describe the use of case histories and case studies in the context of grounded theory. They indicate that this type of theory is least likely to distort the case study, since it is grounded within the case study itself and in other similar cases. If it were generated from the case study alone, it would be too thin - often several cases are required for the level of comparison to achieve sufficiently dense categories. In the present study, not only have several cases been examined, but the phase one material offers a wider

comparison group for some aspects.

The purpose of using a theoretical commentary, of whatever sort, upon case studies is to put the case within a broader context, to seek to offer some idea of what happened in this case, and how, under different circumstances, it might happen differently. In a different sense, the case studies could be seen as illustrating and providing evidence for the emergent theory. They are not, however, 'typical cases', or exemplars. Glaser and Strauss (1977) make a distinction between case histories, where the emphasis is on the story, with the theoretical analysis implicit, and case studies, which "strive for generalisation and testing theory, and the story is a means to those ends".

Interviews

For Phase Two, three semi-structured interviews (see Chapter Three) were undertaken with each respondent (parent or health visitor). The first interview (at 28-32 weeks pregnant) lasted about 30 minutes. The second and third interviews (around 8 weeks postpartum and around seven months postpartum respectively) were in each case longer, lasting 45 minutes to one hour. Parent interviews were developed on the basis of the previous phase of the study, and health visitor interviews were developed in parallel.

Parent interviews

The first interview with parents was inevitably related more to 'public' opinions (see Cornwell 1984) than to concrete realities, since few of the mothers-to-be had had any experience of caring for young children or babies. It commenced with a question directed at discovering the respondent's perceptions of significant factors influencing her baby's health. In this way, the researcher hoped to discover implicit indicators as to her perceptions of health. A further section asked the respondent to identify any previous experience of looking after babies or young children, and asked whether she felt that this had altered her perception of which factors might be significant.

Question 2 asked the parents-to-be how they would decide if their baby was in good health or not. Again it was hoped that this would uncover the implicit if not the explicit concepts of health held by the parents. This question, and to some extent the previous one, seemed particularly likely in practice to lead to problems in answering, which some respondents attributed to the difficulty, for a first time parent, of conceptualising a 'real' baby and its needs. Oakley (1981a) describes the way in which

> ' images of the baby are compounded of past experience and future hopes; a sort of amalgam of what was and what might be, with a spice of ideas about how families ought to be thrown in for good measure. '

She found that less than a quarter of her sample had ever babysat, and only 18% felt that they 'knew a lot' about babies. The previous experience of the present sample was explored in question one and is discussed in Chapter Seven.

The third question asked respondents to identify likely sources of help and advice 'about looking after your baby'. Subsequent prompts explored possible scenarios, and asked the respondents to say why they might ask these people. This question was not asking parents-to-be to identify health advisers specifically, though in the context of previous questions they would be likely to figure. It was intended to encourage them to identify all the resource people whom they envisaged being of use to them with any doubts or queries about child care. This seemed to be an important area to explore in view both of the potential resource available through the health visitor, (see for example Clark 1973, Robertson 1988) and of the informal support network which is often cited as responding to the young mothers needs for help and advice (see for example Buswell 1980). In this way, respondents were also encouraged to describe areas of parenting about which prospectively they had some doubts, or problems which they anticipated arising. The characteristics which respondents would look for in resource people to deal with these were also identified. In this way it was hoped that features which might contribute to building up a positive or a negative view of health visitors would be identified. However, this question related only to abstract ideas, and concrete influences would be explored

separately in later interviews.

In Question 4, respondents were asked to list the health services for babies and children of which they had heard. A probe was included to ask for 'any others?' but no specific lists were given. In this way it was hoped that their knowledge would be identified without prompting, but that 'half heard of' services might be included following the probe. For this reason, no reference was made to health visitors. Any comment made is therefore the respondents own perception rather than a response to the interviewers expectations.

For each service identified, the respondent was then asked about aspects of its probable or possible use, in Questions 5 to 7. She was asked to say how she had heard of the service, how she thought that she would contact the service (or be contacted), what would happen then, and how often she would be likely to use it. She was also asked what sorts of things related to health she thought each service would be likely to help her with, and what sorts of things related to health each might not be able to help with. In this way it was hoped to build up a picture not only of the respondents' expectations of health visitors, ideas of their role and so on, but to place this in the context of their expectations of other services. This whole section could then also be placed in the context of the respondent's perceptions of health, factors affecting childrens health, and ideas about health maintenance, as well as their perceptions of problems in parenting and child care.

The final question, Question 8, asked for <u>details of the ages and occupations or previous occupations of the parents</u>. Although many authors - for example Murgatroyd (1984), Morgan (1983) - have questioned the validity of using occupational classifications to discuss data, (see discussion in Chapter Five), it seemed that some indication of the financial, social and educational position of the parents may be of relevance in considering their perceptions of health visitors - for example in relation to other resources available. Wadsworth et al (1973), looking at use of general practice, discuss the differences in consultation behaviour by different classes in relation to particular conditions. Parents-to-be in some occupations might have had more opportunities to make contact with child health services through these - for example teachers or nursery nurses.

In a final coda to the interview, the respondents were asked if they would like to ask the researcher any questions. Few did so, (three asked questions about the next stage, and one about the purpose of the study) but this did at least offer them the opportunity to clarify any anxieties they had about the interview, and to feel that they were not dominated totally by the researcher's demands. This is important in carrying out the interview in a manner compatible with the theoretical perspective adopted.

Longitudinal studies present particular problems in regard to the relationship between the interviewer/researcher and the respondent, since this must be maintained over a period of time. The researcher must not only establish a successful relationship for one interview, but maintain the respondent's co-operation and trust through a series of contacts. This point will be discussed further in Chapter Five.

At the end of the first interview, an appointment was made to return when the baby was about eight weeks old. In each case, a letter was sent to confirm the interview date about 10 days before the second interview, since it was felt that a written appointment given at the first interview would be very likely to be mislaid, especially in the upheaval of a new baby. This seemed to work well as a method, and was repeated for the next stage.

The second parent interview (at about eight weeks postpartum) was again semi-structured. Question 1 asked the respondent to give the baby's name, so that he or she could be referred to by name in subsequent questions. It then asked the respondent to say whether she found being a parent easier or harder than she thought, or about the same. This was intended to identify how far the respondent felt that her expectations matched up with reality. After two interviews had been completed an additional question was added before this, asking 'how did you find things?', 'how was it?', in other words, how did you find the process of having the baby? It was found that this was a more natural lead in to the question about being a parent, and that

most women responded with quite an extensive answer to this, relaxing and appearing to accept subsequent questions well. Accounts of 'the birth' are a common feature of conversation among women for the first few months afterwards and it may be that in inserting this question, the researcher was, only partly consciously, conforming to social norms in order to strengthen the relationship between herself and the respondent and elicit more extensive and reliable information.

Each of the remaining questions mirrored questions in the first interview. The new parent was asked in Question 2 <u>whether their child was in good health, what led them to say that, and what in more general terms they meant by good health</u>. As in the phase one interviews, this question could now be related to specific, concrete examples as well as to more general ideas, with hopefully an increase in the 'private' concepts rather than publicly acceptable ideas discussed.

In Question 3 respondents were asked <u>what they felt to be the most important factors in keeping their child healthy</u> - again asking the question in a concrete form related to their own child rather than the more general form used previously.

Question 4 asked the respondent <u>to say who they had asked for help or advice about 'looking after the baby'</u>. This question was intended to explore the actual networks in use, any changes in these from those anticipated at the first interview, and also the types of difficulties encountered for which help or advice had

been sought. Again, it was not specifically asked in relation to health/ illness, though the context might have led to some over-representation in this respect. Any aspect of child care was intended to be included by the wording used.

In Question 5, respondents were asked to list the child health services which they had used. Again, the researcher avoided giving a check list, as it was intended to discover the respondent's priorities and knowledge or experience. Again, a probe was used - 'any others' - to try to tease out any other services with which contact might only have been minimal.

Questions 6, 7 and 8 were then asked for each service mentioned in reply to Question 5. They asked the respondent to describe their contact with the service, focussing in practice on the most recent contact. It appeared to be more satisfactory to relate to one specific episode or contact than to ask them about contact generally. Moser and Kalton (1971) have suggested that this does improve recall. In a few cases it was not the most recent episode, but one which was more memorable wich was recalled. This may have a tendency to bias the responses towards contacts which were more unusual, either positively or negatively. Respondents were asked how the contact arose, and how they felt about it. They were also asked how often they thought they might make use of the service in the future (an expectation which could be compared with those expressed previously). Finally they were again asked, but with the benefit of experience, what sorts of things related to health they thought each service could help

them with, and which they might not be able to help with. In this way they were once again identifying their perceptions of deficiencies in the service.

Questions 9 and 10 <u>asked about other services which the parent might have heard of but not had occasion to use</u>. This question was intended to identify any increase in knowledge of the available services, and any expectations about services which had not been used. It was thought that the general practitioner might fall into this category, though in practice the vast majority of respondents had had some contact with the G.P. by the time the baby was two months old. This might have picked up ideas about health visitor contacts if none had taken place, but was most likely to place the respondents comments on services they had experienced in the context of what they still expected.

Finally respondents were asked to identify any significant changes which had taken place, apart from the birth of the baby, since the last interview, and were again offered the opportunity to ask the researcher questions. Another appointment was then arranged, subsequently confirmed in writing about 10 days before the interview. At this stage more rearrangements had to be made, which may reflect the different circumstances between interviews insofar as parents were returning to their normal more active social patterns by the time the baby was seven months old, whereas at two months they were on the whole still relatively inexperienced and found it difficult to get out very much.

The final parent interview, at about seven months, followed the pattern of the first and second. Questions 1 to 9 , though numbered in a slightly different fashion, were identical to Questions 2 to 10 in the second interview. They once again explored parents' perceptions of health, factors affecting childrens health and ideas about health maintenance, ideas about health/care advisers, their most recent contacts with child health services, and their desires and expectations in relation to these and other services.

Since this was the final interview, some specific questions about health visitors were then included, in order to ascertain, if this had not emerged before, the respondents views on them. As this interview took place at around the same age as the phase one interviews, many of the questions used in that were utilised here, in slightly modified form. In this way it was hoped to be able to compare this sample with the original sample, and examine their final perceptions in the light of the earlier material. Question 10 followed the pattern of Question 8 in the phase one interviews, giving an extended lead in to a question which basically asked whether health visitors 'do what you thought they did, or not?' In this way it was hoped, on the basis of work by Marquis (1969), to get a fuller answer. In this case, the answer would be comparable with any comments on the job of health visitors expressed in the first interview. Since many of those had been very vague and somewhat idealistic, it could be anticipated that answers to this question would be rather

negative, but in fact this was by no means the case.

Question 11 asked the respondent specifically <u>to identify any changes she might like to see in the health visitor's work</u>. This mirrored Question 9 in the phase one interview, which had taken place around the same age. It was worded to maximise peoples willingness to respond and offer suggestions, and was used with a further probe as to whether the respondent could think of anything more. Question 12 focussed more specifically on contact patterns (see Question 10 in the phase one interview), and <u>explored both visiting patterns and other forms of contact</u>. In use, where it was not volunteered, differential patterns of contact at different stages or for different needs were also examined.

In Question 13, as in the phase one interview, respondents were <u>asked about a list of specific topics drawn from Orr's work</u>. They were asked to say whether they remembered their health visitor discussing the topic concerned, whether she had been or (if it had not been discussed) could be helpful. A set of plasticised, typed cards were used to facilitate this question. Though if respondents appeared to have literacy difficulties, the researcher read the topics out casually, it seemed likely to be easier for respondents to discuss the sensitive subjects on the list when they were presented in writing. Belson (1968) used this technique successfully in a study of stealing.

Finally respondents were asked to identify any further changes in their situation which had taken place since the last interview. They were then given the opportunity to ask the researcher anything which they wanted to, particularly bearing in mind that this was their last chance. The interview concluded at this point with appropriate thanks for their help over the past ten or eleven months.

Health visitors

Three semi structured interviews were also carried out with the health visitor sample, at approximately comparable times, usually about two weeks after the parent interview. Appointments for each health visitor interview were arranged by telephone after the matching parent interview had been completed. The interview schedules were based upon those used for parents, modified for professionals in discussion with colleagues from social work and medicine.

As with the parent interviews, each started with a preamble about the purpose of the study and of these particular interviews. In addition in practice it was found necessary to point out that although the researcher as a colleague might be expected to know the answers to many of the questions, she needed to know how they would express the answers, and how they went about things, in order to identify factors which might influence clients in a particular way.

The health visitors were first asked <u>to describe in their own words what their job was</u> (what they as health visitors do). As this question was not as clear as it might have been, they were asked in addition to describe their job as they would describe it to a new parent. They were not asked whether or not it was in fact their practice to describe their job in this way, as it was felt that this would emerge from the client interviews.

In question 2, the health visitors were <u>asked about their contact pattern, in particular in terms of visiting and alternative contacts</u>. It was hoped to identify discrepancies between their overall expectations and their individual practice in this case.

Question 3 set out <u>to examine possible reasons for visiting patterns which might emerge, by asking what factors the health visitor would take into account in deciding on her priorities for visiting</u>. This question suffered from being general and theoretical rather than concrete (for example it might instead have asked her to describe why she had chosen to make the visits she had done that day). It also had a slight flavour of exam questions, and the more recently trained respondents in particular tended to answer it in that way. In later interviews of this series, the researcher modified the question to ask in addition about that day's visits, in order to try to improve on these points.

Question 4 utilised the photographs which had been used with parents in the phase one interviews, and asked health visitors to answer the same question - 'can you tell me what you think this health visitor might be discussing?' - and a prompt to pick up any other points. The photographs were not as indeterminate as they might have been, which had tended to limit parent responses. Health visitor responses were also quite limited, but of a different character, inclining to specific operational tasks in relation to developmental assessments rather than general problem areas. Health visitors' use of professional structures to describe interactions is discussed in Chapter Ten.

In Question 5 the area of clinic work was explored. Each health visitor was asked about the level of her clinic involvement, whether this was with Health Authority or general practice based clinics (or both), what she felt actually happened in the clinic sessions, and how she felt about the sessions. She was then asked how she thought parents felt about using the session(s). Where one or all the clinic sessions were open, Health Authority clinics, she was also asked to estimate what proportion of people attending clinic sessions were with her practice. These questions provided the basis for a series of comparisons: first of all concerning parents' and health visitors' perceptions of what actually went on in those clinics, secondly about parents' views and feelings about clinics, and thirdly about any changes which might seem desirable. In addition some impression of health visitors' workload and of contact patterns could be gained.

Question 6 was intended to allow the health visitor to describe areas of work which she would like to develop or spend more time on. This information, it was expected, would provide a comparison between the hopes and desires of parents as to the future development or improvement of the health visiting service, and the hopes and desires of health visitors. As with the parent interviews, the question was made as open as possible, so that it did not necessarily imply major change was necessary, but equally didn't rule it out. A second section to the question acted as a probe and asked about further ideas, related to children under five.

The next Question explored the health visitor's most recent contact (if any) with the client involved in the study. At this stage however, only one health visitor had made contact with the relevant client. She was asked to describe where the contact took place, what happened, and her own feelings about it. If she had seen the client at the surgery/antenatal clinic, she was asked also to describe any contact at home. It was hoped in this way to obtain data for comparison with that from parents-to-be, but as already stated, in the majority of cases, no contact was identified at this point.

In Question 8, the health visitor was asked to look at the same set of cards which had been used with client respondents in phase one, based upon topics identified by Orr. She was asked to say whether she had talked about them with clients, and if so, how

frequently. If she had not, or had very infrequently discussed a topic, she was asked to say why she might not have talked about it with clients. If she had discussed the topic concerned, she was also asked whether she thought that she could be helpful with the subject. This would provide a baseline for later descriptions, by both clients and health visitors, based on these cards, of what topics had in fact been discussed. Responses to this question would, it was hoped, produce an idealised outline of what the health visitor herself expected to be included in her visits to families in general. Though this would be a response to a more structured question than Question 13, Phase One for parents it was felt that it might still provide useful material for comparison with that.

Questions 9, 10 and 11 were designed <u>to examine the health visitors' perceptions about health, factors affecting health and health maintenance</u>, for children under five. Each respondent was asked what she would define as good health for them, what sorts of things she thought affected health for them, and how she would advise them about keeping healthy. These questions were intended to be directly comparable with the initial questions of the parent interview, and hopefully to highlight any differences of emphasis or content between parents and health visitors. Each question was made as open as possible, to minimise researcher influence. Since the health visitor was being asked to discuss a generalised group of clients, it was recognised from the beginning that this might prove to be a difficult set of questions to answer, lacking a concrete focus. In addition, the

generalised nature of the questions led to a generalised response. This effect was less marked where advice was being asked about than health itself, but was true for all three questions. Moser and Kalton (1971) have noted that questions which ask about general opinions tend to receive responses which are vaguer in content than responses to questions about people's immediate experience. Cornwell's (1984) description of techniques for obtaining public and private accounts (discussed in Chapter Two) is also relevant.

The final question in this interview asked in three sections <u>for some background data on the health visitor respondent</u>: what year did she qualify as a health visitor? what areas had she worked in before coming into the community? and which age group (of 5) did she come into? Although this seems a simple enough set of questions, a number of comments should be made. The intention of the question was to gather details of her age and experience for use in the analysis. There were no particular problems with the section about year of qualification, which did at least give a guide as to the type of training received. However, no provision was made to identify health visitors who had had a career break for any reason. In retrospect, a further section should have been added, and might in addition have allowed for details of any updating. The second section again identified what it asked for, but was worded in a way which tended to cut out any description of community based experience in other disciplines - for example school nursing. Again in retrospect one could speculate that such information might have been usefully correlated with data on

various aspects of client perceptions. The third section worked well (age groups were typed on a plasticised card similar to the others used) but the researcher realised in the course of using this that she could be said to have discriminated against client respondents in not allowing them a similar way of retaining details of their specific age. Alternatively, she might have asked her colleagues to state their ages: This option was avoided in order to reduce possible embarrassment to some colleagues with all of whom the researcher might continue to work.

The second and third interviews with health visitors were almost identical, save that the final interview was one question longer. They began with a question which asked the health visitor <u>to describe in her own words 'how X has been doing since the last time we spoke'</u>. She was briefly reminded in each interview of the approximate time of the last - 'baby was about two months old then'. The design of this question left the respondent to determine her own priorities within the parameters of her perceptions of the family concerned and her ideas about the researcher's intentions. This was in line with the general approach used, but, whilst it gave a relatively easy beginning to the interview in terms of focussing on a concrete person and her situation, the interview situation appeared to generate some anxiety in response to the casual enquiry 'how has she been doing'. A number of the respondents wanted to clarify the question by identifying a particular topic like development, and asked if this was what was meant. The researcher usually repeated the question - 'how has she been doing', and added 'generally'.

This was normally sufficient to start the health visitor's response. Again this demonstrates the health visitors' tendency to adopt a professionally structured approach (discussed in Chapter Ten). It was hoped that these assessments of the study family's situation would provide information on two fronts: How far the clients perception of 'how she was doing' matched that of the health visitor and what the health visitor felt were priorities about the family.

Question two in both these latter interviews was designed to explore the health visitor's most recent contacts (if any) with the study family. Although the question was designed to ask only about the last contact, the last contact in the clinic situation was the one typically described first, (by parents as well as health visitors). This would fit in with a relatively frequent clinic attendance rate described by parents at seven months, and a reduction in the frequency of six month checks by health visitors due to a change of policy during the currency of this study, whereby the six month check became optional at the health visitor's discretion. Because of this, respondents were also asked in these interviews to describe the most recent contact in the home. The question was broken down into sections as Smith (1975) has suggested that this improves response relevance and content level. The sections related to location, what happened, and how the health visitor felt about the contact. Material from responses to these was intended to offer descriptions of contacts from the health visitors' viewpoint which would be directly comparable with those of the same events - particularly in terms

of home visits - or similar ones (clinic sessions) described by parents.

In the third question, as in Question 8 in the first health visitor interview, the respondent was <u>asked to look at a set of cards giving topics based on those identifed by Orr</u>. Rather than the more general question asked in the first interview, she was this time asked to say whether she had 'talked about X with this client'. If she had, she was asked how frequently she might have done so, and to give an example if possible. She was also asked whether she felt that she could be helpful about this topic. If she had not discussed the topic, she was asked why she might not have done so. In many cases this was anyway volunteered - in relation to 'elderly relatives' for example, where none lived locally, or they were not 'elderly'.

In the final interview with health visitors, one extra question was added, <u>to explore any alterations in their job over the period of the study after the first interview</u>. In this way it was hoped to identify any altered commitments (increased or decreased), cover for colleagues etc, and possibly any courses attended etc. These might potentially have altered the health visitors ability to fulfil the patterns of visiting etc described in the initial interview and/or altered her priorities. In the interview schedule the period asked about was 'the past six months' but before this was actually used, it was realised that though that time would cover the latter two interviews, changes occurring after the first interview might equally have

significantly affected the health visitor's approach in the antenatal and early postnatal period. The time asked about was therefore extended. In retrospect it is also hard to see why a similar question was not included at the end of the second interview, as this would have reduced the problems of recall associated with this question.

Recording interviews

Each interview was taperecorded, in order to obtain the maximum accuracy in recording clients' responses, with the minimum bias from the researcher. The acceptability of tape recording has been discussed by a number of authors. Field and Morse (1985) indicate that a small machine, preferably with a lapel or tie-clip microphone is likely to be most acceptable to respondents. They point out that the length of the tape is important in reducing the obtrusiveness of recording, since if the tape needs to be turned over in the interview, this tends to draw attention to the recorder, and result in some loss of data. Where this has happened in the present study, respondents have indeed tended to become, for a short time at least, more reticent.

Belson (1967) describes research into the effects of tape recording on accuracy of response in survey interviews. He employed an obtrusive machine, with an operator, alongside an interviewer in a doorstep survey of 105 peoples' readership habits, carried out in London. He suggests that whilst tape recording increases the accuracy of reported responses from lower

class respondents, it reduces the accuracy of reported responses from middle and upper class respondents. Belson also noted a tendency on the part of all his subjects to become more formal when tape recorded. However, his method, as described above, was intrusive. Clark (1984) however though using much more unobtrusive machines, suggested that tape recording health visitor - client interviews resulted in what was perceived by many participants as a 'conscious improvement in performance', which was thought to be maintained during all the recordings.

Tape recording of interviews is also useful in determining interviewer effects in the process of interviewing. Belson (1965) suggests that interviewer errors are quite common. He found that:

> 'interviewers deviated frequently and markedly from their instructions, sometimes failing to explain the key terms or to repeat them as required, sometimes leaving them out altogether, shortening questions, or failing to follow up certain ambiguous answers in the manner required.'

Collins (1968) (quoted in Boyd and Westfall, 1970) studied the behaviour of interviewers, and suggested that:

> 'individual interviewers would have consistent preferences for the use of certain words and ... would thus bias data collected, especially when open-end questions were used.'

He found 'substantial' differences between interviewers, both in the consistency of their word choice and in their tendency to be 'wordy'. In guided interviews of the type carried out in the present study, in which mainly open ended questions are used, the possibilities for bias are greater than those offered by a more structured approach. However, the researcher was able to review her delivery of questions and prompts using the tapes and transcripts. In this way, she could learn to reduce some sources of error - for example by clarifying appropriate prompts, and using question wordings given. Others could be accounted for at the analysis stage, though interpretive errors would then contribute to the problem.

Methods of analysis

Background

In analysing the data which had been collected, the aim was to try to understand the meanings of the section of the world being studied for the respondents. It was also hoped to be able to explain it in terms which would make sense to them. Psathas (1973) argues that the key issue for social research is 'whether the results of an enquiry fit, make sense and are true to the understanding of ordinary actors in the everyday world'. Very often, nurses have found the results of research into their work incomprehensible, or at best difficult to apply in a practical situation, because it has been based on ideas and theories which

have come from outside their experience. Patients and clients have more rarely been given the results of research, let alone in any form which was comprehensible. Oakley's study of the transition to motherhood however, was published in a Pelican version (1981a) as well as in the more academic form (1980). Though this is perhaps more likely to be accessed by middle class people, it is at least an example of the way in which qualitative material can be shared with the lay reader, when it is removed slightly from its academic context.

Policy makers and employers tend on the other hand to look for 'facts' about services and people, whether clients or providers. Working in the context of a health authority post, and examining an area - client perceptions - which became suddenly more fashionable amongst managers after Griffiths' report (1983), there could have been some pressure to produce a more quantitative report, and to do more statistical analysis. In practice this was more of a problem at the stage of submission to the District Ethical Committee, which has a medical/ quantitative background (see Chapter Three), and needed assurance that the results of a qualitative analysis would be valid.

The Grounded Theory approach

Analysis was undertaken following the methods of Glaser and Strauss (1967). Their 'grounded theory' approach is well known in qualitative research, since it builds up from the ground - from the data - concepts and then theories which relate directly to

the data. It is in essence an inductive approach, rather than the more traditional deductive approach of positivist studies.

The deductive approach requires the production of a hypothesis, which is then tested, and supported or shown to be false. It requires preconceptions on the part of the researcher, which the Interactionist wishes to avoid. However, one of the major criticisms of Glaser and Strauss's work, put forward by Bulmer (1979) is that they assume a 'Tabula rasa view of enquiry' - that is a blank mind prior to setting out to develop categories. It is clearly not possible to keep one's mind free from presumptions and prior conceptualisations. Kaplan (1964) points out that :

> 'We always know something already and this knowledge is intimately involved in what we come to know next, whether by observation or any other way. We see what we have reason of seeing.'

This is true for any researcher, but even more obvious when researching the clients of one's fellow professionals. The question of bias will be discussed further in Chapter Five.

Glaser and Strauss saw the research process as a progression from raw data to categories (concepts), their properties, and then to substantive grounded theories. Low level concepts were to be generated by the constant comparison of data: incidents and comments would be compared one with another. The concepts generated by this comparison would be delineated by their

properties (themes demonstrating their dimensions). The developed concepts could then be linked into theories and used to explain the data. Concepts are elaborated as the data collection continues, and further comparisons are made.

As concepts emerge, they indicate areas for further data collection. Glaser and Strauss describe this as theoretical sampling. They say that:

> 'the sociologist must.. be clear on the basic types of groups he wishes to compare in order to control their effect on generality of both scope of population and conceptual level of his theory.'

They suggest that comparisons of groups of exactly the same substantive type (for example parents of children in a given age group) will lead to a relatively simple theory which is applicable to this one type of group. Comparison of different kinds of groups (for example parents and old people, or parents and professionals) will lead to more wide-ranging theories. Minimising differences leads to the collection of a substantial amount of similar data. Similarities in data bearing upon a category help to verify it, by verifying the data behind it - that is, the category is not the result of a one-off aberration. The basic properties of a category also emerge more sharply from groups with minimal differences, as do those differences that do exist. Maximising differences between groups increases the chances of collecting more varied data bearing on a category, but

also highlights 'strategic similarities'. It encourages the faster development of a dense theory.

When comparisons cease to offer any new or different features of a category, the category is said to be "saturated', and no further data collection is necessary in this area. This may occur after a very few observation periods or interviews, or after several. The researcher then moves on to data collection related to other categories. Theoretical saturation is reached when new categories seem to 'fill in' the same sections of theory more and more densely. To achieve it, the researcher will, as discussed above, maximise the differences between data collection groups to generate as wide a variety of categories as possible.

Melia (1982) states that she was left, after using Glaser and Strauss's approach,

> 'with a sense of having fallen short of their ideals...
> until (she remembered) their definition of a theory which
> involves regarding theory as a strategy for handling data
> and for describing and explaining the phenomenon in
> question'.

Their major work (1967) on the generation of grounded theory, whilst, as Melia indicates elsewhere (1982, ibid), confusing and wordy at times, does give a picture of the simple unfolding of data collection, categories, further data collection, more categories and properties and the development of substantive

theory. Relatively few of the researchers who have used this method of analysis have given any very detailed account of what this entailed in practice. Melia is rare in indicating the difficulty she experienced in using the approach, and in describing in some detail how she produced categories from her data. The present author's method is described on page 102.

Transcribing

In the present study, transcripts were prepared from tapes of interviews. One secretary transcribed all the tapes. This enabled the researcher to feel confident about the confidentiality of the interview data, since it was only handled by the two of them, and the secretary did not undertake any work for other nursing or health visiting staff. All respondents had been assured of confidentiality, and this was particularly important in relation to handling the opinions of clients about staff, and staff about their work in a situation where the researcher is employed by the same authority. This is discussed further in Chapter Five.

For an 'average' interview of 45 minutes duration, between two-and-a-half and three hours transcription time was required by the secretary. A total of 123 tapes were transcribed over the two phases of the study - around one hundred hours of transcribing. For each tape, a transcript was prepared which included the researcher's input in upper case and the respondents' input in normal mixed case. Indistinct passages were shown as dotted lines. Problems such as "Aeroplane flying over" - obscuring the

interview sound completely - were recorded by the secretary in red. All proper names of individuals were removed and replaced by letters. Each tape was checked by the researcher, who managed to fill in some of the dotted line sections from her jotted interview notes and/ or listening. She also, wherever possible, noted where responses were made by another individual (for example grandmother, husband), and removed references to places which would have been identifiable.

In use, some refinements would have been useful if they had been planned at the start of the study. Firstly, it would often in analysis have been useful to know the tone or emphasis with which something was said - for example was it said aggressively, or rather as a joke? Of course this might not mean that it is a joke, but it may demonstrate something about the individual's perception of the point, and their feeling about other people's views. A variety of codes and symbols are used by researchers using conversational analysis to represent differing aspects. Secondly, there were occasionally long pauses when someone was considering what to say - yet these are represented in the same way as indistinct conversation, by a dotted line. Some workers, such as Anderson (1979) have used bracketed times inserted into the text to indicate the length of a silence in seconds. Thirdly, although it was sometimes done by the researcher from her jotted notes, on the whole the detail of people's non audible non verbal responses was omitted and not recorded. In view of the work of Bernstein (1964) and others, quoted by Deutscher (1969/70), this could be a significant loss with the less verbally articulate

respondents.

Developing themes and concepts

Each transcript (and the diaries in the first phase - which were already in written form) was then examined to pick out categories or themes which seemed to arise. The researcher read through each transcript and noted every comment or reference which appeared to indicate a category. For example:

A/13   'I had a fleeting visit from a young lady who said she had just popped in to get my name and details because she was leaving -- Then another lady came and B was 6 months -- and all she said was when she visited, was he starting to say mum and dad -- if they hadn't existed I wouldn't have missed them'

This fragment might include relevant quotes for a category related to contact - 'a fleeting visit','I wouldn't have missed them' - some related to perceived role - 'just popped in to get my name and details', 'all she said was when she visited, was he starting to say mum and dad' and some related to value -- 'all she said was', 'if they hadn't existed I wouldn't have missed them'. Each was noted on a separate sheet, labelled with the code number, interview number and the page number from the transcript, to enable easy reference back.

Notes were made on other sheets which indicated ideas and thoughts occurring to the researcher during analysis. This included notes when the respondents' replies appeared to reflect what they thought the researcher wanted to hear rather than their actual views, notes where the researcher appeared to have inadvertently influenced or perhaps misinterpreted the respondents reply, and ideas about the possible connections between categories which occurred to the researcher.

Other workers handling taped interview data have suggested various methods of analysis. Newton (1987) in an unpublished paper suggested that selective transcription of material was satisfactory. He used a wordprocessor to sort his coded material, initially writing it straight into the computer with codes (for data categories and for approach) as he selected it. Morse and Field (1985), on the other hand, state categorically that

> 'It is not possible to analyse a tape without a written transcript' and that:

> 'One of the most serious mistakes made by the novice researcher is to skimp on the transcripts. At this stage make at least three copies and separate the original from the working copies'

It is not clear whether they recommend this for convenience in analysis, or, as it seems from the subsequent text, for fear of fire or loss. They suggest posting one copy home if working in the field and travelling, in order to avoid losing all three. Murdock (1971) and Wiseman (1974) describe further refinements of technique.

Checking for reliability of categories

All categories which were noticed were written down, not just those which appeared to be important. It was thought that the categories which appeared least important - those perhaps in Wiseman's 'miscellaneous' envelope - might turn out to be the most helpful. Becker (1958), describing the process of analytic induction used by him in participant observation studies, states that this may be true for an observer, who should record all incidents which appear to have even the smallest bearing on the interactions being studied.

To check reliability in the present study, some transcripts from each stage were checked for emergent categories by a non-health visitor (a parent of two young children, with social work training). It was hoped in this way to determine whether any major areas were being missed or misinterpreted by the researcher as a health visitor. The checker found seven major categories, none of which he developed into sub categories, but which fitted with the categories (ten in number) previously allocated on an initial run through by the researcher. This appeared to be

satisfactory. It highlights the fact that this sort of data often needs several examinations before some categories are picked out. This appears to be partly due to the researcher's inability to hold more than a limited number of analytic categories in mind (Field and Morse, 1985) and partly to the creative nature of the process, in which the person analysing the data must pull out threads from it and make connections between these - thus often temporarily blurring other links.

An additional check will take place after the completion of the study, in feedback discussions with respondents and, to a lesser extent, other colleagues, during which it is hoped to clarify and check on the validity of the themes and concepts abstracted. Feedback to respondent clients and involved colleagues is important to the study. All participants will be sent a brief summary of the main findings, and invited to discuss their views on it with the researcher, either individually or in a group. Feedback to respondents is an area which is often omitted from medical and nursing studies, often because it is seen as inappropriate, but which seems to be an important consideration when the study is about those same people's views, and asks them to contribute both time and information for little or no immediate gain.

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Summary

This chapter has described the methods used to undertake this study. The sampling technique used for both phases, and the design and use of research tools (interviews and diaries) have been described. Tape-recording, transcription and the process of analysis using the grounded theory approach have been discussed. The use of a case study approach to the examination of process (Phase Two) has been outlined.

Chapter Five

Methodology - A Discussion

This chapter discusses issues and problems arising from the methods used. Difficulties arising in interviewing, particularly those relating to gender and class, and problems of repeated interviewing are described. Problems relating to the context of the research, and possible affective biases are discussed. Ethical issues are outlined. Issues relating to the categorisation of respondents by occupation or class, and social stratification are also considered in some detail.

*   *   *

Background

In undertaking and reporting any piece of research, it is important to consider the limitations imposed by the methods used. Some of the problems encountered - for example response rates - have already been discussed (see Chapter Four). Major factors in the relatively poor response rate at Phase One appear to have been the mobility of Priority Area residents, and the use of a written initial approach. The internal validity of the study (whether different results would have been achieved if different methods were employed) has been alluded to in Chapter Three, in discussion of the choice of methods. Reactivity may also have

been important here, since respondents in both Phases of the study knew that the researcher worked for the Health Authority, and was seeking information about how its services were viewed. However, none identified the researcher as a health visitor, and by maximising the respondent's freedom of response (discussed below and in Chapters Three and Four), the effect seems likely to be minimised.

The external validity of the study - that is the generalizability of the study - is also dependent on various factors. Respondents' reactivity to the process of interviewing may result in changes in that which is being tested. This is particularly important where repeated interviews are used (discussed below). The use of standard classifications of occupation (also discussed below) may assist in generalising from the study. The reliability of the study - how far the results would be independently replicable - is also important. In the present study the process of analysis of data is central in this. The use of cross-checking has been described in Chapter Four. Schatzman and Strauss (1973) indicate that even the same researcher re-viewing his data may discover new perspectives. However, these should not negate previous work, only illuminate it.

Interviews and interviewing

Problems of class

Deutscher (1969/70) discusses some of the difficulties arising in interviewing, related to the assumption often made by researcher and respondent that they are communicating 'in the same language'. This is of particular importance when, as in the present study, it is intended to include clients from a variety of socio-economic backgrounds. Schatzman and Strauss (1955) suggest that the response of the middle class respondent to an interview situation is very different from that of the working class respondent. For the middle class respondent, the interviewer is an educated stranger, a type with whom he or she probably has already had dealings. The working class respondent on the other hand , they suggest, has mainly been used to communicating with 'listeners with whom he shares a great deal of experience and symbolism', and may feel self conscious in talking to the educated stranger.

Bernstein (1964) suggested that class based differences existed in the use of language, and that working class people tended to use non-verbal communication to compensate. If this is the case, (though Bernstein's work has been criticised - see for example Rosen, 1972) interviews themselves, being generally designed by middle class people, are likely to give a restricted picture of working class ideas. Transcripts of interviews are likely to produce an even more restricted view, since they tend to concentrate on the verbal, and indicate only some audible non verbal cues such as laughter. They can be supplemented by notes taken at the time which indicate the interviewer's observation of

for example fidgeting in relation to one question, but detailed note taking is itself counter productive in other ways. Whyte (1960) describes the effect of note taking in formalising an interview situation.

Problems of gender

As well as the class related problems of interviews, Oakley (1981b) has indicated that problems arise from the 'predominantly masculine model of sociology and society' which is adopted by most social science researchers, and reflected in their reports. She suggests that a number of issues are generally not commented upon -

> "social/personal characteristics of those doing the interviewing; interviewees' feelings about being interviewed and about the interview; interviewers' feelings about interviewees; quality of interviewer-interviewee interaction; hospitality offered by interviewees to interviewers; attempts by interviewees to use interviewers as sources of information; and the extension of interviewer-interviewee encounters into more broadly based social relationships."

Oakley suggests that women are particularly likely, either as interviewers or as interviewees, to want to violate the traditions of social research. As interviewers they are trained to respond in a different manner to their natural response - to

be 'friendly and interested (but) not get too emotionally involved with the respondent' (Moser and Kalton, 1971); never to 'provide the interviewee with any formal indication of (their) beliefs and values' (Sjoberg and Nett, 1968).

As respondents, women are used to being questioned by a wide variety of people. But Finch (1984) suggests that they are likely, because of their privatised domestic workplace, to be lonely, and to welcome the opportunity to talk to a sympathetic listener. If the interview takes place in the home, conducted by another woman in a relaxed manner, it is likely to take on the characteristics 'of an intimate conversation'.(Finch ibid). In this circumstance, not only will the respondent react differently towards her interviewer, but the interviewer will find the execution of her trained responses difficult or impossible, as they will destroy the interview situation.

The interviewer - respondent relationship

The respondent in an interview is in a sense an 'outsider' to the professional process of interviewing, and his or her views about the interview, or failure to maintain 'scientific' detachment in the relationship with the interviewer (by offering hospitality, asking for information, or treating the interviewer as a friend) may therefore be seen as of low value, not worth describing in a report. Sjoberg and Nett (1968) suggest that both interviewer and interviewee must be 'socialised' into the correct interviewing behaviour. This seems to be particularly inappropriate where the

researcher is taking an Interactionist perspective, since by its very nature, the respondent's perceptions and constructions of the world must be of value - including, logically, her constructions and perceptions of the interview itself. In addition, where, as in the second phase of the present study, a longitudinal series of interviews are being used, there will inevitably be an alteration in the interviewer- interviewee relationship, which it seems important to document.

However, it is also important to consider the questions which are raised by the 'unscientific' behaviour of the respondent. Oakley (1981b) says that 'one piece of behaviour that properly socialised respondents do not engage in is asking questions back'. She goes on to list other authors' suggestions for dealing with this problem, and thus minimising the potential for bias. (Galtung, 1967; Selltiz et al.,1965; Goode and Hatt,1952). In her study of motherhood, she decided after the pilot interviews 'that when I was asked questions I would answer them'(Oakley, ibid). She said to them that she was answering from her own experiences as a mother, and referred people to professional resources when appropriate. Her reasons for doing this were firstly to avoid adopting 'a purely exploitative attitude to interviewees as sources of data', second that she saw the role of the interviewer as 'a tool for making possible the articulated and recorded commentary of women' - a tool for women, rather than a tool of the researcher, and thirdly that she found that traditional responses such as not answering, or evading, questions, or not giving feedback, was not helpful in promoting 'rapport'.

In Oakley's study, many of the questions asked related to medical procedures (31%) and baby care/ development/ feeding (21%). She was able to answer these from her viewpoint as a mother, with access to greater knowledge of the structure of the hospital and of professional attitudes. In the present study, the problems were slightly different. The researcher is a health visitor, and therefore bound by both the UKCC rules of professional conduct and the Royal College of Nursing ethical guidelines (1977), to which the District Health Authority's Nursing Research Committee subscribe. It had therefore been decided in the initial stages of this study that she would:

i)   not interfere in the practice of colleagues,

ii)   refer problems mentioned during the interview to the
        family health visitor, except in a crisis where the time
        lag would be too great and

iii)   maintain confidentiality between herself and the
        interviewee in relation to specific attribution of
        material (discussed below).

In practice, relatively few questions were asked in the course of the interviews. In the first phase they related primarily to common sleep and feeding difficulties or the availablity of local facilities for toddlers. In the second phase they included some

about childbirth and a few about common anxieties of the same sort. At the end of each interview, an opportunity was included for every mother to ask the researcher any questions she wanted. Whilst few took this opportunity, a total of ten did so (six in Phase One and four in Phase Two), mainly asking what was the purpose of the study, what was she going to do with it and similar things. (6% of Oakleys mothers asked this type of question, and 15% asked what she describes as 'personal questions'). In the present study eleven mothers (four at Phase Two) used this as an opportunity to make comments on matters which they felt strongly about, such as the maternity services, or the state of the nation – often useful material, which was dealt with as part of the interview in analysis. In this way they were able to express their own priorities even more clearly than may have been the case in the main body of the interview.

Oakley (1981b) also identifies the tendency of interviewees to offer hospitality and the tendency to move into a closer, more socially oriented relationship as examples of 'inappropriate' behaviour in a traditional interview setting. She notes that at 92% of her interviews she was offered tea or coffee or some other drink. 14% of the women also offered her a meal on at least one occasion. In the present study, this type of material was only recorded incidentally, as passing reference or in the clinking of a mug or glass. However, a large proportion of mothers on most occasions offered a drink of tea or coffee or something of the sort – including one who offered orange juice as a remedy for the researcher's cough. No meals were offered, but Oakley interviewed

her respondents for longer at a time, and in some cases was present at the birth of their child, which intuition would suggest might tend to produce a closer bond with the women concerned. Certainly she maintained links with more than a third of the women she interviewed, for at least four years afterwards, and states that 'four have become close friends'. In the present study, whilst many respondents have expressed interest in seeing the results of the study, only one mother in the first phase has made contact with the researcher to date, to report a change in her views subsequent to the interview - to 'set the record straight'. On the other hand, several of the mothers went to quite a lot of trouble to ensure that all the interviews were completed - informing the researcher of changes of address, or arranging interviews for times when they were not working (those who returned to work or took up jobs as the baby got a little older).

The interviewer - respondent relationship is clearly of importance in obtaining this degree of co-operation, and 'rapport' in the interview itself. Sheatsley (1951) suggested that women are better interviewers than men, married men better than single women, and those 'majoring' in psychology, sociology and anthropology best in interview performance. In psychological experiments, usually based in a laboratory, the perceived age of the experimenter has been discussed as an element in influencing subject responses, as has the respondent's perception of experimenter role and personality (McGuigan 1963). Studies quoted by him suggest that a 'less threatening' environment (a young

female experimenter) resulted in subjects learning a task more quickly. Birney (1958) suggested that the perceived status of an experimenter could produce different responses in subjects. He found that better scores were achieved by student subjects with a 'faculty member' as experimenter than with a student experimenter. Scott (1984) indicated support for these results in her study of postgraduate research in sociology. She and a female colleague, both relatively young, interviewed and observed researchers, many of them quite well established in sociology. They felt that:

> "many male academics, and not just those in positions of power, were either overtly or unthinkingly patronising...our theoretical and methodological competence was constantly called into question. Many men attempted to take over the interview and began to interview themselves"

She also, as can be seen, indicates that the fact that she and her colleague were female may have had some relevance to their treatment by her largely male sample. Oakley (1981), as indicated above, suggests that women responded positively to being interviewed by a woman, in a deliberately non-hierarchical way.

Burgess (1982) discusses recent research into methodological aspects of participant observation which indicate the extent to which personal characteristics can influence roles, relationships and data. He quotes Golde (1970) who indicates that specific

behaviour is triggered by women - greater assistance than that given to men, for example. Gupta (1979) and Pettigrew (1981) give examples of the limitations which perceived role, sex and status can place on field researchers. For instance, Pettigrew describes how womens role in the Sikh 'jats', to which she was expected to conform, limited her data gathering to certain settings which were acceptable. Yet her family connections with certain influential people enabled her to gain access to people and to papers which were illuminating to her research.

Rosenthal (1963) in another laboratory based study indicates that perceived "warmth" in the experimenter can increase verbal responses. Experimenter 'likeability' - better rapport and compatibility with subjects - has been found to produce different data and more useable responses to open-ended questions (Brown, 1955). Boyd and Westfall (1970) state that:

> "several writers have suggested that interviewers should 'play' the role which best suits the situation and thus be able to obtain rapport which will induce respondents to co-operate"

As they go on to say, however, it would be difficult to train interviewers for this chameleon-like role, or indeed to identify its features. Neither does it seem entirely ethical to play a role which 'suits' in order to induce respondents to co-operate. It seems that in practice, most interviewers function as themselves, and develop the skills necessary to produce at least

a minimum response. Cicourel (1964) suggests that each interview involves a basic social process, and that it is unrealistic to expect the interaction of different interviewer - respondent pairs to be similar, since the individuals concerned will affect each other differently. He quotes a study by Hyman et al (1954) and says that it shows:

'not only the importance of common sense decisions during the interview but also that a set of interviews could be distributed like the variety of interpersonal exchanges that occur in everyday life'

Comparability, in the classical sense, is thus, he argues, not possible in the interview situation.

In the present study the interviewer was the researcher: no other interviewers were involved. She has had the advantages of being female, and of roughly similar age to many of the parent respondents. Her role was presented as that of a researcher working for the District Health Authority, which, though accurate, was intended to avoid two problem areas: Firstly to avoid her too ready identification as a health visitor, (which might have heightened the testing effect and increased respondent reactivity) and secondly to encourage a level of response beyond that which might be accorded a 'student' (an interview was declined on the assumption that she was a student) but not influenced by knowledge of her immediate professional status. In practice, the persona of DHA researcher appeared to have high

status - able to get things done - for some parents, and official status - but not necessarily accessible - for others. Responses varied according to the individual respondent's placing of the researcher in these categories.

A third status related category into which the researcher overtly fell during the first phase of the study was that of mother. During the time of the interviews (August - November 1984) the researcher was in a fairly advanced state of pregnancy. A number of respondents commented upon this, and appeared to feel some rapport as a result. Oakley (1981a) was also pregnant in the course of her study of women's experiences of pregnancy, and quotes the women whom she interviewed who asked about her own experiences of pregnancy, childbirth and mothering, and came to look on her in many cases as a friend. Whilst in the first phase of the present study only one interview was carried out with each child's parent or parents, it seems that this identification of experience may have been helpful in promoting a positive and more effective interviewer - respondent relationship.

Repeated interviewing

As indicated earlier, little is written in the methodological literature about repeated interviewing or the effect of longitudinal studies on interviewer - respondent relationships. The majority of comments are related to the problems of long waiting periods, changes in 'variables of interest', changes in instrumentation and the need to use appropriate time gaps (see

for example Smith 1975). Laslett and Rapoport (1975) do however discuss the advantages and disadvantages of repeated interviewing. They suggest that in order to gain more information in greater depth than might be the case using a more traditional, hierarchical relationship between interviewer and respondent,

> 'an attempt is made to generate a collaborative approach to the research which engages both the interviewer and respondent in a joint enterprise'.

They advocate interviewers responding to interviewees reactions to the interview situation, rather than trying to eliminate them as undesirable. Rather than taking an apparently objective stance of detached curiosity, they are suggesting a closer, responsive relationship. Oakley (1981b) states that:

> 'common sense would suggest that an ethic of detachment on the interviewer's part is much easier to maintain when there is only one meeting with the interviewee'

This seems indeed to be likely, and was indeed borne out by the present researcher's experiences in the two situations, phase one and phase two of the study.

Perhaps some more relevant methodological literature relates to the position of the participant observer, who, like the researcher undertaking a series of guided interviews, is involving him or herself with 'subjects' over a period of time,

trying to 'get to the bottom' of their world.

Gans (1982) describes some of the problems faced by the
participant observer in undertaking his / her research. He
suggests that 'most participant observers are psychologically on
the margins of the social situations and relationships they
study'. He quotes Everett Hughes (1960) who pointed out that it
is often 'middle class' researchers who investigate 'working
class' communities, and that they, like anthropologists, cannot
ever fully internalise the norms and values of another culture.
Gans (ibid) suggests that the participant observer inevitably
becomes involved unconsciously, and sometimes to an extent also
consciously. He cites the example of a study of his about the
people of Boston's West End, during which he became
psychologically involved when the city threatened to tear down
the area as a slum, and subsequently, on completion of his study,
wrote a critical analysis of how slum clearance was handled in
the area. In the interview situation too, it is difficult for the
researcher to cross class / culture barriers, and she is often at
the margins of understanding - though as Hughes (1960) also
points out:

> 'a person cannot make a career out of the reporting of
> reminiscences unless he is so far alienated from his own
> background as to be able to expose and exploit it before
> some new world with which he now identifies himself.'

However, involvement with the respondents, though it should be avoided according to textbooks (see for example Smith,1975 - 'the fieldworker must be able to detach himself from the situation to be studied'), is inevitable, over time, and it is the handling of that involvement, and what that implies, that are important to explore. Gans (ibid) suggests that guilt about researching people, and catching them unawares, leads to increased identification with them. Miller (1952) describes a situation of 'over rapport' encountered by him in a study of trade union leadership. He suggests that this placed two types of limit on him. First, he was accepted into friendship by the leaders, which tended, by social means, to limit his investigations and his criticisms. Secondly rapport with leaders could result in lack of rapport with the rank and file members - not only will the latter be less forthcoming with someone they see as 'the administration man', but the researcher will tend to develop the leaders' perspective on any problems, and be less able to pick up the members' view.

Miller suggests that the researcher must ask himself 'at what point does closeness to the subject limit the research role?' Schwartz and Schwartz (1955) describe the affective features of a participant observer - subject relationship. They say that involvement in the observed's emotional life is inevitable, and that quite a lot of this involvement may be subconscious. For example, they mention that:

'When low morale was a dominant aspect of the ward context, the investigator discovered that he too was functioning less effectively'

However, they go on to say that involvement is necessary to facilitate the observer's understanding of the observed's 'inner life and their social world'.

Researcher and health visitor

In the present study, the researcher is a health visitor, and hence socialised into health visiting perspectives - see Dingwall (1977). This presents difficulties in interviewing clients and in interviewing colleagues. With the former, having established a degree of acceptance as a Health Authority researcher and mother, client perspectives were shared quite freely by the majority of respondents. Whilst at first, health visitor perspectives were dominant in the researcher's approach to the data, gradually the client perspective became more dominant, making it harder to see the health visiting view. In relation to colleagues, for some at least, the researcher was regarded very much in the way that Miller describes being seen - as an 'administration man':this affected their willingness to be outspoken, or in one case to be taped, since they were uncertain whether some of the things they said might reach managers. In these relationships, quite a lot of time was put in to reassuring them that the researcher was not a 'mole'. To a large extent this was facilitated by the

researcher's retention of a clinical role, and ability to
demonstrate 'sameness' to the health visitors. The ethical
questions raised by researching one's colleagues in a bureacracy
are addressed below.

Questions of bias

The idea of bias implies that there is an objective reality. The
interactionist approach suggests that realities are, rather,
social, the product of individuals' interpretations and
constructions. However, it remains important to explore ways in
which the researcher may influence her data collection or
interpretation. Schwartz and Schwartz (1955) state that in
addition to the socio-cultural aspects which have been much
discussed, emotional aspects of the investigator's relationship
with other people, and with the investigation itself need to be
explored. They put forward a list of questions which should be
considered:

> 'What does (the observer) believe people are "basically",
> and what does he feel they "ought to be"? What
> perspectives does he have on human activity - long or
> short range, broad or narrow, subtle or gross? How much
> does the investigator need to be 'right....? Will he tend
> to see what he expects to see in his data? How much
> failure can the investigator sustain without becoming
> discouraged or unconsciously moving in the direction of
> forcing success by distorting the data?'

They suggest that the way to deal with bias is to become maximally aware of it, and to explicitly state it, so as to prevent distortion of observations. Denzin (1978) asserts on the other hand that triangulation of methods 'forces all researchers to be self-consciously aware of how their every action can influence subsequent observations'. He includes in his book a paper by Sieber (1973) which suggests that 'the fieldwork method' should include 'observation, informant interviewing and sampling techniques'. In the present study, clients from two groups (Priority Area and Non-Priority Area) were sampled, and interviews were supplemented at phase one by diaries. At Phase Two, comparison was also made with health visitors.

In the present study, the researcher attempted to make herself as aware as possible of possible areas of bias, and utilised feedback discussion with client groups and examination of transcripts by a non health visitor as specific tools for this in the data analysis phase. In the planning and data collection phase, discussion with her supervisor and seminars given to undergraduate research methods students assisted in determining possible affective biases. They were/ are:

As a health professional, the researcher's symbolic universe differs from that of client participants (see for example Johnson, 1972). Unjustified assumptions may be made that words or actions mean the same to her as to them. Health visiting involves the establishment of a relationship (CETHV, 1977; Robinson 1982;

Clark 1984), which must be deep enough 'to enable the client to explore, identify and "offer" to the health visitor those underlying issues which were of concern to her' (Robinson, ibid, p.88). Communication should ideally be very good, and the health visitor's understanding of the client's perceptions clear. In practice however, Robinson indicates 'a lack of congruence between the health visitor's objectives, and the client's need.' This is the essence of the motivation of the present study, examining the form of this incongruity, and the process by which it occurs.

Linked to this is therefore a tendency to look for incongruity - indeed this is also the crux of the constant comparative method of analysis, whereby incidents are compared, and much is learnt from inconsistencies. Similarities may go unnoticed.

As a mother, the researcher's experience takes her further ahead than the antenatal mothers in process, and itself contributes to her ability to understand/ interpret their meanings. Yet that very closeness of experience may also act by making her feel that her own, individual and very subjective experience is theirs, rather than listening to what they are saying or doing.

As a Health Authority employee there is pressure on the researcher to undertake work which is 'relevant', 'useful' (to managers) and completed on time. This might tend to force reformulation of research methods and analytical perspectives to produce such work.

As a post-graduate student there is pressure on the researcher to produce research which is new, and a problem which is clear and well defined. Broader or more repetitive studies such as managers might prefer are less acceptable academically. This to some extent counteracts the previous point, but can result in a narrowing of view such that links to wider themes made by the respondents are not taken up or used.

The researcher functions as a colleague of the health visitors involved in the study. Their expectations are therefore that the researcher shares their vocabulary and concepts – yet the researcher is also affected by the client respondents and by her own response to socialisation. Her assumptions about what they mean may be entirely different from theirs. This area of potential bias is partly dealt with by asking them to treat her as a novice – but that is easier said than done when also constructing a guided interview which is conversational, talking in a relaxed fashion to an acquaintance.

Bureaucratic pressures result in a tendency for the researcher to cause the minimum of disruption – to colleagues (avoiding managers' disapproval), or to others – the staff of the antenatal clinic for example. In the former case this might result in less probing or exploration of apparently shared concepts. In the latter case, it could result in allowing clinic staff to largely determine the venue where potential respondents were seen.

In practice the mothers who were eligible to be included in Phase two of the study were seen in a small room near the sister's office, where doctors normally took their coffee, and which had white coats hung on the door, and official papers on the noticeboard. This tended to emphasise the researcher's identification with the health authority, and gave her some status. It might also have tended to distance the researcher from the parents concerned, though there was little evidence of this in interviews.

The venue of the interview itself is another feature which has important effects on the 'success' of the interview. Where the interview takes place on the respondent's territory – usually home but also possibly their workplace in some circumstances, they feel more in control of the situation. They may build up rapport more easily and respond more fully. Equally they may be able to avoid situations they do not want to face – for example by arranging appointments to terminate a threatening interview. The interviewer needs to be aware if he is being manipulated.

Ethical issues

Some of the ethical issues confronted by this study have been addressed elsewhere, in particular, the obtaining of informed consent, and the approach to situations where the researcher is asked for help. The most significant ethical issues raised for the researcher by this study were however in the area of

confidentiality.

The first issue was in dealing with data from clients about colleagues. Normally, where subjects have no direct relationship to colleagues, transcription and analysis can take place in the researcher's office with no difficulty, though of course care must be taken. In this case, care had to be taken that the health visitor concerned, or a colleague, would not be able to identify comments about herself, and their origin. The usual methods of data protection were employed, in that interviews, tapes and transcripts were kept in a locked filing cabinet, and only available to the researcher and her secretary. Tapes were wiped as soon as they had been transcribed and checked. As the researcher and her secretary initially shared an office adjacent to clinic premises with several other workers, with whom the secretary also worked, and were frequently visited by health visitors and other local professionals, particular care had to be exercised in the process of transcription to avoid visitors or other colleagues hearing the tapes or viewing the interview notes or transcripts.

Similar problems occurred in relation to the second issue - the handling of data originated by colleagues, or about them, in a context where the researcher was responsible to the same management structure. The same safeguards were employed. However, some colleagues, as described above, appeared uncertain about the researcher's role in relation to management and were for example unwilling to be taped, or guarded in their statements while being

taped. Whilst technically the research data may belong to the Health Authority, as one of the funding agencies, it will be the continuing responsibility of the researcher to maintain the confidence of clients and colleagues.

Occupation, class and social stratification.

There has been considerable debate over several years about the adequacy or otherwise of the Registrar General's Classification of Occupations, ever since it was first developed in 1911. The Classification assumes that:

> 'there is considerable homogeneity within, and difference between, each of the constituent categories, and that the categories reflect some general, albeit vague, ordering or hierarchy of skill, status or what you will' (Coxon and Jones, 1986)

Bland (1979) is said to have effectively demolished these assumptions.

The Classification has been criticised because it does not allow for the rapid changes in available types of job between censuses - Morgan (1983) states that between 1950 and 1960, almost 26% of occupations were redefined into different classes or dropped and replaced by others. It has also been criticised (Fox and Goldblatt 1982) because it does not correlate as well with some variables such as educational level as it does with others such

as mortality or morbidity. They suggest that the reason for this is that the structure was designed to correlate well with indices of mortality and morbidity, and that other variables may be at work in the case of educational level.

The Classification has also been criticised (Fox and Goldblatt, 1982; Murgatroyd, 1984) for its failure adequately to represent womens' position. The practice of classifying women by their husband or, if unmarried, father's occupation, originated in the early part of the century when the majority of women were not economically active. This is no longer the case, when a large percentage (56% in 1980) of women work at least part time for money, whether within or outside the home. 80% of economically active married women in most social classes have husbands in the same social class , but only 66% and 46% of women in social classes II and III nonmanual have husbands in the same social class. This mainly reflects the greater concentation of men in the III manual class. Yet women, and indeed children, tend to conform to their spouse's / parent's classification in respect of patterns of morbidity and mortality (Fox and Goldblatt, ibid). This is probably, as they suggest, due to the influence of the man's occupational position upon the lifestyle and environment of his family.

The Black Report (1980) suggested that for couples, male and female occupations should be used together in analysing various health conditions and experiences such as infant and childhood mortality. Fox and Goldblatt (op cit) suggested that womens

attitudes and educational level as reflected in their own occupational position could be particularly relevant in relation to their health behaviours and their children's development and achievement. Murgatroyd (1984) found that the Registrar-General's Social Class categories were of little value in ranking women's occupations. She suggested a revised set of groupings - 'Women's Social Groupings', which she felt would offer "a more satisfactory basis for classifying women's occupations". She also noted a more general point, that skill distinctions are inappropriate to many jobs now, and the 'blue/white collar' division in particular is of little relevance to women's occupations.

A further criticism which has been made (Morgan, 1983) of the Classification is that it does not take account of people who are unemployed, except as a 'lumped-in' category. Their experiences and education and training are thus all hidden in one group which is as heterogenous, especially nowadays, as the population at large. Linked to this is the inadequacy of the classification to deal with retired people, particularly if they have been retired for some while. Fox and Goldblatt state that for some people, their standard of living, accommodation etc alter considerably by the time they have been retired for ten years, and that this undoubtedly affects their perspective on life and their mortality. An analysis based upon a 1% sample of the 1971 census showed that the Standardised Mortality Ratio for retired men aged 65-74 years classified by their last recorded occupation did not show the linear class gradient characteristic of men of working

age, though as a group the manual group had a higher mortality rate than the non manual.

Changes in occupation over time, a feature of our society which was almost unknown in 1911, are another area in which the Classification is inadequate in offering some indication of the individual's likely experiences and training. Coxon and Davies (1986) suggest that this is an area which is inadequately explored in the sociological literature.

Several attempts have been made to produce a more adequate description of social stratification (Murgatroyd, 1984; Stewart et al, 1980; Coxon and Davies, 1986). Coxon and Davies attempted to critically examine 'the current received account of social stratification... in its own terms' and to 'investigate how these new cognitive and methodological approaches could be exploited for a new understanding of social stratification'. They asked subjects to look at occupations and to rate them as similar/ most and least similar in a triad, on general standing, income, knowledge, social usefulness and prestige. They later asked other subjects to arrange a set of 16 occupations in groups according to which they felt most naturally went together, and to explain their reasoning . They felt that peoples' everyday classification of occupations was based upon a much wider and changing set of variables than any of the fairly rigid classifications produced before. They attempted to discover what ordinary peoples' classification was based upon, and some of the features which might lead to adaptation in it. Whilst they suggest that a much

richer account of peoples place in society can be achieved in this way, they concede that their methodology is too complex for widespread use

In practice, all of these criticisms must be borne in mind when looking at social stratification in the context of a research project. Ultimately, the method of classification which has least flaws in respect of the aims and objectives of the study must be used, with any additional data which might be appropriate. In the present study, the Registrar General's Classification of Occupations 1980 was used. Both father's and mother's occupations were requested, and as much detail as possible obtained, since in earlier work some difficulty had been encountered in classifying inadequately described jobs (e.g. engineer). For those who were unemployed at present, social class was based upon their most recent previous occupation: even so, in some cases, no job had been held since leaving school.

$$* \quad * \quad *$$

Summary

Chapter Five has discussed issues arising from the methods used in this study. Problems of interviewing, in particular those relating to gender and class, and the interviewer-respondent relationship have been discussed. The response of the middle-class respondent to the interview situation is likely to be very different from that of a working-class respondent. Women

interviewers and respondents are likely to want to violate the traditions of social research - for example by developing a more 'personal' relationship. Researcher characteristics can be important in obtaining co-operation over a period of time. Problems of repeated interviewing have been explored. In particular, the need to develop rapport, but remain detached, has been discussed. Possible areas of bias have been considered. Ethical difficulties relating to the context of the research have been examined - especially questions of confidentiality. Finally, issues relating to the categorisation of respondents by occupation or class, and social stratification have been described. Despite considerable criticisms of the Registrar General's Classification, it remains more closely linked to morbidity and mortality patterns than alternatives, and has therefore been used for the present study.

Chapter Six

Results: The Context

In this and the following five chapters, the results of the study are described. The main emphasis is on Phase Two results. This chapter starts with an outline of the way in which the results are set out. Some simple quantitative data about the samples used are then presented - for example the age, employment status and social class of respondents, which is intended to place the interview material, discussed subsequently, in context.

*   *   *

Structure of reported results

Melia (1987) describes some of the difficulties associated with reporting findings from qualitative data. The most important problem is that of how to effectively mesh the developing themes arising from the data with the theoretical interpretation necessary to make sense of them, whilst at the same time allowing the respondents to be heard. In addition in the present study the complexity of the design, incorporating as it does comparisons over time, between residents of different areas, and with professionals, make the development of a clear structure for reporting essential.

The findings of this study will be set out in six chapters. The first chapter (this one) presents some simple quantitative data about the samples used, such as age, employment status, and social class, and discusses possible relationships with aspects of the other findings. The next four chapters (Seven to Ten) describe how the themes and categories which were drawn out in the analysis of the data developed through the stages of the study, and examine comparisons between them.

In Chapter Seven the main concept areas arising in parent interviews at Stage One of the study are outlined. Mothers-to-be were around 28 - 32 weeks pregnant at this stage. The next chapter describes the themes and categories found in parent interviews at Stage Two of the study, when the baby was around eight weeks old. Changes and developments since Stage One are discussed. In Chapter Nine the content of the Stage Three interviews with parents is discussed. These were undertaken when the study babies were approximately seven months old. Themes and concepts arising here are discussed, and compared and contrasted with those from earlier stages. Material from Phase One interviews is also included, where it appears to be illuminating. (Phase One interviews involved parents of children aged between six and twelve months.) In each of these chapters, material from Priority Areas and Non-Priority Areas (for definition see Chapter Four) is also compared.

In Chapter Ten, the health visitor sample is outlined. The themes arising from the health visitor interviews are described, and

compared and contrasted with parent views. Themes found in each category are discussed stage by stage, sequentially, in the relevant section. In this way patterns emerging can be most easily followed, and contrasted with those arising in parent interviews.

Subsequently, case studies are used to explore some of the main concepts which have emerged in the data as a whole in more depth. Six case studies are considered - three of Priority Area parents and three of Non-Priority Area parents. They offer illustrations of the way in which particular parents and professionals developed themes, and the contexts in which they did so.

Why a quantitative analysis?

Since this is a qualitative study it might be thought unnecessary to describe the sample used in any detail, as it is not the intention to develop a detailed statistical analysis. However, some characteristics of the samples used will be outlined, in order to set the emergent themes in context. Simple quantitative data about variables such as age, employment status, area of residence and social class will be described, and possible relationships with other findings discussed. Some counting of responses will also be used in subsequent chapters to indicate the strength of propositions made.

Silverman (1985) suggests that quantification has a valid role in deepening and extending the usefulness of qualitative data. He

indicates that it is the misuse of quantitative methods which have led to their unpopularity with qualitative researchers - the imposition of arbitrary categories and "ex post facto interpretations of tests of significance". Setting qualitative data in a quantitative context, and counting "the countable, preferably in terms of the categories actually used by the participants" (Silverman, ibid) will enable those who read the results to critically review them, understanding their origins. In a health care context, where the predominant model of research has been epidemiological, quantitative analysis is still highly valued. Describing the quantitative context may also facilitate the consideration by health professionals of the concepts and themes presented.

Characteristics of the samples

It is important to consider various features of the samples which might influence the study findings. (For details of how samples were obtained, see Chapter Four). In particular it is important to look at those variables which could be considered influential in any differences in perception which might occur. Parental age, the sex of the child, employment status, single parenthood and class distribution are considered.

Distribution by parental age and area

Parental age as a variable might be thought to be influential in perceptions of health and of service providers such as health

visitors. Linked to age is experience, and also the development of social skills. Simms and Smith (1984) in their study of teenage mothers' views on child health services found that the majority (90%) were satisfied with the service offered. Graham (1979) suggested that older mothers' views differed substantially from those of younger mothers.

In phase two of the study, the parents in both types of area were slightly younger overall than those in phase one (mean for mothers 25.8, compared to 27.5 and for fathers 27.2, compared to 29.8). This probably reflects the fact that 24% of mothers in phase one were not primiparae, since no straightforward way of sampling first born children from the list provided had been developed. In phase two, all mothers included were primiparae. Tables 1 and 2 show the distributions by area for phase two.

Table 1 <u>Distribution by maternal age and area - Phase II</u>

Mothers	Priority Area	Non Priority Area	Total
Mean age	23.7	27.6	25.8
Standard dev.	3.7	5.5	5.0
Range	16 - 29	18 - 35	16 - 35
	n = 9	n = 10	n = 19

$t = 1.829$ $d.f. = 17$ Significant at 0.05 level

In this sample the age range was quite wide, both within each
group and for the whole sample, though not as wide as for phase
one - see Tables 3 and 4. However, one mother was only 16 at the
start of phase two. The differences in age between areas were
just significant. The trend may be caused by the tendency for
class differences in age at becoming a parent (Werner, 1985).
This of course assumes that the division into Priority Area and
Non-Priority Area is significantly related to differences in
socio-economic group, a point discussed further later in this
chapter. The mean age for the total group is a little below the
mean for all mothers at any legitimate birth in England and Wales

in 1983 – 27.5 years (Werner, 1985).

Table 2 Distribution by paternal age and area - Phase II

Fathers	Priority Area	Non Priority Area	Total
Mean age	26.3	28.0	27.2
Standard dev.	4.9	3.8	4.3
Range	21 - 36	22 - 36	21 - 36
	n = 9	n = 9	n = 18

$t = 0.8225$ $d.f. = 16$ Not significant

Once again, the age range was quite wide, but the standard deviation for each group relatively small. Non-Priority Area fathers were slightly older on average, but this was not significant. Fathers in both groups were older than mothers.

In phase one, the mean age of parents in the Non-Priority Areas was higher than that in the Priority Areas. This might be seen as contributing to any differences which occur between the groups. Tables 3 and 4 show the age distributions by area for mothers and fathers respectively in phase one:

Table 3   Distribution by maternal age and area - Phase I

Mothers	Priority area	Non Priority area	Total
Mean age	25.28 years	29.32 years	27.5 yr
Standard dev.	5.4	4.27	5.16
Range	18-38	23-41	18-41
	n = 18	n = 22	n = 40*

$t = 2.582$ $d.f. = 38$ significant at 0.01

* One respondent did not give details

Though the age range in both samples was wide, the standard deviations were relatively small. The differences in age between areas were significant at the 0.01 level, using the t test for independent samples. This may relate to class differences in age at becoming a parent - see Werner (1985) discussed above. The mean age for these mothers approximates more closely to the mean for all mothers at any legitimate birth in England and Wales in 1983 (Werner, ibid).

Table 4   Distribution by paternal age and area - Phase I

Fathers	Priority area	Non Priority area	Total
Mean age	27.88 years	31.41 years	29.87 yrs
Standard dev.	5.77	4.31	5.23
Range	18 - 41	24 - 42	18 - 42
	n = 17	n = 22	n = 39

$t = 1.2595$ $d.f. = 37$ Not significant

Again, amongst the fathers the age range was wide, but the standard deviation relatively small. Differences in age between areas were not significant. Parental ages in phase one, though slightly greater for both mothers and fathers, were only significantly different (at 0.05 level) from those in phase two for fathers ($t = 2.0308$, $d.f. = 55$). This is important in comparisons of phase one interviews with those in stage three, phase two.

Distribution by sex of children and area

It has been suggested that the sex of a child can influence the

experiences and attitudes of its parents (Jones 1987). In the phase two sample, the sex of children was of course not known at the time of sampling. In practice, the sex distribution of children in the sample was not significantly different between areas. In this sample (see Table 5) there were rather more female than male children overall. The reverse was the case at phase one, though this was not significant ($X2=2.5738$ with Yates' correction, d.f.=1). In the population of England and Wales as a whole, the proportion of male to female births in 1985 was 385 to 366 (Central Statistical Office, 1987). This represents a ratio of 1.05:1.

Table 5 Distribution by sex of child and area - Phase II

	Priority Areas	Non Priority Areas	Total
Male	4* (44%)	3* (33%)	7
Female	5 (56%)	6 (67%)	11
Total	9 (100%)	9 (100%)	18 +

d.f. = 1   x2 = 0.4675   >(with Yates')

Not significantly different

+ One parent withdrew before child was born

----

* N.B. expected numbers are <5 in each cell - test stability is said to be reduced (Cohen and Holliday, 1982) though some have argued otherwise (Everitt, 1977). It is therefore debatable how valid this result is.

The sex distribution of children in phase one was not controlled for, but was not significantly different between areas (see Table 6).

Table 6 Distribution by sex of child and area - Phase I

	Priority Areas	Non Priority Areas	Total
Male	10 (56%)	15 (65%)	25
Female	8 (44%)	8 (35%)	16
Total	18 (100%)	23 (100%)	41

d.f. = 1 $x2 = 0.4928$ (with Yates')

Not significantly different

Employment status by area

Another variable which could be influential is employment status.
It could be suggested that as unemployment causes differences
from the 'normal' lifestyle and expectations of a family - for
example due to the presence of both parents at home, reduced
income, or increased stress in the family and can affect health
status (see for example Brenner, 1977, Fagin and Little, 1984),
so it could account for any differences between groups if it
occurred significantly more in one than another. Tables 7 and 8
show fathers' employment status in samples for the two phases.

Table 7 Employment status (fathers) by area - Phase II

Fathers	Priority Areas	Non Priority Areas	Total
Unemployed	1 (11.1%)	0 (0%)	1
Employed	8 (88.9%)	8*(100%)	16
Total	9 (100%)	8*(100%)	17

* one father was a student and has been categorised as employed rather than unemployed.

Data for one father was not supplied as he was not present, nor in contact.

Chi square test was not carried out due to very small expected frequencies.

Table 8 Employment status (fathers) by area - Phase I

Fathers	Priority Areas	Non Priority Areas	Total
Unemployed	5 (29.4%)	3 (13.6%)	8
Employed	12 (70.6%)	19 (86.4%)	31
Total	17	22	39

Data missing for one, one not present

$X2=1.5280$ d.f. = 1   Not significant

(But see note to Table 5 concerning small expected frequencies)

Male unemployment rates for Newcastle in the 1981 census were:

Priority Areas   26.9%

Non-Priority Areas   12.5%

The sample for phase one appears to be reasonably representative
in terms of employment rates, and as the City rates quoted are
for 1981, it is likely that they would be higher in 1986/7. The
phase two sample is too small to draw any conclusions about
representativeness. However, in addition to the father who was no
longer in contact with the child's mother in this group, two

other fathers were not cohabiting at the start of the study, three by the end of the study. Some of the effects of employment/ unemployment upon families may be masked by the effects of single parenthood for these women.

Single Parenthood

Single parents are another group who are likely to have different experiences of motherhood, even in the antenatal setting (see MacIntyre 1976). Three (later four) women out of nineteen (15.78%, later 21%) in the phase two sample were single parents, and one out of forty-one (2.4%) in the phase one sample. This difference was not tested statistically as the numbers were very small. The percentage of single parent households in Newcastle at the 1981 Census was 2.5%. It is not clear why the phase two sample should contain a relatively large percentage of single parents compared to the phase one sample. The hospital at which the phase two sample was drawn is not noted for taking single parents. The distribution of single parents by area was as follows:

	Priority Areas	Non Priority Areas
Phase I	1	0
Phase II	2(3)	1

Class distribution by area

Another important feature of the two samples and their sub groups which may have some significant influence on the participants' perceptions is social class. The parents' occupations have been classified according to the Registrar General's Classification of Occupations 1980. Problems with the use of this system are discussed in Chapter Five. For those who were unemployed at the time of interview, socioeconomic group has been assigned on the basis of their most recent previous occupation. Even so, in some cases no job had been held since leaving school. Two parents were university students. Tables 9 and 10 show the class distribution of fathers in each sample:

Table 9 Class distribution (fathers) by area - Phase II

	I & II	III N & M	IV & V	Total
Priority area	2 (22.2%)	5 (55.5%)	2 (22.2%)	9 (100%)
Non Priority	6 (75%)	2 (25%)	0	8* (100%)
Total	8 (47%)	7 (41.1%)	2 (11.8%)	17Ƴ(100%)

[------------------------]

* 1 father was a student

Ƴ details were not given for one father

X2 = 4.966   d.f. = 1 (III, IV and V collapsed

together)

(with Yates')

Significant at 0.05 level.

Table 10   Class distribution (fathers) by area - Phase I

	I & II	III N & M	IV & V	Total
Priority area	2 (12.5%)	7 (43.75%)	7 (43.75%)	16* (100%)
Non Priority	11(50%)	6 (27.27%)	5 (22.73%)	22Υ (100%)
Total	13(34.2%)	13(34.2%)	12(31.6%)	38 (100%)

[--------------------------]

  * 1 also unemployed since leaving school

   1 father not present

Υ 1 indefinable - transcription problem

  d.f. = 1   (III,IV and V collapsed together)

    x2 = 5.979   with Yates'

  Significant at 0.05 level

There are considerable differences on inspection of the class
distribution found for both samples between the two types of
area. This is not surprising since the main reason for selecting
clients from both Priority and Non-Priority Areas was to enable
comparison of data from broadly different socio-economic groups.
Since one of the criteria for establishment of Priority Areas was

socio-economic deprivation, (see Chapter Four), a class difference was felt to be likely. Though the significance tests suggest that differences may not be as great as anticipated, they support the possibility of differences existing, in both phases. When the total sample of fathers for both phases is examined, differences between areas by class distribution significant at 0.01 level are found.

In considering the comparison of Priority Area and Non-Priority Area data at phase two, it should however be remembered that some fathers with non-manual occupations classified up to and including class I were resident in Priority Areas. Where differences in perception on this basis are apparent, they will be discussed.

The class distribution of mothers has also been examined for both samples, since many studies (for example Fox and Goldblatt, 1982) have suggested that in some circumstances the mother's socio-economic group is as influential as the father's. (However, since most authors have indicated that the father's occupational classification is an accurate guide to morbidity and mortality for children, it may be that this is less important in the context of the present study.) This point is discussed further in Chapter Five. Tables 11 and 12 show the distributions for phase II and I respectively:

<u>Table 11</u>   <u>Class distribution (mothers) by area - Phase II</u>

	I & II	III N & M	IV & V	Total
Priority area	1 (12.5%)	5 (62.5%)	2 (25%)	8 ⅄
Non Priority	3 (33.3%)	5 (55.5%)	1 (11.1%)	9*
Total	4 (23.5%)	10 (58.8%)	3 (17.6%)	17

[----------------------------]

⅄ 1 unemployed since leaving school

* 1 student

d.f. = 1 (III, IV and V collapsed together)   X2 = 1.382

Not significant

Table 12   Class distribution (mothers) by area - Phase I

                I & II   III N & M   IV & V   Total

Priority area   3 (21.43%)   4 (28.57%)   7 (50%)   14 *

Non Priority   10(45.45%)   9 (40.9%)   3 (13.64%)   22 Ɏ

Total   13(36.1%)   13(36.1%)   10(27.8%)   36
                              [---------------------------]

        * 3 unemployed since leaving school

          1 trainee

     Ɏ 1 unidentifiable (transcription problem)

              d.f. = 1   x2 = 2.416

        (III,IV and V collapsed together)

              Not significant

The sample for phase two is very small, and no reasonable
generalisations can be made. The class distribution for mothers
in the sample for phase one still shows quite a considerable
difference between the types of area, with far more mothers in
the Priority Areas falling into the manual semi-skilled and

unskilled categories. However, even when the categories are collapsed together, this difference is not significant. When the mothers from the two phases are grouped together, a significant difference can be demonstrated at the 0.05 level ($X2 = 6.428$, d.f. = 2). Overall, these results suggest that the assumptions made in sampling from the two types of area to reflect possible socio-economic effects upon perception are broadly supported.

<p style="text-align:center">*   *   *</p>

Summary

This chapter started with an outline of the way in which the results are set out in this and subsequent chapters. Some simple quantitative data about the samples used were then presented - for example the age, employment status and social class of respondents. It was explained that this was intended to place the interview material, which will be discussed subsequently, in context. It was noted that Phase Two mothers living in Priority Areas were significantly younger than those in Non-Priority Areas, and that overall fathers in Phase One were significantly older than those in Phase Two. The sex distribution of children in the study was not significantly different between areas. The Phase Two sample contained a larger proportion of single parents than might have been anticipated. The class distribution of fathers in both Phases was significantly different between Priority and Non-Priority Areas. For mothers, the difference was only significant if mothers from both Phases were considered together.

Chapter Seven

Results: Parents-to-be

The next four chapters (Seven to Ten) describe how the themes and categories which were drawn out in the analysis of the data developed through the stages of the study, and examine comparisons between them. In this chapter the main concept areas arising in stage one are discussed, and the main themes and comparisons outlined. In Chapters Eight and Nine, results from stages two and three will be described. In Chapter Ten health visitor responses will be considered.

*　　*　　*

Developing themes and categories

Using Glaser and Strauss's grounded theory approach (1967), all interview transcripts were examined as they became available. From each, all items and themes which could be identified were written down on sheets of paper for comparison purposes. They were compared with all items and themes arising from previous interviews. From this comparison, an attempt was made to form groupings (sub-categories) and categories from the items and themes. For example 'thinking it out for myself' might link with

'we decided', in indicating that the parent(s) had some control. 'I needed someone to tell me' also appeared to focus on control, but from a different angle - it was a different theme within the concept of 'power and control'.

Though this sounds like a two or three stage process, in fact it occurs more or less in parallel with the initial identification of themes and ideas, since when the researcher is reading the transcript, she is not only noticing ideas, but also comparing them mentally with ideas seen in previous transcripts. The groupings are 'formalised' by writing the themes down on sheets in their groupings after the relevant comparisons have been identified.

Some of the categories formed are linked directly to the contexts in which they arose - for example 'accessibility' may have arisen in relation to questions about the most recent contact with the health visitor - yet it also arose when discussing the health of the child. In the first instance the category 'accessibility' is a response to an externally (researcher) defined topic area, which remains within the immediate description of the contact. In the second instance, the respondent has responded to the externally defined topic, (the child's health) and has made her own jump across to a linked, internally (respondent) defined topic area (availability and accessibility of support). It could be argued that categories arising from the latter situation,

being less influenced by the researcher's vocabulary and ideas, may be more valid. Where differences in the ideas arising between internal and external contexts occur, these will be highlighted.

The final stage of analysis occurred in the process of writing up the results, as in clarifying and linking the thematic groupings which had emerged into categories and a substantive theory, further connections became clear. The eight main concept areas identified were:

Health, health problems and other concerns

The need for help - locating the problem

Advice, support and comparing notes

Choosing help

Knowledge and experience

Legitimation

Relationship or problem centred?

Power and control

The interview data at each stage will be discussed in relation to these headings.

Quotes from phase two interview material are identified using a code. This includes digits for parent (P) or health visitor (HV), the individual's personal code (two digits), the interview code (1,2 or 3), and a code for the area - Priority (P) or

Non-Priority (N). For example an excerpt might be coded P181N -
parent,personal code 18, first interview, resident in
Non-Priority Area. Phase one interview material is coded
similarly, but with A for phase one (all parent interviews) and
without the interview code, since there was only one with each
respondent.

Background - Antenatal mothers

Stage one interviews took place when the mothers-to-be were
around 28 - 32 weeks pregnant. In three cases their partners were
present for part or all of the interview, in two their own
mothers were present for part of the interview. Interviews varied
in length when transcribed from three pages to twelve (mean
length five pages). Clearly the level of content in those
interviews (three - one Priority Area and two Non-Priority Area)
which ran only to three pages is considerably different to that
in the twelve page transcript. They tended towards more limited
answers, and were not easily drawn out at this initial interview.

Health, health problems and other concerns

Definitions of health were explored with the parents-to-be. What
would they mean by a healthy baby? What factors might be

important in keeping it healthy? Almost two thirds (11) of the parents at the stage one interview mentioned the baby being "happy" or "content" as being important in judging whether it was in good health. Ten parents mentioned "not crying" as being important. A smaller number of parents mentioned the importance of the baby "gaining weight" or "feeding well".

It may be that the images of motherhood and indeed of babies put over by the media, particularly in the antenatal literature (see Graham 1977) tend to reinforce the image of the perfect healthy baby as a smiling and/or sleeping beauty. A recent edition of a magazine for parents (Parents magazine, April 1988) contained eleven pictures of babies, all of whom were smiling or sleeping. Where crying babies are discussed in literature for lay people, (for example Phillips, 1983), this tends to be in the context of coping with a problem, or even an illness - 'colic' or an allergy for example. The norm is conveyed as being 'not crying'.

Antenatal parents were asked: "What do you think will be the most important factors in keeping your baby healthy?". Of 18 respondents, 11 included diet or food. In some cases this was emphatically the most important factor:

PO51P   'From what I understand that is how the baby grows, so it is very important to make sure its getting the right amount em, if you're giving it enough, obviously its

going to grow, put on weight, so that what I see as one of the main things.'

For other mothers who cited food or diet, it was not as significant at the first interview:

P111P   'Oh, keep it happy, clean and well fed.
         AND WHEN YOU SAY KEEPING IT HAPPY?
         Well I mean you can keep it happy, a baby, clean and well
         fed, but it can still be ill a lot because you're not
         taking any notice of it'

Whilst diet is mentioned, 'taking notice of' the baby - for its emotional well being - is far more significant. This mother is one whose work experience would have given her opportunities to handle young children and learn about their needs. She is unusual in this respect, since most of the parents who placed greater emphasis on social and emotional aspects of health at this stage had little or no experience of children.

Hygiene, cleanliness and avoidance of infection feature strongly in the antenatal interviews. (Nine parents mention an environmental factor of this sort). One mother (PO21N) describes how she will make sure that everything is 'clean and tidy' and have sterilising equipment for feeding her baby, then goes on to describe her aversion to public parks, where infections can easily be picked up from dogs and cats, and her intention to

avoid 'the way babies get handed round from people to people'. This mother places a lot of stress on cleanliness and avoiding infection. Implicit in this and other comments is the idea of health as non-illness. The wider environment is also associated with enabling or disabling health. One mother expressed this uniquely in terms of pollution and radiation at the antenatal interview:

P121N   '..I wouldn't like to live in a polluted area or near a
          factory, smoke, dust and that'

For most mothers however, the idea of environment is less macroscopic, and related to the home which they would provide for the baby:

P061N   'Generally the environment we provide in our home in
          terms of warmth and food and general cleanliness...
          Emotionally of course there's extras there that mean good
          relationships between us and the baby, but er the
          cleanliness thing is the thing that is most on my mind at
          the moment.'

These very practical, physical concerns contrast strongly with the very much more socio-emotional definitions of a healthy child given by many parents-to-be in answer to the question -'How would you decide if it was in good health?'. Those parents who did not include happiness/ contentedness in the characteristics of a

healthy baby came from a variety of backgrounds and experiences, the common denominator of which appeared to be ready access to experience and information about babies. This access was through direct experience, through closely involved relatives, or through social contact with health professionals. Where this was not present, good health appeared to be seen as an ideal based on media images and society norms, even though the influences which are thought to operate on health indicate that a more practically based model underpins this.

The need for help - locating the problem

Another way in which health problems may be categorised is in relation to the need for help. What magnitude is the problem? At the first stage, parents have little idea about what to expect, including the sort of problems which may occur. Their perceptions of likely problems are closely linked to their perceptions about the sort of help they may need, and where it might be available.

For example, several (nine) mothers indicate that if their babies were to cry they would be uncertain what that might mean:

P101N   "For crying and things like that - if its perfectly
         normal or the baby's in pain..., People say a lot of it's
         instinctive. I'm relying on this instinct to come into

being. "

This mother hopes that 'instinct' will help her to decide what, if anything, is wrong. Most of the parents in this phase of the study had little or no experience in caring for babies and young children, even for short periods. (See section on knowledge and experience). They cited a variety of sources of information utilised in the antenatal period. Some (5) had read books, magazines and newspapers:

PO61N   'On what I can read you tend to concentrate in the first
         twelve months on getting everything right that you can do
         in terms of providing rather than playing with the baby
         or being there all the time for the baby'

Others (3) had listened to radio or television programmes :

PO21N   'Radio 4 - There was something about an orange light in
         the child's room - advising against it'

Much of the information gleaned from these types of source was very practical advice, or advice about the goals of interaction with a baby. In three cases it related specifically to the risks of cot death. "I've got this terrible fear of these cot death things that are so prominent ... in the newspapers" (P191P). Anxiety about death or disability was mentioned by five parents.

Others currently relied on relatives and/or friends for information :

PO71N   (asked friends with children)"Things like...how do you
         know when they're hot and cold when they're little and er
         how much clothing do they need on and er just all those
         little practical things"

At this stage the focus of information seeking from lay people is on practical questions relating to the welfare of the forthcoming baby - 'How do you know? What should I do? Can I? ' Parents-to-be appear to anticipate problems to do with practical caring.

Advice, support and comparing notes - choosing help

Many parents at stage one were confident in their ability to cope with health and related problems. Few went so far as to suggest that they would not require help or advice in looking after the baby. Grandmothers, friends and relatives were frequently cited as resources. The type of problem confronted was seen as important in choosing help. Many parents were vague about the professional help which would be available to them.

In response to the direct question: "Who do you think you might ask for help or advice about looking after the baby?", choices of lay people (22) and of health professionals (20) were roughly equal. This may be due to the focus of the question which was on 'looking after' the baby rather than health care specifically, to pick up a wider picture. However, including mentions made elsewhere of current advisers, professionals featured more. Most of the mentions made elsewhere were in relation to advice on "anything wrong"(P171N) - unspecified, and feeding - especially by those intending to breastfeed.

Parents tended to cite the GP as a resource for when the baby was ill, or the problem was seen as serious:

P111P   "If it was something serious I would go to the doctor"

This mother is confident of her own ability to judge whether some symptom is serious or not. Another mother said that she would go to the GP "if I thought the baby was physically ill" (P201N). Again, this mother demonstrates confidence in herself at this stage. Studies such as those by Spencer (1979), Pattison et al (1982) and Cunningham-Burley and Irvine (1987) suggest that such confidence would not be misplaced, since parents in these studies correctly identified symptoms as serious, and in general consulted GP's appropriately in relation to significant problems. This is however of interest when compared with mothers' perceptions of their need for help at stages two and three. At

stage two, self confidence is much reduced, and reliance on professionals increased. By stage three, confidence is returning, and less help is sought.

Despite this confidence in their own abilities, few parents felt that they would not require help in looking after the baby. One indicated that she was unlikely to seek help, - "I don't ask anybody else now, so why should I start now?"(P141P) - but conceded that she might ask her mother about anything of relevance. Her own mother was the prime example of an experienced relative to whom many mothers-to-be felt they would turn:

P191P   "My mums always - every time I ring her up its - now have you done this, and have you done that. My mum's had five children so she's always there to ask, sort of for help.

Another mother-to-be described her mother as a "sounding board" (P061N), with whom she felt she would check out her uncertainties , and again referred to her mother's experience in bringing her and her brother up. Yet another mother-to-be suggested that her mother would have a vested interest in providing advice and support to her daughter, since this was her first grandchild and "she wants everything to go right"(P131P). Geographical accessibility was not seen necessarily as a problem:

P201N   "Probably the things like crying and sleeping....I'd probably phone me mum first"

The type of problem ("anything that I wasn't quite sure about"-
P201N) seems to be of more significance. Unlike the confidence
with which these parents generally indicate that they would seek
medical help, more general health or behaviour problems about
which they might be uncertain are usually thought more suitable
for lay help.

Sisters, sisters-in-law and friends who had slightly older babies
were also suggested as advisers. They fulfilled an additional
role for some, if not all, of the eleven parents who mentioned
them:

P191P   "I've two or three close friends who are - one's just had
         a baby and the other one's pregnant, so its sort of quite
         nice. I don't feel isolated as if its only me having a
         baby and everybody else hasn't"

They provided company in the journey into a new role and a new
set of experiences - companions in fortune to reduce the
isolation felt by the person entering the transition to
parenthood (see for example Clulow (1982), or Ong (1983)).
Another parent indicated that parentcraft classes offered a
chance "to swap ideas"(PO21N) - a theme which is developed by
other parents in subsequent stages.

Many of the mentions of health professionals were vague in nature. A number of women mentioned midwives' visits. One had met her health visitor at the antenatal clinic held at her doctor's surgery. Though the clinic was mentioned relatively little as a likely source of advice, it featured in parents' descriptions of services in just over half the interviews at this stage. It was often mentioned as somewhere that the expectant mother had been to with or heard of from a friend or relative with a young child. Many parents were largely unaware of the available professional network, or confused various aspects of it. Only the clinic appeared to emerge with a more concrete identity for them:

PO51P   "At the clinic. I'm not sure, so I think go to the clinic for anything"

PO81P   "Just the clinic. I don't know, I don't really know a lot about anything"

A few parents (four) at this stage specifically rejected the advice of family or friends in favour of that of professionals. Examination of their answers in contrast to 'the norm' highlights assumptions in the normal data, in the manner that Glaser and Strauss (1967) describe. One parent rejected lay advice primarily on the basis that:

PO51P   "everybody's got their own individual way of coping and bringing up a baby and you know one person might say oh well I wouldn't give the baby that and somebody else

might say oh well yes I think you should, and I think you can get too much advice."

She also commented that 'times have changed' compared with when grandparents were bringing up children. These remarks highlight the implicit themes in other comments, that one individual (usually the baby's grandmother) will be able to give overall guidance to avoid conflict, and that child care advice, as common sense, might be seen as readily adaptable to the present, or alternatively as changing very little in a generation. The changes visible in the literature of child care over the past few decades indicate that the latter is not true, even though children might be thought to be much the same in essence. Another couple remarked that they would not seek advice on child care from some of their friends as they did not see eye to eye on this matter (P021N). This draws out the implicit idea that advice is usually sought from those with whose ideas one is largely in sympathy.

Experience and training, accessibility and approachability appear to be of particular importance amongst the criteria upon which potential advisers are selected. At this stage the parents' ideas of possible problems are embryonic, and their contact with health professional advisers has generally been minimal in practice.

Knowledge and experience

Parents at stage one described two types of knowledge in relation to the helpers they used. These were 'professional' knowledge, and common-sense, experience based knowledge. The latter was described as exclusive to lay advisers at this stage. Most of the parents at stage one had little or no experience of caring for babies and young children, even for short periods. Those who had experience of work with young children and babies, or who had very close access to people who had that type of experience, or to other relevant information sources tended to look upon children's health more in terms of disease - and less idealistically - and to locate possible problems in a disease based framework.

Amongst likely sources of information and advice cited by parents at this stage - books and magazines, antenatal classes or clinics and midwives, relatives and friends, mothers and mothers-in-law, child health clinics and health visitors, and GPs - two types of knowledge or information can be discerned. One is the professional knowledge which professionals have - "that's their job"(PO51P). 'Professional help' is mentioned by several parents as desirable if significant problems are encountered. Sometimes the need for 'professional' knowledge is implicit rather than explicit in the interview data. For example, one mother commented:

P121N   "If I think the baby's not well obviously I would go and
         see the GP or the health visitor, you know, ... that sort
         of people and ask them for their advice em otherwise, if
         there is just a little doubt or problem I may not think
         is important I might ask around the experienced mothers,
         you know, friends of mine"

Professional knowledge is here related to the child being not
well – the GP or the health visitor will give advice. If the
problem is assessed as less important – 'little' – then the
second type of knowledge – arising from experience – will be
utilised.

Knowledge arising from experience – 'common sense' knowledge – is
attributed exclusively at this stage to lay people:

P191P   "My mum's had five children so she's always there to ask,
         sort of, for help"

The possession of children is cited as a qualification for
advising in fifteen stage one interviews – all relating to lay
sources. The reason for this is indicated in the following:

P061N   "..someone more experienced, like my mother, who actually
         remembers er will say, yes it looks bad but its not bad
         really and if you're worried go to the doctor..."

She feels that her own mother is likely to remember similar episodes, and their outcomes, and using this, to help her to make a decision. In this encounter she will also, like many of the others, be building up her own knowledge base -

P161P   "Me mam will be around, and me sister-in-law and that. I'll just have to keep on asking until I find out what to do".

At this stage this type of 'experience-based' knowledge is not attributed to health professionals at all, nor is it suggested as a desirable attribute by those who prefer professional advice.

The parents' own experience of children appeared to be of significance in relation to their definitions of health, and thus their location of problems within a framework of 'known about' problems, resources and solutions. For example, those parents (seven) who did not include happiness/ contentedness in the attributes of a healthy baby came from a variety of backgrounds and experiences. Three had some experience of young children, but had not lived with them day to day. The fourth had no previous experience of preschool children, but lived with her mother-in-law. The fifth indicated that her own mother called frequently and was already advising her on what to do and what not to do. The sixth and seventh mothers had no previous contact with or experience of children. Both were older than the mean for

the sample, suggesting wider life experience. One had been a librarian and the other a medical technician. Both had enhanced access through their work to health information, and the latter was experienced in negotiating health care systems, albeit from a professional perspective.

All of these mothers had access, directly or indirectly, to greater levels of experience and information about babies than the other parents. This might, in a variety of ways, have led them to take less idealised positions and/ or more medicalised positions in relation to defining a healthy baby.

Legitimation

Two types of legitimation are described at stage one. The first is the legitimation of sharing a situation - being pregnant - and the problems and anxieties of that state - with other mothers. The second is the legitimation of the lack of child care skills which some mothers perceived in themselves.

Eleven mothers commented at stage one on the importance to them of friends or relatives who had recently had or are having babies. The following example was cited earlier:

P191P   "I've two or three close friends who are - ones just had

         a baby and the other ones pregnant so its sort of quite

         nice. I don't feel isolated as if its only me having a

         baby and everybody else hasn't"

In sharing her situation with others, its essential normality is

emphasised, and it is normalised - legitimised.

Four parents expressed doubts of their own ability to make

appropriate judgements of health related needs or offer adequate

care to the baby when it is born. This situation could be

legitimated by suitably knowledgeable lay people or

professionals. One mother described how she discussed this with

her own mother:

P141P   "- I says when it cries, when you've fed it, changed it

         and everything, that's when I would start to worry. You

         know, in case anything was wrong with it, like

         afterwards. But she says 'there's always some reason.

         You'll know, understand yourself, when you've had it'"

This grandmother is not only legitimating this mother-to-be's

current uncertainty, but is setting up the 'norms' for the next

stage - 'you'll know'. She is suggesting that parenting is in

essence a matter of instinct - automatic response to the demands

of the baby. Not 'knowing' appears unthinkable to the

grandmother.

Relationship or problem centred?

Whilst most parents' ideas of all the child health services were somewhat vague, their expected patterns of interaction were less so. Relationships were valued in projected interactions with health visitors. Getting on well, showing interest and individual attention were all thought to be important. Most parents at this stage expected health visitors to deal primarily with problems. They described two types of role - firstly judging and checking, and secondly offering support.

Relationships were mentioned as important by six mothers. In discussing who she might ask about what sort of problems, one said that she would first of all ask her mother, but:

PO21N   "I think if I got on well with the health visitor that
        came to me then I would turn to her.."

The relationship is seen as the significant factor in choosing the health visitor as an adviser - rather than her knowledge - which this mother may be assuming - or her ability to reassure. Although most (15) of the parents who comment on the role of the health visitor do so to the effect that they will be there to

deal with problems, in a few cases, discussion of their expectations of other professionals can be illuminating. Another mother describes her experiences to date in the antenatal clinic, and concludes:

P051P   "You know you feel, although you might have questions, you feel what's the point in asking, you know, they're not really interested at all. You know you feel more at ease on a one to one basis..."

Interest in her is important to this mother - one facet of a 'good' relationship. So also is individual, one-to-one attention, and she goes on to say that she expects to be able to find out the answers to questions she wouldn't have dreamt of asking in the antenatal clinic, from the midwife and the health visitor, as they visit her at home.

Another facet of client-health visitor interaction which was illuminated in the stage one interviews relates to the role of the health visitor. Though few respondents had any substantial idea of the health visitor's role (four had no idea that she existed), those who had some idea included two main types of role. The first (described by nine) was the judgemental role:

P221N   "They actually come to the home and have a look and see what you're doing to the child, whether you're abusing them"

For some parents this was seen more in terms of judging or checking on developmental progress or even environmental health than child care, but still retained overtones of acceptance or rejection of the child and/or its parents.

The second type of role described (by six) was the support role:

PO61N   "I'm expecting a lot of support in that sort of area, in the sort of physical side of er caring for a child from the midwife and the health visitor who are coming into my home"

One mother (P131P) described how her perception of the health visitor's role had been altered, through a visit when she had discussed it with her health visitor, from a judgemental role to a support role - 'to make sure you're coping all right'. Her health visitor had laughed at the idea that she might visit because: '(she) thought people was battering their babies', and in so doing had convinced the mother that she was fulfilling a support role rather than a judging role.

Power and control

Though interactions were discussed prospectively, several parents
described the importance of being as independent and
self-sufficient as possible at this stage. They wanted to retain
some degree of control over their actions in relation to the
expected baby.

Seven of the parents clearly expressed the value they place upon
being independent and self-sufficient as far as possible. This
point was made by some in response to the question on who they
might ask for help or advice (see P141P above) and by others in
discussing services they had so far encountered:

P021N   "Personally I'm very self sufficient anyway. I don't rely
          much on other people --"

Other mothers, who appeared to value professional sources of help
highly, described how they had in practice taken initiatives to
increase their own knowledge and hence their independence:

P101N   "..you tend while I've been at work to just keep up with
          what stage you are - and everything's related to
          pregnancy and now I've started to think I must start to
          read round for afterwards"

All but five mothers had just finished work, permanently or
temporarily, at the time of the first interview. Each of their
jobs, though considerably varied, had demanded some degree of

independence, whether as a clerk/typist or a librarian. These mothers-to-be were treating the new job of mother much as they had treated their old jobs - intending to use 'experts' and resources of various kinds but primarily to be self sufficient. Ong (1983) describes the transition to housewife which takes place just prior to the transition to mother, and discusses how women react to the reduced status of the housewife. She suggests that it is frequently raised by the apparent sacrifice of work-based status in order to be a 'better' mother - mothers being seen as high status in society in general. The majority of mothers in this study appear to be working to achieve and maintain their status as mothers, through displaying independence and competence in the new 'job'. Even amongst those who had least confidence in their own abilities, the importance of actively seeking help and finally achieving competence comes through:

P161P   "I'll just have to keep asking until I find out what to
         do"

Comparisons of Priority Area and Non-Priority Area Responses

One of the ways in which it was always intended to consider interview material at each stage was to make some comparison between the responses of parents living in Priority Areas and those living in Non-Priority Areas. As there was some evidence of differences in the socio-economic status of parents in the two

types of area, it was thought that their experiences and environment might have significantly influenced their perceptions, of both health and health visitors. At stage one there were nine parents in the Priority Areas and ten in the Non-Priority Areas.

At stage one parents in each type of area expressed similar ideas about definitions of health and non-health. The main difference found was not in relation to area of residence but in relation to access to experience: Of the seven mothers who had greater access to experience, and defined health less in socio-emotional terms, four lived in Priority Areas and three in Non-Priority Areas. (Four had husbands in manual occupations, and three non-manual). Diet and food were mentioned very frequently by both groups, (six Non-Priority parents and five Priority) as were hygiene, cleanliness and avoidance of infection (four Non-Priority and five Priority).

Whilst the likely problems to be faced by mothers in both groups were thought to be very much the same, sources of information did differ to some extent, though numbers were too small for statistical analysis. Only one parent from a Priority Area said that she had looked at written information, compared with four from the Non-Priority Areas. Her husband was from a non-manual occupation. The three who mentioned that they had listened to radio or television programmes were all from Non-Priority Areas.

However, those nine who were using or expected to use the information available through antenatal classes and clinics included four from Priority Areas (two with husbands in manual occupations). Information seeking in both groups tended to focus on practical questions relating to the care of the baby.

The distribution of advisers mentioned by parents at stage one showed no significant difference in mentions of lay or professional advisers between parents from the two groups. (Chi Square = 1.014, with Yates' correction; degrees of freedom = 1). Neither was a significant difference found between manual and non-manual groups (Chi Square = 0.5335, with Yates' correction; degrees of freedom = 1). The mothers' own mothers were cited as advisers slightly more often by the Priority Area parents, and health visitors and GP's by the Non-Priority Area parents. No clear reasons for this emerged. The distance at which mothers lived did not appear to be a deterrent to consultation, as telephone contact was cited as likely in three cases. There is some evidence (for example, Black Report, 1980) that people from social classes I and II tend to use health services more than those in classes IV and V.

Professional knowledge and common-sense knowledge were indicated as being important by parents in both types of area. Professional knowledge was more often associated with dealing with important or 'serious' problems, and illness. 'Common-sense' knowledge,

arising from experience, was attributed to lay advisers, and
generally related to decisions about how serious a problem might
be, or help in dealing with 'little' problems. Parents in both
groups demonstrated the same pattern:

P201N   "If I thought the baby was physically ill I'd go to the
         doctors ... Er probably the things like em crying and
         sleeping, before I go to the health visitor, I'd probably
         phone me mum first."

P081P   "(Friends) for things that aren't like medical concerns.
         SO WHAT SORT OF THINGS WOULD YOU ASK THEM ABOUT?
         I'm not sure. If it wasn't well, but I didn't think it
         needed to go to the doctor, to see whether their child
         went through it"

The need for legitimation, though not much in evidence at this
stage, was to be seen equally in responses from both types of
area. Parents in both groups expressed doubts about their ability
to make judgements of health related needs and their skills to
care adequately for the baby once born. Sharing of their present
status and concerns with other mothers enabled respondents to
feel 'normal' in a new role (mother-to-be), and to feel that
their concerns were legitimate.

Patterns of interaction with child health services were described
in similar terms by both groups. 'Getting on well', individual

attention and showing interest were thought to be important by parents when looking for an adviser. However, most parents who commented on the role of the health visitor (six in Priority Areas and nine in Non-Priority Areas) indicated that they thought that she might primarily deal with problems. Many comments were extremely vague, and prefaced or concluded by remarks such as:

P201N   "I'm not quite sure really. Er, I know she comes to visit...

Of these, four in Priority Areas and five in Non-Priority Areas suggested that she would have a 'checking' or 'judging' role. The remainder indicated that she would offer support to them. Parents classified as manual were equally divided between those who anticipated a checking role, and those who did not.

Parents from both groups described the importance to them of being independent and self-sufficient. This did not mean that they would not seek help or advice, but that they indicated that this would only be after trying to cope themselves, and that they would retain the final decision. Three parents from the Priority Area (two manual) and four from the Non-Priority Area (none manual) commented to this effect. Parents in both areas expressed their desire to maintain a degree of independence through acquiring information:

PO61N   "I want to get lots of information from independent
         sources for myself."

P191P   "I know you shouldn't go by books and read them literally
         and treat them as bibles, but it is a help if you know.."

Independence in decision-making, usually through the possession
or acquisition of information appeared to be valued by both
groups.

Summary

The majority of parents-to-be saw a healthy baby in terms of
happiness and contentment, or 'not crying'. Those who did not
define it in this way appeared to have access to greater
experience, either directly or through a close adviser. Food and
diet, and hygiene and environmental health predominate amongst
the factors which it was suggested would be important in keeping
the baby healthy. Most parents-to-be had little experience in
caring for babies and young children, and were uncertain as to
what problems might arise. They relied on a variety of sources of
information, including the media and lay and professional
sources. The main focus of information seeking was on practical
issues relating to the welfare of the forthcoming baby.

Despite their lack of specific information, several parents demonstrated confidence in their own ability to cope, and expressed their desire to be independent and self-sufficient as far as possible. The choice of advisers depended upon the likely problems envisaged, together with the perceived experience and training, accessibility and approachability of potential advisers. Two types of knowledge were identified. Professional knowledge was generally related by parents-to-be to the child not being well. If the problem was assessed as less important, then 'common sense' (experience based) knowledge was to be utilised. This type of knowledge was not attributed to professionals at all at this stage.

In relationships with lay advisers some degree of legitimation of 'parent-to-be' status and of uncertainty had already occurred. Relationships were valued in anticipating interactions with health visitors. Getting on well, showing interest, and individual attention were thought to be important. However, most parents expected the health visitor to deal primarily with problems. Two types of role were described by parents-to-be: Firstly, judging and checking, and secondly, offering support.

Relatively few differences were found between respondents from Priority Areas and those from Non-Priority Areas. The main difference was in information sources - the media played a much

reduced role as an information source for Priority Area

respondents in comparison to those from Non-Priority Areas.

Chapter Eight

Results: Life with the new baby

This chapter describes the themes and categories encountered in parent interviews at Stage Two of the study, when the baby was around eight weeks old. Changes and developments since Stage One are discussed. Priority Area / Non-Priority Area comparisons are again made, though few differences are found.

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Background - stage two

Stage two interviews were each undertaken when the baby was around eight weeks (two months) old. At this stage there were eighteen respondents, nine from each type of area, one having been lost since the previous stage. Most interviews took place with the mother alone, but in one case a mother was babysitting an active toddler during the interview, in one case grandmother was present for part of the interview, and in two cases partners were present for part of the interview. The interviews were generally longer than those at stage one, with transcripts ranging in length from three pages to ten pages, but a mean of

seven pages. Most parents were more responsive, and discursive answers appear to fill a greater proportion of the transcripts than in the first stage.

Health, health problems and other concerns

Now that they had a baby to care for, respondents were once again asked how they would define good health for their baby, and how they would go about maintaining it. At the first stage the majority had put forward a picture of a 'happy, contented' baby, taking a socio-emotional definition of health. A minority had suggested a more disease-based idea. This was now predominant, closely followed by functional definitions (related to feeding for example). Important influences upon health had been seen as food and diet, and hygiene related areas. These remained significant.

By the stage two interviews, at about 8 weeks post partum, good health was a much more concrete concept for the new parents - for example related to the amount of feed he would take - and much more closely linked in to illness or non health. "Nothing serious wrong" was a major grouping. Mothers remarked:

(P142P) (Yes)"She's never had nothing."

(P162P) (Yes) "She had a little bit of cold when she came out of hospital and apart from that, nothing"

(P022N) "Yes, cos I got landed with a bad cold last week and she didn't catch it, she's no bother that way"

As before, colds were largely excluded from the negative definition of health, since they were generally dismissed as non serious. Most mothers, as before, defined their children as being in good health. However, some expressed this rather tentatively, stating that they didn't know whether they were right in interpreting the baby in a particular way . One mother appeared to contradict herself in the course of this interview. She first of all said:

P052P   "Well he hasn't been too well since he came out of hospital. I've had the doctor out to him three times. Em and I've had to call on the health visitor"

However, when asked whether he was in good health or not, she said:

P052P   "I think generally yes...from what the doctor said, the (blocked) nose and the thrush is quite common. He hasn't had illnesses as such"

She appears to be subscribing, after advice from the doctor, to the idea that nothing serious wrong = health. Since the doctor says that nothing serious is wrong, the fact that she previously believed that there was sufficient wrong to call out the doctor and the health visitor (though the latter it emerged was for feeding problems) is subordinated to this view. Her continued slight anxiety is demonstrated in her initial response to a general question about the baby, (he hasn't been too well) and her emphasis to the researcher three times that the doctor had said 'its a common thing'. She added,

PO52P   "It's not something that he's had that he shouldn't have had at that age"

The idea that babies should not have some problems - rather than could not - raises the issue of responsibility for health and illness. The question arises in relation to the health or otherwise of the baby, and reflects somewhat the pattern found by Cornwell (1984) in relation to adult health and illness. Non-health should ideally be defined, she suggested, so that no blame attaches to the individual who is ill.

Functional definitions of health incorporating themes such as appetite and weight gain, with the addition of activity levels and sleep patterns, were popular with the new mothers:

P062N   "He's feeding well, he's putting weight on in line with
         the curve... so he's thriving I think"

Growth and/or feeding feature in definitions of health in all
except seven of the stage two interviews. Its importance to the
mother is demonstrated in one example when the mother says

P212P   "She takes her feeds fairly regularly. She doesn't mess
         about with her feeds."

('Messing about' is seen as negative - it is often used to
express bungling or spoiling something.) This seems to support
Oakley's (1981a) suggestion that ' A major theme of the early
weeks is feeding'. She goes on to suggest that:

> 'A baby that is feeding and growing 'well' is a prize for
> the mothers efforts, a tangible token of her love and
> work. Conversely, a baby who gains weight more slowly
> than it 'should', and who perhaps cries a lot and seems
> unsatisfied, is a thorn in the mother's flesh, a sign of
> maternal failure...Such an attitude is fanned by the
> professional advisers of baby feeding...who take it as
> axiomatic that the baby's growth and happiness must
> depend on a mother's care.'

The predominance of physical and functional definitions at stage two may stem from both the relative newness of the child and its functions, and the importance of feeding in particular. Feeding is focussed on by 11 of the 18 respondents at this stage, with remarks like:

P112P   (slightly uncertain as to her baby's health) "Yes-really...Sometimes he'll wallop off a six ounce bottle when he's only supposed to be on five, and the next day he's exactly the opposite"

Quantities of bottle might indicate the level of care given for this mother (see Oakley 1981a). She would rather the baby took more than less, even though his erratic pattern probably gives him an average feeding pattern over 24 or 48 hours. The quote also illustrates how rule bound she is: 'he's supposed to be on' x ounces. This is an important element in parents' reactions to uncertainty.

Another mother says:

P142P   "Eeeh but she eats. I mean six weeks I was feeding her on the tin, 8 ounce bottles , I mean, she wants them now. She's on baby rice and she's only 8 weeks old."

Once again, quantities of food are seen as betokening health, though in this case the baby is seen as making the rules.

The health visitor's role in encouraging the definition of a
healthy child as one who feeds well or gains weight is
illustrated by the following:

P172N   "One day she got cold, and then I thought oh, must be
she's ill. She (HV) said when she's taking milk properly,
having a properly feed, that means she's alright, you
know"

Clearly a functional definition is being utilised by this health
visitor, which the mother has fully subscribed to.

Developmental progress and activity levels also feature quite
strongly in supporting parents' definitions of good health. For
example one mother commented :

P192P   "I can tell that he's thriving. Every day he's doing
something different and he's holding his head up now. You
put him on his tummy, he lifts his head up and things."

The same mother is at pains to point out that he is by no means
'perfect' -

P192P   'he does have his screaming matches at times and his
crying times, but apart from that - '

This is in interesting contrast to many of the more idealised definitions of health given at stage one. This particular mother gave quite a broad definition in the first interview which included the baby not being unsettled or unhappy. Sleep versus activity feature in another example of this type of definition of good health in terms of function:

P152P   "When she's awake. Like at first she wasn't aware, she was sleeping all the time. She's more aware of things now."

At this stage, the parents are still exploring the possibilities of the new baby, and it's abilities are perhaps more worth mention than at a later stage. Here, being awake rather than asleep is seen positively.

Whilst at stage one, being happy and/or content featured strongly in the parents' ideas about their baby's health, at the second stage it occurs in only five interviews, though the child is said to be 'bright' or 'bright and alert' in two further interviews (totalling seven out of a stage two total of 18).

Amongst influences on health, avoidance of infection and related themes were mentioned nine times at this stage. Some parents became more aware of this area. For example, at the second

interview, one mother, who at stage one had emphasised 'taking notice of the baby' now emphasised the avoidance of infection. She talked about sterilisation of bottles and dummies, clean clothes, and keeping away "from other kids em like me friend's childrens got the mumps"(P112P). She also mentions taking him out every day for a 'bit of fresh air' - a related concept though perhaps a little incongruous in the inner city.

The need for help - advice, support and comparing notes

In stage two, advice and advisers appear to be much more specifically practical in approach than at stage one, and professionals are mentioned more than anticipated.

These interviews took place when the babies were around 8 weeks old - well within the three months which experience suggests is the time taken for the new mother to regain her confidence and feel 'back to normal'. There is no immediately obvious reason why mothers, relatives and friends should not feature more substantially. They are mentioned in 10 of the 18 interviews - compared to 22 citations at stage one as potential advisers. Midwives and health visitors feature in most cases. One or the other, often both, are mentioned as offering advice, or being asked for it, in 16 of the 18 interviews:

P032N   "(The midwife) I asked about little things - me more than
         her, but - the umbilical cord coming off you know... Its
         just by watching other people, how you handle them, you
         learn to handle them from people who have children"

The latter comment highlights the point that verbal help and
advice is not essential to a helping and supporting relationship.

Where midwives and health visitors are cited, it is generally in
relation to some of the practical difficulties of the early
weeks. Feeding, whether by breast or bottle, is a major topic,
cited specifically in 11 cases. However, rashes or potential
rashes, colds, and difficulties with communication from the
hospital are all given as reasons for consulting a professional
for advice. Some degree of contrast may be found here with the
preference for lay advice at stage one, other than for 'serious'
problems. A partial answer may lie in the fact that most parents
indicated that the problems with which they had consulted their
health visitor (or other professionals) had been of some concern
to them:

P102N   "About two weeks after she'd been born I noticed [X], and
         I had immediate panic, so I phoned the health visitor"

P122N   "For instance although I was taught how to bath the baby,
         when you come to real practice, you know you come home,

things are different. You don't have everything lying round you, the baby you know she seems so fragile - I was in a panic - the doorbell rang and here was the midwife - I said please come and rescue me!"

Panic is a word which is reiterated in these and several other similar interviews. Although it sounds rather over-dramatic, it appears in a 'story' setting each time, suggesting that it is a 'private' account (Cornwell 1984) and probably more accurately reflects the anxiety of the first few weeks at home with the baby, (under-estimated at stage one) than a more socially acceptable comment.

A mother who had indicated earlier that she would rely heavily on health professionals for advice had had considerable contact with her GP and health visitor. She had experienced a number of problems, including several with feeding, and commented that :

PO52P   "it doesn't tell you these things in the book, so I obviously had to ring her up"

For this mother, having tried one 'reliable' source ('the book'), contacting a health professional (the health visitor) becomes an imperative - 'I obviously (sic) had to'.There is a moral implication here reminiscent of the imperatives found in Parsons' (1951) description of the sick role: In that role, the patient is subject to an imperative to seek appropriate help - otherwise, as

in Cornwell's (1984) work, continued illness may be seen as blameworthy. This mother is thus seeking to avoid blame for her baby's feeding difficulties.

Another mother described how she would start to panic (sic) if she could not get hold of professional advice rapidly. She had had an apparent crisis in the first week at home when told that her baby had had an abnormal scan, and had had difficulty in contacting someone to reassure her that in fact all was well. This appeared to have influenced her to think what she might do in a future health crisis:

PO62N   "If there was something seriously wrong with the baby I
         may well be making 3 phone calls and not getting in touch
         with anybody who can advise me straight away...I'd have
         to take him to the hospital... I would frankly be
         panicking if I was here on my own... When you start
         thinking like that you start feeling very insecure.

She also noted that there had been a difference between the support she felt she had from the midwife's daily visits and the health visitor who was available by phone. The latter was less supportive. Two themes are highlighted by this example - firstly 'feeling very insecure', and secondly availability of or access to help and advice.

Relatives and friends are asked about such matters as the baby's length of sleep, or colds, and used as forums for discussing issues such as weaning. "Comparing notes" and "chatting" with friends or relatives with babies is found helpful in sharing information and in mutual reassurance:

P132P   "Me cousin, she's just had a baby so we're always swapping facts and things. She tells me what happens and I tell her."

In one case where the health visitor had provided less support than the mother had anticipated or felt she needed, she chatted with relatives and friends about a rash:

P022N   "we got together and tried all sorts of things and in the end it was probably Z's sister-in-law that gave me some Metanium which cured it"

Ironically this was a mother who had thought that she would rely heavily on her own mother and on her health visitor for advice.

Choosing help

Choice of helpers depended upon a number of factors at stage two. At this stage of course, parents were commenting upon their own

experience of services, - who they had chosen as an adviser - rather than what was in many cases a totally hypothetical situation at stage one. The type of approach used could be important.

One mother commented that her health visitor was not directive enough:

P102N   "very nice but she seemed to agree with everything you say and let you sort things out yourself. I didn't find I got any constructive help."

The non-directive approach was seen as unhelpful. She went on to comment that her health visitor was:

P102N   "a nice lady but I would have thought she would have been far more supportive and she hasn't been"

In this case, the health visitor had been uncertain about one particular problem, but had then said oh its probably OK but go to the GP if you wish. The GP had referred the baby to hospital, and although all was indeed well in the end, the mother's confidence in the health visitor was clearly reduced. She had also apparently failed to give the mother specific advice about a feeding problem, which had reinforced the mother's disillusionment. This highlights another possible factor in the

choice of an adviser - if the parent's experience of a service is consistently poor, then it appears that she will tend to use it less. This mother felt that she would tend in future to go straight to the GP.

The same interview also demonstrates how receptivity to advice was in part dependent on agreement with what was said, though different styles of approach by health visitors can be significant. This mother, having found her own health visitor to some degree inadequate to advise her on a feeding problem, decided next to take her daughter to the clinic:

P102N   "Another health visitor saw me and suggested that I -
         instead of expressing milk, 'cos I've had absolutely
         masses of milk, she suggested that I started giving
         complementary bottles out of mixed, you know, made up
         stuff to stop producing - well that sort of advice I can
         just do without! And I think well ... she had a
         completely different attitude to my health visitor, my
         health visitor thought it was great, breast feed at all
         costs, but there again, she wasn't so good for giving
         advice."

This mother had fairly strong ideas about what she wanted to do, (breastfeed), but needed help to do it. She found the non-directive approach unhelpful at this stage, but rejected the directive advice she was given, because it did not tie in with

her pre-existing beliefs. Both the mother's beliefs and her preference in terms of approach needed to be taken into account.

The majority of references to health visitors indicated that they had offered more specific advice, in relation to practical problems. Two mothers described how they had been agreeably surprised by the nature of their health visitor's involvement:

P132P   "I didn't realise it was just to keep you right and tell you about their feeding and things like that"

Health visitors were cited as a resource used in relation to one or more practical problems - especially feeding (5), as well as sleeping (2), rashes, sticky eyes, housing and 'silly questions'. Most such comments implied that some specific advice had been given - at least partially a directive approach. This appeared to be seen as satisfactory when it worked, "she says.... and I think that's what worked really" (P142P), but was dropped if it did not seem to work, or if the problem diminished:

P192P   (evening crying)"the health visitor, she said I could start giving him juice, but he's never really bothered much with the juice, he's quite happy with his feeds (now)"

Comments made about other professionals could also be illuminating. Being a new parent is a tiring experience - mentally and physically. Indeed, one mother commented that she 'could have slept on a clothes line!' (P052P). Advice about dealing with this situation is important:

P142P   "It's at night time you really get tired isn't it? I mean people say to you...this is the doctor - have a sleep when they're asleep in the afternoon. How can you when you've got washing and you're on your own and you've got to tidy up and everything?"

This example demonstrates the importance of offering advice which is relevant and appropriate to the situation. The doctor's advice appears untenable in the situation in which this mother lives, given her assumptions about standards of hygiene, housework and so on. As well as matching the style of advice given to the client and making the content palatable, advice must be relevant and realistic.

Personality was seen as important in choosing an adviser by some parents:

P192P   'That helps actually when the personalities are nice. You don't feel as if your house is being invaded.

The implication here is that when personalities are not right, you __do__ feel as if your house is being invaded, or you are being threatened. Personality can help to reduce this problem. This mother went on to say that she had wondered at first why health visitors came - 'is it to make sure you can cope?' - 'are they looking at your house?' Personality could also be important in choosing to use (or not) lay advisers - "my mum is not a baby sort of person'(P202N)

Although it may be argued that they do not strictly count as advisers, the use of books as sources of information and advice was mentioned by four mothers. Three mentioned that their babies 'didn't conform to the books at all' (P102N), or that the topic they needed was not covered (P052P) and thence turned to other sources. Written materials were mentioned more positively as a resource at stage one by four parents. Books were less responsive than most human sources of advice. In addition, the reason that some mothers could not see what they needed may have been the absence of vital clues in the text - such books are written by people who already know many of these, and who frequently assume that others do also.

Three other themes relating to the choice of advisers appeared in the data at this stage. The first was that of access (ability to reach a service), and linked to it, availability - to be used. Twelve parents commented on access to one or more of the child

health services at this stage. One mother described how easy access to her health visitor was:

P192P   "there's lots of telephone numbers if you want to ring anybody and they make it quite clear that you can ring any time, no matter how silly you think the question is.."

This mother had not needed to make use of the numbers, but was happy that they were available if needed. Another mother stated her concern about access:

P062N   "It's very difficult to contact people by telephone... if the health visitor has to go out away from the office, I can't contact her. Then I would have to ring - I'd ring the doctor, and the doctor's not there in the afternoon ..."

This mother had previously experienced difficulty in getting in touch with an adviser about a problem, (see section on advice above), which had subsequently been resolved. It appears likely that this had influenced her perceptions of the accessibility and availability of advice.

The same example also illustrates the second theme which emerged from the data - that of a hierarchy of advisers. In choosing an adviser, advisers are sometimes ranked in a hierarchy. The

hierarchy appears to be based on different considerations for different people. Six parents suggest that there is some sort of differentiation possible between advisers on the basis of one factor. In this particular example, it seems that availability might be the significant factor. In another, knowledge might be more important (P172N). For another parent, the type of problem may be the crucial factor (P132P).

Clinics have already been mentioned as a source of advice, and since they are staffed by health visitors and doctors, many of the same themes arise in respect of them. However, organisational aspects form a theme in themselves, linking up to the theme of the parents' experience of services, and to the question of accessibility and availability. An additional complication exists in that some are GP clinics, staffed by the mother's own health visitor and GP, and with the capacity to prescribe if required. Others are Health Authority clinics, at which the health visitor may or may not be the one who normally visits at home, and the Health Authority doctor is unable to prescribe.

Three parents had only attended a GP clinic, five had attended both GP and Health Authority clinics, and 10 had only attended a Health Authority clinic. One mother who had attended both clinics commented:

P202N   "...not a doctor who can prescribe anything. I'm not
         quite sure what she is. I didn't like that one big room
         where - cos you had to change your baby on your knee on
         the little wooden chair with all the other mothers all
         squashed, changing their babies and I couldn't hardly
         manage him really. But the S clinic is just like a proper
         doctor's surgery, you wait and then you just go into the
         room with the health visitor. That's a lot better. And
         there's a changing mat and there's a lot more room to
         change the baby and there's not a lot of screaming babies
         all together in one room."

Four out of five mothers who had attended both types of clinic
preferred the GP clinic. The organisational aspects commented
upon by other mothers in relation to clinics in general included
waiting time (P052P),(P082P); privacy (P022N),(P072N); 'not
knowing what would happen' (P192P); changing facilities (P132P)
and social contact (P062N),(P112P). As in the example given, each
was quoted as a factor which had affected the parents' choice of
clinic, or in some cases a factor which had affected their access
to or use of the clinic service.

At stage two, it appears that advisers are primarily valued for
providing practical help and advice. Books may be used as sources
of advice, but are not wide-ranging or flexible enough to
substitute for personal help and advice. Several factors affect
parents' choice of advisers. These include the type of approach

preferred - directive or non-directive, the parents' previous experience of the advisers available, and their beliefs. Most parents appeared at this stage to accept a fairly directive approach, which would accord with their apparent uncertainty in their new role. The personality of the adviser, and the relevance of the advice given on previous occasions could also be of importance in choosing sources of help in future.

Knowledge and experience

Whereas at stage one, few mothers had any experience of caring for babies and young children, even for short periods, at stage two, they had been doing so for about eight weeks. In discussing their initial experiences of parenting, and of various advisers, the dichotomy between 'professional' and 'common-sense' knowledge found at stage one was reinforced and some additional themes emerged.

The new parent was often without any but the slightest experience, and even those with some previous experience of child care seemed to find these first few weeks difficult. It was not just lack of information, but physical and sometimes social stresses which cause problems. One mother, a single parent, said:

P142P   "It's at night time you really get tired isn't it? ... I
          mean it's all right for them saying have a sleep during
          the day, its just more work for you to do later - isn't
          it?

She had helped in the care of her much younger sibling for many
years, but she went on to say that she hàd been worried about her
baby's feeding pattern, and had sought information and
reassurance from her health visitor. She had previously felt that
her mother would be the only person she would apply to for help.
However, she now cites the health visitor, and only mentions her
mother once, as disagreeing with the amount she bathes her baby.
She had previously advocated experience as the predominant source
of child care information. Her own experience tells her that
relevant information can be obtained from a professional source.

This difference in practice indicates that she now sees the
health visitor as the more appropriate source, but does not
indicate clearly what sort of knowledge she expects to receive -
common-sense or professional. Unlike some other parents in the
study, she does not comment upon the health visitor's own
experience and whether she might have children or not. Her
expectation is that the professional will give her the
information she wants - which she has. Another mother (P102N)
commented that she had thought that health visitors were "highly
qualified", but now felt that midwives were "far more practical".
It was practical help and advice that was being valued here,

rather than learnt 'professional' knowledge, even though the source of the practical help was equally professional.

Practical skills and basic advice were highly valued by all mothers at this stage. However, at this stage, unlike the first, parents recognised that professionals could offer practical skills and advice, and would often use professionals as much as lay sources to provide them. The decision as to which to use appeared for most parents to be based on the level of need perceived, as well as the factors discussed above involved in choosing an adviser. For example, one mother said:

P132P   "If it was just something everyday I would ask me mam rather than bother the - going to the doctor and things. But if it was something for his health I would go to the doctors"

The assumption implicit here is that her mother will know about everyday things - and that health is not everyday.

Other parents, including P142P quoted above, explicitly stated their preference for professional advice. Another mother who did this said:

P172N   "If suddenly something up I talk to my mother-in-law and I say 'Oh, something wrong with her'. But - what she say

I don't believe her, I ask her advice you know, but still
I go to my health visitor.
WHY DON'T YOU BELIEVE IT?
I think ... they just use the guess, you know, do this
sort of thing it might be better, the doctor and the
health visitor, they know more than - you see?"

This mother clearly distinguishes between guesswork (based on
experience) and knowledge (based on education). Her mother-in-law
is immediately available to discuss problems with, so she asks
her, but still checks with what she perceives to be a more
reliable source.

Legitimation

Two types of legitimation were described at stage one -
legitimation through sharing a situation, and legitimation of the
lack of child care skills which some mothers perceived in
themselves. At stage two, a third type of legitimation was
described. Checking with a more reliable source is a way of
legitimating the advice given. If a number of sources are checked
with and agree, it is a way of legitimating the action taken as a
result. If one adviser is seen as more reliable, (see above),
that advice may be preferred to legitimate the action planned. At
stage two, parents described lay legitimation of their patterns
of child care, and of their own uncertainties.

Swapping facts and comparing notes have already been discussed (see advice section). Four parents specifically mention these activities, although more mention discussing a problem with a friend or relative who has young children. In comparing notes -

P192P   "Chatting, seeing how she was getting on and how I was getting on"

- they are able to share their ideas and pool their acquired knowledge, but also to legitimate their own pattern of child care through comparison with their peers - 'seeing ... how I was getting on'.

Another mother, describing what she had discussed with friends said:

P212P   "Things about how often they wake up for feeds in the night and how much they sleep in the day. Just about the general chaos of having a baby - and how you can't get anything done any more."

At this level the interaction appears to be about reassuring the new parent that she (or he) is experiencing the same feelings of tiredness and inadequacy as most. In sharing an experience she is attempting to legitimate it. If it is common, it is less likely

to be due to some genuine inadequacy. As in the first stage, sharing feelings and ideas with the peer group seems to be important in reducing the isolation felt by someone making the transition to parenthood.

An interesting point in relation to legitimation is that the grandmother who was present for part of an interview at this stage, went out of her way to promote her daughter as a mother with the researcher (whilst her daughter made a drink):

P132P£ "She's a good mother actually for her first time ...
         she's very attentive and she's very loving towards him.."

She may have seen the researcher as a representative of authority, and wanted to offer her assessment of her daughter in relation to other mothers, to confirm from her experience that she was a 'good' mother - to legitimate her daughter's behaviour as a mother.

At this stage, interactions with professionals were not generally described in terms of legitimation. They were usually seen as directing parental behaviour (not legitimating previous decisions), or giving information. In three cases the information given indicated that a 'problem' was common, thus increasing the likelihood of its legitimacy. Thus despite the widespread use of professional help, legitimating at stage two was largely a lay

function.

Relationship or problem centred?

The patterns of interaction which parents expected at stage one had involved valuing relationships with health professionals including health visitors. Getting on well, showing interest and individual attention were all cited as important. Nevertheless, most parents at stage one expected the health visitor to deal primarily with problems, taking either a judging or a supporting role.

At stage two, three mothers said that they had revised their previous opinions of health visitors and other health professionals. A mother who was 'insulted' by authority (in the shape of midwives) at stage one, remarked at stage two that:

P142P   "I thought like sort of health visitors came, sort of looked over your house and that, 'cos I've seen them do it. I've seen them do it in other people's houses, right, and I says to her, 'cos I says you can have a look round, and she says no, I can see you're managing, so I mean she was er... she's dead nice. I've got her home phone number as well.

Here the health visitor's reported response to the mother's offer may be seen as reinforcing the idea that she was judging the mother's ability to cope. Equally it may be that this is how the mother remembers the interaction because of her own perception that this is the health visitor's role, and because she appears to have 'passed'. The fact of having the' health visitor's home phone number on the other hand appears to suggest that the relationship (embryonic as it must be at this stage) is not that of a judge and judged, but of two human beings. The health visitor has made herself a little vulnerable and human in giving her own home number, rather than staying distant as a judge. She has deliberately made herself more accessible. The home number also indicates that she has a life beyond her present role. The possession of the number is referred to by this mother almost as an indicator of the health visitor's 'nice'ness.

Whilst at stage one, relationship and problem centred interactions were quite distinct for most parents, at stage two the separation is not so clear. One of the problems is that most descriptions of contacts with the health visitor revolve around advice which has been given, or problems which have been resolved. They are in essence problem centred. Only in eight interviews is it possible to clearly discern comments, such as that above, which show that a relationship with the health visitor is valued.

Another mother commented that her health visitor was "very casual" and "just pops in"(P072N). It is not clear however whether informality is automatically congruent with forming a friendly relationship. Contrasts in the way that various professionals are spoken of can be enlightening. In one interview, the midwife was seen as "a little bit bossy"(P202N). The health visitor on the other hand is described as having "a chat", as well as doing checks. The latter suggests a more positive and friendly relationship than the former.

Eight respondents described their interactions with the health visitor in terms of the problems about which they had been consulted, or the help they had offered. Not all of these were positive in tone: One respondent described how she and her husband had asked the health visitor :

P082P   "To write we a little note, just a little note just saying that it would not be very good for the health of the bairn and she wouldn't. She refused and it wouldn't have hurt her to write it to see if we could get it"

The health visitor had failed to fulfil their expectations - which indeed were not so high as to expect that a letter would necessarily solve their problem (with housing), but that it might have helped.

Another mother said that she saw her health visitor every week 'at the baby clinic', and had been visited twice at home, but added:

P162P   "about once a week she rings up to see if everything's alright"

The implication here is that she is checking for problems. If there are none, if everything is alright, then there need be no further action. These ideas revolve around what is in essence an image of the health visitor as a judge of parenting, of environment, or of adequate care. 12 parents described their health visitor's role in this way, although four also described a parallel supportive role. Though it may be that this image emerges from media treatment of cases such as that of Jasmine Beckford (Blom-Cooper Report, 1985), it appears from the present study that this image is not on the whole extant at stage one - in the antenatal period, but emerges in stage two. If the media image is important it may be that it is latent, and only emerges consciously when contact is made with the health visitor and it is articulated. It may subsequently be modified. One mother described how her understanding of health visitors changed after she articulated it:

P132P   "When I first went to see her when I was pregnant ... She said did I know what the health visitors did and I said,

yes, you go round to make sure that you haven't beat up your baby. She said no. - I didn't realise it was just for everyday sort of people."

However, not everyone expressed this very specific aspect of the judging role - making sure 'you haven't beat up your baby'. Others described it in terms of checking that the baby was healthy and developing normally. It may be that this perception of the health visitor is developed from the insecurity of the new parents in their role, and a feeling that the health visitor is 'official' - a representative of authority. It may alternatively be that the health visitor herself has by now usually had an opportunity to describe her role:

P052P   "She said that her general role in my case was that she kept a general check on the baby until he was sort of five years old, until he started going to school...

The parents by now know the 'public' image of the health visitor - both from her and from other parents. It is possible that this is therefore what the respondents chose to present to the researcher at this stage. However, their descriptions of actual encounters still tend to bear out their generalised perceptions of the interaction between health visitor and client, whether these be relationship centred or problem oriented.

Power and control

At stage one, several parents had indicated that they valued
retaining maximum independence and control of their actions
towards the expected baby. However, at stage two parents felt
very differently. Directive approaches were valued by many
parents, and only one mother felt that she had needed little or
no help. However, information to increase coping skills was still
valued.

'Support' in dealing with problems was mentioned as important by
ten parents who valued a relationship centred interaction.
However, there was still some evidence of a desire to remain
independent, as well as receiving adequate help. For example, one
mother said:

PO62N   "I want to know what's going on, you know, what to expect
         and where to go for assistance and she's very supportive
         - a bit over supportive at times in terms of - I know its
         part of the job, I suppose they've got to look for signs
         of stress and undue worry and possible depression em, cos
         it does happen.... I always feel as though she was
         looking for more than there was."

She wanted information which would help her to cope herself. But although she recognised that some people needed more help, she herself did not feel that need, and resented her health visitor 'looking for more than there was' - checking that she was coping?

Whilst at stage one seven parents clearly expressed the value they placed upon being independent and self sufficient, at stage two only one mother explicitly said that she had asked:

PO82P   "nobody really ... I'm managing quite well up to now"

although she agreed that she had contacted her GP about the baby being windy, and said she did attend the clinic "every couple of weeks". She had asked her health visitor to intervene in her housing problems (see above), but had not received the help she wanted. However, the question was directed towards help or advice on looking after the baby. All the other parents were busy learning to come to terms with being new parents, too busy with practical matters to concern themselves with their independence and self sufficiency. As discussed earlier, a directive approach was generally acceptable, as parents sought concrete answers to their dilemmas about feeding, sleeping and so on. In their initial uncertainty they were willing to hand over some control to anyone who could help them to manage. On the whole, this meant that control was given to professional helpers.

Comparison of Priority Area and Non-Priority Area Responses

Some comparisons were made between interview material from parents living in Priority Areas and those living in Non-Priority Areas. At stage two there were nine parents living in the Priority Areas and nine in the Non-Priority Areas. One mother, from a Non-Priority Area, had been lost. The interview data was examined to determine whether there were any indications that the differences in socio-economic status of the two groups, and hence their different experiences and environment had significantly influenced their perceptions.

At stage two, not being ill - the medical model - featured strongly overall, but particularly amongst parents in the Priority Areas - eight out of ten mentions at this stage. All mothers with husbands in manual occupations used this definition, but less than half of those with husbands in non-manual jobs. Expected frequencies were too small for a Chi Square test. Parents in both types of area tended to define health more in terms of functional aspects such as feeding than at stage one. Feeding figured in all but two comments relating to function - and those two fell one into each area. Five parents in the Non-Priority Areas mentioned socio-emotional aspects of health as important, compared to two from Priority Areas. Statistical analysis was not made due to small numbers - (expected values

less than five).

At this stage, though the numbers are small, it appears that there is a slight trend for Priority Area parents to define their children's health in terms of illness - on the disease based model. At stage one most parents-to-be defined health in socio-emotional terms, with no area based difference. Those who tended towards other definitions had access to wider experience. At stage two a slight change can be perceived. All the parents have now gained some direct experience. It may be that the experience of the parents from Priority Areas includes more illness - certainly more Priority Area parents (five) mention their child having had a cold or infection. Only one Non-Priority parent mentions her child having had a cold.

There is slightly less differentiation between the groups in respect of functional aspects of health. When the important influences on health cited by parents are examined, food and feeding are mentioned by seven Non-Priority Area parents and six from Priority Areas. It remains the most important influence on health for everyone. Environmental influences, especially hygiene and avoidance of infection also feature in both groups (six Priority Area parents and four Non-Priority parents mention one or more of these areas). Four parents in the Non-Priority Area mention play and stimulation as important, compared with one in the Priority Area. No parents from the manual group mention play

or stimulation as important. This may reflect the difference found in a similar direction in the use of written/ media sources, which tend to emphasise the importance of play and stimulation (see for example Leach, 1979).

Help had been required by parents in both groups with a variety of topics. The majority of these, in both groups, related to i) feeding and related topics, and ii) infections and rashes. Other topics included sleep, an oozing umbilicus, housing, a birth mark, and a group of comments such as: "general everyday things" (P132P). Table 13 shows the distribution of the problems where help was sought, by Area.

TABLE 13   PROBLEMS WHERE HELP WAS SOUGHT, BY AREA - STAGE 2

	Feeding Related	Infections & Rashes	Other	Total
Non-Priority	4	5	6	15
Priority	9	3	8	20
	--	-	--	--
Totals	13	8	14	35

$X2 = 2.0321$ $d.f. = 2$ Not significant

There was no significant difference in the distribution of problems between areas, although there appears to be a trend towards more problems in the Priority Areas. There is some evidence for this from sources such as the Black Report (1980).

Table 14 shows the distribution of advisers listed at stage two, both in relation to a direct question and in mentions elsewhere:

TABLE 14   ADVISERS LISTED AT STAGE TWO

	Non-Priority	Priority	Total
GP	4	5	9
Midwife	5	4	9
Health Visitor	3	8	11
Clinic	0	1	1
Grandmother	1	4	5
Relative	1	2	3
Friend	1	2	3
Books/booklets	2	2	4
	--	--	--
Total	17	28	45

The number of advisers used by the Priority Area parents is
rather greater than that used by the Non-Priority Area parents.
It seems likely that this is related to the increased mention of
problems. However, there is no significant difference between the

Area groups in their use of lay or professional advisers (X2 = 0.8226, with Yates' correction, d.f. = 1). At stage one grandmothers were cited as potential advisers slightly more often by Priority Area parents, and health visitors and GP's by the Non-Priority Area parents. At stage two, though grandmothers still feature more heavily as advisers amongst Priority Area parents, health visitors, midwives and GP's are also more frequently cited. Parents from manual groups also cited professionals more frequently than at stage one.

Use of child health clinics also varied between the two areas: Parents in the Priority Area predominantly used Health Authority clinics (seven), with only two having also used their GP's clinic. However, amongst parents from the Non-Priority Area only three had used solely Health Authority clinics, three solely GP clinics, and three both. In part this may be due to the distribution of practices running their own child health sessions, but it will inevitably lead to rather different experiences.

Three parents in Non-Priority Areas and two in Priority Areas (all from non-manual groups) indicated that they operated a hierarchy between advisers based on the type of knowledge and experience that they possessed. However, there does not appear to be any consistency in the precise pattern of such hierarchies at this stage - for example whether it consists of grandmother,

health visitor, doctor, or health visitor, doctor, or grandmother, health visitor. This seems to depend upon all the other factors involved in choosing an adviser. Another Priority Area respondent said that she compared lay and professional sources of advice and usually took the professional advice. Legitimation through 'comparing notes' with the peer group was found in interviews with three Priority Area parents and one Non-Priority Area parent.

Patterns of interaction with health visitors were described largely in terms of problem centred discussions. However, of the eight parents who commented about the importance of characteristics such as 'getting on well' at this stage, two were from Priority Areas and six from Non-Priority Areas. A slight trend towards a more relationship centred orientation can be seen amongst the Non-Priority Area parents, though numbers are too small to test its significance. Whilst there were some indications that parents from both groups still valued self sufficiency to some extent, only one parent, (non-manual), from the Priority Areas, indicated that she remained largely self sufficient in terms of help and advice at this stage.

Summary - Stage two

In the stage two interviews, at about 8 weeks post partum, good health was a more concrete concept for the new parents than at stage one - and much more closely linked to non health. "Nothing serious wrong" was a major grouping. Functional definitions of health incorporating themes such as appetite and weight gain, as well as activity levels and sleep patterns, were also popular with the new mothers. Growth or feeding feature in definitions of health in all except seven of the stage two interviews. The predominance of these physical and functional definitions at this stage may stem from both the relative newness of the child and its functions, and the importance of feeding in particular. Developmental progress and activity levels also feature quite strongly in supporting parents' definitions of good health. At stage one, being happy and/or content featured strongly in the parents' ideas about their baby's health. At stage two, though it is still mentioned, it occurs only in five interviews.

At this stage, it appears that advisers are primarily valued for providing practical help and advice. Books may be used as sources of advice, but are not wide-ranging or flexible enough to substitute for personal help and advice. Several factors affect parents' choice of advisers. These include the type of approach preferred - directive or non-directive, the parents' previous experience of the advisers available, and their beliefs. Most parents appeared at this stage to accept a fairly directive approach, which would accord with their apparent uncertainty in their new role. The personality of the adviser, and the relevance

of the advice given on previous occasions could also be of
importance in choosing sources of help in future.

Though some legitimation of the uncertainties of early parenthood
was described through 'comparing notes' with friends and
relatives with young children, interactions with professional
advisers were predominant. In the majority of cases these were
described in terms of problem centred activities, but the
development of friendly relationships was also valued by just
under half the parents. Health visitors were seen as having a
supportive role by about half the respondents, and a judging role
by just over half.

There were relatively few differences between Priority Areas and
Non-Priority Areas. There was a slight trend for Priority Area
parents to define health in disease based terms, which may relate
to their slightly increased incidence of problems. Priority Area
parents cited a considerably larger number of advisers, but there
was no significant difference between the groups in their use of
lay and professional advisers. There was a slight trend towards
the perception of relationships as important amongst Non-Priority
Area parents.

Chapter Nine

Results: Gaining confidence?

In Chapter Nine the content of the Stage Three interviews with parents is discussed. These were undertaken when the study babies were approximately seven months old. Themes and categories arising here are discussed, and compared and contrasted with those from earlier stages. Priority Area and Non-Priority Area data are looked at once again. Material from Phase One interviews is also considered, where this appears to be illuminating.

* * *

Background

Stage three interviews took place when the study babies were approximately seven months old - that is, about five months after the previous interviews. 16 mothers were interviewed - seven from Non-Priority Areas, and nine from Priority Areas - with no other relatives or friends present. Two other mothers, both from Non-Priority Areas, who had taken part in stage two, were lost to the study by this stage. In this chapter the content of these interviews will be discussed, and compared and contrasted with themes and categories arising in earlier stages. Phase One data,

from interviews undertaken with 41 parents of children aged between six and twelve months, will be briefly summarised, and important differences identified.

Stage three interviews varied in length when transcribed from six pages to 18, with a mean length of over 11 pages. Although the interview schedule for this third and final interview included some more detailed questions in relation to health visiting, it was not expected to result in more than a 50% increase in content (based on Phase One interviews). The mean length of these interviews was more than twice that of the initial interviews. This may in part reflect an increase in rapport between the interviewer and the remaining respondents.

Health, health problems and other concerns

At stage three, the parents interviewed had considerably more experience with babies and young children, and their care and welfare. They were asked, as at earlier stages, whether their child was in good health, if so, what they meant by that, and what they thought were the main influences on his or her health. At stage one, being happy and/or content had been the predominant theme in parents' ideas about their babies' health. At stage two, 'good health' had been a more concrete concept for the new parents than at stage one, much more closely tied to 'non

health'. "Nothing serious wrong" was a major grouping, and functional definitions of health, incorporating themes such as appetite and weight gain as well as activity levels and sleep patterns, were equally significant.

The main emphasis at stage three returned to social and emotional definitions of health. 'Nothing serious wrong' and functional definitions of health were also found, but to a lesser extent. Nine stage three parents used emotional and social definitions in describing their child's health, looking at the child's response to his or her surroundings and to other people:

P073N   "I mean she's been in good spirits and I think that's been good health"

P203P   "He's very lively and boisterous and bouncy ... got plenty of life in him"

The reason for the re-emergence of this theme as predominant at stage three is not clear. It may be developmental in that the child is becoming a more social being at seven months. In addition, parents' confidence has greatly increased at this stage (see power and control section) so that disease-based definitions and functional difficulties (for example with weight gain or sleep patterns) may seem less important. There may also be a normative aspect in these definitions, in that societal norms for babies, demonstrated in the media and in publications

for parents are, as stated in Chapter Seven, to be bright eyed, alert and smiling, or peacefully sleeping. At stage one this appeared to be a possible factor in the predominance of social and emotional themes in definitions of health. At stage two, practical difficulties, with feeding in particular, and anxiety about potential illness predominated. At stage three, as other aspects assume less importance, the social norm may reassert itself in influencing parents' perceptions.

The definition of health as 'nothing serious wrong' was used by six parents at stage three. Ten had utilised it at stage two. The thrust of this definition was to identify that the baby had:

PO63N   " ..no problems that we've had to consult any
          professional medical people about"

Those people utilising this definition all defined their own children as healthy. Most had only suffered colds and other minor problems which had not required 'professional medical' help. However, five of the 16 children whose parents were interviewed at stage three were 'ill' or receiving treatment at the time. They might have been expected to use this definition quoting their children as examples of ill health which had needed intervention.

In practice three such mothers used it, but did not define their children as ill. When asked if her child was in good health one said:

P163P   "Yeh, she's got eczema, that's the only thing, but apart from that she's fine... There isn't anything wrong with her"

Eczema can often be a considerable problem, and although this particular child appears to get it only in response to certain foods, it might still have been a sufficient problem for the mother to say that her child was not in good health. It is interesting to consider this in the light of Cornwell's (1984) work. Eczema is an illness which is often associated with psychosomatic elements. Cornwell indicates that it would fall into the category which she calls 'health problems which are not illness' - problems 'not amenable to medical treatment'. Whilst this is debatable, since a number of possible treatments exist, it is possible that the mother may be defining eczema as 'not illness' and therefore 'nothing (of any significance) wrong'.

Another parent, whose daughter had a rather more substantial problem, at least in the short term, also defined her child as in good health. The child was wearing a cumbersome splint following the late discovery of a congenital hip dislocation, yet the mother responded:

PO83P   "Yes   WHAT MAKES YOU SAY THAT? She's lively, she's
cheerful, she's never had anything wrong with her yet -
cross fingers."

It seems that as in the previous example, this mother might be
regarding congenital dislocation of the hips (CDH) as a health
problem which is not illness. However, the child was admitted to
hospital for three weeks, and came out with a splint which makes
dressing and changing her quite difficult. Hospitalisation and
treatment would indicate that Cornwell's criteria for defining
'health problems which are not illness' are not met. Although
efforts have been made by the media to promote CDH as a
relatively common problem, for example in The Archers, BBC Radio
4, it is only found in 1 in 60 children at birth, and resolves
spontaneously in the early weeks in 85% of cases (Meadow and
Smithells 1973). It could hardly therefore be regarded as 'normal
illness', commonplace enough to ignore in defining health as
nothing serious wrong. However, this mother may be interpreting
health as the absence of 'real' illness (Cornwell 1984) -
defined as serious life threatening or more long term conditions
such as cardiovascular conditions, cancer, diabetes, epilepsy and
other major disabling diseases. Since CDH is neither life
threatening nor long term, this would be possible. If she had
subscribed to a functional definition of health, the current
difficulties for her child in mobility might have led her to
describe her as not in good health.

At this stage, the tentative nature of many parents' use of 'nothing serious wrong' at stage two has changed to a confident assertion of health, even when indicators such as hospitalisation suggest that the child may not be in 'good health'. The 'moral imperative' to keep the child healthy, discussed in Chapter Eight, may be important here.

Health defined in relation to function - including feeding, sleeping and activity levels - is used less at this stage, (five times compared with 13 at stage two). It is frequently found in association with another grouping:

P193P   "He's always smiling and laughing, energetic, shouting at everybody. He's happy, he sleeps well, sleeps right through..."

Feeding does not feature so strongly in definitions of a healthy child - four mentions compared with eleven times at stage two - but it is still often mentioned as an important influence on health:

P203N   " I think obviously feeding him, feeding him the right things has kept him healthy."

It seems possible that these changes may relate to the development of the child, and of the parent's own skills and confidence. The child at seven months will usually be becoming established on a weaning diet. He or she will probably also be sleeping for a long period at night, and will usually have established a routine which his or her parents will keep to. At the same time, the child's personality will be developing, as he or she learns to communicate verbally, and the parent may be more aware of his or her moods. Food remains important as an influence, but is no longer a central indicator of health.

At stage three, as at previous stages, parents were asked to describe factors which might influence their children's health. At stage one, the main influences mentioned had fallen into two groups - food and diet related influences, and hygiene related influences. At stage two, appetite and weight gain were again seen as important influences, together with activity levels and sleep patterns. Hygiene related themes were mentioned by half of the parents at stage two. At stage three, food and diet was the most mentioned influence, followed by themes relating to hygiene and avoidance of infection. Whilst activity levels and sleep are no longer seen as important, the pattern has otherwise changed little since stage one.

Twelve mothers at stage three cited food and diet as an important influence on their child's health. "Feeding him the right things"

(P203N) is a commonly used phrase. In most cases it is taken for granted that the researcher knows 'the right things', but one mother, describing influential factors, said:

P053P   "Obviously diet now with X being 7 months he's on to virtually three meals a day. Just giving him a variety. Introducing as much fresh food and - fruit. I tend to do - when we have casseroles and that, I tend to do meals for him so I don't have to rely on buying the stuff so he's obviously getting the veg and the meat and stuff. And I give him as much fresh apples and he had a field day at Christmas with the satsumas..."

This mother describes how she gives her son a diet which she regards as healthy. Freshness is an important idea, (it appears twice here), as is the idea of variety. There is an element of moral judgement in the use of the phrase 'the right things', in that it is implied that if the child is fed on things which are 'not right' he may become unhealthy because of the mother's action or inaction. This appears to tie in to the idea put forward at stage two, that growth, and hence feeding, were often seen as linked to the mother's care.

At stage one, hygiene and the avoidance of infection, together with environmental aspects of health had been mentioned nine times. At stage two they were again mentioned by a similar number of parents. At stage three, seven parents mention cleanliness,

immunisation and avoidance of infection. Only one of the seven
mentions injections as significant. All seven mention cleanliness
or avoiding infection - preventive activities which are within
the mother's control. For example, one mother says:

PO23N   "if people have something wrong with them bug wise, not
         letting them get too near"

A medical, disease based model of health and illness has been
internalised by them.

A further influence, which did not feature substantially at stage
one or two, is stimulation - taking notice of the child.
Stimulation is listed as important by five mothers at stage
three. It is usually linked to "making sure he's happy"(P193P) or
"making sure she isn't bored" (PO73N). Another mother comments
that her son's health is influenced by:

P113P   "People. Loads of people. You know if he's got loads of
         people around him he's happy. He plays a lot."

For this mother the emphasis on company may also in part reflect
her own isolation, having become a single parent between the
second and third interviews. Perhaps the most surprising thing at
this stage is that stimulation is not more prominent amongst the
influences people describe on health, when social and emotional
definitions of health are the most common. It may be that it is

taken for granted, but it seems more probable that physical influences such as food and diet, and lack of infection are seen by parents as more significant in influencing their child's health.

The need for help - locating the problem

Problems - of both health and management - are categorised by parents at stage three in relation to their degree of need for help. At stage one, parents had little idea about what to expect, including the sort of problems which might occur. At stage two, practical difficulties - with feeding, but also colds and rashes - predominated. 'Panic' was mentioned by several parents in relation to the problems they faced, and seemed to reflect their intense anxiety in the early weeks.

At stage three, there appear to be three groupings of problems. The first is 'silly little things' - things with which parents need help, but feel that they should not. The second is problems which cause them anxiety or worry, but which do not fall into the third group - problems which are 'serious'. Several parents defined health as nothing serious wrong. No parent had experienced any problem which they now regarded as 'serious'.

Four parents at stage three describe "silly little problems"
(PO63N) - also described as "trivial" (P193P). These are not
specified in more detail. The implication is that they are
totally unimportant problems. The parents are devaluing their own
concern, because, implicitly, they should be able to cope with
'silly little problems' without help. In each case they discuss
seeking help, or not doing so, from professional advisers. At
stage two, professional advisers were widely used to allay
insecurity and uncertainty at all levels. At stage three they are
consulted about 'worrying' problems, whilst 'comparing notes'
appears to be the method of choice for dealing with lesser
queries. It is possible that it is also at least partly due to
professionals' responses to problems presented to them (see
previous chapter for examples).

The second group of problems described were those which produced
a relatively substantial feeling of anxiety. Eight mothers at
stage three described problems which had 'worried' or 'bothered'
them. One mother had asked her own mother about her baby's nappy
rash:

P143P   "'cos I was frightened, it was worrying."

Another mother described how her view of problems had altered as
a result of the advice she had received. She had been very
uncertain and anxious earlier on in the child's life:

PO63N   "He was sick three or four times earlier on when he was
         smaller and I was worried and had him to the doctors"

The doctor had explained how to distinguish serious vomiting from
ordinary posseting - "she gave me some idea of how serious it
was". This mother goes on to say that she does not now usually
need help when her baby is sick, as she knows how much is normal,
thanks to her doctor's explanations. Parents attempt to locate
new behaviour or symptoms in their 'already known about'
framework. How important is the problem? What sort of help is
appropriate? They attempt to explain divergences of behaviour
from what they regard as normal or usual. Where some explanation
can be found, the parent may be less anxious and feel less need
to seek help.

These problems, unlike the previous group, were those which they
believed it to be acceptable to seek help with. One mother
described a degree of anxiety (about her daughter's hips) which
had led her to query the expressed viewpoint of clinic staff
until, as she put it:

PO83P   " She [the clinic doctor] was that sick [fed up] she just
         said right go to the hospital ..."

This indicates the existence of very severe anxiety at that
point, sufficient to oppose professional views. Though this

mother, as described above, now said that her child had nothing serious wrong, the implication of her actions was that she had thought that something was seriously wrong and needed a hospital doctor's opinion. The definition of 'nothing serious wrong' in itself supports the idea that the third level of problem consists of those which are serious.

Advice, support and comparing notes

In describing health and health problems, parents also described how they had learnt to manage them. Interviewed when their babies were around seven months old, stage three mothers listed a variety of sources of advice and help consulted up to that time. Overall however, less advice and help had been sought since the previous interview than had been the case between the first and second interviews. Where, previously, multiple contacts with professional advisers such as midwives and health visitors had been described, many parents said that there had been a reduction - voluntary or involuntary - in the level of contact. This was attributed by some parents, who had sought less help, to increasing confidence (discussed in power and control section).

At stage two, professionals had been listed as advisers 30 times, compared to 11 listings of lay people. Though professionals were cited only slightly more (27 times) than lay sources of help and

advice (22 times) at stage three, the main change in distribution of advisers was the increase in reliance upon friends. Friends were cited only three times at stage two, but nine times at stage three. At both stages, the relationship was usually described as one of 'comparing notes'(P203N), rather than seeking advice. Though the researcher probed with each parent interviewed to ascertain whether they had used informal sources such as friends and relatives, it may be that these groups are under-represented due to parents not seeing their contribution as 'help or advice'. Enquiring who parents talked things over with, or who they chatted about the baby to might have uncovered more informal networks.

This was highlighted by one mother who commented that she didn't remember having

P123N   "to go for advice specially on any occasion, but I do like to hear people's opinions. Sometimes they (other mothers) talk, they say, oh has she had her teething diarrhoea yet, things like this, then I like to hear ... well then what happens and what shall I do?"

'Hearing people's opinions' or 'comparing notes' is an important element in decision making about the child's health at this stage. One mother described how she had asked:

P163P   "at the clinic and just friends and that and anybody who
         I think's been away with a little baby ... What things to
         take and that. Like the feeding and keeping them out of
         the sun and that. What to put on them. Just mainly to do
         with the heat"

She had asked 'anybody' - with what she saw as relevant
experience - to clarify the areas she felt concern about.

One of the groups who featured marginally as 'advisers' at this
stage highlighted another mechanism through which informal help
occurred. One mother (P123N) commented in relation to her
childminder that she gained 'practical tips' about things, mainly
how to achieve a task, such as weaning. The minder would mention
that she had tried the baby on such and such a food, and the
mother would think, that's a good idea, why didn't I think of
that? Another carer could offer this type of approach.

The use of lay advisers, especially friends appeared to be
related to the nature of the problem, as well as to the parent's
own confidence. Many comments (as described above) referred to
the 'minor' nature of many of the parents' queries and concerns:

P193P   " Just about teething and if - he had a rash under his
         neck and I said to my friend did yours get that? And she
         said 'oh yes, but it clears up once he stops slavering

and its constantly wet. Just keep putting a dry bib on him.' You know, things that you feel are a bit trivial to keep asking the - "[trailed off]

Whereas it seems reasonable to discuss 'minor' matters with someone who is a friend, or to whom one can offer a reciprocal service, the implication of most of these remarks is that professionals, including the health visitor are too important or too busy to approach with 'minor' matters.

Choosing help

The process of choosing advisers was also asked about. At stage three advisers were selected not only on the basis of the parent's own confidence or the type or level of problem encountered, but on the basis of the potential adviser's accessibility, approach and personality. This was not dissimilar to the situation at stage two. The possibility of a hierarchy of advisers had first emerged at stage two, but was not so strong in stage three interviews. Though no specific pattern was described, health visitors were mentioned either as a point of referral, or as a gatekeeper to 'higher' services

At stage three, as at stage two, the characteristics of the adviser and the service offered were seen as important in

choosing advisers. Practical day-to-day advice was rated as
important. Advice needed to be seen as relevant and appropriate
to the current situation. For example, some mothers identified
that their own mothers were not always able to give up-to-date
advice:

PO63N   "Advice from mother or mother-in-law is great in a
         practical sense (but) sometimes it's a bit out of date
         ... There's so many things that she doesn't - didn't
         realise, you know."

The help that grandparents can give is limited by the length of
time over which they are recalling symptoms and suitable courses
of action, and to some extent the degree to which thinking on
childcare has changed.

Choosing advisers also relates to the level of access available.
One mother (P193P) consulted her chemist when her son had a cold.
She had previously listed an extensive range of potential
advisers. She pointed out that the chemist was very near - less
than 100 yards away. Many parents commented on the accessibility
of health visitors as advisers, particularly in the context of
clinics. Nine parents indicated that their predominant contact
with their health visitor since stage two had been through the
clinic.

Six parents commented on the difficulties that they experienced in gaining meaningful access to health visitors - both at home and in the clinic. Lack of time to talk was often mentioned. For example, one mother said:

P143P   "They ask questions man but they like, when you want to say anything, they're always in a hurry. You know what I mean? Like they just haven't got time. I like to talk with people, I like to talk me problems over. I've got one thousand problems but it builds up inside of me..."

The health visitor fails to listen - apparently because she hasn't time. If she does have time, she does not seem to recognise this mother's need to talk through her problems, though she is a relatively young single parent. The health visitor presents herself as 'busy'. 'Busy'ness can create two sorts of barrier to communication - firstly 'someone that busy must have more important things to do than listen to me', and secondly, anyone that busy must be important - and hence separate from the ordinary person. Another parent (P023N) described her health visitor as "remote".

Different advisers might be consulted about different problems. Sometimes access to one could be negotiated through another. The idea of a hierarchy of advisers emerged at stage two. At stage three, though a few parents described transitions between levels

- for example from grandmother to chemist to G.P. (P193P) - the idea was more implicit in statements made about the sort of things which different people - for example the doctor and the health visitor - might deal with. Health visitors were mentioned as making referrals to other services (P203N) or offering access to GPs (P063N).

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Knowledge and experience

At stage three, the parents interviewed had considerably more personal experience with babies and young children. Their own common sense knowledge had expanded, and they had also had greater opportunities to absorb professional knowledge. The move towards 'comparing notes' demonstrates this, since each participant in the process has some knowledge or experience to contribute. Some parents commented that they were more self-reliant. At stage two, parents had used professionals more than lay sources to provide the practical skills and basic advice which they valued. At stage three despite the move to 'comparing notes, some parents described professional advice as more authoritative and reassuring. There was also evidence that health visitors were seen as combining common sense and professional knowledge (see Case Study B).

As at earlier stages, experience was cited as important in relation to lay advisers at stage three. Nine mothers mentioned it as a rider to their choice of adviser:

P053P   "Well me sister 'cos she has a family as well"

This amounts to the legitimation of the individual or group as an adviser. Similar comments were made by other mothers, though some indicated that current experience was preferable. For example, one mother who would ask her mother-in-law first for help, added that she would often go to other people as well because:

P173N   "It's a long time (since) she had the children - 23, 24 years"

Whilst experience is cited in relation to lay advisers, it is generally experience of other children. However, where childminders were cited as advisers (in two cases), they were not only offering their own previous experience with other babies, but empirical testing with this baby. In both cases the problem area was weaning. Unlike other lay 'advice', which could be fallible, their advice was seen as effective. However, there were only two parents for whom this situation arose.

Though help and advice from friends had increased, professional advice was still sought by a substantial proportion of parents. One mother described why she had needed professional advice as well as lay advice:

PO63N   "I think it was important for us ... to feel there was some medical advice somewhere to go to and that was coming from a doctor or a health visitor was a bit more authoritative than coming from grandmother who says oh it's nothing, because you're never really sure"

'Medical' knowledge - in itself an interesting assumption - professional, learnt knowledge - is seen here as more authoritative and more reassuring than lay knowledge. This mother includes health visitors with doctors as dispensers of 'medical' knowledge. She goes on to say that advice from her mother or mother-in-law:

PO63N   "is great in a practical sense, sometimes its a bit out of date"

Her implication is that practical advice is rather different - and generally based on experience, which may be in the past. However, she goes on to say that the health visitor too has 'been great on practical advice', giving examples of her advice in relation to weaning, and the use of a babywalker.

The health visitor, whilst advising on a similar range of topics to lay advisers and supporters, is generally cited as more authoritative. She is usually cited at a 'higher' level in the hierarchy of advisers, or as the final arbiter:

P213P   "We've never needed to ask the doctor about anything, we've asked the health visitor about feeding because we've had one or two problems when we introduced her onto solids ... but apart from that really, I've just compared notes with other mothers with babies at similar stages"

This mother goes on to indicate that the major thing she had compared notes on was weaning but that "everybody else's baby seemed to like being introduced to solids", so she had turned to the health visitor.

Two parents at stage three commented specifically on the change in their own experience over the five months since the previous interview. A change here was also evident in many of the other interviews in relation to the types of help sought and the sources approached. One mother commented:

P063N   "..but with experience we have realised that they (spots) will go in a few days"

and   " .. now we've settled down a lot and if its a rash we
           say oh we'll have a look tomorrow.."

Alongside the several statements about panic at stage two, the
idea of 'settling down' seems to make sense as a reduction in
anxiety induced by experience. The other mother made the link
with common sense more explicit:

P073N   "If you could rely on yourself its all just common sense.
         I suppose, you know, you turn to someone else for
         reassurance, more than anything. Sort of positive .
         information that they can give you... I think as the baby
         gets a bit older, you just get more confident, you know,
         that you can rely on yourself. You can handle problems"

She is learning to rely on herself - and on 'common sense'
approaches.

Legitimation

Legitimation by professionals, both of the child's health status
and of the parent's actions in respect of that health status was
important at stage three. Eight mothers commented on episodes
where such legitimation had occurred. At stage two, legitimation
by lay sources such as friends and grandparents was more evident.
Whilst this was an inherent part of the process of 'comparing

notes' at stage three, it was less explicitly discussed on the whole. Several parents at stage three were willing to describe situations which suggested that their child was not always or completely healthy, but legitimised these to the researcher by indicating that this was atypical or superficial.

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Parents described a number of situations where their child's health or illness status had been legitimated by professionals. In some cases they had indicated that the child's developmental progress was normal:

P113P   "I was worried, 'cos he wasn't even bothering ... She was
         all right about it. She (previous HV) explained that some
         of them do that and some of them don't even crawl at all"

In other cases, they had said that the mother's anxiety about a symptom was legitimate. For example, one mother (P053P) had sought help from the GP when her baby started vomiting: the GP had said that it was normal for her to worry about this, though it didn't require much treatment.

Parents' actions in respect of health and health problems were also legitimated by professionals. Seeking help appropriately was an important concern:

PO63N   "All I wanted to know was em, what do I do - would she
         come and look at it or should I take X to the doctor,
         because I've been brought up not to go straight to the
         doctor when I think it's something not very important"

Some parents outlined situations where their actions had been
legitimated. The mother who had called out her GP for a vomiting
baby indicated that she felt that her action in doing so had been
legitimated by his response. One mother mentioned her feelings
when her actions had apparently not been legitimated:

PO23N   "I got a bit upset because the doctor implied that I was
         overfeeding her, despite being breast fed, I was
         overfeeding her and that was why she was so tall"

She felt that she was doing what she had been told was 'right' -
breastfeeding - and yet the doctor was suggesting that she was
not doing right, she was overfeeding her daughter.

In answering questions about whether their child was in good
health, most parents said 'yes'. Seven parents at stage three
described specific stories (private accounts) which suggested
that their child was not always or completely healthy. They
legitimised their position by saying things like (P113P)
'Basically he's in good health', the publically acceptable
response, even when describing their child's immediate illness
and ongoing problems:

P153P   "She had an ear infection about, I think it was the beginning of X. And they took her into hospital. And I think it was a week later the health visitor says that she was starving. And she wasn't starving ... Apart from her ears she's all right"

Though their definition of 'health' may incorporate such deviations, it seems equally possible that parents avoided saying outright that their child was not healthy since such an admission might reflect on their care.

Relationship or problem centred?

The pattern of the interaction between client and health visitor, and the client's perception of that interaction had altered fairly substantially by stage three. Lay advisers had assumed a greater input (as indeed has occurred in other studies - see for example Buswell, 1980). This had usually taken the form of comparing notes, altering the relationship between adviser and advised. The health visitor had often been seen considerably less.

At stage one, relationships with health professionals had been valued highly by many parents. At stage two, though relationship

centred attributes were still valued by some, problem centred interactions were predominant. At stage three, relationships became important again. Nine mothers commented on the nature of the relationship which they had with their health visitor. Of these three were at least partly critical - two of these had changed health visitor since the previous interview. Checking and judging were still seen as a significant role by 15 parents. The majority linked this to developmental checks, but a substantial minority linked it to judging child care, including policing child abuse.

Parents at stage three generally described their health visitors in terms which suggested the existence of a positive relationship - "she's smashing" (P133P) - or - "easy to get on with" (P163P). Some described particular incidents which had demonstrated this to them:

P053P   "I mean she couldn't do anything for me but it was nice to know that she seemed to have cared enough to come out and see if there was anything that they, you know, could do"

A caring relationship had been identified by this mother when the health visitor had called a number of times following a family bereavement.

Two parents had changed health visitor since the previous interview. Both had an apparently successful relationship with one health visitor, and an unsuccessful relationship with the other. One had felt that her previous health visitor was "looking for problems that weren't there"(P063N), and commented that this had made her "over-sensitive". She identified the need to 'belong' in a relationship and commented of her new health visitor:

P063N   "I think she was there (at the clinic) before she was our health visitor, but we didn't chat as long before we, sort of met properly ... she knows exactly what the set up is and she seems a lot more relaxed than the first one"

Meeting properly - being aware of each other - made a difference to the interaction between parent and health visitor from this parent's viewpoint.

The other mother (P113P) who had changed her health visitor felt that the second, met only at the clinic, was "only doing what she had to". She contrasted this unfavourably with her previous health visitor who used to "have a good natter", and was "interested". The third mother who commented negatively about relationships said that:

P023N   "Both the GP and the health visitor are something
         completely remote"

In part this remoteness as she described it was one of physical
access, but in part it was also a lack of interest in her
problems. Interest was identified at stage one as an important
facet of a relationship between client and adviser.

Many parents at this stage still described the health visitor's
role in terms of checking and judging. For the majority (10) this
was linked primarily to developmental checking:

P193P   "She wanted to check all his limbs. She took his nappy
         off and everything. In fact he had to be completely naked
         I think, and she just checked all his arms and legs
         and... she checked his eyes ... and to see if he was
         grasping and sitting up and - I think that was it"

Some parents however also identified a role for the health
visitor in checking "that everything's all right with (the
baby)"(P123N). The majority felt in addition that there was a
need for support where mothers were not coping:

P163P   "They're always asking if you're all right, but what
         happens if you're not all right? Do they do something?"

A few explicitly mentioned a role for the health visitor in 'policing' child abuse. This was almost entirely confined to discussion of the health visitor's role or potential role with other people:

P203N   " - say there was child battering or something. ... I
        wonder if they keep an eye on children that are, possibly
        are at risk. you know. If the mother never takes the
        child to the clinic, will the health visitor know?"

Only one mother indicated that she thought that her health visitor had been checking whether she might be abusing her child (as distinct from whether or not she was coping).

Power and control

Whilst at stage one, independence and self sufficiency had been valued, at stage two, parents tended to assume a more dependent role, directed mainly by health professionals. At stage three this dependence had been reduced, and parents felt greater confidence in themselves. Comparing notes offered the opportunity for a reciprocal helping relationship.

Parents at stage three had made less use of health professionals for advice in recent months, due to levels of access available. They had increased their use of friends overall, particularly in comparing notes:

P203N   "With friends you sort of compare notes ... What they eat and what they don't eat. Em what did they weigh at so many weeks and that kind of thing"

In comparing notes they were each able to offer help to the other, at one time or another. The relationship was therefore one of reciprocity, rather than of power resting with one or the other.

Two mothers, mentioned earlier, described their increased confidence as parents. They felt able to make decisions on a wide range of child care matters for themselves. They were in control. The changing pattern of interactions of other parents suggested that a similar change had occurred for them. They used professionals selectively, as a resource, but generally coped without them, retaining control themselves.

Comparisons of Priority Area and Non-Priority Area Responses

At each stage, comparison has been made between the responses of parents living in Priority Areas and those living in Non-Priority Areas. There was some evidence of differences in the socio-economic status of parents in the two types of area, and it was thought that their experiences and environment might have significantly influenced their perceptions, of both health and health visitors. At stage one, few differences were found between areas. The main difference was in relation to information sources - the media played a much reduced role as an information source for Priority Area respondents in comparison to those from Non-Priority Areas. At stage two once again there were few differences, but a slight trend for Priority Area parents to define health in disease based terms, which could relate to their slightly increased incidence of problems. Priority Area parents also cited a larger number of advisers. At stage three there were seven respondents in Non-Priority Areas, and nine in Priority Areas. There were few important differences between areas. Two mothers, both from Non-Priority Areas expressed their feeling of increased self-confidence as parents.

Parents in each type of area expressed similar types of themes overall in describing health and non-health. There was no difference at this stage between areas in the choice of definitions. The trend found at stage two, towards Priority Area parents using a disease based model, was not repeated. At stage two it was suggested that this might have arisen out of their

greater experience of illness. It seems possible that with increased confidence, they would find it easier to cope with these illnesses and the child's social development would take precedence in their minds.

Factors which parents thought might affect children's health did not differ substantially between areas. Food and diet was the most important factor cited by both groups. Five parents - three Non-Priority Area and two Priority Area - described the importance of social and emotional factors such as stimulation.

At stage three, parents in both groups described three levels of problem - 'silly little things', 'worrying', and 'serious' - implying different levels of need for help. There were only minor differences in the occurrence of both themes between the two types of area. There were few differences between areas in parents' choice of advisers at stage three. At stage two, Priority Area parents had cited a considerably larger number of advisers, but there was no significant difference between groups in their use of lay and professional advisers. At stage three, parents from both types of area cited similar numbers of advisers, amongst both lay and professional people.

Common sense knowledge was more valued by parents in both types of area at stage three than at stage two. Three Non-Priority Area

parents and six Priority Area parents mentioned experience as important in their choice of an adviser. Professional knowledge was still felt to be important by some parents in each group - for example as an authoritative source when 'everybody has different views'(P083P). Two mothers, both resident in Non-Priority Areas, articulated the effects of their own increased experience upon their confidence in decisions about childcare. However, parents in both groups commented that they now tended to see less of professional advisers such as the health visitor, and to compare notes with friends who had "been through it"(P193P).

Comparing notes was also an important element of legitimation of parenting, and of children's health and health problems. At stage two a marginal difference had been found in this type of legitimating activity between areas. At stage three, there was no difference - similar numbers of parents in both groups compared notes with friends in this way. Legitimation through interactions with health professionals also occurred approximately equally between areas.

Whilst at stage two interactions with health visitors had been described mainly in terms of problem centred discussions, this was less evident at stage three. Characteristics such as 'getting on well' had been mentioned more at stage two by parents from Non-Priority Areas. At stage three, though relationships were

valued by parents from both types of area fairly equally, slightly more positive comments - for example, 'easy to get on with'(P163P), 'she seemed to have cared enough'(P053P) - came from parents in Priority Areas. The one negative comment - suggesting that the health visitor was remote - came from a Non-Priority Area parent.

Checking or judging development was seen as part of the health visitor's role by all but one stage three parent (from a Priority Area). Checking on child care was described as part of the health visitor's role by four Priority Area parents and two from Non-Priority Areas. This was linked to a role in supporting the mother by three Priority Area parents and one from a Non-Priority Area.

Phase One comparisons

Some differences were found between parents in the two phases of the study. However, it should be remembered that parents in Phase One were sampled over a slightly wider age range, were more in number (41), and included 24% with older children than the study child. They were also only interviewed once.

In defining health, Phase One parents placed their main emphasis on 'nothing serious wrong', social and emotional definitions of health arising less, and more or less equally with functional definitions, in interviews. In stage three responses, social/ emotional definitions were most common. The phase one data shows 22 parents (out of 41) citing 'nothing serious wrong'. Just over two thirds of the parents responding in this way were primiparae. In practice the difference of emphasis between Phase One and Phase Two ('nothing much wrong' / social and emotional) was not significant (X2 = 2.066, d.f. = 2).

In considering Phase One responses to an enquiry about influences on health, similar themes were found to those at stage three. However, in Phase One data two attitudes towards achieving prevention could be discerned. Some parents advocated 'external' protection:

AO6N   "I still sterilise things which I think is important
        until they are a year old"

while others preferred the idea of 'internal' protection:

A30P   ".. well she mixes with a lot of older children - goes to
        the nursery and that - so she gets immune - it builds up
        their immunity to things - plus having two older
        children, they bring things home and that"

Injections could be seen as 'internal' protection. This contrast appears to emerge more clearly in Phase One data because 'internal' protection emerges most strongly amongst the multiparous mothers.

The idea of a hierarchy of advisers, seen at stages two and three, was more often explicitly described by Phase One parents, together with its relationship to perceived problems. 17 parents described a double or triple layered approach to help and advice. For example, one mother said:

A10P   "If I've got any problems I generally ask my health visitor. I go to the doctor with something really important ... I've asked her (HV) about things like em, he hasn't been sleeping well, has had a bit of a cold, and if it was important to take him to the doctors, or if it didn't matter"

The health visitor here is the first line of contact, but is also potentially someone who can assist in deciding whether further action by the parent is necessary. If the mother is uncertain, she will ask for help to decide. Other parents identified a pattern of 'comparing notes' with grandparents and friends, talking to the health visitor if they wanted to know anything, or about 'owt unusual' (A26P), and consulting the doctor if the child 'wasn't well'(A25N), or with 'something really

important'(A10P).

In Phase One data, there were 23 respondents in Non-Priority Areas and 18 in Priority Areas. Differences in socio-economic status were stronger. Only one substantial difference was identified. Friends were mentioned as advisers and helpers only by parents from Non-Priority Areas (four out of 24). At stage three this was not the case - they were mentioned by both.

Summary - stage three

Parents defined health at stage three, as before, according to three main themes: 'nothing serious wrong', functional ideas - for example food and diet or sleeping, and social/ emotional aspects. At stage one, the idea of a 'happy and content' baby had been predominant. At stage two this had altered to an emphasis on 'nothing serious wrong', although the other themes had developed at this stage. At stage three, the main emphasis returned to social and emotional definitions of health.

Influences on children's health were described. Food and diet was the most mentioned influence, as it had been at previous stages, with hygiene and avoidance of infection a close second, also much as before. Stimulation and socio-emotional influences were

mentioned by five parents at stage three. Only one parent, at stage one, had previously mentioned this type of influence, despite the importance attached to social and emotional aspects of health.

Problems were categorised by parents at 'stage three into three levels, which had not previously been evident - at stage two the emphasis had been on practical problems with which help was needed. The three levels of problem found now were: Firstly, 'silly little things' - things with which they needed help but felt that they should not. The second was problems which caused them anxiety or worry, yet which were not in the third grouping - 'serious'. No parent had in fact experienced a problem which in retrospect appeared to them to be 'serious'. 'Nothing serious wrong' was a phrase used by several parents.

Parents described how they had come to manage health and health problems in their children, through advice and support from other people, and through comparing notes. At stage two, professional advisers had been valued mainly for offering practical help and advice, with a fairly directive approach. Lay advisers had featured much less. At stage three the choice of advisers was fairly evenly split between lay people and professionals, with many citing both. However, many parents said that they found themselves relying more upon friends, and comparing notes, than they had anticipated. The idea of a hierarchy of advisers, first

noted at stage two, emerged again at stage three.

Experience was described as important in relation to lay advisers by stage three parents. However, some parents described professional advice - based primarily on professional knowledge - as more authoritative and reassuring. There was some evidence that health visitors were seen as combining common sense and professional knowledge. Whilst advising on a similar range of topics to lay advisers and supporters, they were generally seen as more authoritative, and were usually cited at a higher level in the hierarchy of advisers.

At stage one, several parents expressed their desire to be independent and self sufficient in being a parent. At stage two, they tended to become more dependent. Two parents at stage three indicated how their own experience had changed since the previous interview, making them more independent, more able to rely on themselves. The alteration in types of help sought and attitudes to help and advice at this stage suggest that this may also be true for other parents.

Legitimation, both of the child's health status and of the parent's actions in respect of that health status was important at stage three. It had generally taken two forms - the comparing of notes with friends - which had occurred to some extent at each

previous stage, and legitimation, of parent behaviour in
particular, by health professionals, which was less evident than
at stage two.

The pattern of interactions between client and health visitor,
and the client's perception of those interactions, had altered
fairly substantially by stage three. Other advisers had assumed a
greater input, and the health visitor had been seen considerably
less than at stage two. A relationship which incorporated
interest, and meeting on equal terms - 'properly' - was valued.
Nevertheless, health visitors were seen by a majority of
respondents as having a judging or checking role. At stage two,
just over half had described this as a role of health visitors.
At stage three a majority of parents identified a health visitor
role in developmental checking. Some in addition identified a
role in checking on child care, with a small number identifying
'policing' child abuse as important. A majority of parents also
identified a support role for the health visitor.

As at previous stages, relatively few differences emerged between
respondents from Priority Areas and those from Non-Priority
Areas. There were no significant differences in definitions of
health. Interactions with child health services, and in
particular with health visitors, were described in broadly
similar terms by both groups.

Though stage three was predominantly described in this chapter, comparisons were drawn with data from Phase One where these appeared to show different trends or to strengthen associations. Parents in Phase One were however sampled over a slightly wider age range, were more in number, and included 24% of parents with one or more children older than the study child. Relatively few differences were identified.

Although at Phase One 'nothing serious wrong' was the predominant definition of health used by respondents, the overall distribution of definitions at Phase One was not significantly different from that at stage three. In considering influences on health, multiparous mothers described protection from infection as possible internally or externally, a difference which did not emerge amongst primiparae at either phase. The hierarchy of advisers was more clearly defined at Phase One, and the link to particular levels of problem identified. Friends were cited as advisers solely by Non-Priority Area parents at Phase One.

Chapter Ten

Results: The health visitors' view

The health visitors of half of the children involved in Phase Two
were interviewed on three occasions, each about two weeks after
the parent interview. In this chapter, the health visitor sample
is described. The themes arising from the health visitor
interviews are outlined, and compared and contrasted with parent
views. Themes found in each category are discussed stage by
stage, sequentially, in the relevant section. Patterns emerging
can thus be readily followed, and contrasted with those arising
in parent interviews.

*   *   *

Background

Ten health visitors of study families (those available at the
requisite time) were also interviewed, in order to achieve some
comparison of client and health visitor views. They were
interviewed on three occasions to parallel parent interviews, but
usually about two weeks after them. (Parent interviews took place
when the mother was around 28 weeks pregnant, and at eight weeks
and seven months postpartum.) The questions which health visitors

were asked were broadly similar to those put to parents, in that they were asked to give their definitions of health, to discuss their perceptions of their own role, and to describe their most recent interaction with the study parents.

Of the ten health visitors initially included in the study, one refused to be tape-recorded, although she agreed to be interviewed. One went on sick leave shortly before her third interview was due. One health visitor's client withdrew at the second stage, so no further interview was requested from the health visitor. One parent changed health visitor locally during the research, and the replacement health visitor agreed to be interviewed for the relevant stage. There were thus seven complete sets of tape-recorded interviews, though in one of these, the third interview was with a different health visitor to the first and second.

The health visitors interviewed were a varied group. They had qualified between one and 26 years prior to the first interview, six of them in the past five years. They had been asked to indicate their age groups. Two were aged between 26 and 35, five between 36 and 45, and three between 46 and 55. They had a wide range of nursing experience, with paediatrics, orthopaedics and midwifery featuring strongly. Intensive care and coronary care work, theatres and surgery were also mentioned as well as occupational health, school health and district nursing.

Unlike the preceding chapters, although similar themes will be covered in this chapter, and compared and contrasted with parent views, health visitor responses at all three stages will be discussed sequentially in the relevant section. The headings used in discussing these results will be:

Health, health problems and other concerns

Looking at problems and offering help

Legitimation

Relationships and roles

These differ from those used in discussing parent responses, since they are derived from the consideration of health visitor data in the light of parents' themes. Other themes arising in the health visitor data have not been considered.

Health, health problems and other concerns

Stage one

At the first interview, health visitors were asked what they would define as good health in children under five. Parents at the first stage had largely favoured social and emotional

definitions, relating to the baby being 'cheerful' or 'not crying'. In contrast, amongst health visitors development featured in four responses, and functional aspects such as activity, eating or sleeping in five. Social and emotional themes were found in four responses. One health visitor expressed this well:

HV051P   "A child who follows the normal milestones of development really, happily and er I don't know how to - in a caring household. A happy child who is well looked after with all - you know, we all need to be fed, warmth, shelter, to have all the necessary essentials for life... A child who if there's any problems, that the parents do seek em some advice, who do give any immunology, vaccinations that are available to ensure that they do have a healthy life. Who give, not only in the physical sense but looking after the mental health... they don't give in to the child all the time, who are, who have a sensible approach to bringing them up"

Only three health visitors mentioned absence of disease:

HV201N   "No obvious pathology ..."

though others (for example HV05/P above) mentioned immunisations as relevant to maintaining good health. Functional aspects of health were particularly described in terms of 'activity'- for

example:

HV201N "You have to look at healthy active toddlers don't you"

Activity was seen as an essential ingredient of a healthy child by four respondents. One health visitor said that she would define as healthy:

HV111P "A child who is able to carry out em normal daily living with a sense of em wellbeing"

She went on to say however that her mental picture was of "a lively child with a sunny disposition" - once again picking up on activity as the important element of functioning for her amongst preschool children. Only one respondent (HV191P) described a range of functions which she would expect to consider, including eating, sleeping, walking and running, concentration on tasks, and interest in books.

Social and emotional aspects of health were primarily described in terms of being 'happy', cited by four health visitors. However, three health visitors mentioned the importance of parents' responses to the child, and of a caring environment. Another (HV181N) said that the child should be 'integrated into society', but did not elaborate on this. At this stage, parents were focussing mainly on the social/emotional aspects of health, with little idea of 'normality' save a 'happy' baby, who didn't

cry. They did not identify their own role as important in achieving this.

Factors which health visitors identified as likely to affect health, and advice which they might offer to parents about maintaining health were also asked about, since these points would be explored with parents at each stage. The two predominant themes identified by health visitors as likely to affect health were diet and parenting. The latter was taken to incorporate ideas such as 'stimulation', and 'providing a · routine'. Parents at stage one generally cited food and diet as most important, much as health visitors did, but hygiene and avoidance of infection were also a significant category for them. Parenting was only mentioned as important by one mother at stage one. The tendency for the subject (parent) to attribute causality externally, whilst the observer (health visitor) attributes it internally, to the subject, has been described by many workers, including Heider (1958) and Jones and Nisbett (1971).

Diet was generally mentioned by health visitors along the following lines:

HV191P   "You see they don't eat their dinner but then they'll eat the sweets sort of thing and obviously if you stop the sweets they'll eat their dinner"

This actually linked patterns of parenting with ideas about 'good diet'. The health visitor is looking at the role of the parent in encouraging children to eat a healthy diet, whilst the parents - at stages one and two in particular - see the child's disposition to eat as central. They attribute problems to the child, or to the environment, whilst the health visitor is ready to attribute difficulties to deficiencies of parenting.

Comments brought together into the theme of parenting included comments such as:

HV181N   "Mummy or daddy. The parents' level of motivation, the level of care..."

A wide variety of other factors were mentioned, including smoking, environment/housing (for example whether the child lived in a high rise flat, and what facilities were available in the area), hereditary influences, immunisations, and child abuse. Much of the advice which health visitors said they would give to parents of under fives related to the factors they had suggested as affecting health. Dietary advice predominated, with the acquisition of a routine also seen as important. Advice on immunisations was also cited, along with the importance of fresh air, exercise, stimulation and play. Here again, health visitors appeared to be focussing on different areas to parents. Parents at stage one were vague about their likely needs for advice, but

tended to predict needs in relation to problems. Health visitors on the other hand are describing prevention orientated activities.

Stage two

Health and health problems were not specifically asked about at later stages, but emerged from the descriptions of interactions. Feeding was a predominant theme at stage two, when health visitors were describing their interactions with families with a child of eight to ten weeks. Parenting skills and developmental progress were also mentioned at this stage. Parents at this stage were focussing on practical problems, and described health in terms of 'nothing much wrong', with functional aspects (such as feeding, or sleep) a close second.

Only one health visitor did not mention feeding in relation to 'how the child was getting on'. Amongst the rest comments such as:

HV022N   "She has been breastfeeding beautifully"

were commonplace. In addition, five health visitors mentioned that they had discussed weaning, for various reasons –

HV202N   "We talked about weaning because it was a bit soon but he
          was very unsettled..."

Other reasons included the health visitor going on holiday, and
the grandmother suggesting solids.

Four health visitors at this stage mentioned development in their
discussion of the family. The comments were fairly restricted -
"She's developing very well" (HV212P) and gave little or no
detail of what was meant, except in one case where the child's
response to toys was mentioned (HV182N). Six health visitors on
the other hand discussed the mother's parenting skills and
attitude. For example, one health visitor commented:

HV112P   "I think initially she found motherhood very difficult.
          She was very opinionated without a knowledge base. But
          with I hope a non-judgemental approach, that has altered
          - she's more open to advice"

The comments usually described the level of parenting skills and
any changes or development in these over the first few weeks. At
this stage parents discussed the practical aspects of parenting
in response to a question, but still did not attribute the baby's
behaviour and development to their own activities.

Only one health visitor commented on the child's emotional state
- at the very superficial level of "he's a happy boy"(HV052P).
Two health visitors mentioned coping with specific difficulties -
one problems about feeding, including cracked nipples and
subsequently constipation, and the other an umbilical tag which
had been treated by the health visitor with a styptic pencil.
Some had got on to the baby's skin. This caused the health
visitor such anxiety that she asked the researcher to turn off
the tape-recorder while she described what had happened. The
mother however hardly mentioned this episode, then or later. Just
as the parents focus on practical issues at this stage,
especially on feeding, so do the health visitors. Whether this is
in response to the needs of the families as expressed by the
parents, or whether the health visitors themselves recognise that
different themes are important at this stage is not clear.

Stage three

Development was mentioned in relation to the child's well-being
by almost all the health visitors at stage three:

HV063N   "And you know they obviously all just take such great
          pleasure in X's achievements - Oh he can do this, he can
          do that and we had to see all the little tricks ... He is
          a lovely sociable baby."

Only two health visitors did not mention development at all. In one case the child was described as 'sturdy', and a patch of dry skin was discussed. In the other, stimulation and feeding were mentioned. Development is rapid at this stage, and babies are developing relationships with those around them. They also probably have more achievements for parents and health visitors to discuss than at the previous stage.

Four health visitors mentioned feeding or diet as significant. In two cases, this mirrored difficulties that the parents had experienced with feeding:

HV213P   "The last thing she discussed (at home) was her diet and that was about a month or so ago. She was em wondering how she could get her from first stage on to family foods ..... (now) she's got a really good appetite and eats well..."

This extract indicates that this theme did indeed emerge as a reflection of the parents' concerns at this stage. Food and diet was seen as an important influence on health by parents at this stage.

In describing a child's health status, topic areas which may have derived from professional 'history' taking were used as well as

more general themes such as feeding. Development is itself probably a borderline topic. In some cases, particularly where a little time had elapsed since the last contact, health visitors brought out their records as an 'aide memoire', and resorted to reading through the topics listed before they felt able to say how the child and his or her family were.

Among 'professional' themes, immunisations were mentioned by three health visitors. In one case the mention related to a patch of dry skin which developed following the injections. In another the health visitor elaborated on her initial comments to explain that:

HV06N   "Mrs C wanted to take some time before the first
         injection just to make sure it was okay."

In the third instance where injections were mentioned, it was in relation to the mother's discussion of immunisations with the GP in the clinic setting. In each case, something apparently slightly unusual drew attention to the issue. Though the theme derived from the professional framework described in the records, it was highlighted because in this instance it did not fit the norm.

Stimulation and responsiveness were mentioned by two health visitors in describing a child. (Social and emotional aspects

were the most important at this stage for parents.) In both cases they were mentioned in the context of the child's response to a developmental check. Unlike the situation in relation to immunisations, neither child apparently 'failed to fit' the ideal type - both were cited as (HVO53P) "very bright, well stimulated" children. It is however possible that both children and their families were unusual in the caseloads of their respective health visitors. One had a caseload of families the majority of whom she described as:

HVO63N "very time consuming ... (and spent) a lot of time on associated issues, like advice about benefits, housing problems and all the usual things"

Equally perhaps the 'ideal type' image was felt to be worth describing.

At stage three, development was the predominant theme in health visitors' descriptions of the child and the family. Along with other themes such as immunisation status and responsiveness, it often appeared to derive from a professional framework, and to be primarily mentioned in relation to 'failures to fit' the ideal. Parents however focussed mainly on social and emotional aspects of health. Diet was seen as an important influence on health by both groups.

Looking at problems and offering help

Stage one

Parents at stage one had had little or no idea what sort of health needs or problems to expect. The health visitors, since most of them had not met the specific study families at the first interview, gave generalised answers to questions about their visiting pattern and how they developed priorities. From these some idea of their perceptions of health needs and problems, albeit idealised, could be obtained.

The majority (nine) described the need to look at the parent's situation - for example, "skills in mothering"(HV031N); "inexperienced, isolated mums"(HV181N); "if she needs plenty of support"(HV211P). The possibility of mental illness, particularly depression, was also mentioned by four health visitors. Whereas parents tended mainly to talk about problems and needs in relation to the baby, the most important factor for health visitors in considering their priorities are parents and their problems. Only one health visitor is exclusively child centred in her description of her priorities. The rest talk about proactively seeking out parents who lack skills or are isolated, but most other topics are mentioned as important areas in which

to respond to the expressed needs of parents. Only three health visitors mentioned feeding problems as an important area of work:

HV191P   "Quite a few ring about little feeding things or
                whatever. Then I go out and visit them ..."

Interestingly this health visitor is describing feeding problems as 'little' - implying not important, and similar to the description of some problems used by parents later. Crying was mentioned by one health visitor. In addition, one health visitor mentioned medical problems as important:

HV021N   "I'm visiting one mum sort of every day at the moment
                whose baby turned blue etcetera and is worried'

This problem was causing the mother 'worry' - again reflecting the themes used by parents in describing problems. Housing and financial stresses were each also mentioned by one health visitor.

Stage two

At stage two, parents placed particular value on practical help and advice. Several mentioned feelings of 'panic' in the context of descriptive accounts of the early weeks at home. Health visitors focussed on both the assessment of parenting skills, and

on practical aspects of help given, particularly feeding. Responding to need was again seen as important, though some degree of planning was described. Developmental need was seen as important in the planning of help and advice. Help offered was discussed in terms of support, availability and information giving. Four health visitors experienced some difficulty in recalling their contacts with the clients concerned (at ten weeks postpartum) and used records to prompt themselves about what they had discussed. They appeared reluctant to admit to not meeting their own standards.

Health visitors described their assessments of the mothers' skills and what implications these had for support or other action on the part of the health visitor:

HV182N ".. she's very independent and she's quite good at facilitating her own resources in a way for all she's quite young. Em she's quite capable. ...... she's not got a great need for you to be there a lot."

Mothers were described as 'capable', or 'growing in skills' by half the health visitors. None was felt to be unusually anxious or 'panicky'. A particular need for help was identified in relation to some mothers. One had been unexpectedly bereaved and was identified as requiring support in feeding problems which arose concurrently with (or possibly as a result of) this. The health visitor said that she had "visited quite a lot"(HV052P).

Another was identified as needing extra visiting "because she's breast feeding"(HV062N). She had now been "given telephone contact availability". In both of these examples, the level of support is described in relation to the level of contact or availability of the health visitor. A third mother was identified as having marital problems described at this stage as 'desperate'. The health visitor implied that she had listened to the mother. She said "I could empathise with her"(HV022N) - appearing to describe a relationship rather than a clear role. In each of these situations, the health visitor had responded to a particular need, to a greater or lesser extent. Other topics mentioned as having been discussed and responded to included teething troubles, a rash, an umbilical skin tag, and consent for immunisation. Each of these was mentioned by one health visitor. Parents at stage two were beginning to identify a role for the health visitor in checking development, and in judging (assessing) parenting.

Parents at stage two identified feeding as an important influence on health. They discussed patterns of feeding, and changes of method. Weaning was not mentioned. However, five health visitors (interviewed two weeks later) had either mentioned weaning to the mother already, or said that they planned to mention it at their next visit. This appeared to be seen as a particularly important topic at this stage. Two health visitors said that they had mentioned it earlier than usual:

HV202N   "We talked about weaning because it was a bit soon but he
          was very unsettled. And I said, rather than leave it
          until I did the three month check, when I do weaning, you
          know, in a lot of detail, I would start off, in case he
          was very unsettled during the holidays and leave her with
          the leaflet and some samples and we did the discussion."

The implication in both cases was that it was normally seen as
appropriate to discuss weaning in relation to a developmental
stage, but that it was important to discuss it sooner rather than
later. In this case the baby's routine was described as
unsettled, so the health visitor responded to need with
information. Other health visitors said that they planned to
discuss weaning soon:

HV072N   "I said I would come and talk to her about weaning ...
          when the baby was beginning to need - "

Responding to need, and developmental need appear to be the two
principal factors governing the timing of advice and help.
Development itself was mentioned as a reason for contact by two
health visitors, in relation to the standard local four week
check.

Advice and help were described in terms of support, linked to
availability, and information giving. Quantity of visits and

availability was frequently linked to the level of health visitor support needed. For example, a young mother was described (see also above) as one who was 'capable' and 'independent', and :

HV182N "Hasn't got a great need for you to be there a lot"

Other health visitors (for example HV052P and HV062N above) described the increased need for them to visit their clients, to offer support.

Information giving or sharing was mentioned in relation to a number of topics, particularly weaning. In the description above (HV202N), the health visitor outlines how she and the mother ('we')'did the discussion'. Discussion is mentioned by other health visitors in this context - for example:

HV212P "We discussed introducing the baby rice and when to give it"

Discussion is usually described as a shared activity - 'we discussed' - although the health visitor indicates that she gives an input of information. For example, another health visitor said:

HV192P "I think we did discuss about heating, heating in the room and so on. I think she wanted to know ... she was worried about the baby being cold in the bedroom"

The mother's contribution to the 'discussion' appears to be a question, or an anxiety perceived by the health visitor. The description of the interaction as a discussion may indicate that the health visitor sees it as a shared encounter, rather than a more didactic interaction which might have been described as telling the mother about something. Equally it may reflect the style of the overall encounter, during which both mother and health visitor did some talking. Many parents at this stage identified the health visitor's input as directive, though the development of friendly relationships was discussed by just under half.

Another form of information giving which was described by five health visitors at this stage was the use of leaflets or pamphlets. These were mentioned predominantly in relation to weaning, (see above) and often in association with giving samples:

HV052P   "I was going with some more leaflets and some samples for her ... "

However, two health visitors indicated that they had also given the mother a leaflet about immunisations:

HV062N   "I hadn't got a great deal of stuff to give her, but I did send her some immunology stuff in the post after my

visit, ... just to see if a bit more information might -"

Written information is seen as supplementing verbal information.
It may also be seen as reinforcing it, or as allowing parents to
absorb it at their own pace.

One health visitor appeared to have used leaflets on a much wider
variety of topics. They were mentioned four times, relating to
separate topics, in the course of this interview. The health
visitor suggested that this was because this mother liked written
information to read through herself:

HV212P   "I went through that (weaning) with her and I'd taken her
          some leaflets because she always likes em things to read
          through."
          "I've given her a leaflet on infectious diseases and
          things ... they don't seem to know a lot about childhood
          illnesses and things"
          "I discussed the development at the time and I've also
          given her a leaflet on the development over the first
          nine months"
          "I gave her a leaflet on grandparents and how it was
          important to involve them, and the visiting would drop
          off."

This pattern of communicating information is rather different
from the pattern used by other health visitors, yet the mother

does not describe her health visitor's input in a different way. It is not clear whether the use of the leaflets enhanced the information sharing, from a low level, or whether they actually had little effect. The leaflets themselves are not mentioned by the mother at this stage, and only the development leaflet is mentioned at stage three. (At that point, the mother describes how she had felt that "really it was up to me and nobody was going to tell me" in relation to weaning, since she had received differing advice from a number of sources including the health visitor.) This health visitor clearly values written sources, and believes that the mother does. The mother's responses suggest that they are less important as an information source than the health visitor thinks.

Four health visitors were unable fully to recall what areas they might have advised or helped with, and three used records to assist them in remembering. Even so, this was not foolproof:

HV192P   "Well of course its very difficult if you don't write
          every single thing down to remember back what you've
          discussed completely. I've no doubt that we've discussed
          injections. The immunology programme..."

Phrases like 'I've no doubt' and 'I must have' or 'I usually' seemed to indicate a certain amount of difficulty in recalling what had happened. Parents had said that they could not remember if they could not. Health visitors seemed to feel that they ought

to remember, even though the encounters that they were being asked to recall were each one or two amongst perhaps twenty or thirty families with children of a similar age currently being visited. In part they were perhaps saying that they ought to have discussed X, so if they couldn't recall doing so, they 'must have'. The professional imperative to do so suggested that they could not admit to not having done so, especially to a colleague.

Stage three

At stage three, health visitors generally described study parents as having few problems and little need for advice and help. A reduced level of contact with professional advisers was reported by parents at this stage, but many indicated that they would have valued seeing the health visitor more often, about problems of various kinds. Of the eight health visitors who remained in the study at this stage, five had last seen the parent and child at home for the six month check, about four to six weeks previously, and the remainder had seen them at the clinic, often within the last month. The nature of interactions in these settings was described, particularly the degree of privacy and the means of information sharing. Parents at this stage found themselves relying on friends for help more than anticipated. They described relationships with health visitors as important, and expressed more need for contact, particularly through home visits (where greater privacy was valued).

Most of the health visitors at stage three described parents in positive terms, indicating little need for advice and help.

HV053P   "She did very well actually"

HV203N   "They're doing very well indeed"

Six commented on the child's development - not surprisingly since many of the recent contacts were in the context of developmental assessments:

HV213P   "Her development and everything is perfectly normal for her age"

Parents meanwhile were seeing health visitors more in terms of development checking at this stage.

Other comments made by health visitors at stage three included some updating of the problems described at the previous interviews - an umbilical skin tag, feeding, bereavement and marital problems - all of which were said to have been resolved, wholly or in part. However, this was not specifically attributed to health visiting interventions. One new problem was identified, with a mother rather than a child - the health visitor had directed the mother to the GP, but had also used the opportunity "to talk about pelvic floor exercises"(HV053P).

At this stage more contacts were occurring in the clinic setting, and health visitors outlined these. In describing contacts in the clinic, opportunities for individual conversation were highlighted. Timing of visits, and the degree of 'busyness' of the clinic were seen as important:

HV023N   "It tends to be quite busy but once the room was empty of people, she could confide in me"

HV213P   "She tends to come at the end of, you know, about three o'clockish ... the clinic tends to be quieter at that time, so er she never has to wait around very long. But she doesn't socialise very much. She just tends to get the baby seen to and go, but we always have some sort of discussion"

The main consideration, at least in the first of these examples, appears to be confidentiality. If the clinic is busy, this is more difficult to attain. One health visitor described a similar constraint in respect of a home visit, when a friend had been present for part of the visit:

HV053P   "We didn't go right through the discussion when her friend was there"

Several parents at this stage identified a need for more contact with health visitors, and a preference for home visits, as they offered more time and privacy.

As at stage two, 'discussion' between health visitor and parent is mentioned by a number of health visitors. For instance, it can be seen in the examples above. Again the word is used to describe the conversation between health visitor and parent. In the latter case it is used in a way which suggests that it has a standard structure - 'the discussion'. A discussion might be expected to take place with all parties contributing. If it is negotiated between two or more parties, it will not have a standard structure. If on the other hand one person controls the shape of 'the discussion', then the nature of the interaction is altered. Leaflets were the other major means of information exchange described at stage two. The use of leaflets in this way is mentioned by only one health visitor at stage three - the one who had used this means heavily at stage two.

Legitimation

Processes of legitimation, of the child's health status and the parents' actions in respect of that health status, were described by parents at stages two and three. At stage two, legitimation by lay sources was predominant. At stage three, professional

legitimation was described by a substantial proportion. Some health visitors described a role as legitimator at stage one, and a few described instances of legitimation in relation to study families at stages two and three.

Stage one

At stage one, only three health visitors of those interviewed had actually met the relevant parent, one of those only briefly in an antenatal clinic. Two who had not met the parents concerned described a role as a legitimator of parents' actions. For example:

HV111P   "There's many girls em that you really do find have basically the right idea about what they should be doing with it - but they don't have the confidence in their own abilities. I think I would see myself as the motivator and educator of the mum at one particular time."

In addition one health visitor described the role of the clinic, and more particularly the medical officer, in legitimating action, or more often inaction, in respect of ill-health:

HV051P   "They're reassured that it is phlegm or something like this, catarrh with the little one, and they don't need to go to the doctors but they're reassured"

Stage two

At stage two, three health visitors described legitimating the actions of study parents in respect of their children's health. The clearest example of this was in the case of the mother who had a family bereavement, and simultaneously experienced feeding difficulties. The health visitor commented:

HV052P   "She really did you know, lose her supply. And er I supported her in changing because I felt it was putting her under too much pressure to try and do it and reluctantly I felt it would be the best thing for her and the baby..."

At the same time as she describes how she legitimated the mothers decision (a situation also described by the mother) she is legitimating her own professional judgement - explaining why she took the decision to support this mother, and intimating her reluctance in so doing.

Stage three

Interestingly, at stage three, when parent interviews indicate a greater amount of professional legitimation, the only example described in detail by any of the health visitors is the same one, (HV053P) still seen as an important watershed in this relationship. Another health visitor mentions reassuring a mother whom she felt was anxious - which may or may not have involved legitimating the parent's perception of the problem.

Relationships and roles

Health visitors' perceptions of their own role, and of their interactions with clients were explored. At stage one all health visitors were asked to describe their role, and indicated a predominantly prevention based picture. Assessing and supporting roles were described in addition. At stage two, the roles which emerged appeared to be those of informing and supporting parents. By stage three, these roles still existed but were less important. Health visitors reflected on the nature of their interactions, and appeared to adopt a predominantly relationship centred model. Parents at all stages tended to value relationships where they felt that there was interest and the opportunity to meet on equal terms. A judging or checking role was described by parents at stage two, emerging more strongly as related to developmental checking at stage three, though with a minority relating it to child care. The latter role was only explicitly explored by one health visitor, at stage one, in

describing what she did not do.

Stage one

At stage one, each health visitor was asked to describe, in her own words, what her job was. Though each description varied marginally from the next, prevention and health education/ promotion were the two strongest themes. For example, one health visitor said:

HV191P   "The promotion of health in the community. I think health visitors are notoriously bad at describing exactly what they do"

Another commented:

HV211P   "Our work is mainly preventive, we try and em improve people's lifestyles and em by suggesting ... by suggestions and things that would make their life easier em - trying to improve their health by attending the clinic and visiting their GPs and em surveillance"

Only three descriptions did not explicitly incorporate either health promotion or prevention. They tended to take a mechanistic approach to the description of what a health visitor does:

HV201N "Responsibility for pre-school children, the antenatal
period when I'm involved, after delivery, after birth, er
pre-school, routine visiting, screening, involvement when
appropriate with school children five to 16 ..."

The list ran on for another ten lines.

Other areas described by health visitors at this stage as
included in their roles included

HV111P "to give (the mother) confidence in her abilities" and
"to assess both the child's, the baby's development, and
their social setting and their social need"

as well as work with other groups including mentally and
physically disabled people, and elderly people. One health
visitor also described what she was not:

HV051P "Well preventative is the main, our main job, you know,
telling, trying to explain that you're not a social
worker... To enlighten them what you do I think is an
important thing at the beginning and how you can help
them and telling them about the developmental checks that
we do and why we actually do them and that you're not a
snooper as some people see you"

She is explicitly denying the judging role which some parents picked up at a later stage in relation to child care and welfare. One other health visitor commented implicitly on this role when she said:

HV031N   "Children would be the priority. A social worker said to me that everyone's very child oriented since the Beckford case. It doesn't alter the fact if something happens someone'll say why didn't you see that child"

This health visitor is implicitly accepting at least the external expectation that she has some responsibility for children at risk of abuse.

Stage two

At stage two, two predominant roles emerged from the descriptions of interactions with parents. These were support - in feeding, and in bereavement, and information giving - seen particularly in relation to weaning and immunisations:

HV032P   "I remember leaving a pamphlet for her cos she wasn't sure as to whether the injections..."

Over half the parents had identified a judging or checking role at this stage, in addition to a generalised supportive role.

Stage three

At stage three, whilst these roles continued to some extent, particularly the support role, the quantity of interaction with parents was reduced. "Reassurance"(HV063N) was mentioned by one health visitor, and "talking through problems" by another (HV053P). Health visitors at this stage reflected on their interactions with parents and appeared to favour a relationship centred model. For example, one of those who had not managed to see the mother antenatally commented that she would have liked to have done so -

HV053P   "I think if you try to get a relationship going in er the
          antenatal period, it does help.

Another, who had taken over the mother after the second interview, making a similar point about the development of an effective relationship, said:

HV063N   "I never think its the same when you haven't done the
          first visits ... it alters your future visits, you know,
          so I think you've got to work at those visits a little
          bit more to keep the relationship going"

Both of these health visitors were indicating that the earlier in the process of parenthood a relationship commenced, the easier it was likely to be to maintain.

A slightly different point was made by two other health visitors. Each of them noted that relationships take time and testing to develop. One remarked:

HV023N "She is very very open when you get close to her, but it took a while. It took a few visits before she opened up"

This is particularly ironic since this parent felt that the health visitor was remote. The other health visitor was more circumspect:

HV203N "I'm really wary about saying I've got a good relationship with anybody... But I would certainly feel, you know, that we had the basis of a good relationship. I don't think its been tested because, you know, we've not really had any problems, so we've just got along nicely"

She indicates that as well as time, testing out the relationship would be necessary before it could be regarded as 'good'.

Many of the health visitors had not seen their study client, except at the clinic, for some months - sometimes almost since the previous interview. None identified this as a problem - many said that they had built up a 'relationship' with the parents, which would enable parents to contact them if necessary. This seems to suggest that their role is either seen as complete, or as problem centred - they will solve problems on demand. Parents however noted that they had not seen their health visitor very much, or that (see for example Case Study A), she was in a hurry, or very busy. They did not identify a reduced need, indeed some (see for example Case Study C) felt that they would have liked to see her considerably more, to talk through possible problems. This represents something of a reversal from stage one, when the health visitors were putting forward a preventive role, and parents saw her as problem oriented. The health visitors' perspective may be influenced by the other demands on her time, and the need to justify her reduced input to herself.

Summary - health visitor responses

Asked to describe 'good health', health visitors at stage one placed their greatest emphasis on definitions of health related to function. They attached less importance to social/emotional aspects than did parents. The two predominant themes identified by health visitors as likely to affect health were diet and parenting. The latter was taken to incorporate ideas such as

'stimulation', and 'providing a routine'. Parents at stage one generally cited food and diet as most important, much as health visitors did, but hygiene and avoidance of infection were also a significant category for them. Parenting was only mentioned as important by one mother at stage one.

Health and health problems were not specifically asked about at later stages, but emerged from the descriptions of interactions. Feeding was a predominant theme at stage two, when health visitors were describing their interactions with families with a child of eight to ten weeks. Parenting skills and developmental progress were also mentioned at this stage. Parents at this stage were focussing on practical problems, and described health in terms of 'nothing much wrong', with functional aspects (such as feeding, or sleep) a close second.

At stage three, development was the predominant theme in health visitors' descriptions of the child and the family. Along with other themes such as immunisation status and responsiveness, it often appeared to derive from a professional framework, and to be primarily mentioned in relation to 'failures to fit' the ideal. Parents however focussed mainly on social and emotional aspects of health.

Parents at stage one had had little or no idea what sort of health needs or problems to expect. The health visitors, since most of them had not met the specific study families at the first interview, gave generalised answers to questions about their visiting pattern and how they developed priorities. From these some idea of their perceptions of health needs and problems, albeit idealised, could be obtained. The majority described the need to look at the parent's situation.

At stage two, parents placed particular value on practical help and advice. Several mentioned feelings of 'panic' in the context of descriptive accounts of the early weeks at home. Health visitors focussed on both the assessment of parenting skills, and on practical aspects of help given, particularly in relation to weaning. Responding to need was seen as important. Developmental need was seen as important in the planning of help and advice. Help offered was discussed in terms of support, availability and information giving. Some health visitors experienced difficulty in recalling their contacts with the parents concerned at this stage. They also appeared reluctant to admit to not meeting their own standards.

At stage three, health visitors generally described study parents as having few problems and little need for advice and help. This fitted with the reduced level of contact with professional advisers reported by parents at this stage, though not with all

parents' wishes. The nature of health visitor - parent interactions was described, particularly the degree of privacy and the means of information sharing. Parents at this stage found themselves relying more upon friends for help, and noted the importance of relationships with health visitors. Several identified a need for more contact, particularly at home (picking up the theme of privacy.)

Processes of legitimation, of the child's health status and the parents' actions in respect of that health status, were described by parents at stages two and three. At stage two, the majority of legitimation described was by lay sources. At stage three, professional legitimation was described by a substantial proportion. Some health visitors described a role as legitimator at stage one. A few described instances of legitimation in relation to study families at stages two and three.

Health visitors' perceptions of their own role, and of the interactions between themselves and clients were described. At stage one, the main theme discussed was health promotion and prevention. Assessing and supporting were also described as taking place. At stage two, supporting and informing were the two main roles which health visitors outlined. These were also mentioned at stage three, though the number of health visitor - parent contacts was reduced. Health visitors at stage three described the nature of their interactions with parents and

appeared to favour a relationship centred model. The judging and checking role which was predominant in parents' perceptions was only mentioned explicitly by one health visitor, at stage one.

Chapter Eleven

From themes to theory

This chapter outlines the eight main concept areas which emerged from the interview data. Each is explored in turn, considering the themes from which it is developed, and changes over the stages of the research. Links are made for each concept with the wider literature. Finally, a substantive theory is put forward, linking the concept areas.

* * *

The development of theory

Glaser and Strauss (1967) describe how themes may be abstracted from interview data or observational material, by a process of systematic inspection and coding. As the themes are compared, concepts - categories - may be developed. The themes form properties of these concepts. Ongoing comparison of concepts leads to the recognition of links between them, and the development of a substantive theory, grounded in the research data. At each level, saturation will occur when no new themes, or new links can be found. Where substantive theories are developed in this way for several different areas, a grounded formal theory may be generated, which Glaser and Strauss argue will be less abstract, and less "divorced from ordinary people and everyday

life" than is generally thought to be the case with formal theories.

Eight main concept areas emerged from the interview data in this study. They included:

Health, health problems and other concerns

The need for help - locating the problem

Knowledge and experience

Legitimation

Advice, support and comparing notes

Choosing a helper

Relationship or problem centred

Power and control

Some of these were externally (researcher) determined by the interview structure - that is, the interview included a question which was likely to generate answers in particular terms. An example of this might be the 'health, health problems and other concerns' concept, which was usually discussed in relation to a question about their child's health. Nevertheless, such themes were usually also addressed in the context of questions where no such effect was anticipated, and were thus only partially external. Other concepts emerged totally internally, from the respondents themselves. For example, 'knowledge and experience' or 'legitimation' arose in discussion of support structures and of specific experiences. Internally generated concepts may be seen as possessing a greater validity than those which are solely

externally generated, when the intention is to examine the client's perceptions.

Development of theory is described by Glaser and Strauss in terms which suggest that it is inevitable once the categories have been identified that patterns emerge which link them, just as they emerged from the original data. This is perhaps an over-simplification of the process involved, which is more akin to the completion of a jigsaw puzzle. Just as in completing a puzzle, the shape needed may be known, but must also be recognised and placed correctly, so the potential pattern and direction of a link between concepts may be recognised, but must also be filled out and made clear. Further examination of data shades in the gaps in the categories (concepts) and their properties (the themes from which they are developed), and helps to strengthen or establish further links, making the substantive theory stronger overall.

Discussion of concept areas

The eight main concept areas which emerged from the interview data are described and discussed in relation to relevant literature. Some theoretical links are developed.

Health, health problems and other concerns

In the present study, perhaps because respondents were solely discussing the health of children, 'health' was defined in three

ways -

* as 'nothing much wrong'

* as functional well-being

* as social/emotional well-being

'Nothing much wrong' defines health as the converse of illness -
on an essentially disease-based model - often referred to as a
medical model. This was to some extent implicit amongst those
parents-to-be who felt that hygiene and the avoidance of
infection were important influences upon children's health. It
became more explicit at stage two, when the baby was a reality,
and their concerns about it, even to the level of panic, were
strong. It was still quite important at stage three, but was
balanced more by other definitions.

Many respondents said that their child had had various minor
illnesses - diarrhoea and vomiting, coughs and colds, but still
maintained that the child was in good health. He or she had had
nothing serious wrong. Part of their responsibility as a 'good'
parent might be seen as maintaining the child's health. 'Health
problems' might be acknowledged where a clearly recognised
disease process or an external factor such as poor housing could
be identified as directly or indirectly responsible for ill
health. This definition of health also highlights the timescale
on which such judgements of health are made - several
respondents' children were overtly ill around the time of one or
more interviews, but respondents chose to look at their overall
health pattern. This may have been in order to minimise the

effects of this incident, or because the illness was in no case life threatening or long term.

Functional well-being was defined in terms of functional norms for eating, sleeping, eliminating, and motor, language and perceptual skills. These norms were defined by respondents initially through reference to 'expert' sources (magazines and books, health professionals, experienced lay contacts) and latterly through their own experience, and that of their peers. Failure to conform to these norms was seen as a problem, but not necessarily a health problem. In some cases, norms about patterns of functioning and the development of functional skills were altered to fit the situation. For example, parents who initially said that feeding 'regularly' would be normal functioning came to recognise at a later stage that more erratic patterns based on the baby's need were perfectly normal. Feeding and sleeping patterns quite often differed from those expected. In other instances the problem was defined as one of management rather than health – for example, the need to establish a routine bed time.

Social/emotional well-being was defined in terms of the child's apparent response to its environment. Children who were described as healthy in this way were said to be 'happy', 'responsive', 'alert', 'contented'. These and similar definitions were implicit norms of social/emotional well-being. Social/emotional health was the primary definition used by parents antenatally. This might be linked to the idealised views transmitted by the media

about babies and young children, which frequently suggest that they are permanently 'happy and contented'. This definition of health became much less important at stage two, when the physical care of the baby and its susceptibility to disease appeared to lead to the 'nothing much wrong' idea predominating. By stage three, the baby's social skills are increasing, which may be significant in the resurgence of the social/emotional theme in definitions of health.

Whilst most functional norms could be fairly clearly defined in concrete terms, social/emotional well-being involves a much more subjective judgement. Those who were thought to have problems in this area were described for example as 'whingy', or not responding 'normally'. Whilst social/emotional problems might be associated with ill health, again, they were not necessarily seen as health problems, but as social or environmental problems. For example, lack of company was identified by one parent as the reason for her baby's 'whinging'.

Cornwell (1984), as discussed earlier, suggests that a tripartite classification of illness exists in the public (shared) accounts of her sample of East End people. 'Normal' illness incorporates the infectious diseases which children are expected to catch, and infections in adults that are not severe. These illnesses are commonplace, and easily treated by medicine. 'Real' illness includes "the major and 'modern' disabling and life-threatening diseases". Cancers, coronary heart disease, epilepsy and diabetes feature in Cornwell's list. Whilst all these conditions require

medical treatment, it will by no means necessarily be successful.
Her third grouping is 'health problems which are not illness':
problems associated with natural processes - for example ageing -
and problems which are thought to stem from the person's nature
or personality, such as allergies, asthma or eczema. These
problems were seen by her as not amenable to medical treatment
(though both asthma and eczema can present serious symptoms which
are amenable to medical treatment). However, all the examples
given related to physical conditions, or conditions having a
physical effect.

Implicit in Cornwell's model is a definition of health as
'nothing much wrong'. Her explicit model categorises health
problems on the basis of the medicalisation of health and
illness. She suggests that "medical and lay concepts of health
and illness are related, that the relationship is not equal, and
that the medical view dominates" (p122). Participants in
Cornwell's study found difficulty in defining health other than
as 'non illness'. Her interviewees attached moral worth to the
state of good health, and assigned a discreditable position to
ill health, which must then be retrieved by legitimation of
illness on the medical model. The concept of moral worth arose
from a philosophical standpoint which indicates that individuals
have a choice about whether or not they act 'responsibly' - work
hard. Illness prevents them from doing this, and so is seen in
Cornwell's study as likely to be discreditable.

In the present study, parents define children's health more widely, to incorporate function and social/ emotional aspects. Mayall (1986) discussing similar findings in a study of parents of toddlers and young children suggests that:

> "There are standards and measures for good health in children, whereas for adults we have no similar measures. From the child's birth onwards, mothers have before them a view of the child as having tasks to perform, not least because health visitors and doctors and leaflets at the clinic promote the view that there are weights to be achieved (for babies) and milestones to be reached"

In other words, she is, like Cornwell, suggesting that a professional definition of health is predominant, having been internalised by mothers 'from the child's birth onwards'. However, she indicates that that definition is widened for children to incorporate developmental and functional tasks. It may also be that as adulthood is reached the health potential of the individual is seen as diminishing, just as other changes slow down or stop. In the present study, the alterations in definitions of health over the stages of interviewing indicate that broader social influences are at work antenatally and in the first year. Whilst literature may be important antenatally, particularly for some groups, family and peer group influences are also significant. Norms are derived from these sources as well as from health professionals. For example, one mother commented:

P113P   "Me friend up the road, X, ... She generally tells us
         what he should be doing. You know, she says oh well its
         time he had a cup, give him a cup and oh em get him in
         that baby walker... "

As the child is developing, so concepts about its health develop.

Antenatally, babies' health is perceived primarily in terms of
social/emotional and functional well-being. Graham (1977)
describes the way in which antenatal literature reinforces
stereotypes of 'contented' babies, and 'normal' patterns of
feeding and sleeping. Subsequently, at stage two, the non-illness
model of health becomes equally important. This may reflect the
wish, antenatally, to deny any possible imperfections such as
disease, or the difficulty in envisaging an ill child at that
stage. Some parents in the present study described their
anxieties about such situations. Equally, the influence of
professionals, and, potentially, of their definitions of health,
is strong at this stage. By stage three, social/ emotional
definitions re-assert their importance, perhaps influenced by the
development of the child to a more 'social' stage. Parents are
'comparing notes' with other parents, and re-defining norms based
upon their own and their peers' experience. Other people's
children have similar 'problems' - their own may therefore be
seen as 'normal'.

The number of factors which parents believe may influence health becomes greater at later stages, and the perceived controllability of those factors becomes less. Antenatally, food/ growth and prevention of infection predominate. The presence of the latter indicates that there is an illness based model of health at this stage, but seems to reflect the medicalised antenatal literature and classes rather than any specific ideas of illness. Later such factors as 'fresh air' and 'teething' are also thought to be important influences on health.

Health problems are essentially seen as relating to disease processes and individual breakdown. However, problems relating to the care and management of children and their environment are often not seen as 'health problems', but as inadequacies of the child's management or environment - (for example one child was identified as 'whinging' because he was lonely.) They thus hold a similar moral status to 'health problems that are not illness' - the parent could be held to be responsible for them. However:

    i) parents are not necessarily seen as initially expert, - it is acceptable to be uncertain as a new parent

    ii) 'solutions' are usually thought to derive from experience, including other people's, or

    iii) from changes demonstrably outside the control of the parents - externally attributable causes must be produced.

Health and management problems and the need for help

Health problems may be categorised in another way, in order to examine the relationship between health, child health and management problems and the need for help. Health itself should present no need for help, provided there is no ongoing threat to its maintenance. Should such a threat exist, then help will be required. Health and management problems are described by parents as falling into three groups:

a- 'Trivial/ silly/ little problems'

b- problems which create a substantial feeling of insecurity/ anxiety/ uncertainty

c- problems which are definitely significant or serious

Problems in category a) are those which mothers feel that they 'ought' to be able to cope with without help. Although some inexperience is acceptable in the new parent, (legitimised in the tradition of grandmothers' involvement in the early days), there is still a moral imperative to cope, particularly with basic caring functions.

Problems in category b) are frequently those where a parent is unclear as to whether the origin is physical, requiring medical help, or behavioural, requiring help in management. At stage two these problems were very common, (see for example case study A), and professional help was frequently sought. Help could be needed to decide upon an appropriate course of action, or to legitimate it. In many cases such problems were then re-classified into

category a), when parents' increased knowledge and confidence generally enabled them to cope.

In later stages, help was often sought from friends, relatives, or sometimes health visitors in relation to choosing an appropriate adviser (see for example case study B). This was frequently because parents could not decide whether they were dealing with a problem in category a) or one in category b). Professionals were most commonly seen as dealing with the latter.

Problems in category c) are those where there is no doubt in the parent's mind that help is required, and no doubt as to the source. These problems were described in abstract terms since none had been experienced, but parents said that they planned to use doctor or hospital if serious problems occurred.

Each parent may place similar problems into different categories, dependent upon her/his experience and knowledge at the time. Each parent attempts to place a new problem upon a continuum between 'Normal' and 'Abnormal'. (Spencer (1979) indicates that parents of young children were on the whole able to distinguish serious illness from 'wellness'). Help is required to place each problem into its context - to locate it in the 'known about' universe. Once it is 'known about', help is required to deal with abnormal or serious problems:

'Normal'---------------- Uncertain------------- 'Abnormal'
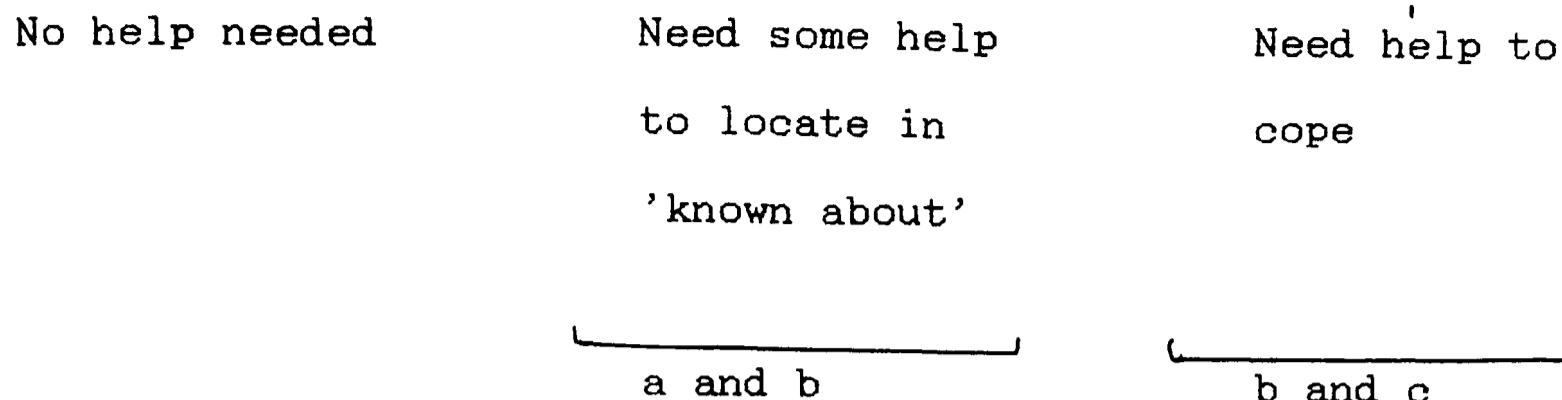
No help needed	Need some help to locate in 'known about'	Need help to cope

a and b

b and c

The dichotomy between normal and abnormal becomes clearer the greater the parent's knowledge and experience.

Initially the uncertain area is the largest. Uncertainty is generally unacceptable. Adults expect to know the 'rules' which govern situations. In dealing with children and child health and management, there are few if any general rules. Rules develop around the specific child and his/her responses. This is a major factor in the uncertainty experienced by new parents.

As experience builds up, and parents learn the 'rules' for their child, the uncertain area diminishes, and the boundaries between 'normal' amd 'abnormal' become clearer. Conditions such as colds or rashes become accepted as 'normal' - because they occur commonly and they are self-limiting: they get better without any intervention. The child's personality and usual patterns of eating and sleeping become recognisable. Nevertheless, since the child is always developing new skills, and growing and changing physically, an uncertain area remains - something that a parent was certain about at two months may be an area of uncertainty if it recurs at seven months.

Experience and Knowledge

Knowledge as described by parents appears to take two forms -
'professional' - based in explicit theory, taught, publicly
valued in society (see case study A) and 'common sense' - based
in observation, experience and implicit theory, and poorly valued
in society (see case study E). Its content, in the context of
this study, relates to 'norms' of health and behaviour, and the
resources available to achieve them.

Parents lacking both experience and taught knowledge of children
tended to value professional knowledge. Initially, at stage one,
they expected to learn, to receive knowledge, from health
professionals. As they built up experience of their own, over
stages two and three, their need for further professional
knowledge was reduced, and more value placed on sharing
experiences with their peers, building up a pool of common sense
knowledge.

Parents with experience of young children - either as carers or
in a family environment - valued experience highly. They expected
to receive help in developing their common sense knowledge from
experienced people. At stage one they only attributed this type
of experience and common-sense knowledge to lay people. At stage
two they came to place more value on professional knowledge as a
way of 'checking out' or legitimating experience, and by stage
three to realise that professionals too could offer

'common-sense' knowledge.

Different types of problem could require different sorts of knowledge to cope with them. Some parents could use both common-sense and professional knowledge in looking at the causes of a problem and deciding upon appropriate action. Each parent appears to develop an equilibrium between the use of common sense knowledge from experience and professional knowledge based on teaching. The point of equilibrium appears to depend upon previous experience of childcare, present experience of services and current problems. To some extent the distinction between the two types of knowledge is blurred, since experience may incorporate internalised concepts from professional knowledge, and common sense ideas may initiate theoretical debate and the development of professional knowledge.

Inter-relationship between common-sense and
professional knowledge for parents

Fig 2

Experience

Common
Sense
Knowledge

Teaching

Professional
Knowledge

P R O B L E M

Coping
Skills

Decision
Made,
Action
Taken

Outcome

- 331-
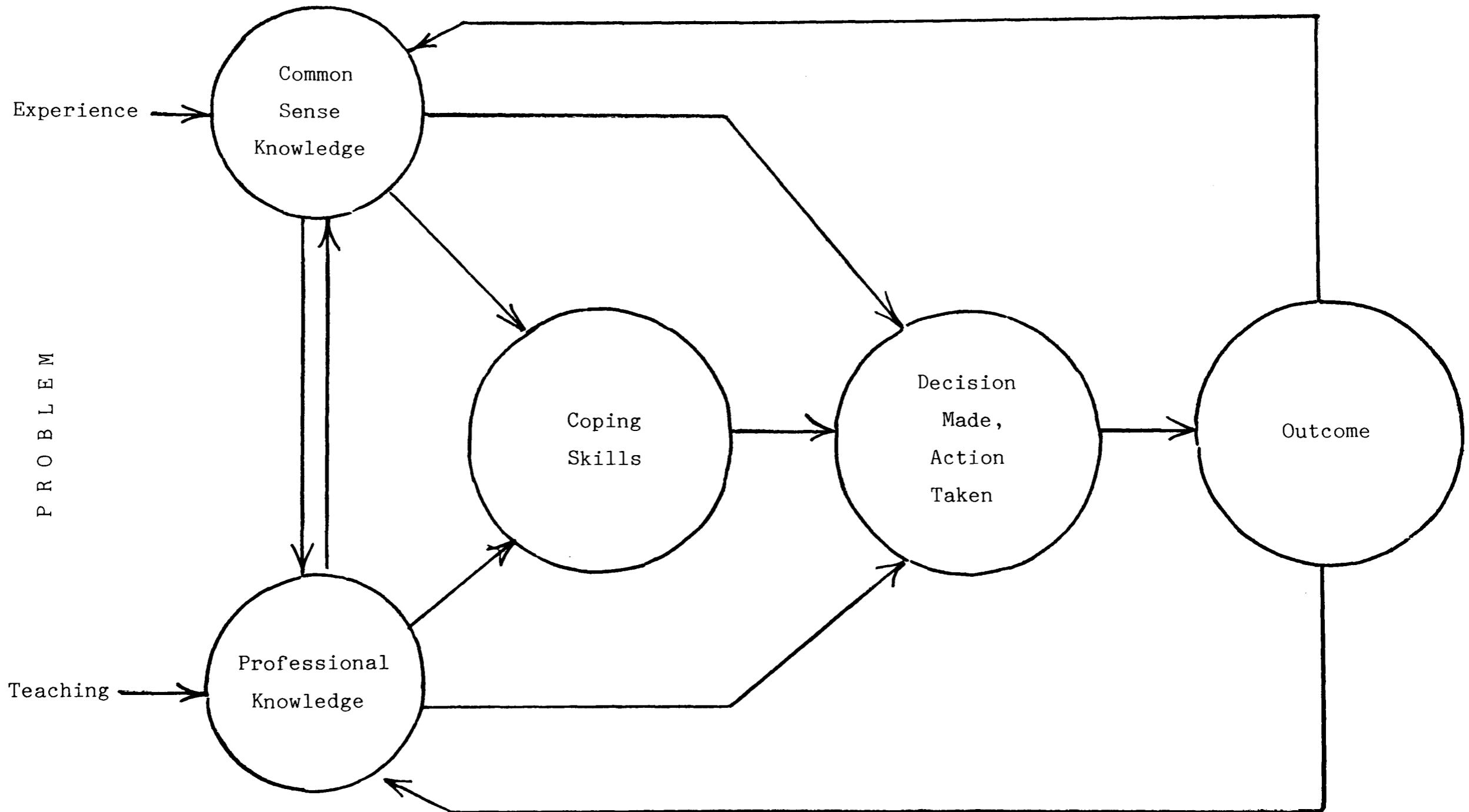
In Figure 2, the inter-relationship between common-sense knowledge and professional knowledge amongst study parents is represented. It is postulated that its equilibrium is affected by taught information and by experience - of similar situations and of services for instance. The position of the equilibrium affects coping skills and decision making about a specific health or childcare problem - for example, if experience is limited, skills will be more superficial. A parent may be concerned about a crying baby, and not realise that the child needs winding (P112P). Once winding has been carried out successfully, that skill is added to her repertoire, and her knowledge about 'wind' is increased. The outcome of the action will feed back to affect the knowledge of the parent, and adjust the equilibrium.

Legitimation

Legitimation is described in relation to the parents' initial uncertainty in various situations, the child's health status and the parents' actions - planned or executed. Legitimation must be carried out by a representative of the group or groups to which the parent refers for approval - by someone who has knowledge (common-sense or professional). Legitimation by grandparents, professionals and the peer group were described in this study.

Ong (1983) discusses the way in which women are expected, publicly, to value motherhood, and to see it as a 'natural' role. Despite feminist criticisms of this one-sided position, (Rich, 1977), it remains strongly held in society at large. Implicit for

many people in the idea that motherhood is 'natural' is the idea that the skills of motherhood are largely instinctive - common sense. Experience may then be seen as reinforcing instinctive responses. However, when 'instinctive' responses are described, they appear to relate to the recognition of very basic problems - hunger, thirst, and discomfort, and not to the range of other problems which face the new parent.

The assumption that a mother 'ought' to be able to recognise health and related problems in her baby, and to rapidly learn the skills needed to cope with them leads many parents to describe problems as 'trivial' or 'unimportant', particularly when they do not generate much anxiety. They 'feel silly' not knowing things which they assume are 'common sense knowledge'. Their self image is devalued. Professional responses which reinforce this reduction of self image result in greater uncertainty about future action. To rectify the situation, parents want:

* legitimation of the problem and guidance on how to cope with the problem
* legitimation of their lack of recognition and coping skills
* legitimation of their plans for action to cope

There are two basic forms of legitimation described by respondents - firstly through 'sharing' with peers or grandparents and secondly through an 'official', professional view. 'Sharing' with other parents and experienced people often

legitimates a problem through acknowledgement of its 'common-ness'. If many other people experience or have experienced the same problem, and/or the same uncertainty as to ways of coping then their experience is 'normal', and they are not inadequate as parents. Sometimes, where a problem is not commonly shared, an "official" view is seen as important in legitimating the problem as 'not their fault': legitimation of the problem as external - for example caused by disease - must be given by a professional, whose expertise is valued by society. Doctors are more frequently cited in this way than health visitors, perhaps because their role is seen as more specific to disease.

As legitimation takes place, initially in the main by professionals, the parents' repertoire of 'approved' actions expands, and their confidence in their own decision making increases. They can also recognise a wider range of problems readily. Gradually legitimation of the problem decreases in importance. Where it occurs, it tends to involve 'comparing notes'. Legitimation of parents' plans for action to cope becomes gradually more common. The situations where legitimation is required are reduced in number. At the same time, lay or professional advisers may be used. Legitimation of all types gradually decreases in importance as parental confidence increases.

Advice, support and comparing notes

Three types of helping relationship were described by parents in this study. These were advice, support, and 'comparing notes'. Each represents a different emphasis in the helping relationship. Over time, different types of helping relationship are favoured, which, it is suggested, may relate to the different emphases of each. Each relationship, if successful, facilitates decision making.

An adviser may offer support, but support is not essential to advice, nor vice versa. Advice may be described as the provision of information and guidance. The emphasis is on the 'other' who offers the advice. If it is accepted, that other is in some sense steering the parent, controlling her/his actions.

The characteristics of 'good' advice defined by respondents are that it should be:

> practical in the situation (not unrealistic or apparently inappropriate given available resources)
>
> effective in dealing with the problem (it should work!)
>
> understandable (explained so that the parent is clear what is required)

Support involves the corroboration of information, the provision of reassurance and understanding. Its emphasis is on the 'self' who is being supported in controlling her/his own actions. 'Good' support exists when the respondent feels in control.

'Comparing notes' offers a third approach - 'comparing' suggests that this relationship is based in mutuality - each can help the other. On one occasion, one partner may offer more, on the next, the other. Either advice or support may be offered within this relationship. This relationship was always cited positively, but it may be postulated that if mutuality was not present, for example if a baby's development was outside the normal range in the group, the idea of 'comparing notes' would break down.

In the antenatal period, the primary emphasis is on advice - information and guidance. The parent-to-be frequently feels she knows little or nothing. However, several parents indicate that they intend to be as self sufficient as possible. Need is less immediate than it will be postnatally, and the 'controlling' aspect of advice may therefore be less obvious.

Immediately postnatally, advice is central - deficits of knowledge and information are realised in relation to specific problems. Parents want direction and guidance in dealing with new and unfamiliar problems. However, the new parent is often tired - "I could have slept on a clothesline" - and feels isolated. Support becomes important to her. She needs reassurance that she is still able to make some appropriate decisions, and to control some situations. Opportunities to compare notes are welcomed at this stage because they provide awareness that she is not alone, and that she has something to contribute herself. However, at stage two she remains largely dependent.

Moving towards stage three, at which the child will be seven months old, advice continues to be sought in the early weeks and months. However, as knowledge and experience grow, the need for advice is reduced, though it remains in existence, since each new stage of the baby's development generates new problems. Parents take back more control of their own situation. However, the need for support continues. Though parents' skills increase, many situations in the first year of the baby's life are essentially new, and reassurance is required in dealing with them. Comparing notes becomes far more important as skills increase, because not only is any experience contemporary, but control of the situation is maintained, through the operation of mutuality by parents who each have something to contribute.

Advice may be offered by lay people and professionals. Lay advice is generally said to be legitimated by the adviser's experience - "she's brought us up, she should know". Professional advice is seen as largely based on professional knowledge. By stage three however, health visitors appear to be recognised as deriving some at least of their advice from experience.

Support appears to depend upon the existence of an informal relationship. It cannot easily be offered or received where only a formal relationship exists. Support should also be needed - a 'felt' need. Support offered when it is not seen as necessary (see case study B) may be seen as judgemental - the would-be supporter has judged the parent to need corroboration,

reassurance and understanding. If the parent feels that she/he is coping, this is insulting to her/his self image.

'Comparing notes' is dependent upon a mutual relationship, through which the comparison of symptoms, behaviours and strategies for coping with the peer group expands knowledge. Thus an initially inexperienced group is able to develop knowledge based on pooled experience, and to discuss and digest strategies for managing children's health and welfare.

Choosing help

Whilst the choice of particular types of relationship appeared to be influenced by the parent's need for information and desired level of control, the choice of specific helpers was influenced by a variety of factors. Some related to the problem or situation involved, some to the available advisers, and some to existing knowledge and experience.

The type of problem (health or management) perceived and the level of problem or need for help perceived were of importance. Different people would often be consulted about functional problems as distinct from social/ emotional problems. If a problem was seen as 'silly', it was more likely to be dealt with through informal, probably lay sources.

The availability of potential advisers, supporters and others also made a difference to the choice of help. Some grandmothers

were to hand, others were not. Some health visitors were seen regularly at the clinic. The visiting pattern of others varied from frequent to not at all over the period of the study. 'Other mothers' (the peer group) were met in classes and clinics as well as among pre-existing friends. The accessibility of potential advisers or supporters was also noted as important. Some were theoretically accessible, but in reality difficult to contact. This was found to be true of GP's and of health visitors.

Another important factor in choosing help was the knowledge already possessed, and linked to that, the experience already amassed. As indicated earlier, as confidence increased alongside improved knowledge and experience, less need was felt for advice, and more for support or for comparing notes.

The relevance of past encounters with particular potential advisers or supporters was identified. A preference for 'sympathetic' advice was expressed, and in some cases, especially at stage two, a preference for overt, apparently active, directive responses to problems rather than apparently passive responses such as listening. The effectiveness of past encounters also seemed to be important. If advice or support from an individual had been seen as helpful in the past, they were likely to be considered again, particularly for similar sorts of help. The personality of potential advisers or supporters, where they had been previously encountered was also influential in choosing help.

The stage at which the choice of help was being made was the final important factor (see for example Case Study A). At stage one, few parents had any contacts other than with hospital and relatives. Few had any experience or knowledge of child health and care. At stage two, most had had close contact with midwife and health visitor. By stage three, the majority had gained confidence in dealing with most aspects of their child's health and welfare, and were also in most cases experiencing reduced contact with the health visitor.

Relationship/ Problem Centred

A dichotomy between a relationship centred and a problem centred model of health visiting has been put forward in a number of other studies. Orr (1980) identified it as significant amongst mothers in her study of mothers in Northern Ireland. Robinson (1982) describes health visitors also using these two approaches to health visiting. She says that clients in her study generally perceived 'successful' health visiting for themselves as the establishment of rapport, but felt that health visitors were generally problem oriented with other families.

In the present study the development of a relationship with the health visitor was highly valued by most parent respondents. The following dimensions of such a relationship were identified:

Close	–	Remote
Sharing	–	Directing
Caring	–	Uncaring
Interested	–	Not interested
Understanding	–	Not understanding
Trust	–	Mistrust
Responsive	–	Not responsive

By stage three the relationship was seen by most parents to be on the positive end of these dimensions, and was thought in that case to be successful.

The development of such a relationship – often described as 'like a friend' – was compared by some parents with 'being official'. The 'official' role was seen as relating to judgements and assessments – normal/ abnormal, good/ bad, legitimate/ illegitimate – in relation to the health and management of the child and the mother's health and resources. Responses to this role were dependent upon the type of judgement and its outcome (for example legitimating a child as 'normal', or judging a parent to be 'bad'), and on the relationship between the parent and the professional (for example the level of trust and of understanding perceived to exist between them) – see for example Case Studies B and D. Where previous experience of professionals had been of negative judgements, (for example in the hospital setting), initial perceptions of health visitors were frequently limited to ideas of 'poking their nose in' – judging things which are not their concern (see for example Case Study C). Without

exception, these views were modified through the development of a relationship.

Instrumental activities were frequently linked to 'being official' - measuring, weighing, examining. The 'scientific' nature of such activities was implicitly valued above 'ordinary' activities such as 'playing' or 'chatting' in the context of making a judgement, although chatting was seen as symbolic of a close relationship.

Although 'being official' was often seen as the opposite pole to 'like a friend', in practice most health visitors were seen as making some assessments or judgements. Where a positive relationship existed, these could be used by the parent in supporting and legitimating their care and management of the child. In some cases the positive relationship also operated to over-ride the negative connotations of judging or assessing in relation to friends, such that a health visitor might be asked to visit to help a friend to cope.

Power and control

Questions about power and control underlie many of the alterations which occur in relationships between health visitors (and other health professionals) and parents over the early months of contact. Control lies with different people at different stages.

As adults, most people value having control of their lives - being able to make up their own minds, to do what they want to when they want to. Certain situations exist in society which withdraw control from the individual. Parsons (1951) suggests that in becoming a patient, the individual must take on the sick role, and conform to the obligations of that role, controlled by professionals, rather than his own desires. Ong (1983) describes how women at the point of becoming mothers (which she identifies as high status in society) are also expected to take on the subordinate status of patients.

Antenatally, several parents expressed the value they placed on being independent, self-sufficient as far as possible. Others described their feelings of 'knowing nothing' and needing help to learn. Following the birth of the baby, feelings of tiredness and isolation were expressed. Alongside these feelings, increased needs for advice and information ('to know') and support ('I want 100% support') were identified. Latterly, as knowledge and experience increased, so did parents' confidence in decision making, whether as individuals or in groups.

Health visitors were seen as functioning in a variety of roles in relation to parents. These included:

An official/ judge/ assessor

This was most often found in relation to development, but included a substantial minority who saw judgement in

relation to child care or abuse. Judgement represents
power being exercised openly and completely - to permit
or not to permit activities for example.

An adviser/ information source

Advisers and sources of information usually derived their
information either from experience or from professional
knowledge. Knowledge is one source of power - a
significant one for professionals (see for example
Johnson 1972). Advisers are powerful people, able to
guide others' actions.

A gatekeeper to other resources/ services

Health visitors were seen by some parents as able to open
up access to other services, particularly the GP. Control
of access to resources and services indicates a degree of
control over outcomes.

A pathfinder - indicating landmarks for decision making

This role was indicated by some parents as one which the
health visitor (or another professional) undertook,
placing symptoms or behaviours in context, so that future
decisions would be more easily made. In this way they
were handing over the knowledge which enabled them to
make decisions to the parents - handing over the source
of much of their power.

A facilitator – helping clients to make decisions themselves

> This was a very similar role, described in relation to
> those who offered support in developing and using
> decision making skills. Facilitation thus increased the
> confidence of parents in making their own decisions,
> tending to increase their control over events.

A supporter

> Health visitors who offered support were offering
> reassurance and understanding to the parent concerned.
> The focus of this type of relationship was on the parent
> and not on the health visitor. The parent was being
> supported in controlling his/ her own actions.

A friend

> Some health visitors were described as being 'friends' –
> or 'just like a friend'. Whilst it may be argued that
> control rests with one rather than another at any given
> time, friends are generally seen as equal to oneself.
> Control of interactions – for example of what to do, or
> what to talk about – passes from one to another. Power,
> where it is held by one more than another, is normally
> left beyond the 'friend' relationship. Indeed, if it
> begins to impinge, the friendship will begin to be
> destroyed. Thus the description of the health visitor as
> a friend implies equality of control in interactions, as
> well as some personal warmth.

Though, as stated before, being 'official' and being 'a friend' do not represent absolute opposites, roles which involve the control of information or resources represent powerful roles, whilst roles which encourage client decision making represent a move towards equality. As the parent gains in experience and knowledge, and develops confidence in decision making she/he learns to decipher the landmarks, and to 'work the system' for access. If at the same time a positive relationship has developed with her/his health visitor, then an ongoing supportive role will be maintained, which may even develop into friendship.

Development of a substantive theory

Figure 3 demonstrates some tentative links between concepts which have been discussed above. In essence it is suggested that the nature of previous knowledge, and the nature of problems encountered influence the choice of helper and the degree of parental control at each stage. Whilst the relationship demonstrated in Figure 3 remains broadly similar, the balance shifts between the elements (the concepts). If the relationship is considered at each stage, emphases will be seen to vary.

At stage one the situation is characterised primarily by 'greyness' - uncertainty about possible problems or resources. Even the types of problems to be faced are uncertain. Many parents have little common sense knowledge and are dependent upon professional knowledge - from antenatal clinic, GP, midwife or

books (see Case Study B). They have little idea of problems likely to be encountered, but envisage possessing a measure of control in dealing with them. Professionals are described in ways which suggest that they might fulfil a 'pathfinder' role (see Case Study A) - indicating direction and handing over skills - but there is little detail. Parents who have previous experience have some idea of possible problems, and anticipate maintaining their independence supported by more experienced lay helpers. They do not see professionals as important.

By stage two, problems needing help are important, sometimes causing 'panic'. Common sense knowledge is limited (but being gained quite fast). There is now a large 'grey' area between problems defined as normal and problems defined as abnormal. Professional help is chosen predominantly to resolve the debate between normal and abnormal: For example, is this level of vomiting normal? (see Case Study B). Professional control is accepted as necessary, even desirable, in order to get help. Even parents with previous experience rely quite heavily on professional help. As problems are categorised by professionals, and appropriate action taken, the outcome is fed back to increase the parent's knowledge.

At stage three, the parent has increased in both common sense and professional knowledge. She has developed her ability to discriminate problems (see Case Study A, B). The 'grey' area has diminished as 'normal' and 'abnormal' become more clearly defined. The parent's skills in coping with problems have

increased. With this, the parent's self confidence has increased and she looks for a more reciprocal relationship with helpers, such that control is negotiated. Previous outcomes also influence this (see Case Study B, F). Even where professional help is sought, the desire for greater parental control influences which professional, in what context, is sought.

A substantive theory

Fig 3

Affects level of
Parental Control

Common Sense
Knowledge

Desire for
own control

INCIDENT

Decision Making Process
Categorise Problems;
"Normal" <-> Abnormal

Choose
Adviser/
Helper

Decision
Making
Process

Action

Effects/
Outcome

Professional
Knowledge

Desire for
Professional
Control

Affects level of
professional control

-349-
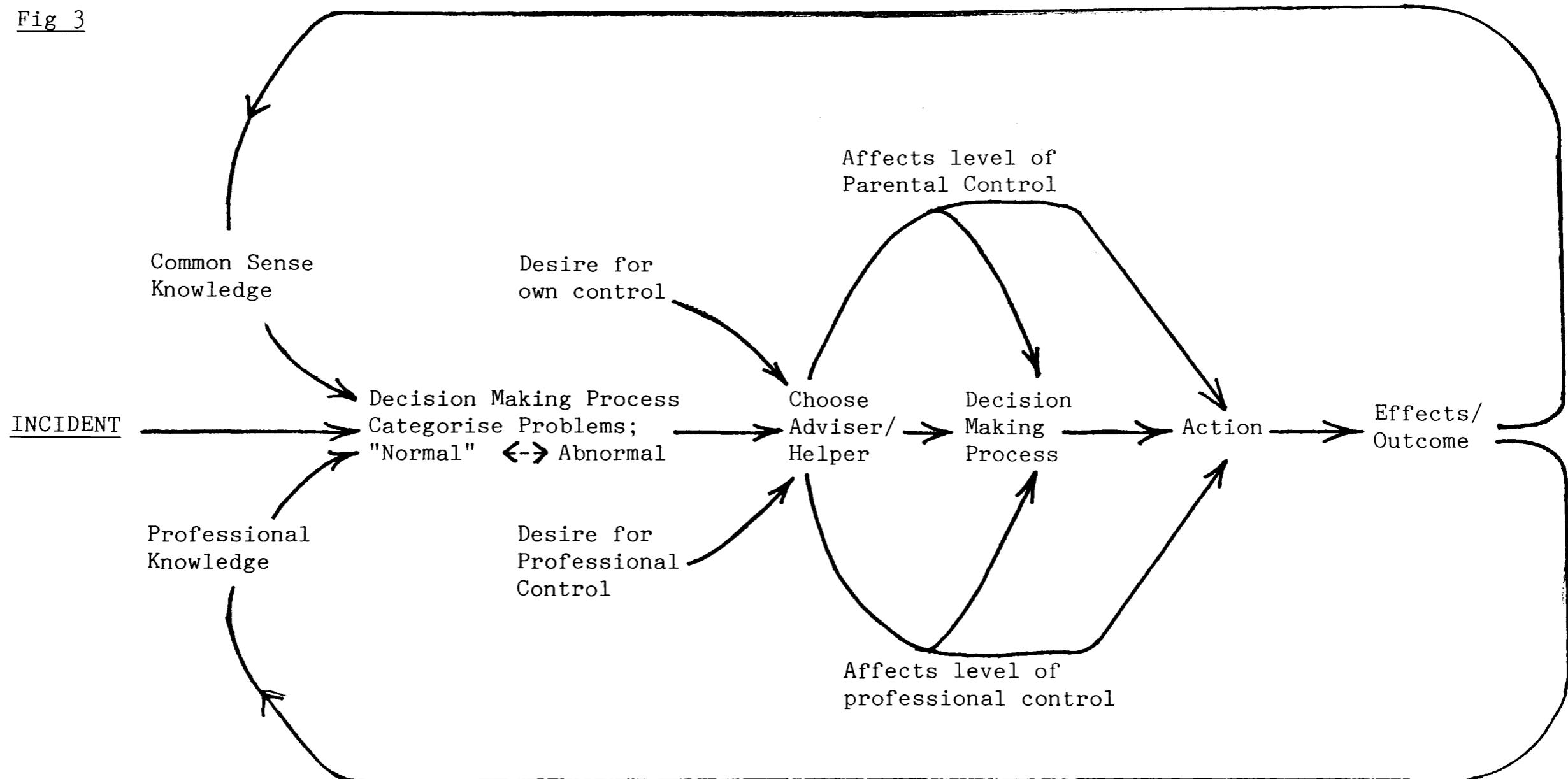
It can be seen that the process leads ultimately to some form of action (or non action) in relation to the child. The effects of this feed back to the various preceding levels: an action which is legitimated will be repeated in similar circumstances if they arise later. This is part of the process whereby the conversion takes place from stage one to two and thence to three.

The relationship between the health visitor and the parent is only touched on in Figure 3, insofaras it influences the choice of a helper, and the action taken. However, differences of perception between the two are important in considering the process of change which occurs from stage one through to stage three.

At each stage health visitors' perceptions of health, of problems, of legitimation and of their own role influence their behaviour. Initially their perceptions are dissimilar to those of parents. For example, they consider parenting to substantially influence health, whereas parents indicate that food and environment are the crucial factors. This is in line with theory on causal attribution (see for example Jones and Nisbett 1971) which suggests that people commonly see others as the source of their actions, but see themselves as acting according to environmental constraints.

At stage two, health visitors and parents are much closer, though still retaining some dissimilarities - for example parents place a stronger emphasis on relationships at both stages one and two

than do health visitors. This closeness of perception appears to be achieved through a mutual focus on practical issues, and a substantial degree of contact. Both health visitors and parents identify similar health problems and see a role for the health visitor in providing practical advice, which is valued by parents. Support is also valued by both at this stage.

By stage three definitions of health, perceived need for help (as compared with perceptions of actual help provided) and perceptions of the health visitor's role are all diverging once again, although relationships are valued more highly than before by health visitors. The health visitor's perception of the client's need for help, and of her own role with the family as the child grows older may be affected by her desire to avoid a mismatch between her perceptions and the reality of the demands upon her time. Hence, as the child grows older, and practical problems are reduced, she may largely deny the existence of other needs, to avoid the requirement to offer a service beyond her capacity (see Case Study A). Alternatively, she may be defining her role primarily in terms of problem solving, seeing a reduction of practical problems as indicating success, leading to withdrawal of input. The value placed upon the health visitor's involvement at each stage appears to reflect the degree of divergence or otherwise of her views when compared with those of the parent concerned.

Whilst the most likely explanation of the acceptability of professional control to parents is in the perceived need for

help, it may also be noted that where views converge, a greater degree of external control is acceptable to the parent (see Case Study C). As views diverge, less external control is accepted, even where a positive relationship has earlier been achieved (see Case Study A).

The other area initially addressed by this study, and which has not so far been discussed in this chapter, is the effect of socio-economic influences on perceptions. Since very few differences were found between categories derived from Priority Area and Non-Priority Area responses, the substantive theory outlined above is thought to be applicable in both types of area. It seems possible that the changes taking place at this time produce effects which are greater than the cultural and experiential differences assumed to exist between clients from the two areas. However, the limitations of the sample should be borne in mind.

The substantive theory is, in effect, a developmental theory. It suggests that there are three strands running through the health visitor - client interaction. Those strands are:

The development of the parent as a parent

The development of the child

The development of the health visitor - client relationship

Each strand can be seen in several of the concept areas, and in the links between them. The development of the parent as a parent encompasses changes in knowledge and experience, altering understandings of health and health problems, and a changing need for legitimation. In addition, the parents' need for advice, support or comparing notes varies dependent upon their level of confidence in themselves as parents.

This is intimately bound up with the development of the child. Initial concepts of health and health problems - based on little or no direct knowledge - give way to the reality of a child, whose major demands are functional. A functional approach to health and health problems is adopted. As the child grows and develops, becoming by seven to eight months a more social being, the parent's concepts of health also alter, to become focussed more strongly on social/ emotional ideas of health. As the child grows older, and larger, and visibly stronger, some of the anxieties of the early weeks and months - about cot death, or about infection for example - are diminished, reducing the need for reassurance, and increasing parental confidence.

Thirdly, the development of the health visitor - client relationship can be seen alongside the other two strands. Parents valued the development of a relationship with the health visitor, and where it was successfully established, felt close even when actual contact was limited. Where a relationship did not develop, even apparently parallel perspectives could not produce closeness

(see Case Study D). The development of a relationship was also linked to the management of power and control: where the health visitor appeared to match her approach to the perceived needs of the parent - whether for self determination or for direction - this was generally linked to the development of a strong relationship. Whether the strength of the relationship which developed enabled the health visitor and parent to match their needs more closely, or whether because the needs of parent and health visitor matched, a stronger relationship developed, is not clear.

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Summary

This chapter has outlined the eight main concept areas which emerged from the interview data. These were:

> Health, health problems and other concerns
>
> The need for help - locating the problem
>
> Knowledge and experience
>
> Legitimation
>
> Advice, support and comparing notes
>
> Choosing a helper
>
> Relationship or problem centred
>
> Power and control

Each was explored in turn, considering the themes from which it was developed, and changes over the stages of the research. Links were made for each concept with the wider literature. Finally a substantive theory was put forward, linking the concept areas. It was suggested that the nature of previous knowledge and the types of problems encountered influence the choice of helper and the degree of parental control desired at each stage. Whilst the relationship remains broadly similar, the balance between the elements (the concepts) alters at each stage. The value placed upon the health visitor's involvement at each stage appears to reflect the degree of divergence or otherwise of her views when compared with those of the parent concerned. The substantive theory is, broadly, a developmental theory. It indicates that there are three strands running through the health visitor – client interaction. They are:

The development of the parent as a parent

The development of the child

The development of the health visitor – client relationship

Through the intertwining of these strands, the concepts are linked together. A dynamic model of the interaction between client and health visitor is the result.

Chapter Twelve

Where should we go from here?

No study is complete without some indication of the signposts it gives for the future. This chapter will describe the implications of this study for health visiting practice, management, education and research, and recommendations arising from these. Some parts of the study have implications for more than one of these areas. Each area will be discussed separately, and relevant points noted. Though the study is qualitative, and considers a relatively small number of parents (and even fewer health visitors), the methodology enables concepts to be identified which are important for this group, and are likely to be of relevance to other similar groups. Implications are therefore cited broadly, recognising that some may need modification for other groups.

Implications for health visiting practice

Health visiting practice is defined as the work done by field level practitioners (usually), in direct contact with clients. It includes home visits, clinic sessions and face to face work with clients done on other occasions such as in groups. These implications are therefore those which impinge upon those relationships, and which the individual practitioner might initiate.

1. <u>The importance of recognising the changing pattern of parents'</u>
<u>needs and perceptions over the first year of contact</u>

The first important implication of this study for practice is the
requirement to recognise the changing pattern of parents' needs
and perceptions over the first year of contact. Whilst other
studies (Graham 1979, Buswell 1980) have indicated that a change
in satisfaction with child health services takes place in the
early months, little attention has previously been paid to other
areas of change - for example in definitions of health, or
perceptions of need. In providing a health visiting service for
families with children under five, it is important to recognise
alterations in perceptions, of needs and of roles for example, as
they occur. In this way the service provided can respond to the
needs expressed by parents, (for example for greater autonomy, or
more support), or explanations can be offered of why it does not
(for example financial constraints or reduced staffing).

2. <u>The need to be clear in defining health, or discussing health</u>
<u>problems or influences on health</u>

Related to this is the need to be clear in defining 'health', and
in discussing health problems or influences on health. Each
health visitor must be able to state her own beliefs clearly, and
with an understanding of common lay beliefs. The definitions of
health and of health problems used by parents in this study did
not 'fit' most of the time with those of health visitors. Parents
placed more emphasis on social/ emotional aspects of health. They
attributed influence on health to external factors such as diet

and environment. Health visitors emphasised functional aspects of health, particularly developmental progress, and identified the role of parents as important in influencing health. Whilst practical problems such as those with feeding were often similarly defined by parents and professionals, other types of problem were not always recognised by both groups.

3. The requirement to look more carefully at achieving joint definitions of planned/ intended help

Thirdly, the study indicates that health visitors should look more closely at producing joint definitions of intended help for clients. This first of all assumes that the problem is jointly defined, as discussed above. The available solutions must be clear to both health visitor and parent, and jointly considered. Some parents in this study found that their health visitors offered help which they did not want. Others did not offer help which parents felt that they should. Still others offered solutions to problems which were viewed as impracticable, given circumstances or attitudes which further discussion might have ascertained. In order to achieve joint definitions through discussion, communication skills will also need to be refined.

4. The importance of explaining clearly to parents the experience and knowledge that health visitors can offer

The study also suggests that it is important to explain clearly to parents the experience and knowledge the health visitor can offer. Many parents at stage one had no idea what a health visitor might do, or even that such people existed. Even at stage

three, perceptions of the health visitor's background and immediate functions were somewhat limited. Knowledge based advice had in some cases been offered without explanation of its assumptions and origin. A clear description, at an early stage, of the knowledge base and the experience which the health visitor can offer will facilitate parents in making appropriate use of her. Explanation of specific knowledge should be given wherever possible.

5. The requirement to ensure that each health visitor's knowledge and skills are up to date

It is important to ensure that each practising health visitor's skills are up to date. Taught knowledge and that gained from experience should be updated regularly, since additions to knowledge continue to occur. Professional knowledge is frequently cited as more reliable than lay knowledge. Professionals therefore have a responsibility to maintain its standards, quite apart from the statutory responsibilities of any Registered Health Visitor.

6. The need to explain clearly to parents the full range of roles of the health visitor

Because of the limited perceptions held by parents about what health visitors might do, even at stage three, a need to explain the full range of roles the health visitor can offer is identified. Many parents were unclear about aspects of the health visitor's role beyond that relating to young children – and even this, as described above, was only seen by most from a limited

perspective - as a family supporter or as a judge of development and/or child care. Those who suggested greater input to families with young children, or expansions of various aspects of the health visitors role, were frequently unaware of the other calls on the health visitor's time. Some parents saw a role for the health visitor almost entirely limited to judging and checking, in particular on child care. This could produce some diffidence in utilising the health visitor as a resource. At the same time, another parent who had encountered a different aspect of her health visitor's role said that it had been more important to her than the child oriented aspects. A broader understanding of the health visitor's role might enable her to work more effectively, and be used more appropriately by parents. It should however be recognised that the greater the range of roles adopted, the greater is the potential for conflict between them, placing increased stress upon the health visitor.

Implications for management

'Health visiting management' is taken to be the primary structure which controls use of resources and defines aims and objectives for health visiting practice. It includes a wide variety of levels, from those setting local aims and objectives for a neighbourhood to those setting them for a district or beyond. Many of the implications highlighted for practitioners at an individual level are also relevant at a collective level for managers to act upon.

Managers as well as practitioners need to recognise the changing pattern of parents' needs and perceptions over the first year of contact. This has implications for the consideration of the appropriate pattern of visiting or clinic provision, and the development of new ways of working. Proposals for changes in the level of service offered should also be considered in the light of parents' perceived needs.

Parents in the study identified a preference for 'comparing notes' at stage three. This seemed in part related to their increased confidence, in part to the types of problem encountered, and in part to a reduction in contact with health professionals. In order to assist and encourage this process, whereby parents take on more control of their situation, managers should encourage health visitors to function as facilitators, enabling parents to meet with other parents and to share ideas, and attempting to facilitate the building up of a lay resource network. It should be recognised that this type of approach would require adequate professional resources, and would not provide a way of reducing these at a stroke.

The importance of adequate updating of knowledge has been described above. In an area where change is frequent as knowledge is added to day by day, managers as well as staff may be considered to have a responsibility to ensure that what is offered to parents is absolutely up to date, since they aim to offer a high quality service. Currently managers can create

opportunities for updating and maintenance related to service aims and objectives. With the advent of Continuing Professional Development programmes, these will become a compulsory provision.

Implications for education

Education for health visiting has been taken as the process whereby Registered General Nurses are given both the theoretical context and the practical skills required to practice health visiting as it is currently defined. It takes place in Universities, Polytechnics and other institutions of Higher Education, and during field placements with an experienced health visitor who is a fieldwork teacher.

Probably the clearest implication of this study for health visiting education is the need to ensure that communication skills and interpersonal skills are well taught. The ability to form relationships, to convey information and to respond to cues are all described as central to the functioning of health visitors who are judged to be 'good'. Problems with one or more of these areas produce descriptions of health visitors as 'remote' or in other ways inadequate.

The importance of facilitation has been described above. Whilst facilitation skills may be developed by practitioners through in-service opportunities and through use, new health visitors should receive training in how to facilitate clients' use of lay resources and 'comparing notes'.

Another implication of this study is that clear teaching of models of health and illness which recognise the wide variety used day to day by clients must be developed. Each qualified health visitor must be able to state her own beliefs about health, health problems and influences on health. At the same time, the study suggests that health visitor students should be made aware of the changing pattern of parents' needs and perceptions over the first year of contact. Whilst at some points, health visitor and parent perceptions appear to run closely together, and health visitor involvement is rated highly, at others they diverge widely and health visitor involvement is less highly valued. Education for health visiting should enable students to understand and work with parents' perceptions.

The study also indicates that health visitors need to develop skills in achieving definitions of planned help which are shared with the parent. This suggests that educationalists must encourage health visitor students to learn to describe their planned help clearly to parents, and to discuss the advantages and disadvantages as fully as possible. Where definitions are not held in common, parents may expect too much or even not enough from health visitors. Plans may also turn out to be unrealistic if the specific situation is not discussed.

Many parents expressed uncertainty about the role of the health visitor - both in relation to children under five and to other aspects. Educationalists need to clarify the role of the health

visitor for students so that they can clearly explain it to other people. Many health visitors described their role mainly in technical terms - 'prevention' - 'health promotion' - and did not appear to be able to explain what functions this involved, nor how these might relate to the parents' expressed needs. Most parents were unaware of the wider range of activities undertaken by health visitors, or the rationale for these. In considering the reduction in contact experienced by parents at stage three, some understanding of this wider context needs to be conveyed to them, and health visitors need skills to do this.

Implications for research

In considering the implications of this study for health visiting research, some suggestions are made for further work on various points. Some further exploratory studies, using qualitative methods, are suggested, in addition to a follow up of the present study using quantitative methods.

Although qualitative methods have a number of advantages in the study of client perceptions, (in particular the increased opportunity for clients as respondents to define study content, and the richness of data obtained) the broader applicability of the concepts and substantive theory developed in this study could be examined using a quantitative approach to survey a very much larger sample. This method would tend to lose fine detail, but it would enable the researcher to examine the probabilities of particular concept relationships at any given time, and could

enable the theory to be refined. Methodological triangulation of this type is intended to develop a fuller picture of the study area as a whole, which can be supplemented by the in depth picture obtained from the current study.

This study has suggested that different levels of client control in interactions are acceptable to parents at different stages in the first year of health visitor - client contact. Using qualitative approaches, such as depth interviews and diaries, the relationship between the level of control in a given interaction and the action taken (its type, the degree of compliance with any advice given, and its outcome, for example) could usefully be explored. At the same time, specific interactions between health visitor and client may be examined (using observation or tape-recording - see Clark 1984). The style of the interaction, including the level of client control, the process of development of an action plan, and the level of previous knowledge and experience could be monitored. Each could be compared and contrasted with the content of the others. In this way the effects of different levels of client control on patterns of coping with various health problems could be elucidated.

In view of the pattern of change in parents' perceptions over the first year, it appears that it would be useful to examine a group of parents of children in older age groups to see if the changes continue. Mayall's study (1986) of parents of children aged 18 to 36 months gives some indication that they do, with parents adopting a more professionally oriented perspective. However,

since it does not focus on precisely the same areas, a further study would be required.

Since various ways of developing existing teaching and practice have been suggested above, another recommendation for the use of research would be to examine and evaluate recommended alternative methods of practice (or teaching) - for example facilitation. This would require an action research approach, in which the existing situation would be monitored, then the change introduced, and the ongoing development of the situation examined.

Finally, this study indicates that a wide range of health visiting interactions exist where further detailed information needs to be obtained in order to facilitate a more effective and responsive service. Examples might include work with community groups, elderly clients, 'well woman' and health promotion work, or supporting /advising on specific issues such as bereavement, mental health, or sleep.

Summary

This chapter has described the main implications of this study, and the recommendations arising from them. The implications relate to four areas - health visiting practice, health visiting management, health visiting education and health visiting research. Some give rise to recommendations in respect of more than one area. They include:

The importance of recognising the changing pattern of parents' needs and perceptions over the first year of contact;

The need to be clear in defining health, or discussing health problems or factors influencing health;

The requirement to look more carefully at achieving joint definitions of planned/ intended help;

The need to explain clearly to parents the full range of roles of the health visitor, and clarify their role with under-fives and their families;

The importance of explaining clearly to parents the experience and knowledge that health visitors can offer;

The requirement to ensure that health visitors' knowledge and skills are up to date;

The need to ensure that communication skills and interpersonal skills are well taught;

The importance of encouraging health visitors to function as facilitators;

The importance of considering the relationship between levels of control and action taken;

The importance of considering the broader applicability of the concepts and substantive theory using triangulation of methods.

The need to explore whether a similar changing pattern of parental perceptions is found in subsequent years;

The need to examine and evaluate recommended patterns of practice and teaching;

The importance of exploring in more detail specific areas of health visiting practice;

Chapter Thirteen

Conclusions

In this chapter the overall study is reviewed. The original aims are considered in relation to the study's findings. The recommendations are placed in the wider context of health care policy.

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This study of client perceptions arose out of an awareness that, as a practising health visitor, the researcher knew little or nothing about how her job was seen by the people she visited. Extended informal contact with groups of clients led her to believe that this was an important area to explore, since it might enable health visitors to provide a more responsive and effective service.

The study itself was carried out in two Phases. The first Phase was intended to explore how members of two client groups identified and interpreted their health needs, and perceived health visitors at a given point in time. Responses from Priority Area and Non-Priority Area clients were to be compared. The second Phase of the study was designed to examine the process of identification and interpretation of health needs, and of development of perceptions of health visiting services which took

place amongst first time parents. In addition, it was intended to compare clients' process of identification and interpretation of health needs and their perception of health visiting services with those of health visitors. A comparison was also to be made between the perceptions of clients from Priority Areas and those from Non-Priority Areas.

Eight main concept areas emerged from the interview data. These were:

Health, health problems and other concerns

The need for help - locating the problem

Knowledge and experience

Legitimation

Advice, support and comparing notes

Choosing a helper

Relationship or problem centred

Power and control

A substantive theory was put forward which offered a link between the concept areas. It was suggested that the nature of previous knowledge and the types of problems encountered influence the choice of helper and the degree of parental control desired at each stage. The balance between the concept areas alters at each stage, whilst the relationship remains broadly similar. The value attributed to the health visitor's involvement at each stage appears to reflect how far her views diverge or otherwise when compared with those of the parent concerned. This theory is

broadly developmental. It suggests that three strands run through the health visitor - client interaction: Firstly the development of the parent as a parent, secondly the development of the child, and thirdly the development of the health visitor - client relationship.

In the light of these findings, the aims of the study may be reviewed. The first aim was: 'To explore the process by which members of a client group identify and interpret their health needs.' The development of parents' definitions of health, and their categorisation of health problems in relation to the need for help have been discussed. The role of knowledge and experience and the importance of legitimation in this process have been considered.

Health itself is defined by parents to incorporate functional and social / emotional aspects, as well as non-illness. Health and management problems are described by parents as falling into three groups, dependent on the perceived need for help. Help is required to deal with abnormal or serious problems, which must be legitimated as such. The dichotomy between normal and abnormal becomes clearer the greater the parent's knowledge and experience.

The second formal aim of the study was: 'To examine the process by which members of a client group develop perceptions of health visiting services.' This aim has been addressed in considering how parents develop their categorisation of problems in relation

to the need for help, the helping relationships which they perceive as available to them, and the ways in which they choose specific helpers. It has been further illuminated in the discussion of parents' perceptions of the health visitor's role as relationship or problem centred, and in questions about power and control which underlie many of the alterations which occur in relationships between health visitors and parents over the early months of contact.

From an initially limited perception of health visitors, parents' views were modified through the development of a relationship. Though antenatally parents frequently valued independence, following the birth most felt an increased need for advice, information and support. Interactions with health visitors were mainly problem centred. Later most health visitors were seen as making some assessments or judgements, but where positive relationships had developed, could be used by parents in supporting and legitimating their decisions about the care of the child.

In its third aim, the study was intended 'to compare clients' process of identification and interpretation of health needs and their perception of health visiting services with those of health visitors.' In the examination of health visitors' perceptions alongside those of parents, and the identification of a pattern, for most themes, of convergence followed by divergence, this was achieved. Health visitors' perceptions were initially almost totally dissimilar to those of parents. Definitions of health,

perceived need for help and perceptions of the health visitor's role became closer in the immediate postnatal period, but then diverged once more.

The fourth aim of the study was 'to make a comparison between the perceptions of clients from Priority Areas and those from Non-Priority Areas'. This was considered at each stage of the study, though very few differences were identified. It is not clear why this should be. It may be that the alterations taking place at this time produce effects which are greater than the cultural and experiential differences assumed to exist between clients from the two areas.

The recommendations made as a result of this study relate to four areas: health visiting practice, health visiting management, health visiting education and health visiting research. There are twelve recommendations in all. Some relate to more than one area. In the context of a changing health service, in which consumerism and accountability are key themes, recommendations identify changes of practice which will firstly improve communication between health visitors and clients, and secondly focus on the development by health visitors of appropriate knowledge and skills to meet the demands made by clients. Significant amongst these will be skills in facilitation of clients' use of resources and 'comparing notes'.

Following the United Kingdom Central Council's "Project 2000" report (1986), changes are likely in the structure of basic nurse

education which will go on to affect health visiting education and practice. Whatever the revised role which the health visitor develops, the need to explain it clearly to clients will continue. The importance of achieving effective skills in communication with clients will undoubtedly also remain. Project 2000 also looks towards the achievement of a research-based profession. Further exploration of areas considered by this study may enable future practitioners to build on it, not only to develop a more widely applicable theory but also to develop new patterns of health visiting practice, management and teaching.

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Summary

In this chapter the overall study has been reviewed. The original aims and method were described, and related to the study's main findings. Recommendations arising from the study were placed in the wider context of health care policy, in particular in relation to the concepts of consumerism and accountability, and the implications of "Project 2000".

Appendix One

Case Studies

The six case studies which follow explore some of the main
concepts which have emerged in the data as a whole in more depth.
They offer some illustrations of the way in which particular
parents and professionals developed themes, and of the contexts
in which they did so.

*   *   *

Background

Glaser and Strauss (1977) suggest that case studies can help in
developing theory, enabling links to be made between particular
concepts, and pinpointing contrasts and contradictions. Six case
studies will be considered. Three are of Non-Priority Area
parents, and three of Priority Area parents. In two (one from
each type of area) no health visitor interviews are available,
but various themes are usefully highlighted. Selection of case
studies for inclusion was made on three criteria:

1   Completeness of parent interviews - i.e. no set of
        interviews was included where the parent had dropped out
        of the study before the end. Three were thus omitted.

2   Detail of parent interview content - as indicated earlier, some interviews were rather briefer than others, and some parents less fluent in expressing their ideas. Where similar ideas were expressed in more than one interview, the more fluent example overall was chosen.

3   Range of parent interview content - Bearing in mind that the aim of these case studies was to illustrate how the main themes emerged and changed in particular contexts, case studies were chosen which appeared to bear on a number of the concepts, and in total, to cover them all.

Each of the main concept areas covered in previous chapters will be explored in the case studies, though not all will feature in each:

Health, health problems and other concerns

The need for help - locating the problem

Advice, support and comparing notes

Choosing help

Knowledge and experience

Legitimation

Relationship or problem centred

Power and control

An outline of the main points illustrated by each case study precedes it. Within the case studies themselves, a chronological

approach is adopted, which helps to cement the description of ongoing patterns.

Case Study A

Case study A explores several of the concept areas identified. Mrs A identifies her own initial lack of knowledge, and preference for professional advisers. She demonstrates her need for legitimation of her parenting. Finally she comes to rely largely on lay advisers, whilst valuing her caring relationship with her health visitor.

Mrs A was interviewed three times, with no-one else present. She was in her mid twenties, and lived in a Priority Area. Her occupation was classified as III non manual. Her health visitor was also interviewed three times.

Mrs A - Stage one

At stage one, Mrs A said that she would know that her baby was healthy if it was:

P051P   "content and I thought it was putting on weight"

This was a mixture of socio-emotional and functional ideas about what would represent health for a new baby. She placed great emphasis on the influence of food and feeding in keeping the baby healthy - above all other possible influences. She said:

P051P   "Obviously the baby's going to need em, obviously the
         first few months, milk, whether you're going to breast
         feed or bottle feed but from what I understand that is
         how the baby, you know, grows, so it is very important to
         make sure its getting the right amount, em, if you're
         giving it enough, obviously its going to grow, put on
         weight, so that's what I see as one of the main things.
         ANYTHING ELSE YOU CAN THINK OF?
         Obviously the care that you give the baby"

In making these statements, though she was the most emphatic in her description of the importance of food, Mrs A was following the pattern of the majority of mothers at this stage, defining health in socio-emotional terms as well as functional, and seeing feeding as a major influence on health.

In answer to a question about her previous experience with children (none) she went on to talk about the advantages as she saw them of not having any experience. The first was related to the diversity of advice and help available. She said that it

would be a help to have no experience because:

P051P   "everybody's got their own individual way of coping and
         bringing up a baby ... one person might say oh well I
         wouldn't give the baby that and somebody else might say
         oh well, yes I think you should, and I think you can get
         too much advice"

Having no fixed position, she would be able to develop her own
way of doing things.

She went on to indicate that her mother and her mother-in-law
would be giving her out of date advice - 'times have changed'-
and that she didn't know what she would actually need until she
was put into a situation. At the time of this first interview she
said that she was:

P051P   "just (going) by the professional people, what they've
         told me, at the parentcraft classes and people what with
         going to the antenatal - obviously they know, that's
         their job - they've got more idea than you know, your
         friends will."

To her it appeared obvious that they would know the answers to
her questions, because it is their job to do so, as she sees it.
She sees professionals as almost de facto knowledgeable. At the
same time she says that since this is her first baby she doesn't

know what to expect - she doesn't know what is normal. She is identifying her own lack of knowledge, and her need to acquire it. She appears to be identifying professionals as advisers because they offer knowledge - of a more reliable sort than lay advisers - and simultaneously identifying her own lack of knowledge.

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Mrs A identifies clinics as likely to be a primary source of professional advice and help, also acting as gatekeepers to other services, such as the GP. She also identifies that two other factors will be important: firstly serendipity -

PO51P   "It depends on who the first person is you come into contact with"

- if the problem was not too worrying, she would consult any available potential adviser, professional or lay, bearing in mind the degree of problem experienced. She would still tend to get a professional check on lay opinion. However, secondly

PO51P   "Obviously you can't go running to the doctor's every time there is something wrong"

- the seriousness of the problem must be assessed, because professional time must not be used unnecessarily.

At this stage, whilst Mrs A feels that her need for help is unclear - it is identified here as mainly a need for knowledge - her preference for professional advice, as knowledge-based rather than experience-based, is clear. Overall, parents at this stage were divided, with slightly less taking this view than the reverse - that lay advisers, especially grandmothers, would be preferable to professionals.

Mrs A goes on to outline how she sees the clinic and the health visitor functioning. She sees the clinic as a 'specialist' service. She envisages its staff having:

P051P   "more time to sit and go through things with you"

than either the GP or the antenatal clinic in her experience. In both, she said, she had found that:

P051P   "You sit and wait and you go in and 'how are you' and
          that's it, they're away"

The organisation removes the opportunity to respond meaningfully to the question 'how are you'. More time offers the possibility of a worthwhile exchange.

She hopes that the health visitor will tell her:

PO51P   "This is what we're looking out for ... within the next
         couple of months it should be able to do this"

- explaining what she is doing, and what sort of skills the child
should be achieving at each stage. Both 'having more time' and
'explaining' are ideas which appear to relate to a relationship
centred approach, though Mrs A is also indicating that she sees
the health visitor as 'looking out for' developmental progress -
or not - potentially a more problem centred approach. Most
parents at this stage valued a relationship centred approach,
particularly signs of interest in them. In valuing,
prospectively, time spent with her, and explanations given to
her, Mrs A was going along with this.

Finally, Mrs A commented, in relation to the clinic, that:

PO51P   "If there wasn't somebody coming to the house and saying
         oh you must take the baby to the clinic, I think you
         would have a tendency just to plod on and only if there's
         any problems would you go. I'm relying on her to say..."

She seems to be arguing for a professionally initiated structure
for support and information. Most other mothers expressed a
desire to be self sufficient at this stage. However, Mrs A does
indicate earlier that she sees professionals as a resource for

her to use, not be used by.

Health visitor A - stage one

The health visitor concerned with this family had not yet met
them when interviewed. Her description of a healthy child was one
that was reaching "normal milestones" for development, lives
"happily,... in a caring household"(HV051), is "well looked
after" in terms of food, warmth and shelter, and whose parents
seek advice if they experience problems. In discussing factors
which affect health, she lists diet and sleep patterns, the use
of the clinic or doctor, and immunisation, as well as adequate
stimulation and play to develop an enquiring mind. This list
indicates that like Mrs A she includes both functional and
socio-emotional factors in her definition, but unlike her
emphasises stimulation.

She indicated that she saw her role not only in 'prevention' but
in health promotion, and perceived problems for other people in
distinguishing her role from that of a social worker or a
'snooper'. Amongst her priorities for visiting she listed:

HV051   "The age of the parents. If they're young and
          inexperienced. The household, what kind of a household.
          If there's been pressures in the past, the past history

they may have, if they've been depressed. They may have
financial worries..."

These priorities are broadly social and structural. Only
depression may be seen as a health problem, and its aetiology is
thought by many to be social, especially since Brown (1978)
undertook his major study. A preventive role, with situational
priorities, was commonly described at this stage.

In describing the clinic, health visitor A focussed on practical
issues - facilities and practice. Physical and social 'comfort'
for baby and mother appear to be important to her. Of these,
'social comfort'- such things as privacy - appears to have
significant implications for the development of relationships. It
indicates that she values opportunities to develop relationships.

Mrs A - Stage Two

At stage two, the baby was about eight weeks old. Mrs A remarks
that the baby "hasn't been too well" - defining this in terms of
the fact that she has had the doctor out for the baby three times
- for oral and anal thrush and for a blocked nose, and has called
on the health visitor a few times too. However, she then
qualifies this by saying:

P052P   "He hasn't had any illnesses as such"

Though she has needed to seek help with various problems, she does not define him as 'ill' - this equates to the idea that there has been 'nothing serious wrong' with him. This is the most common parent definition at this stage. •

In a description by Mrs A of one of her contacts with the health visitor, a number of other themes are highlighted:

P052P   "Er, the health visitor's been out because I haven't
         really known if what was happening was right, or em, one
         instance I was breast feeding and he bit us and I
         couldn't feed him, but I didn't know if I should continue
         feeding him on one side or completely stop altogether,
         you know, or what to do. 'Cos it doesn't tell you these
         things in the book, so I obviously had to ring her up and
         she came out to see me and she brought me samples of milk
         and she said oh well feed him off one side and give him
         two ounces, stuff like that, so I did have her to turn to
         you know. Otherwise I would have just been left, you
         know, wondering what to do."

Mrs A's uncertainty and lack of knowledge - 'I didn't know' - is emphasised. She wants a solution to a practical problem. 'The book' is inadequate, so the health visitor is contacted. This is

in keeping with her desire for professional - knowledge based - advice at stage one. The health visitor selects a course of action for her, thus legitimating her in taking it.

Mrs A also indicates that she feels that her needs are perhaps trivial -

PO52P   "the things you're asking her you think, eeh, it seems silly asking little things like that, but, if you don't ask you never - " (trailed off)

However, the health visitor can legitimate her actions or non-actions as a parent. She describes how her health visitor identified one problem as 'three month colic' - giving it a name, making it more 'real'. She then said that there was nothing at all that the parents could do, relieving them of the guilt associated with a screaming baby:

PO52P   "It put me mind at rest and I thought well he's obviously in pain but there's nothing I can do for him"

She legitimated their non-action. At a later point in this interview, Mrs A described how the health visitor had legitimated her in ceasing breast feeding, after ongoing problems and in the face of a major trauma - the death of her father. Expressions of legitimation by health professionals were quite common among parents at this stage.

Mrs A describes the role of the health visitor in terms of 'keeping a check on the baby', and 'coming round..' She expresses some surprise at the range of areas of work which the health visitor covers, and highlights a possible role as a gatekeeper to other agencies. Checks on development feature centrally in her descriptions. Though she gives some examples of her use of the health visitor which indicate that other roles are also significant, she does not mention these specifically.

Home visits - 'coming round' - seem to be important. This terminology appears to indicate a friendly relationship. She says:

PO52P   "I think having someone coming into your own home makes you feel more at ease than having to go to an office or somewhere 'cos you tend just to sit there and nod your head and say yes. And when you come out and get home, you think why didn't I ask this, eeh well I didn't like to and stuff like that. I think it's different when you are in your own home and there's only the two of you and you can say what you want, and even if it's a silly question, there's nobody there, sort of, other than yourself, and, you know, the person who has come round to see you."

The main theme which emerges from this passage is the effect of being on 'alien' territory in the hospital or clinic, where the power rests with the professionals. Mrs A describes her feeling of insecurity in her own views - 'I didn't like to', and a tendency to conform - 'nod your head and say yes'. In the home situation she feels she has more control - 'you can say what you want', and sees a better opportunity to seek advice without losing face - even about 'silly' things. Mrs A's description is unusual at stage two. Most parents laid greater emphasis on the quality and content of interaction with professionals - what they did and how they did it, and to some extent on the development of relationships with them.

Health visitor A - stage two

Two main ideas emerged in this interview, which was carried out two and a half weeks after the parent interview. The health visitor spent some time discussing the cessation of breastfeeding. She said that she had visited Mrs A

HV052P "quite a lot to try to promote the breastfeeding"

She felt Mrs A had been "doing okay" until her father died suddenly. This contrasts slightly with Mrs A's picture of ongoing problems, to which her father's death added the last straw. The health visitor went on to say:

HV052P   "And I supported her in changing because I felt it was
          putting her under too much pressure to try and do it, and
          reluctantly I felt it would be the best thing for her and
          the baby if she did discontinue"

She describes her position as supporting the course of action
already decided upon by Mrs A, and thus legitimating it, rather
than advising a course of action to take. This answer may be
influenced in this direction if the health visitor feels that the
researcher as a professional colleague might disapprove, or if
she herself feels that she has failed to achieve her expressed
aim of maximising breastfeeding amongst the mothers she visits.
Mrs A's health visitor also mentioned that she had discussed
weaning with Mrs A, who was going to follow a pattern carried out
successfully by her sister, with a baby some months older. Again,
it appeared that Mrs A had decided upon a course of action, based
on lay advice, and had used the health visitor to legitimate it -
a role which the health visitor accepted. A few health visitors
at each stage identified legitimation as a part of their role.

The health visitor also expressed a wish that she had managed to
"get to know" the family "before she had the baby". She feels
that she:

HV052P   "may have been of more help to the family had I known the
          situation beforehand, and even when I had asked about
          illnesses in the house when I did my primary visit with
          the baby, she didn't tell me that her father had cancer,
          and, well, he'd had operations."

This suggests that 'getting to know people' - relationship
building - is important for this health visitor in terms of
carrying out her job. However, it also indicates that she felt
somewhat inadequate - 'I might have been of more help' - in her
response to them in relation to the bereavement - Mrs A had said
that the health visitor was helpful. The health visitor appears
to be 'blaming' Mrs A for not telling her her father was ill as a
means of displacing her own feelings of inadequacy and guilt.

Mrs A - Stage three

The third interview was carried out when the baby was seven
months old. By this time, Mrs A had come to the conclusion that:

P053P   "There doesn't seem to be any rules"

- on issues such as weaning. She had decided to 'play it by ear'.
This had led her to rely more on lay advice - from her mother and
her sister - and to see the health visitor as helping with more
major problems and with development checks. Mrs A defined health

in terms of 'nothing serious wrong', of food and growth (functionally) and of her baby's interest in play (a socio-emotional area).

She saw the health visitor's approach in relation to immunisation as essentially non-directive:

PO53P   "She didn't actually say it was a good thing for it to be done... My husband and I discussed it and I told her what we wanted"

In this way, it appears, she and her husband were enabled to feel that they had genuinely made the decision about what they wanted. At the same time, she was 'comparing notes' with her sister for information. In both situations she felt some degree of control. On another occasion she had experienced an overload of information from professionals:

PO53P   "Sometimes I think they go into too much detail. They tell you too much and its all flooding round inside your head..."

Too much information can produce confusion - just as harmful as the effects of too little information. The sensation she describes implies being at least partly out of control. As in many of the interviews at this stage, feeling in control, and having a say, come over as important to Mrs A.

The health visitor is described in this interview mainly in relation to her accessibility, and her 'busyness'. This is Mrs A's main justification for consulting her sister - though it is questionable whether she needs a justification. Contacts with the health visitor are limited in part by circumstance (at the clinic) and in part by time (in the home). Mrs A described her health visitor's most recent visit. She was:

P053P   "running late and it was lunchtime so really she didn't have the time to - I mean I asked all I wanted to but she said herself she would like to stay a bit longer and play with him, get to know his nature and that, but she thought ' I haven't got time'..."

At the clinic Mrs A says that the health visitor only has time to weigh the baby, ask if there are any problems, and pass on to the next child:

P053P   "If you want to talk at length there are other people waiting"

'Busyness' is seen as the primary reason for a less than ideal service. She is also critical of the clinic temperature, and the length of time she has to wait. It is not the health visitor's fault -

PO53P   "It's just that they're so short staffed. They just can't
         cope"

Here Mrs A is legitimating the professionals' inadequacy.
Currently her own actions were largely being legitimated by her
family. An inadequate professional service leads people to rely
on other (lay) sources of help and advice.

The other major point which is made in this interview is that Mrs
A still values the degree of support she received from her health
visitor following her bereavement:

PO53P   " She came out quite a lot. Just because she was passing
         she popped in. I thought that was very good of her. She
         needn't have done that... I mean she couldn't do anything
         for me but it was nice to know that she seemed to have
         cared enough to come out and see if there was anything
         that they, you know, could do"

This was seen as beyond what she needed to have done, and hence
to demonstrate that she genuinely cared - the 'real' nature of
the relationship between herself and Mrs A. Despite Mrs A's
switch to lay advisers, she remains positive about her health
visitor. Where a relationship is seen as existing at this stage,
other parents similarly value health visitors whom they see
infrequently.

Health visitor - stage three

In the third interview with this health visitor, which took place
about two weeks after the third interview with Mrs A, the health
visitor was generally satisfied with the family - "they've done
very well". She appears to be taking a broadly functional model,
based on how they have coped with the care of the baby, the
bereavement, and with problems. She still regrets not having met
the family before the baby was born, but feels that she does
communicate with Mrs A - "we do talk". She feels that she has a
relationship with her.

She comments that, after the bereavement, she visited Mrs A "for
quite a while", but goes on to say:

HV053P   "I don't know if I helped.. Maybe I helped being somebody
          she could talk to, in that way, but I didn't have any
          stock of things I could help her with, to be honest"

The health visitor appears to feel that she should have made a
more overt contribution to the situation than to offer herself as
a listener, She does not appear to realise that Mrs A seemed to
value her brief visits as offering 'care' akin to friendship,
even though she could not do anything practical.

Summary

Mrs A identifies feeding as central to her ideas about health. She describes her initial lack of knowledge, and preference for professional advisers. At stage two she continues to prefer professional advice, and demonstrates her need for legitimation of her parenting. At stage three she comes to rely mainly on lay advisers, whilst valuing her caring relationship with her health visitor.

Case Study B

In Case Study B the main concepts explored are those concerned with the need for help, the choice of appropriate help, and the parent's interaction with the health visitor. Two unusual features of this case are important - a situation of acute anxiety about the child, and a change of health visitor. Each highlights particular themes.

Mrs B was interviewed three times, with no-one else present. She was in her early thirties, and lived in a Non-Priority Area. Her occupation was classified as falling into Registrar General's Class I. She changed health visitor in the course of the study, but the new health visitor agreed to be interviewed, so three health visitor interviews were obtained.

Mrs B - stage one

Initially Mrs B described the importance she placed on 'environment' in keeping the baby healthy:

PO61N   "Generally the environment we provide in our home in
          terms of warmth and food and general cleanliness"

She went on to explain that this was her main concern at that time because they had just moved house:

PO61N   "Because we have got a lot of work to do before we get
         this place in a position where you know ... I would feel
         it was clean enough for a baby to come in"

She added that emotional 'extras .. that mean good relationships between us' were also important, but reiterated that cleanliness was her major concern. This was a concern echoed by many of the parents at stage one, though only a few had recently moved house.

Asked how she might recognise when her child was healthy, Mrs B first talked about appearance, then went on to say that she would be:

PO61N   "bound to think it's crying too much ... it will probably
         be my own, my own tension that is causing the problem but
         em - "

Mrs B, at this stage, is as much concerned about her own health as that of the baby, and her own ability to cope with the forthcoming baby. These are the major needs that she sees in relation to help and advice.

It is in this context that Mrs B describes her intentions in relation to help and advice. "From day to day" she hopes to use her mother as a "sounding board". However, she also intends to "go to all the clinics" and to make sure that:

PO61N   "the professionals have a regular oversight of the baby and how well the baby is coming along"

Here some sort of development related role is indicated, and clinics are seen as important. She later describes how the clinic will check the baby's sight and hearing "and obviously things like its not a battered child". This checking role - in relation to development and to child care - is also identified by other parents at this stage.

Mrs B goes on to say that she has:

PO61N   "Always wanted to have a lot of faith in the health professionals so I would like to say they could help me with everything. All of them ought to cater for all my (sic) health needs to a certain extent"

Mrs B's hope is that health professionals will deal with all her health needs, at least to a certain extent. Her focus on her own health is reinforced later in this interview: she feels that she has to be in peak condition to look after the baby well. This is a unique statement within these interviews, (see discussion of

attribution theory in Chapter Seven) and appears to reflect her awareness of her own major role in the care of the forthcoming baby. However, her primary concern is that health professionals fulfil a problem oriented role, alongside her mother's place as a 'sounding board'. This two tier approach is seen several times amongst parents at stage one.

Health visitor - stage one

Her first health visitor, interviewed for the first time about two weeks after Mrs B, outlined a broad concept of health in relation to under fives. It could be affected by "life - everything", though she went on to include illness and feeding as areas that were particularly important in influencing health. She did not mention cleanliness or avoiding infection as important.

She went on to describe her job as primarily "preventive and supportive" - indicating that much of her time was spent in supporting single parents and young mothers, or mothers with babies who had problems. Mrs B was not a single parent, nor young. The health visitor felt that her GP clinic was important in developing an awareness of her role and deeper relationships with the majority of her clients. She thus appeared to value a relationship centred model of practice.

Mrs B - stage two

At the stage two interview, when her baby was eight weeks old,
Mrs B defined health in essence as 'nothing serious wrong'. She
said that the baby was in good health, but added:

PO62N   "There's little things you worry about"

Her own concerns and anxieties she suggests are 'trivia' - little
things - relatively unimportant. Her most important anxiety had
related to a test done on the baby when in hospital: A request
for a retest had been received at a weekend, by letter, and she
said that she was

PO62N   "terrified that something was going to be dreadfully
         wrong"

She had been unable to obtain any satisfactory reassurance until
the following Monday - no "human contact", which she felt would
have helped. This had represented a potentially serious problem.

Mrs B discussed the help she had received from various sources.
She had felt supported by the daily visiting pattern of the
midwives:

PO62N   "You knew somebody was coming who you could ask questions
         within 24 hours"

The midwives had been accessible, and had answered questions -
given information. She went on to describe how she had coped when
the baby had had a rash:

PO62N   "I rang the health visitor and she said take him to the
         doctor, and the doctor gave us some cream for him"

The health visitor had helped Mrs B to decide on an appropriate
course of action. She had acted as a referral agent - suggesting
an appropriate pathway to follow. On another occasion however,
when the baby had had a swelling in his groin, Mrs B had taken
him straight to the doctor, recognising that this was not normal,
and that she needed medical help. In each of these practical
situations, professionals responded to the needs which Mrs B
generated. Other parents described similar events.

At the time of this interview, Mrs B looked to her mother:

PO62N   "for support more than advice really"

She said that she had talked to her when she felt vaguely aware
of a problem but couldn't "put (her) finger on it". Her mother
was thus, as she had predicted, functioning as a 'sounding

board'. Mrs B had made use of the clinic for weighing and for the baby's six week check, but said that she didn't "actually know what (went) on". She thought it might be of use as an information source, but had not made use of it in this way. She had seen her health visitor several times, both for specific "tests and things", and in response to phone calls. She had received a wide range of information from her, and commented that this was 'okay' because:

PO62N   "I want to know what's going on, you know, what to expect and where to go for assistance"

Mrs B still wants to have some control in the situation - to know what is going on. As with Mrs A, who also valued a degree of control at this point, expression of this is unusual in the group overall at this stage.

Mrs B went on to comment that she had found her health visitor:

PO62N   "A bit over supportive at times in terms of - I know its part of their job, I suppose they've got to look for signs of stress and undue worry and possible depression em cos it does happen ... I always feel as though she was looking for more than there was"

A role which might have been seen as acceptable if she had had problems was not so acceptable to someone who perceived her main

requirements of the health visitor in terms of information and specific advice. 'Looking for more than there was' implies the existence of the judging role described elsewhere in relation both to development and to childcare, but related here to the mother herself. In addition, even support, if it is seen as unnecessary, may appear to devalue the capacity of the person being supported to cope themselves. Nevertheless, Mrs B found her health visitor 'very personable', and indicated that she could have told her if she had had problems.

Health visitor - stage two

Mrs B's health visitor, interviewed about three weeks later, indicated that she found this family 'interesting' to visit. She mentioned some of the problems which the baby had experienced:

HV062N   "Had one or two teething troubles and a rash and things like that and she sorted that out herself. She did seek me out at one period, I gave her telephone contact availability..."

Mrs B had indicated that the health visitor had been more influential in relation to the rash.

Discussing other aspects of her involvement with Mrs B, the health visitor commented:

HV062N   "I have certainly talked about problems affecting the
          relationship and one of my little pets is the importance
          of keeping, and having a regular night out with your
          husband ... I did talk about postnatal depression,
          especially when she was going back to work"

Whether it was these or other conversations which made Mrs B feel
that she was 'oversupported' is not clear. The health visitor
however felt that she was just 'starting to develop a
relationship'. She went on to comment that Mrs B was:

HV062N   "One of these ladies that you have lots of nice
          conversations with"

- 'nice conversations' implying something different to a
consultation or an assessment (which Mrs B had seen their
interactions as) and rather more relationship oriented than
either.

Mrs B - Stage three

The stage three interview was carried out when Mrs B's baby was
about seven and a half months old. By this time, she had
experienced a change of health visitor.

At this stage, Mrs B said that her baby was in good health -
'very content' - using a socio-emotional definition, and that he
had had:

PO63N   "No problems that we've had to consult any professional
         medical people about"   .

- a 'nothing serious wrong' definition. The socio-emotional
aspect was strengthened in her description of factors likely to
affect his health, when she commented that the most important
thing in keeping him content was "giving him what he wants, when
he wants it". She went on to describe how, by responding to his
needs for food and drink, or for changing, she and her husband
felt that the baby had learnt that his needs would be met, and
hence only cried when there was something wrong. Cleanliness,
which was so important at stage one, does not feature at all at
this stage.

Mrs B described how the parents' approach to health problems had
altered. "With experience we have realised" - that symptoms such
as rashes will clear up in a few days. Hence they no longer
sought outside help with these problems. As they had gained
experience, they had gained confidence in coping with minor
problems. In relation to sickness, learning was not only from
experience. They had taken the baby to the GP's when he was
vomiting, some months before :

PO63N   "She gave me some idea of how serious it was being sick, that it wasn't a big problem if he was only sick the once and , er, that was the sort of thing I needed to know"

In this case, the GP had provided some landmarks in the decision making process - 'some idea of how serious it was' - so that she was more able to decide appropriately when she needed professional advice. She felt that this was the sort of thing she needed to know - possibly because it gave her some control over decision making. Increased confidence with increased knowledge was described by other parents - overtly by one and implicitly by others.

At the same time, Mrs B had begun to obtain advice from other mothers :

PO63N   "who've said have you tried this and have you tried that. And when we have, it's usually been successful"

Having tested lay advice, she had found it satisfactory. She also commented that she had found that the ongoing postnatal exercise group run at the hospital "filled a gap" for her. It was a place where it was legitimate:

PO63N   "to talk to each other about what was going on with us and our babies ... talking with friends we talk about

other things, not often babies"

This may be a particular problem for some mothers, like Mrs B, with extensive and continuing outside interests. The exercise class enabled the mothers to offer each other mutual support, and gain information about the care and management of their children from each other's practice. In this way they were enabled to gain further confidence in themselves as parents.

She also referred to her mother as having provided "a lot of practical day-to-day advice" - in contrast with stage two, when she had figured as a supporter rather than an adviser. However, she still regarded access to:

PO63N   "some medical advice ... from a doctor or health visitor"

as important. She indicated that although the advice her mother gave her was "great in a practical sense" it was sometimes out of date. She mentioned for example that her new health visitor had talked to her about baby-walkers, which her mother had known nothing about. Later in the interview she described her health visitor as, like her mother, being "great on practical advice". Rather than being seen largely as a referral agent for the doctor, she had become the professional source of practical advice. This role, combining knowledge based information with experience based practical advice, was described by several other parents.

Mrs B felt that she had a relationship with her current health visitor which was different to that which had existed with the first. She said that although she was more emotional and 'touchy' about things in the early weeks after the baby's birth, she:

PO63N   "got the feeling that she [first health visitor] was looking for problems that weren't really there"

This feeling was mentioned at stage two, and has clearly lingered, since the new health visitor had now been in contact for some months. With her current health visitor, she said she:

PO63N   "(didn't) find that at all" and felt "much more relaxed"

She admitted that this might be because she was generally more relaxed now that her baby was seven months old - however, she still felt strongly about the first health visitor's approach, and this might have continued to affect her contacts with that health visitor, had they been pursued.

Mrs B indicated that she had seen her current health visitor at the clinic before transferring -

"but we didn't chat as long before we, sort of, met properly"

The idea of 'chatting' to the health visitor appears in interviews with other parents at this stage. It appears to indicate an interaction which has some 'social' overtones - and implies the development of a relationship. 'Meeting properly' also appears to be linked to the formal establishment of a relationship, as distinct from the often superficial interaction which occurs between server and served in public places such as shops or clinics. For Mrs B, there was a change in the level of communication and the type of relationship which occurred when the clinic health visitor became her home visitor too. Relationships - involving mutuality and interest - are valued by many parents at this stage.

Health visitor - stage three

This interview was carried out with the family's current health visitor, about two weeks after the third interview with Mrs B. She had taken over the family when the baby was around three months old.

The health visitor described the baby as a "lovely sociable baby, who responds beautifully". Her primary definition of health at this stage was thus socio-emotional - sociability and responsiveness. She felt that Mrs A had at first been "quite

anxious" and:

HV063N   "She did need a bit of reassurance more than anything.
         But then when I got to know her..."

Latterly she felt that Mrs B had learned to cope - which reflects
Mrs B's own feelings. She went on to say that Mr and Mrs B were:

HV063N   "the sort of parents that if they have something to ask,
         they ask. Em they accept advice .. They sort of think
         about it, discuss it, and accept the advice for what it
         is... I would say that they are quite receptive to health
         visitors"

She appears to feel positive about their processing of her
advice - implying as it does that the parents have a role in
decision making. She is also indicating here that Mr and Mrs B
seek help when they want it. They retain a degree of control,
much as Mrs B had suggested.

At first, the health visitor said, she felt that Mrs B was
putting on a show - of what ought to be. But she went on:

HV063N   "She's not like that when you get to know her. She didn't
         know me and I didn't know her so perhaps that was to be
         expected. And then of course she began to come along to
         the clinic and I think there got a bit more rapport

between us"

She too sees that a relationship has developed between her and Mrs B. She attributes it to attendance at the clinic, and Mrs B to home visits. Perhaps in fact it is both? The health visitor clearly values the establishment of a relationship with her clients, since she says:

HVO63N   "I never think its the same when you haven't done the first visits... When you don't do the first visits its a little bit - it alters your sort of future visits, you know, so I think you've got to work at those visits a little bit more to keep the relationship going..."

Mrs B however, had felt that she had a better relationship with this health visitor than with the previous one, despite or even because of her involvement in the early stages.

Summary

This case study showed how a mother who expected to rely heavily on professional advice came to use lay help substantially. It also demonstrated how her ideas about the parent-helper interaction altered, including the effects of a potential crisis and of a change of health visitor. The latter particularly highlighted the pattern of establishment of a relationship.

Case Study C

Case study C illustrates how the perceptions of a mother with some experience of young children (a much younger sibling) differ initially from those described in case studies A and B, in relation to the location of problems and the choice of advisers, and the process whereby they alter. Secondly, it picks up how this mother's view of the health visitor's role changes over time. Thirdly it develops the theme of legitimation, both by peers and by professionals.

Mrs C was interviewed three times, with no-one else present. She was in her early twenties, and lived on her own in a Priority Area, with only limited contact with the baby's father. Her occupation was classified as III manual. Her health visitor was not interviewed.

Mrs C - Stage One

Interviewed when about 30 weeks pregnant, Mrs C said, like many of the other mothers, that she would judge her baby to be in good health if it:

P141P   "looked happy and it wasn't crying all the time... played
        nicely... looked content"

These were broadly social/ emotional criteria, though patterns of
play might also be regarded as functional. However, her
priorities in relation to keeping the baby healthy were
environmental - hygiene and safety. She said:

P141P   "If it's not kept clean, it'll get thrush and all sorts
        of things"

Here, a perceived relation between hygiene and infection -
involving an implicit 'health as non-illness' model - is
expressed. She also said that safety was important:

P141P   "making sure that it's safe when its in its cot and
        things like that. Doesn't suffocate or anything"

Mrs C was the only mother who directly mentioned safety, though
three mothers at this stage mentioned their anxieties about the
possibility of cot death. This may relate to her level of
experience with young children, which was more extensive than all
but one of the other mothers interviewed. The difference did not
recur at later stages. Mrs C had a much younger sibling, and felt
that she had learnt a lot from this. She said:

P141P   "They don't just lie still all day and look pretty you
         know"

This experience had also taught her practical parenting skills:

P141P   "how to look after it, how to bath it, to feed a baby,
         keep it clean and things like that... but I think that's
         the most important, patience, cos I mean they all go
         through bad stages"

Patience would help in coping when the baby was less than ideal.

Despite her confidence in her practical skills, Mrs C expressed
some uncertainty about decision making, and described how she had
already turned to her mother - "the only person I would ask" -
for advice about how she might cope if the baby were still to cry
when she had fed and changed it:

P141P   "That's when I would start to worry. You know, in case
         anything was wrong with it, like afterwards. But she says
         there's always some reason, you'll know, understand
         yourself, when you've had it"

Here it appears that her mother is both legitimating her present
uncertainty (it'll be different when you've had the baby), and
also indicating that there is some instinctive understanding of
the child's needs, which develops after the baby is born.

Legitimation of this kind was found in other interviews at this stage.

Mrs C did not envisage asking anyone other than her mother for advice or help:

P141P   "I don't ask anyone else now, so why should I start now, just got to get on with it"

Her position was very self sufficient. This was particularly evident in her criticism of the hospital midwives because they had been "too cheeky". They had offered her help which she did not want, and had appeared to be critical of her status as a single parent (cf MacIntyre 1976). They had offered to:

P141P   "get some baby clothes together... I've told her repeatedly I've never had anything off the social security

She did not want to be dependent on handouts, taking pride in coping herself. Many parents at this stage indicated that they hoped to be more or less self sufficient.

Though she did not envisage requiring any help or advice other than her mother's, Mrs C was aware of the local clinic, and of the health visitor, as possible resources. She had attended the

clinic with a friend, to "get milk and get the baby weighed". In addition to these functions, she said that she thought that the clinic staff:

P141P   "look at them obviously when you take them round to make sure that nobody's hurting their baby, or making sure it's not like being mistreated you know"

The clinic staff are seen here very clearly in a judgemental role.

Mrs C describes the checking she assumes goes on in the third person - to make sure that nobody's hurting their baby - indicating a degree of distance from the situation. They will not be looking so much at her baby, as at the care of babies in general by mothers in general. Discussing health visitors in particular, Mrs C says:

P141P   "I've heard they always pry into people's business"

This suggests an unwelcome involvement in things which are by implication not the health visitor's business. Mrs C appears to feel they may be looking for things which are not there. This feeling may be heightened because she knows they will visit her home - by implication checking on her. Judgemental roles, both in terms of child care and of development, are quite commonly described by parents at this stage.

Mrs C - Stage Two

Mrs C was interviewed for the second time when her baby was about eight weeks old. She felt that she had coped well with the baby in hospital, but had found it difficult to establish a routine in which she could cope with housework, shopping and washing as well as the baby:

P142P   "It just seemed to be washing for evermore"

However, she had now passed that stage, and felt that being a mother was:

P142P   "not as hard as I thought. I mean the way some people go
          on, you would think it was the end of the world. You know
          what I'm meaning. But she does stop a lot of your social
          - well its just natural and it - I mean you haven't got
          as much free time as what you would have."

At stage one, her main concern had apparently been in relation to decision making. Here she indicates that she had been apprehensive about becoming a parent, but that the reality is 'not as hard as (she) thought'.

Asked about the baby's health, Mrs C's priorities were different to those seen at stage one. She said:

P142P   "She's been smashing. She's never had nothing. ...eeeh but she eats!"

Health is described firstly in terms of not being ill, and secondly in terms of function - in particular feeding. This transition from an initially more social/ emotional definition is found in many of the interviews at this stage. Happiness, earlier a central feature of health, is now implicit rather than explicit in her descriptions of her daughter:

P142P   "She's really good. I'd have twenty more like her if I had the money ... she's as good as gold"

'Goodness' in babies is normally associated with placidity and contentment. Happiness may therefore be taken for granted when the baby's health is asked about, since she is regarded as 'good'.

Mrs C still felt that 'cleanness' was the most important factor in keeping her baby healthy - relating it to the experience of a friend with nappy rash. This again picks up the 'health as non-illness' idea, and highlights it as an area where Mrs C feels able to take action herself. It is important to her even though

her mother feels she takes it to extremes:

P142P   "Me mam says to me, 'God, we didn't bath you and go on
         like that when you were little, and there's nothing the
         matter with yous. But, oh I cannot help it"

Despite her mother's views, Mrs C continued to bath her baby
frequently. She sees it as important and impossible to avoid.

Mrs C commented that she found decisions about health relatively
straightforward. She said:

P142P   "Oh I would know, I would know. I didn't think you could
         know, but you can. I know straight away when she's got
         wind with her different cries and things like that, or
         when she's soaking..."

This fits in with her mother's reassurance at stage one. However,
she did consult the health visitor about her baby's feeding
pattern, and was reassured that it was normal - and she was doing
the right thing. (Her action was legitimated). 'Instinct' did not
enable her to deal with this - suggesting that experience and
expectation based on observation of her sibling, rather than
instinct, helped her to learn or re-learn about managing wind,
wet nappies and so on. Other parents at this stage described
their 'panic' over similar practical tasks.

In consulting the health visitor, Mrs C had departed from her
intention to consult only her mother. The health visitor had come
out to visit when Mrs C was worried, had explained what she
thought was wrong, and had advised her how to alter her
management of the baby, giving advice which was practical, and
which seemed to work. Relevance and practicality were important.
This emerged clearly in almost the next sentence:

P142P   "I mean people say to you - this is the doctor - have a
         sleep when they're asleep in the afternoon. How can you
         when you've got washing and you're on your own and you've
         got to tidy up and everything. I mean it's impossible. I
         mean it's all right for them saying have a sleep during
         the day, it's just more work for you to do later - isn't
         it?"

The doctor's advice is seen as inappropriate and impractical in
Mrs C's current position. Many mothers at this stage stressed the
importance of relevant, practical advice.

At stage two Mrs C described her own health visitor as "dead
nice". She said that she had thought that health visitors:

P142P   "Came and looked over your house and that, cos I've seen
         them do it"

However, when she had offered her health visitor the chance to look round, she refused, and said that she could see that she was managing. Mrs C added:

P142P   "I've got her home phone number as well"

The health visitor had refused the overtly judgemental role offered, and had also, in offering her home phone number, made herself more accessible and more vulnerable - like a friend. Mrs C's perception contrasted with stage one, when she had identified health visitors as 'prying'.

Mrs C's ideas about clinics had also altered quite considerably from stage one to stage two. Though she still identified a role in the prevention of child abuse, she also saw them positively as a resource. This appears to be a function of experience:

P142P   "The clinic's like for looking after - I mean - I must
         admit like, if they weren't there, there would be a lot
         more like children hurt and things like that. They're
         necessary. You can always go and talk to them. As I say,
         my friend's having problems at the minute and I just went
         along to the health visitor on X-day when I took her to
         get weighed and told her, cos she knows her, and she went
         straight away. I mean they are marvellous"

The clinic's, and indeed the health visitor's role as a supporter emerges strongly here in a specific example. 'Knowing' her friend - having a relationship with her of some sort - is also identified as important. Mrs C went on to comment that the clinic health visitors would:

P142P   "talk to you about yourself - not just about babies ...
         they're really nice"

In considering her as a person, the clinic health visitors appear to be valuing her, and building a positive relationship. Mrs C contrasted this with the relationship she had with her G.P., whom she described as having "no interest at all", in her or the baby. Interest, and building a relationship are important in her links with health professionals. This pattern is found amongst most parents at this stage.

Mrs C - Stage Three

The stage three interview was carried out when the baby was about seven and a half months old. Mrs C and the baby had just had a bout of sickness and diarrhoea - the first appointment made was rescheduled to allow them to recover. They were recovering when the interview took place.

Mrs C said that her baby had been in good health "all the time, till now". She said that her daughter had:

P143P   "got that new bug, that's all I can think of. Sickness and diarrhoea ... but apart from that she's been really well"

This demonstrates a medicalised view of health - health is 'being really well' - not being ill. Illness is caused by 'bugs'. This is a commonly used explanation of illness causation, borrowed from the medical sciences, (see also Cornwell, 1984), which ties in with Mrs C's continuing view that hygiene - 'cleanliness' - is important in maintaining health - in effect through preventing illness.

The effects of diet on health were also cited at this stage, in relation to the recent illness:

P143P   "Me mam says give her soup, and I give her a little bit of tomato soup for a change and straight away she was bad, vomiting. I think she's a bit young for things like that"

Food and diet were commonly mentioned as influencing health at this stage. This example also demonstrates how she had used her mother as an adviser, but had since decided, having evaluated the

effects of the advice given, that her baby was too young for tinned soup, and now held a different opinion to her mother, based on her own experience.

Despite this specific rejection of her mother's advice, Mrs C indicates that she would usually ask her mother for help or advice before anyone else. She had asked her about:

P143P   "her gums and things. About her teething, because she's having a terrible time with her teeth... I asked me mum about that on her bum cos I was frightened. It was worrying. Anything that's wrong with her I ask me mam."

Mrs C indicates that fear, or worry, cause her to seek help with a problem. She goes on to say that:

P143P   "If I thought there was anything wrong with her like, I'd just phone the doctor out straight away"

In her tone of voice, Mrs C conveys that such things would be more serious than those (worrying) problems about which she would consult her mother. Two levels of problem, also described by other mothers, are identifiable here.

Asked about her use of other services, Mrs C said that she attended two clinics - at one of which her health visitor was

available. She said that she went:

P143P   "Every two or three weeks to get weighed but they don't
         really check her over or anything there, they just weigh
         them and that's that"

This contrasts with her initial view that clinics all checked
that children were not being mistreated, and could also suggest
that she thinks that they should do so. However, she went on to
indicate that she would welcome some check on her daughter's
development, and that it is this which she now feels clinics
should be doing.

Mrs C went on to say that she usually stayed about 15 to 20
minutes, and would:

P143P   "Talk to the women there. Cos I know one of them. I have
         a chat with her... They answer questions if you ask them
         anything"

Since she also said that she wished there were some opportunity
to "sit and talk to other mothers", it seems that 'the women' are
probably the health visitors. 'Chatting' to them indicates a
friendly relationship, as well as the exchange of information,
but opportunities to spend time with other mothers are now also
valued.

At one of the clinics she went to, Mrs C felt that there were more facilities for parents, but mainly for parents of older children. She contrasted the dearth of this type of provision with what had happened in her antenatal classes:

P143P   "We used to all have a cup of coffee and a bit talk and that was great. Everybody used to sit and talk and tell their problems and we used to have a good laugh, you know what I mean? Cos everyone's in the same position really"

Having 'a bit talk' and 'a good laugh' - lightening the problems shared by the use of humour - together with the recognition that she was not alone were the things which Mrs C valued in those classes. She did not see this sort of interaction in any sense as advice or help - it was not mentioned in response to such questions - but she does see its value to her, and regrets that it has not been available to her postnatally.

Mrs C said that she had not seen her own health visitor for some time:

P143P   "I don't know her name. She's from X Clinic. She's lovely, she's really nice and er, she came again when she was four months old, and I've never seen her since"

There appeared to be more feeling of contact in the early weeks than now. This was a common experience amongst the mothers at stage three. In describing what the health visitor had done when she last visited, Mrs C said that she had been:

P143P   "to make sure of the span of her head, things like that... she measured her because I wanted to know how long she was 'cos I didn't know at the time and er, she got a bell and she used the bell but she nearly broke the bell..."

Measurement of the head circumference, perhaps because it is a very evident and unusual thing to do, is described as part of the health visitor's activities by most mothers. The health visitor had also responded to Mrs C's request for information about how long her baby was. Information giving at this stage is usually mentioned in relation to topics like weaning, but responding to requests is quite common. The incident with the bell is recalled more in terms of the baby's activity - 'she nearly broke the bell' - than in terms of it's probable purpose in assessing development. Descriptions of similar visits were given by other parents, though many indicated a development checking role more clearly.

In contrast to her feelings at stage one that health visitors were 'prying', Mrs C commented that she thought:

P143P   "They should come out a lot more"

She said that she had sometimes wanted to talk to her health visitor, not only about her baby, but "for meself". She went on to describe how she was alone with the baby "99% of the time" and the baby "drives us crazy sometimes". Her parents helped her, but tended to spoil the baby - she gave some recent examples. She said that she would like her health visitor to come:

P143P   "Just to talk to you and ask, you know, how things are going. I think someone to talk to who understands what you think, your problems and that - "

She now sees the health visitor as someone who will listen, and who understands - as a potential helper and supporter, not a threat. The health visitor could now fulfil that role for her, but does not do so, because she is not sufficiently available. Her earlier comments about the inadequacies of the clinic (see above) indicate that she believes an opportunity to meet with other mothers would also offer this type of support.

Summary

Mrs C was a mother with some previous experience of young children. Her views on health and on appropriate advisers altered

considerably over the span of the interviews. Whilst at first she believed that she would need minimal help, and that from her mother, by stage two she had found the health visitor helpful. By stage three, rather than seeing health visitors as prying, she expressed regret that they did not visit more often. She also felt more need for peer support. Her problems, rather than being of the practical type that she envisaged, turned out to be more related to her own coping skills and opportunities for social contact. Initially legitimation of her uncertainty as a parent was given by her mother. At later stages the health visitor and clinic staff offered legitimation of her actions.

Case Study D

Case study D focusses primarily on relationship centred themes and demonstrates how similar perceptions held initially by parent and health visitor can nevertheless end in a mismatch. It also indicates some of the factors which may contribute to this, in particular in relation to the type of problem encountered, the level and style of access, and the health visitor's priorities.

Mrs D was interviewed three times, once with her husband. She was in her early twenties and lived in a Non-Priority Area. Her occupation was classified as in Registrar General's Class II. Her health visitor was also interviewed three times.

Mrs D - Stage One

Mr and Mrs D were interviewed together at Stage One, when she was about 32 weeks pregnant. Discussing possible problems and advisers, they felt that they would go to see the doctor if they were 'worried' about the baby. Mrs D said:

PO21N   "I'm only anxious before it's born. I don't think I'll be anxious afterwards"

She expressed anxiety in relation to the possibility of handicap of some sort, a common apprehension amongst pregnant women <>. She also commented at some length on her anxieties about bonding with the baby:

PO21N   "You might not feel the same about the baby as you feel you should"

This anxiety was not expressed by any other parent at this stage. She went on to suggest that it might be difficult to find "someone to believe you" in these circumstances. 'Believing in (her)' appears to be important to Mrs D in an adviser.

She went on to describe the sort of help she hoped for from the doctor. She said:

PO21N   "I don't believe in taking it to the doctor and shoving it full of antibiotics the instant it coughs or sneezes - that just leads to its own problems"

Though the doctor was seen by Mrs D as allaying anxiety, he was not seen as necessarily offering a simple cure. On an individual basis, neither Mr nor Mrs D was very happy with their G.P., quoting from their own experiences when ill. He had failed to promptly diagnose a problem which had resulted in hospitalisation for Mr D. However, this did not appear to prevent them from citing the G.P. as an adviser about their child's health -

perhaps because the type of problem seemed likely to be
different.

Mrs D also indicated that if she "got on well" with the health
visitor that came to visit, she might turn to her for help. Here
it is the relationship which is seen as the important factor in
choosing her as an adviser. Mr and Mrs D argued about the
possible role of the health visitor, in particular about whether
she could:

PO21N   "Tell you what to do"

which Mr D felt would be appropriate, or was:

PO21N   "Not in a position to tell you what to do ... here as a
         guest - we don't have to let her in"

                                .

which Mrs D suggested. She appeared to feel that the health
visitor would have to negotiate her position, developing a
relationship, and hence could only have limited power, whereas
her husband saw her as having authority to 'tell (them) what to
do'. Both saw her as exclusively child centred in her
involvement, in contrast to the health visitor's view.

In relation to other possible sources of help and advice, the
couple felt that they would be unlikely to turn to their friends

as their views on child care differed. Some apparent congruence of views with potential advisers appeared to be important for a number of parents at this stage. The Ds' own parents lived some distance away though one set were moving closer. Mrs D said that she:

PO21N   "would be inclined to think it out for myself"

Other than in dealing with 'worries', Mrs D sees herself as quite self sufficient and able to cope at this stage.

Health Visitor - Stage One

The D's health visitor was interviewed about three weeks after the first interview with them. She said that her role was in:

HV021   "promoting health, as a health educator, child health surveillance, clinics, advice on feeding, weaning, child health, screening the elderly, especially the high risk groups and ... creating or facilitating health enhancing activities"

This seems a rather idealised list, covering themes closely resembling those listed in the CETHV's report on the Principles of Health Visiting. This may reflect her relative inexperience. She had been practising just over a year. She went on to say that

she saw her most of her mothers-to-be at the antenatal clinic, but if not, made an effort to see them antenatally. She had not yet seen this mother however. She described her priorities after the baby was born:

HV021   "Those who need me most are the ones that I have mentioned - you know - the primips, the first time mums, mums with twins, postnatal depression.. "

She describes her priorities in a personal way - those who need her, rather than those who have needs which can be met by particular strategies.

The health visitor went on to describe the G.P. child health clinic she was involved in. She said that the mothers who attended this session "love it", and that they:

HV021   "can talk about anything they feel the need to"

This very uncritical stance may be contrasted with Mrs D's comments at subsequent stages. Her colleagues on the whole were more critical of their clinics.

Describing home visits, the health visitor commented, in response to the prompt list, that she would always:

HV021   "ask about any illnesses. I always take the form with me,
         work through it and tell them exactly what I'm looking
         at. - Marital problems - em I tend to listen. I'm a bit
         out of my depth ... the role is more as a listener, a
         counsellor. - Health problems, yes I'm able to
         comfortably help them"

She went on to say that she would talk to the mother at each
visit to find out how she was getting on: "They do open up".
Whilst acknowledging that she could be 'out of her depth' with
some problems, she presents an image of confident structured
visits, based around a development check, but valuing the
establishment of an 'open' relationship and encouraging mothers
to talk about any problems they may have.

Mrs D - Stage Two

The stage two interview took place when Mrs D's baby was about
nine weeks old. Mr D was at home but made a drink and went into
another room before the interview started.

Mrs D said that the baby was thriving, though she had had nappy
rash. This had been "solved" by a relative who was a nurse. This,
in effect the first health problem experienced by the D family,

was dealt with not by the G.P. or the health visitor, whom Mrs D had expected to be her resources, but by a relative, albeit one with a nursing background. This may reflect the nature of the problem, which was not seen as serious, or the problems of access experienced by Mrs D. Since parents at this stage were mainly using professional advisers the latter appears more likely. Her relative provides easy access to a qualified 'professional' adviser.

Mrs D had experienced some problems with gaining access to the services she wanted to use. She had been attending the G.P. clinic "for weighing", but said:

PO22N   "I hate the set up. It drives me barmy. She (health
          visitor) weighs them. You can't talk about any problems
          because anybody could be walking in at any time"

The health visitor is present at the clinic, but is not accessible for Mrs D to discuss 'any problems' with. Mrs D went on to indicate that she was feeling depressed and:

PO22N   "just not getting on with X (husband) at all"

These are things which she would welcome the chance to discuss with the health visitor, but has not seen a suitable opportunity at the clinic.

In describing other contacts with the health visitor, Mrs D said:

PO22N   "She – doesn't seem to come visiting"

She went on to say that in the seven weeks since the midwife stopped coming she had seen the health visitor at home three times. She commented that to her this "seems really odd", as she had expected to see the health visitor more. Nevertheless, she indicated that the health visitor had "tried as much as she can". She seems in that statement to be legitimating the health visitor's limited visiting (as she sees it) by indicating that she had tried. Other parents on the whole did not think that opportunities for contact were inadequate at this stage.

Talking about her interactions with the health visitor, Mrs D said that her health visitor was:

PO22N   "Very approachable. It feels odd because she's only a
         couple of years older than me"

Approachability is important, particularly in the development of a relationship, but it cannot compensate for inaccessibility. Age is often seen as linked to experience, and it may therefore be that this mother perceives it as odd that someone of similar age to herself can have sufficient experience to advise or help her.

This suggests that the health visitor is being judged by lay criteria rather than in terms of her professional knowledge – which Mrs D does not mention, and may not be fully aware of.

Health visitor – Stage Two

At stage two the health visitor was interviewed about two weeks after Mrs D. She identified that the family situation was problematic:

PO23N   "Things have progressed for the worse..."

and went on to indicate that her own role with the family had been important:

PO23N   "I've had a lot of contact. I see her regularly. We're in touch with X..." [psychologist]

This idea of 'a lot of contact' must be compared with the lack of access felt to exist by Mrs D in the clinic situation, and her feelings about the number of visits done. 'We' are in touch (and later, 'we're' going ahead) might suggest some degree of mutuality in the decision making process – but it could also be used in a patronising manner, or as a 'royal' we. It might equally reflect the involvement of the Primary Health Care Team in decision making.

The health visitor went on to indicate that Mrs D's needs were not primarily in relation to child care, nor physical health –

PO23N   "She doesn't smoke, takes a good diet..."

but for someone to listen. She said that she had visited:

PO23N   "every week, sometimes twice a week, because she needed me a lot... she just wanted me to listen to her"

Mrs D's needs are not those which this health visitor described as amongst her priorities. They verge on the areas in which she said that she felt out of her depth. She seems to have been satisfied that she could help – 'she needed me a lot' – and has put time into this. Most mothers at this stage were focussing on practical difficulties, especially with feeding. Mrs D was faced with marital difficulties which altered her health needs.

However, a clear discrepancy in perception of the contact pattern between health visitor and Mrs D is visible, which cannot entirely be accounted for by the two week delay before the health visitor interview, nor by the general explanation that the mother did not know who her health visitor was, since in this case she clearly did. Though Mrs D was very specific in citing three visits, it is possible that she has underestimated and that the

health visitor overestimated in calculating their meetings from memory. The fact remains that their perceptions of the frequency of these encounters diverge widely. This did not happen with other mothers at this stage.

Mrs D - Stage Three

Mrs D was interviewed for the third time when the baby was about seven months old. The baby was described as "fighting fit". By this stage, the marital problems had improved somewhat, and other more practical problems had become significant - weaning (common to most at this stage), the development of babbling, and what games to play for example.

Describing resources she had used, Mrs D indicated that she had not seen the health visitor at home since the baby was about a month old. She had seen her a few times at the G.P. clinic, but had found the timing of this inconvenient. She felt that her health visitor could not really understand her home difficulties when she had not seen her at home for some time. Mrs D had attended a Health Authority clinic, and commented that when she had asked the health visitor there about a problem with weaning she:

PO23N   "was quite helpful - said I should stop worrying and try

         something else. It's easier now. Just the doctor

         undermined everything" (by suggesting that she was

         overfeeding her baby)

Access to services and understanding - even empathy - from health
professionals was important to Mrs D.   ·

Whereas at stage two Mrs D had felt that her health visitor was
'approachable', by stage three she said:

PO23N   "I don't really feel that I can relate to her very much

         at all ... she wouldn't be the first person I'd go to

         with a problem 'cos I never see her"

Lack of contact is here more strongly expressed, and linked to
lack of a relationship. Mrs D saw a relationship as crucial to
her use of the health visitor. Failure to achieve a relationship
means that the health visitor is less likely to be used.
Relationships were seen as important by the majority of parents
at this stage.

In considering the various specific topic areas (after Orr's
work, 1980), this emerged strongly. Mrs D had not mentioned her
various concerns - listed above - to the health visitor. She was
particularly anxious about the development of babbling because

there was a history of deafness in her family. Commenting on this, she said:

PO23N   "Both the G.P. and the health visitor are something completely remote. I only go because I feel obliged to go"

She has not mentioned her concerns because the two people she originally envisaged as her major advisers are both 'remote'. The idea of the health visitor as 'remote' highlights Mrs D's expectation that she would be close. She attends the clinic from a feeling of 'obligation'. Other mothers refer to professional expectations about clinic attendance. Equally it may be that the obligation is to conform to the peer group. Meanwhile, Mrs D's main source of advice and help has been her mother, by phone and letter.

Health visitor - Stage Three

In contrast, the health visitor, interviewed about two weeks later, said that she had achieved "a great rapport" with Mrs D. She described visits to the clinic as:

HV023N   "sometimes a bit difficult with confidentiality and that"

but said that once the room was empty Mrs D could confide in her. She said that things were going "absolutely marvellously well" for the family now. Describing her own role she said:

HV023N   "I felt for her I was more of a listening ear. She is very very open when you get close to her but it took a while. It took a few visits before she opened up ... for her emotionally I felt I was used. She cried for help really and we channelled that into..."

Listening - being receptive - emerges as important for this health visitor. She clearly values the achievement of a relationship but unlike Mrs D who feels that it has not come about, she feels that it has. Though listening is in essence a passive activity, and often carried out unobtrusively, people will often comment that someone is a good listener. That did not happen here. The health visitor did not appear to pick up fully the problems which Mrs D experienced in using the clinic, nor did she identify the particular concerns mentioned by Mrs D. Other health visitors and parents appeared to recognise more mutual problems.

Overall the health visitor felt that she had:

HV023N   "given her a lot of input, a lot of time. She came in to the clinic nearly every week - poured her heart out to me, and I feel happy now that she's working at it alone"

As at stage two, the discrepancy of these experiences of contact is so marked that it is difficult to identify the truth of the matter. The discrepancy is important whatever its origin, since though both parents and health visitors concerned value a good relationship, lack of contact raises a barrier between them which prevents an effective relationship being formed.

Summary

This case study focusses on relationship centred themes and demonstrates how similar perceptions held initially by parent and health visitor can nevertheless end in a mismatch. It indicates some of the factors which may contribute to this, in particular in relation to the type of problem encountered - social or physical for example - , the level and style of access, including the degree of confidentiality required, and the health visitor's own priorities.

Case study E

Case study E demonstrates how knowledge and experience are valued by parents in different situations and at different stages. It also illustrates how a mother gains in self confidence and becomes more able to cope with health problems on her own.

Mrs E was interviewed three times, with no-one else present. She was in her mid twenties, married and lived in a Non-Priority Area. She had recently moved to the U.K. Her occupation was classified as IV. Her health visitor was not interviewed.

Mrs E - Stage One

At the first interview, held when she was about 30 weeks pregnant, Mrs E defined health in terms of function. A healthy baby would be:

P171N   "growing nice and eating properly everything"

as well as active. She emphasised her own ignorance of babies and young children in general and their health in particular:

P171N   "I don't know very much about them - better to see the
         doctor or the hospital"

Alongside her own ignorance she mentions professional advice. She
would ask the doctor:

P171N   "Is something wrong with the baby?"

because he would know.

Initially however, she would consult her mother-in-law, with whom
she lived - not because of accessibility but because:

P171N   "I think she know more than me, she got children and
         she's got experience... If I see something wrong with my
         baby or his health not well, you can tell, or he's not
         eating properly or something like that. Then I just ask
         her what's wrong then, and she know more than me then she
         can tell me what to do"

This passage highlights three important ideas - Firstly, Mrs E's
perceived need for knowledge and experience in an adviser. At
this stage the fact that her mother-in-law had children and
therefore has experience is taken to mean that she knows about
child health and other issues. This is a common assumption by
parents at this stage. Secondly, the relationship between
knowledge (related to more significant problems) and experience

(valuable in most problems at an initial stage), is identified. A hierarchy, or order of precedence is implied, in which Mrs E will first approach the experienced mother-in-law, and then, if a problem is more serious, go to the knowledgeable doctor, or the hospital. Some other parents imply similar ideas, but these are not found explicitly until the third stage. Thirdly the extract highlights the need for direction which Mrs E identifies - someone to tell her what to do. Unusually, since most parents at stage one indicate that they want to remain independent, Mrs E appears particularly uncertain, saying that she wants a directive approach from her advisers.

Mrs E - Stage Two

The stage two interview was carried out with Mrs E when her baby was about eight weeks old. She felt that being a parent was a lot easier than she had thought. Whilst at first she had had very little rest, she said that she was now "getting used to it". From an initially low level of confidence in herself, Mrs E had now gained some confidence in her own ability to cope. Most mothers had had more confidence at first, and found that they had relatively less at stage two.

Though at stage one Mrs E had suggested that she would first of all approach her mother-in-law for advice, then the doctor or the

hospital, at stage two she said:

P172N   "First of all I go to my health visitor"

She went on to say that although in an emergency - "if suddenly
something up" - she might ask her mother-in-law first,

P172N   "What she say I don't believe ... she just use the guess,
         you know? "

Experience, valued at stage one, is relegated to guesswork at
stage two. Her experience is no less, but a framework of
knowledge is valued more than a mixture of intuition and
experience. Mrs E said that she would normally therefore cross
check with a professional adviser - health visitor, midwife or
doctor -

P172N   "They do this sort of thing ... they know more than her"

The professionals' knowledge is valued more highly. The existence
of the baby and experience of various advisers has enabled Mrs E
to put a different priority on advice from her mother-in-law.
This move towards professional advice at stage two is common to
most interviews.

In discussing how she would decide if her baby was in good
health, Mrs E described how the health visitor, when she had been

consulted, had helped her to gain confidence in herself and her own judgement:

P172N "One day she got cold and then I thought, oh, must be she's ill. She (health visitor) said when she's taking milk properly, having a properly feed, that means she's all right, you know. And if she not having good milk and you know she's not doing everything right, then that's - something up. If she's having a feed properly then everything all right."

The health visitor had explained what she needed to be concerned about, and in effect what was likely to be normal. As a result Mrs E felt more confident in deciding when to seek help.

The health visitor was reported to have visited Mrs E weekly until:

P172N "When first she think baby all right, no problem, if I manage, then I can go to clinic, see her there"

She said that she had been attending the clinic weekly, but at the point of the interview had cut down to fortnightly. She did not appear to feel that the service she had received had been inadequate in any way. However, this may relate to her comment 'if I manage': She may see her health visitor as only having withdrawn her frequent visits at the point where she (Mrs E) was

managing. This would reinforce Mrs E's self confidence and also engender a feeling that the service was responding to her needs. She still expressed considerable benefit from her fortnightly clinic visit:

P172N   "I always feel really better..."

The contact with professional advice is seen as reassuring.

Mrs E - Stage Three

The third stage interview with Mrs E was carried out when the baby was eight months old. It had been deferred for two weeks because mother and baby were ill with diarrhoea and vomiting on the appointed day. Mrs E 's choice of advisers had become more complex at this stage, but like many of the mothers, whilst turning more to lay advice, she retained a view of the health visitor as an authoritative source of help, particularly in relation to development.

She said that she now often sought advice from her mother-in-law:

P173N   "she has the children, she knows"

Despite her comments at stage two, experience now once again legitimates her mother-in-law as an adviser, for illness related problems at least. In addition, she is accessible, since she lives in the same house. As health visiting input decreases, this may be more important. Mrs E described such consultations with her mother-in-law saying:

P173N   "Bring her here and we'll have a look"

Use of the word 'we' (as in case study D) implies sharing - in learning about which symptoms are important and which are not. If her mother-in-law didn't know, Mrs E said that she might ask her "aunties who are nurse". She went on to indicate that they would probably refer her to the doctor "for some sort of medicine". This pattern of advice appears largely to relate to illness or health problems.

In relation to weaning and other developmental aspects of care, Mrs E described her ongoing reliance upon the health visitor. She said:

P173N   "Quite a few things I didn't ask my mother-in-law and I
         go and ask her (health visitor). Quite a few things like
         - she's growing, I don't know what sort of food I should
         feed her and give her. She (health visitor) tells me
         everything"

She reiterated the point she made at the second stage, slightly differently, commenting that it is a long time (about 24 years) since her mother-in-law had her children. Her mother-in-law's information in this sort of area is likely to be out of date.

This is a point made by other parents, who tend instead at this stage to turn to friends - a group which Mrs E does not mention using. She was using the clinic as her main point of access to the health visitor, and now felt that two weeks was sometimes too long between visits:

P173N   "In two weeks there's so many things you want to know"

This may reflect an increase in the type of problems with which she would consult the health visitor, or a loss of confidence in her own judgement, or both. It undoubtedly emphasises the importance of the health visitor as a resource, since mother-in-law, and indeed aunties are readily available but do not provide the relevant advice and help.

Summary

This case study shows how a parent values knowledge and experience differently, depending on her current situation.

Different types of knowledge may be seen as relevant to different types of problem. It also illustrates how a mother can gain in self confidence and become more able to cope with some health problems on her own.

Case Study F

The final case study develops some ideas relating to the ways in which help and advice are provided and the style of the health visitor - client interaction.

Mrs F was interviewed three times, with no-one else present. She lived in a Priority Area, and was on maternity leave from an occupation which was classified as falling into Registrar General's Class II. Her health visitor was also interviewed three times, approximately two weeks after each parent interview.

Mrs F - Stage One

The first interview took place when Mrs F was about 32 weeks pregnant. She was very quiet at the first interview, and generally expressed uncertainty about what would happen after the baby was born. She had no experience of looking after children or young babies, and said that she felt "unsure" about it. She identified immunisation as important in maintaining health, but went on to say :

P211P   "but I suppose it just depends whether the baby comes into contact with any illnesses anyway"

This appeared to fit with a 'health as non-illness' idea of health. In deciding if the baby were healthy, she felt that she would look at whether it was crying a lot,

P211P   "whether it seems happy, whether its restless, whether its taking food"

These include social/ emotional and functional indicators of health.

Mrs F had started attending an antenatal class. She knew that a midwife would visit her after the baby was born, and that a health visitor would take over. Many of the other members of her antenatal class had already met their health visitors, but she had not. She knew that there were child health clinics, but did not know where one might be. She commented that there was also one at her G.P.'s, because she had seen a poster about it. She was rather better informed than many mothers in the study at this stage, but still equally uncertain about the future.

Health visitor - Stage One

The health visitor was interviewed about two weeks after the interview with Mrs F. She defined a healthy child simply as an

HV211   "Active child who's not ill"

This broadly matched Mrs F's 'health as non-illness' concept. Her priorities for visiting, in general, since she had not then met Mrs F, were dependent upon:

HV211   "the mother's parenting abilities, how she's coping and
         if she needs plenty of support"

This indicated that skills in caring for the child were important - relating both to social/ emotional and functional aspects of future health. In discussing specific topics which she might cover with parents, the health visitor said:

HV211   I try and put it into their language so they can
         understand it"

She was interested in methods of communicating effectively and of enabling understanding. In saying that she 'put it into their language', the health visitor is indicating the distance that she perceives between the mothers and herself - whether that is good or bad.

Mrs F - Stage Two

The second interview with Mrs F took place when the baby was about nine weeks old. Mrs F said that she was finding being a parent:

P212P   "More chaotic than I thought it would be, and it takes a lot longer to achieve anything than I ever thought possible"

Nevertheless, Mrs F had had no major problems. She had asked the midwife about some initial problems with feeding, and had sorted that out. She had asked the health visitor:

P212P   "about one or two things. She had a little rash, we asked about that and we've asked the health visitor things like when she's been sick after feeds."

These problems appear somewhat illness oriented, which may reflect the way Mrs F views health visitors and other health professionals at this stage.

Apart from that, she had asked her mother, who lived locally, about some things, and had:

P212P   "compared notes with other people at the postnatal classes ... about how often they wake up for feeds in the night, and how much they sleep in the day. Just sort of

the general chaos of having a baby"

Comparing notes allows Mrs F to legitimate her 'chaos' and to do so in a mutual setting, where she is offering as much to her peers as they to her.

Health Visitor - Stage Two

The health visitor was interviewed for the second time three weeks after Mrs F. She identified that Mrs F had "done very well", and continued:

HV212   "I think she had quite a lot of information before she had the baby and she was well read and she's had quite a lot of family support as well"

The health visitor here seems to be emphasising Mrs F's knowledge base, when in practice her main concerns are firstly illnesses and 'minor ailments', (commonly cited at this stage) and secondly lack of knowledge about the norms of basic family life with a baby. The health visitor went on to say that she had given Mrs F five leaflets on various specific topics:

HV212   "because she always likes things to read through"

The health visitor sees information giving as her main function, despite feeling that Mrs F had quite a lot of information, and is doing it through a prepared medium - leaflets, rather than herself.

Mrs F - Stage Three

The stage three interview took place when the baby was about seven months old. Mrs F described the baby as "happy and content", and said she had had no 'real' problems with her. Asked about sources of help and advice she said:

P213P   "We've never needed to ask the doctor about anything, em, we've asked the health visitor about feeding because we've had one or two problems.. but apart from that really I've just compared notes with other mothers with babies at similar stages."

Other parents remain her preferred resource, as they are for most parents at this stage. She also mentions that some of the leaflets on development provided by the health visitor earlier were "quite useful".

Mrs F indicated that when the health visitor had been asked about a feeding problem, she had made various suggestions, but they

hadn't worked. She had seen her mainly at the clinic, along with another health visitor:

P213P   "When we were having problems with the feeding I don't think they were particularly helpful. They always seemed a little bit vague. And also originally when I asked about introducing solids to the baby, they weren't very helpful about that,.. I came away with the impression that really it was up to me and nobody was going to tell me"

Mrs F's main source of help at stage three is other parents, but she regrets the lack of direction given to her on weaning in the past. Her childminder eventually helped her to wean her baby. She does not appear to have developed a substantial relationship with the health visitor, perhaps because of the limited home contact. Instead she values the mutual exchange with other parents.

Health Visitor - Stage Three

The third interview took place about two weeks after the last interview with Mrs F. The health visitor said that the baby's development was normal. She went on to describe her last home visit, when the baby was three months old. She felt that it had been:

HV213   "Quite a good visit really... she always has questions"

She knew that Mrs F had been "quite concerned" about the baby's transition on to solids, and to using a cup, prior to Mrs F's return to work. They had discussed this in some detail. She felt that the visit had "gone well really". In the clinic situation, the health visitor felt that she had:

HV213   "a very good relationship with her. If she doesn't speak
          to me she speaks to the other health visitor who's here
          and she gets on well with everybody"

Perhaps because Mrs F always talked to her, and usually asked questions, the health visitor felt that she had a good relationship with her. In practice it seems that it was quite superficial.

Summary

In case study F, patterns of advice and help are explored and some ideas about patterns of effective interaction are developed, through discussion of use of leaflets, visiting patterns and style of approach.

Appendix Two

<u>Documentation for study</u>

Phase One Interview

I am doing some work at the Polytechnic, looking at what parents
feel about health visitors and childrens health. I wonder if
you'd mind answering a few questions for me about that?

Would you mind if I used this tape recorder instead of taking a
lot of notes? Do you want to try it out? No names or confidential
information will be known to anyone except me.

Q1   Is (child) in good health? (If not, why not?)

Q2   What do you mean by good health?

Q3   What sort of things do you think affect (his/her) health?
      Anything else?

                                                                    .

                                                                    .

Q4   How do you go about keeping them healthy? What sort of
     things do you think matter? Who do you generally ask for
     help or advice? Anyone else?

                                        .

Q5   Have you taken (child) to the hospital, G.P. or clinic
     doctor about anything in the past six months? (If yes)
     What was it for? (If you don't mind?)

     What happened - do you remember?

     How did you feel about the visit? Why?

Q6a   Have you taken him/her to the child health clinic in the last six months? (If not, when did you last go?)

What happened - do you remember?

Q6b   How did you feel about the visit? Why?

Q7   Can you tell me who your health visitor is? Yes/No

Have you seen your health visitor in the last six months?
(If not, when did you last see her?)
When was it, do you remember?

Where did you see her?

What happened, do you remember?

Q7 (Continued)

How did you feel about the visit/ meeting?

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Probe feelings re H.V. in general

Q8   Before you met any health visitors, you probably had some
      ideas about what they did. Would you say they do what you
      thought they did, or not?

Q8a   Can you tell me what you think health visitors do?
      (Anything else?)

Q9   What would you like to see health visitors doing?
       (Anything different to, or more than they do at the
       moment?)

Q10   How often would you like your health visitor to visit?
       Would you see her anywhere else? (e.g. child health
       clinic?)

Q11   How, if at all, do you think your health visitor can hekp
       with your child's health? How/ Why not?

Q12   (Hand Photograph) Can you tell me what you think this
        health visitor might be discussing?

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Q13   Could you look at the topics on these cards (HAND CARDS),
        and tell me whether you remember your health visitor
        talking about any of them? (SORT CARDS INTO YES AND NO
        PILES)

        The baby's physical health and development (e.g.
        illnesses, development, injections)
        The baby's social development and language (e.g. play and
        language)
        Problems affecting the whole family (e.g. redundancy)
        Elderly relatives (e.g. if they are ill)
        Problems of the mother at home (e.g. depression)
        Family planning
        Marital problems
        Health problems (e.g. dieting, cystitis, smoking)
        Social security

If so, for each, did you think she was helpful? Would you mind
telling me in what way/ why?

Q14   Do you think you would be able to advise on any of the
        others? Which? Why, do you think?

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Q15   Now just a few questions about you - you don't have to
        answer if you don't want to.

        How old are you?   .

        And how old is the baby's Dad?

        Is he in work?

        What is his job/ was his last job?

        Do you work?

        What is your job/ was your last job?

        Child   Male/Female

Is there anything you would like to ask me?

THANK YOU FOR YOUR HELP

Riverside Child Health Project

Atkinson Road Infant School
Atkinson Road
Newcastle upon Tyne

DIARY

It would be very helpful if you could make a note this week of your baby's health - how the baby was - and also if you could write down any contacts - up to four - you have had with health services (e.g. clinic, health visitor, G.P. etc.). Please make a note of what happened and how you felt about it.

I will collect the completed diary on   at

Thank you

Pauline Pearson (Mrs)

----
1. Please write down how the baby has been this week:

    .

----
2. Please fill in one of the sections below or over the page for each time you were in contact with health services this week:

a)Please tick which service you were in contact with

Clinic ___   Health Visitor ___   G.P. (Family doctor) ___

Hospital ___   Other (Please say) _____

Please say why (if you don't mind)

Please could you say what happened?

How did you feel about it?

b) Please tick which service you were in contact with

Clinic ___   Health Visitor ___   G.P. (Family doctor) ___

Hospital ___   Other (Please say) _____

Please say why (if you don't mind)

Please could you say what happened?

How did you feel about it?

c) Please tick which service you were in contact with

Clinic ___   Health Visitor ___   G.P. (Family doctor) ___

Hospital ___   Other (Please say) _____

Please say why (if you don't mind)

Please could you say what happened?

How did you feel about it?

d) Please tick which service you were in contact with

Clinic ___   Health Visitor ___   G.P. (Family doctor) ___

Hospital ___   Other (Please say) _____

Please say why (if you don't mind)

Please could you say what happened?

How did you feel about it?

d) Please tick which service you were in contact with

Clinic ___   Health Visitor ___   G.P. (Family doctor) ___

Hospital ___   Other (Please say) _____

Please say why (if you don't mind)

Please could you say what happened?

How did you feel about it?

Phase Two Interviews

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I am doing some work to look at what people feel about children's health services, in particular looking at people who are about to become parents, and following them through to see what they feel when they have children. I wonder if you would mind answering a few questions for me on that?

I will need to talk to you again a couple of times after the baby is born - is that alright?

I shall also be talking to some of the health professionals who work in this area, to find out their opinions.

Do you mind if I use a tape recorder? No names or confidential information will be known to anyone except me.

Q1(a) What do you think will be the most important factors in keeping your baby healthy? Why?

(b) Do you have any previous experience of looking after babies or young children (Yes/No). Do you think that that makes any difference to which factors you think are important?

Q2 How would you decide if your baby was in good health or not?

Q3 Who might you ask for help or advice about looking after your baby? (why? In what sort of circumstance?) Anyone else?

Q4   Could you tell me what health services for babies and children you know of?
(Probe) Any others? (Ask 5-7 for each)

Q5   Could you tell me about them? (Probe)/How did you hear of that?/ How will
you get in touch?/ What happens when you do?/How often are you likely to use
it/them?

Q6   What sort of things related to health do you think they/it will be able to
help you with, if anything?

Q7   What sort of things related to health do you think they/it might
      <u>not</u> be able to help you with, if anything?

Q8   Now just a few questions about you - you don't have to answer if you
      don't want to.

      How old are you?   _____

      And how old is the baby's dad?   _____

      Is he in work?   Yes/No

      What is his job/was his last job   _____

      Do you work?   Yes/No

      What is your job/was your last job _____

      Is there anything you would like to ask me?

THANK YOU FOR YOUR HELP. Can I arrange to come back and see you after your baby
is born?

Date given _____

As you may recall, I am doing some work to look at what people feel about children's health services, in particular looking at people who are about to become parents, and following them through to see what they feel when they have children. As well as talking to you today, I will need to see you again in about five months time - is that alright?

Do you mind if I use a tape recorder? No names of confidential information will be known to anyone except me.

Q1   What is your baby's name?
(Boy/girl)?

How do you find being a parent – is it easier or harder than you
thought? Or about the same?

Q2   Would you say X is in good health? (Yes/No) Why?

What would you say you mean by 'good health'? How do you decide?

Q3   What do you think are the most important factors in keeping X healthy? why?

Q4   Who do you, or might you, ask for help or advice about looking after X?
      (Why? In what sort of circumstance?) Anyone else?

Q5   Could you tell me what health services for babies and children you have
      used? (Probe) Any others? (Ask 6-8 for each)

Q6   Could you tell me about that (contact)?

      How did you get in touch?

      What happened (then)?

      How did you feel about that?

      How often are you likely to use it/then?

Q7   What sort of things (related to health) do you think it/they could help you with, if anything?

Q8   What sort of things (related to health) do you think it/they could <u>not</u> help you with, if anything?

Q9   Are there any other health services for children or babies which you know of? (Any others?)

Q10   Could you tell me about them/it?
        (Probe) How would you get in touch?

        What would happen when you do?

        How often would you be likely to use them/it?

        What sort of things related to health might they/it be able to help you with, if anything?

        What sort of things related to health might they/it <u>not</u> be able to help you with, if anything?

Alterations of circumstance: _____

_____

Is there anything you would like to ask me?

THANK YOU FOR YOUR HELP. Can I arrange to come back and see you when X is 7 months old?

Date given: _____

As you will probably remember, I am doing some work to look at what people feel about children's health services, in particular looking at people who are about to become parents, and following them through to see what they feel when they have children. Todays is the third interview - the last one.

Do you mind if I use a tape recorder? No names or confidential information will be known to anyone except me.

Q1   Would you say X is in good health? (Yes/No) why?

      What would you say you mean by good health? How do you decide?

Q2   What do you think are the most important factors in keeping X healthy?
      Why?

Q3   Who do you or might you ask for help or advice about looking after X?
      (Why? In what sort of circumstance?) Anyone else?

Q4   Could you tell me what health services for babies and children you have
     used? (Probe) Any others? (Ask 5 -   for each)

Q5   Could you tell me about that (contact)?

     How did you get in touch?

     What happened (then)?

     How did you feel about that?

     How often are you likely to use it/them?

Q6   What sort of things related to health do you think it/they could help you with, if anything?

Q7   What sort of things related to health do you think it/they could not help you with, if anything?

Q8   Are there any other health services for children or babies which you know of? (Any others?)

Q9   Could you tell me about them/it?

(Probe) How would you get in touch?

What would happen when you do?

How often would you be likely to use them/it?

What sort of things related to health might they/it be able to help you with, if anything?

Child health clinics? Health Visitors?

Q10   Health visitors are one of the main people involved with providing child health services.
When we first met you told me your ideas about what health visitors did. Could you tell me now, would you say they do what you thought they did, or not?

Q11   Can you tell me what you would like to see health visitors doing - anything different to, or more than they do now?

Q12   How often would you like your health visitor to visit? Would you see her anywhere else? (e.g. child health clinic)?

Q13   Could you look at the topics on these cards (HAND CARDS), and tell me whether you remember your health visitor talking about any of them?

(SORT CARDS INTO "YES" AND "NO" PILES)

The baby's physical health and development (e.g. illnesses, development, injections)

The baby's social development (i.e. play and language)

Problems affecting the whole family (e.g. redundancy)

Elderly relatives (e.g. if they are ill)

Problems of the mother at home (e.g. depression)

Family planning

Marital problems

Health problems (e.g. dieting, cystitis, smoking)

Social security

(If so) (For each) Did you think she was helpful? Would you mind telling me in what way?/why?

Q14   Do you think that she would be able to advise on any of the others?
       Which?   Why, do you think?

                                      - 118 -

       Alterations of circumstance _____

       _____

       Is there anything you would like to ask me?

       THANK YOU VERY MUCH FOR ALL YOUR HELP

I am doing some work to look at what people feel about children's health services, in particular looking at people who are about to become parents, and following them through to see what they feel when they have children. I also want to compare their perceptions with those of the people who provide the services, in particular, health visitors, because it may help me to understand their ideas more clearly. I wonder if you would mind answering a few questions for me about that?

I will need to talk to you again a couple of times to follow up any patterns that occur - will that be alright? Though all the parents involved have been told that I would also be talking to some of the health professionals working locally, I would prefer it if you would avoid telling them specifically that you are involved, unless they ask you directly. Is that O.K.?

(If Yes) Would you mind if I used this tape recorder instead of taking notes? Do you want to try it out? No confidential information will be known to anyone except me.

Q1   First of all could you describe to me in your own words what your
     job is? (What you, as a health visitor, do?)

     - 120 -

Q2   How often do you usually manage to visit people?

     Do you see them anywhere else?

Q3   In deciding on your priorities for visiting, what factors do you
      take into account?

                              -121-

Q4   (Hand photographs) Can you tell me what you think this health visitor
      might be discussing?   Anything else?

Q5   How many child health clinic sessions do you do?

      Are they G.P. or Health Authority sessions?

      Can you tell me what you usually do in your child health clinic
      session(s)? (Describe both if different)

      Anything else?

      How do you feel about the session?

      How do you think parents feel about using your clinic session?

      What proportion of people attending your clinic sessions would you say
      are with your practice?

      How do you feel about this? (Is it important or unimportant)?

Q6   What areas of work or ways of working would you like to spend more
      time on or to develop?

      Can you think of anything else

Q7   a) Among the people whom I shall be interviewing is   . I
          wonder if you could tell me if you know them?

                                                          Yes/No

      b) Could you tell me when you last saw them?

          Where was it?

          What happened?

          How did you feel about it?

      c) (if applicable) When did you last see them at home?

          What happened?

          How did you feel about it?

          (Repeat for each parent involved in the study)

Q8(a) Could you look at the topics on these cards (HAND CARDS) and tell me whether you have talked about them with clients.

(SORT CARDS INTO "YES" AND "NO" PILES)

The baby's physical health and development (e.g. illnesses, development, injections)

The baby's social development (i.e. play and language)

Problems affecting the whole family (e.g. redundancy)

Elderly relatives (e.g. if they are ill)

Problems of the mother at home (e.g. depression)

Family planning

Marital problems

Health problems (e.g. dieting, cystitis, smoking)

Social security

Q8(b) (If yes) Could you say how frequently you think you would discuss
    this (Often, fairly often, or not very often). Do you feel that you
    can be helpful about it?   Why/why not?

                                    -125-

A8(c) (If no) Can you say why you might not have discussed this with clients?

Now I'd like to ask you a few questions about health in general?

Q9   Could you tell me what you would define as good health?

in children under five?

Q10   What sort of things do you think affect health

in children under five?

Q11 How would you advise   parents of children
     under five, about keeping them healthy?

Q12 Finally just a few questions about you. You don't have to answer if
     you don't want to.
     Could you tell me what year you qualified as a health visitor?   ....

     What areas e.g. orthopaedics, neuro, paediatrics etc, have you worked
     in before coming to the community?

     Could you tell me which of these (HAND CARD) age groups you come in?

     under 25,   26 - 35,   36 - 45,   46 - 55,   over 55

Is there anything you would like to ask me?

THANK YOU VERY MUCH

As you may remember, I am doing some work to look at what people feel about children's health services, in particular looking at people who are about to become parents, and following them through to see what they feel when they have children. I also want to compare their perceptions with those of the people who provide the services, in particular, health visitors, because it may help me to understand their ideas more clearly.

I just want to follow up any further contacts you have had with   since I last spoke to you, is that OK?

I will need to talk to you again a couple of times to follow up any patterns that occur - will that be alright? Though all the parents involved have been told that I would also be talking to some of the health professionals working locally, I would prefer it if you would avoid telling them specifically that you are involved, unless they ask you directly. Is that OK?

(If yes) Would you mind if I used this tape recorder instead of taking notes? Do you want to try it out? No confidential information will be known to anyone except me.

Q1   Could you tell me in your own words how   has been doing since
      the last time we spoke (She was about 32 weeks pregnant then) ...

Q2   Could you tell me when you last saw them?

      Where was it?

      What happened?

      How did you feel about it?

Q3(a)   Could you look at the topics on these cards (HAND CARDS) and tell me whether you have talked about them with this client?

(SORT CARDS INTO "YES" AND "NO" PILES)

The baby's physical health and development (e.g. illnesses, development, injections)

The baby's social development (i.e. play and language)

Problems affecting the whole family (e.g. redundancy)

Elderly relatives (e.g. if they are ill)

Problems of the mother at home (e.g. depression)

Family planning

Marital problems

Health problems (e.g. dieting, cystitis, smoking)

Social security

Q3b   (If yes) Could you say how frequently you have discussed this
      (Often, fairly often, or not very often). Do you feel that you
      can be helpful about it?   Why/why not?

Q3c   (If no) Can you say why you might not have discussed this with this client?

Is there anything you would like to ask me?

THANK YOU VERY MUCH

As you may remember I am doing some work to look at what people feel about children's health services, in particular looking at people who are about to become parents, and following them through to see what they feel when they have children. I also want to compare their perceptions with those of the people who provide the services, in particular, health visitors, because it may help me to understand their ideas more clearly.

I just want to follow up any further contacts you have had with since I last spoke to you, is that OK?

(If yes) Would you mind if I used this tape recorder instead of taking notes? Do you want to try it out? No confidential information will be known to anyone except me.

INTERVIEW - HV3

Q1   Could you tell me in your own words how   has been doing since
      the last time we spoke (baby was about 2 months old then) ....

Q2   Could you tell me when you last saw them?

      Where was it?

      What happened?

      How did you feel about it?

Could you look at the topics on these cards (HAND CARDS) and tell me whether you have talked about them with this client?

(SORT CARDS INTO "YES" AND "NO" PILES)

The baby's physical health and development (e.g. illnesses, development, injections)

The baby's social development (i.e. play and language)

Problems affecting the whole family (e.g. redundancy)

Elderly relatives (e.g. if they are ill)

Problems of the mother at home (e.g. depression)

Family planning

Marital problems

Health problems (e.g. dieting, cystitis, smoking)

Social security

(If yes) Could you say how frequently you have discussed this (Often, fairly often, or not very often). Do you feel that you can be helpful about it? Why/why not?

(If no) Can you say why you might not have discussed this with this client?

Could you tell me if there have been any alterations in your job over the past six months?

(If so) What were they?

How do you feel about that? (Probe for more)

ou want to ask me any questions?

K YOU VERY MUCH

Figures and Tables

Figures

Tables

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